PREVENTION WITHIN A PASTORAL STRATEGY: ASSESSING THE ABC-MODEL

with reference to

THE HIV/AIDS PANDEMIC IN SWAZILAND

by

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DECLARATION OF RESEARCHER

I, the undersigned, hereby declare that the work in this thesis entitled Prevention within a pastoral strategy: Assessing the ABC-model with reference to the HIV/Aids pandemic in Swaziland is my own original work and that I have not previously, in its entirety or in past submitted it at any university for a degree.

Signature…….....

Date…….....

DECLARATION OF LANGUAGE EDITOR

Hereby I declare that I have language edited and proofread the thesis Prevention within a pastoral strategy: Assessing the ABC-model with reference to the HIV/Aids pandemic in Swaziland by Constance N Mamba for the Masters degree in Theology.

I am a freelance language practitioner after a career as editor-in-chief at a leading publishing house.

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ABSTRACT

This thesis critically analyses the appropriateness and effectiveness of the ABC model in the HIV/AIDS prevention within the context of Swaziland. According to Louw (2008:423), the ABC model stands for the following: A = Abstinence, B = Be faithful and C = use Condoms. According to Green and Herling (2007:1) the ABC model has gained the attention of many countries. The attempt of this model in HIV prevention was to "aim at empowering people through value-based programs to basically abstain from sex as long as possible, to be faithful to one intimate partner and to use condoms correctly and consistently" (De la Porte 2006:79).

The assessment of the HIV/AIDS virus in 1983-1984 came as a shock. It was difficult for the church to know at that time how to respond. Some of the responses pointed to the virus as punishment of God. Gradually the church started to become involved in the pandemic. From a Christian spirituality perspective it was argued that the so called ABC model could be viewed as a means of remedy within a prevention approach. The cultural issues as well as human sexuality factors have been discovered to be an obstacle in the ABC model in playing a progressive role in Swaziland.

The cultural factors that prevent the ABC model from accomplishing effective results are listed in the final report of (Whiteside *et al.* 2006: 18-19): *bunganwa* (having multiple sexual partners; a cultural practice of male married and unmarried to have many girlfriends); *kungenwa* (levirate or wife inheritance); a widow is given in marriage to marry the brother of her deceased husband without the consent of the women which exposes women to the HIV virus. This practice is done without the consent of the women. *Kujuma* (occasional overnight visits between unmarried lovers); *kuhlanta* (a young girl bearing the children of her infertile sister); *kushenda* (extramarital relationships); *kulamuta* (a man having a sexual relationship with a younger sister of his wife); and *sitsembu* (polygamy, one man with more than one wife); this is a common cultural practice found in many African countries due to gender inequality (Chitando 2009:26).

This has led to Swaziland being seriously affected by the HIV/AIDS virus (Rupiya 2006:66). The high rate of infection is frightening in a small country with a population of 1 million. As Bishop M, Mabuza, the Anglican bishop indicated, the nation‟s existence is threatened.

(Rosenow 2011: 32). Therefore the researcher proposed a pastoral model which gives dignity to human and adds the spiritual dimension of healing in the pastoral care and counselling. There is an urgent need for church leaders to be empowered to face the HIV/AIDS with knowledge that the pandemic is not a punishment for promiscuous people. The theology of sexuality emphasises the responsibility in every sexual engagement for people to be conscious to whatever decision they take.

OPSOMMING

In hierdie navorsing word die toepaslikheid en effektiwiteit van die ABC model in die voorkoming van MIV/Vigs binne die konteks van Swaziland krities ontleed. Volgens Louw (2008:423) staan ABC (in Engels) vir: A = Onthouding, B = Getrouheid aan een maat en C = Die gebruik van kondome.

Die navorser, 'n geordende predikant van die Evangeliese Lutherse Kerk, bespreek die erns van die voorkoms van die MIV/Vigs-infeksie in Swaziland. Empiries is bewys dat Swaziland een van die lande in Sub-Sahara en die wêreld is met die hoogste infeksiekoers (Rupiya 2006:66). Dit is ernstig in 'n klein landjie soos Swaziland met 'n bevolking van slegs 1 129 000. Die pandemie het 'n impak op alle gemeenskappe in die land en bied'n groot uitdaging vir die Kerk in Swaziland.

Die vraag is hoe die Kerk, in haar pastorale bediening, die ABC model kan gebruik om die globale poging te steun om te verhoed dat MIV/Vigs versprei. Hoe kan die konsep van die ABC model toegepas word sodat die Kerk, as hulpgewende gemeenskap, kan sorg vir die siele van die gemeentelede (*cura animarum*) en effektief inligting omtrent die ABC model kan versprei en uitreik na MIV-positiewe mense?

Die navorser stel voor dat daar verandering moet kom in die gesindheid van die Kerk en dat daar 'n herkonseptualisasie van die voorkomingstrategie en die Skrifverklaring van menslike seksualiteit moet wees. Die Kerke in Swaziland moet hulle houding verander. Daar moet baie meer openlikheid wees sodat sosio-kulturele kwessies openlik bespreek kan word. Daar moet 'n kritiese herbepaling wees van die tradisies en die kerkbeleid rondom menslike seksualiteit en hoe dit betrekking het op die MIV/Vigs-pandemie.

DEDICATION

I dedicate this work to my beloved husband, Jabulani, and beloved daughter, Silondiwe. I thank you for your relationship of cherishing love and encouraging words in times of despair and hopelessness.

ACKNOWLEDGEMENTS

It will be no overemphasis to note that this study would not have come to fruition without the wise guidance of, and encouragement from, my promoter, Professor D.J. Louw. His inestimable suggestions, invaluable practical theological insights, support, creativity and patience have been a delight and an inspiration to me.

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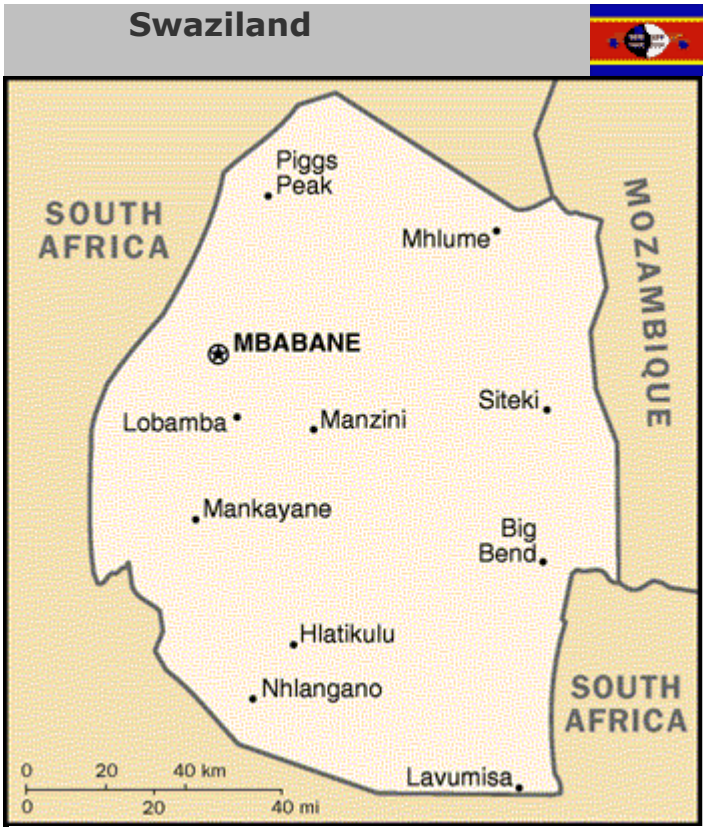
Finally, my sincere thanks to all friends who supported me with their tireless encouragement throughout my work.

ABBREVIATIONS

ABC	Abstain, Be faithful and condomise
AIDS	Acquired Immune-Deficiency Syndrome
CBCS	Community Based Care and Support
CBO	Community-based Organisation
CSC	Council of Swaziland Churches
DRC	Dutch Reformed Church
ELCSA-ED	Evangelical Church in Southern Africa Eastern Diocese
FBO	Faith-based organisation
HIV	Human Immunodeficiency Virus
MSM	Men having sex with men
NERCHA	National Emergency Response Council on HIV/AIDS
NGO	Non-governmental organisation
NSP	National Strategic Plan
OVC	Orphaned and Vulnerable Children
PACA NET	Pan African Christian AIDS Network
SCF	Swaziland Church Forum
SLAC	Swaziland League of African Churches
UNAIDS	Joint United Nations Program on HIV and AIDS
VCT	Voluntary Counselling and Testing

THE MAP OF SWAZILAND



Background: Autonomy for the Swazis of Southern Africa was guaranteed by the British in the late 19th century and independence was granted in 1968. Student and labour unrest during the 1990s pressured the monarchy (one of the oldest on the continent) to grudgingly allow political reform and greater democracy. **Swaziland recently surpassed Botswana as the country with the world's highest known rate of HIV/AIDS infection.**

Location:	Southern Africa, between Mozambique and South Africa
Geographic coordinates:	26 30 S, 31 30 E
Map references:	Africa
Area:	*total:* 17,363 sq km *land:* 17,203 sq km *water:* 160 sq km
Area – comparative:	Slightly smaller than New Jersey in the USA
Land boundaries:	Total: 535 km
Border countries:	Mozambique 105 km, South Africa 430 km.

Contents

Chapter 1:Introduction – research focus and outline

This research will critically analyse the appropriateness and effectiveness of the ABC model in HIV/AIDS prevention within the context of Swaziland. According to Louw (2008:423), the ABC model stands for the following:

A = Abstinence

B = Be faithful, and

C = Condomise.

According to Cohen and Tate (2003:1), Uganda was the first country in Southern Africa to respond to HIV/AIDS prevention. Successful results were observed between the late 1980s and mid-1990s after Uganda had applied the ABC model in HIV/AIDS prevention.

Chitando (2007:19) provides the following detailed explanation of the ABC prevention model: "Abstinence means an individual refrains from engaging in any sexual activity." Chitando opts for abstinence as an effective prevention strategy for couples/partners who are separated temporarily from one another due to various reasons. He further indicated that abstinence is not an easy option for young people who are sexually active and in need of sexual fulfilment.

Faithfulness means being faithful to one‟s sexual partner or spouse. Multiple sexual partners contribute to a high possibility of HIV/AIDS infection. Therefore, faithfulness decreases the possible high exposure to HIV/AIDS. This model requires a dedicated commitment of both collaborates that, in the absence of the partner, abstinence will be practised.

While realising the failure of abstinence and the application of being faithful in the spread of HIV/AIDS, the use of condoms was opted for as a prevention model. However, the effectiveness of condoms depends on their correct and consistent use, but this prevention strategy encounters some cultural and religious barriers (Chitando 2007:20). The next chapter will give detailed information.

The background to this study will reveal the gravity of the HIV/AIDS infection rate in Swaziland and complications that the ABC model has cause in people‟s lives. Whiteside and Sunter (2000:19) highlight the problem encountered in applying the model, that is, "Even if

people have the knowledge, they may not have the incentive or the power to change their behaviour." Economic, social and cultural factors determine the power to change behaviour.

The problem statement and the research question will be supplied to acquaint the reader with the contextual reality of the HIV/AIDS crisis in the country. Among the SADAC countries in the region, Swaziland, like Zimbabwe, is heavily affected by HIV/AIDS (Bala Nath 2001:68).

The pre-supposition will provide a provisional answer to the research problem and the research goal and motivation will be discussed.

The researcher‟s own observation, witnesses and engagement with people and communities that are infected and affected by the HIV/AIDS pandemic will be elaborated in the study‟s motivation.

Thereafter, the methodology used in this study will include the literature review. The last part of the research study will provide the definitions of concepts and a conclusion.

1.1 Background to the study

Swaziland is being rated as one of the countries in Sub-Saharan Africa, as well as in the world, that is the most seriously affected by HIV/AIDS (Rupiya 2006: 66). Other countries in the region that are also heavily affected by HIV/AIDS are Zimbabwe, Lesotho, Namibia, South Africa and Zambia (Dorkenoo *et al*. 2001: 8). The kingdom of Swaziland National HIV/AIDS Response (2009:5) confirms the overwhelmingly traumatic rate of HIV/AIDS infection in these five African countries namely; Lesotho, Botswana, South Africa, Zimbabwe and Swaziland. It is mentioned that these countries are leading with the highest rate of HIV/AIDS infection. The high rate of infection is frightening especially to a small country like Swaziland. National HIV/AIDS monitoring and evaluation annual report (2008:8) reveals that the HIV/AIDS prevalence was at 26% among people of 15-49 years. For that reason the USAIDS has classified the African countries as "hyper endemic countries". However, this raises a question of the effectiveness of the ABC model approach, emphasised in the South African context (De la Porte 2006:2). The HIV/AIDS pandemic is a catastrophe in Swaziland, as the infection rate continues to be on the

rise among the pregnant women in Swaziland. In 2004 the rate was 42, 6% and estimated to be at 45, 8% in 2006 (National HIV/AIDS and evaluation annual report 2008:8).

The impact of the HIV/AIDS pandemic is felt in all communities in the country. This poses a great challenge to faith-based organisations. An appropriate model of HIV/AIDS prevention has not been put in place for the church to put into action in playing a visible role, and foster an atmosphere of care and love to those affected and infected by HIV/AIDS virus. This indicates the seriousness of the impact of the HIV/AIDS pandemic in Swaziland.

Whiteside *et al.* (2006: 2) confirmed the crisis that Swaziland faces, when the overall infection in the country is still increasing. However Whiteside *et al* (2003: 6) indicated that the first case of HIV/AIDS in Swaziland was diagnosed in 1986, since then a rate of drastically growing figures of infection has been reported despite implementation of the global international norms of HIV/AIDS prevention (Whiteside *et al.* 2003: 6).

The growing burden of HIV/AIDS and the increasing number of AIDS deaths has been reported in Swaziland (Whiteside *et al.* 2006:2). The added burden is poverty, 48% of people are living below the food poverty line (Zungu *et al*. 2004:12). This information leads us to question the effectiveness of the ABC model in HIV/AIDS prevention. The high rate of infection in Swaziland poses a challenge to the effectiveness of the ABC model, where a significant number of Swazi"s are employed as migrant labour in South Africa, which reflects separation of families due to work engagement. This migration within and outside Swaziland exposes people to HIV/AIDS infection, "being separated from family increases the risk of HIV infection, as those left behind, as well as those who have migrated, are more likely to seek other sexual partners, who may be infected with HIV" (Zungu *et al.* 2004:13).

The infection rate rises despite the widespread promoting of the use of male condoms as part of the prevention of HIV. Since the beginning of the national HIV response in the country, the promotion of condoms has become more widespread in the general population, with the advent of AIDS as they have been identified as one of the most effective methods of protection from HIV infection" (National HIV and AIDS Response Annual Report 2009: 20).

That derives from the strategic plan which was produced in the year 2000 in the country, the goal of the strategic plan was to "reduce the incidence of HIV/AIDS in Swaziland and mitigate

the impact on the infected and affected individuals, families and communities" (Zungu et al 2004:31). However, this has not prevented the drastic figures of infection as the country is still counted among the high prevalence with infection rate (Chin 2007:69).

The impact of HIV/AIDS infection has caused all sectors in the country, the NGO"s, government working on HIV/AIDS prevention to respond and support the prevention programs. Seemingly no impressive results have been observed, as figures indicate an increasing rate of infection.

Church Forum, a faith based organisation coordinating HIV/AIDS programs in all churches in Swaziland indicated in the National HIV and AIDS Response Annual Report (2009: 48) that prevention intervention of HIV/AIDS will be strengthened through the involvement of religious leaders. From my participatory experience not all faith based organisations have been motivated to integrate the current model of HIV/AIDS prevention programs in their churches. Hence, Church Forum is motivating all faith-based organisations to have HIV/AIDS prevention programs, but presently very few churches are running HIV/AIDS programs.

1.2 The problem statement

It has been highlighted in the background of the study that Swaziland is one of the countries rated among the highest in the world as regards HIV/AIDS infection. This raises a concern and a challenge of seeking a solution to lower the high rate of HIV/AIDS infection. This has led a meeting of religious leaders in Swaziland to discuss about finding a solution in bridging the gap between knowledge and practice of preventing the major perpetuators of HIV/AIDS (Rosenow 2010:12). This resulted from seeing churches in Swaziland not playing a leading role in prevention strategy due to the obstacles of inadequate knowledge on the subject of HIV/AIDS, inappropriate attitudes towards HIV/AIDS and insufficient skills to provide care and support services needed by the communities (Rosenow 2010:88). The lack of knowledge from the church of not knowing how to respond to HIV/AIDS issues compels one to assume that, "Churches at grass roots have not yet yielded the fruits of motivating other churches to meet and share information on HIV/AIDS and establish partnerships within the country and with other organisations on HIV/AIDS prevention. They have an attitude on HIV/AIDS issues which leads them to be silenced, in denial and pointing a finger in blame" (Messenger 2005:8). Within a

prevention strategy, the ABC model seems to be not appropriate when applied within the cultural setting of Swaziland. Some of the obstacles seem to be the factors that the model does not address like the unequal status of women, cultural norms of multiple casual sex, sexual coercion and exploitation of young girls, cultural practices that promote inequality between women and men and practice (Rosenow 2010:4).

1.3 Research questions

In line with the above problem, the researcher intends to answer the following research questions:

- What is the root cause of the high infection rate in Swaziland, despite the wide spread of the information on prevention programs of the ABC model in HIV/AIDS prevention?
- What causes the faith-based organisations‟ reluctance to play a leading role in applying the ABC model for HIV/AIDS prevention? Church leaders do not invest sufficiently in prevention; often they do not act as role models (Mngadi 2009:56).
- Does the ABC model address the problem of human sexuality appropriately within the Swaziland cultural context?
- With reference to a holistic approach to human sexuality in pastoral care and counselling, what are the limitations of the slogan “Condomising” in the ABC model when applied to the notion of human sexuality?

1.4 Presupposition

If faith based communities should acknowledge that the pandemic of HIV/AIDS has strongly struck Swaziland, and denote their commitment in prevention strategy involvement the high rate of HIV/AIDS pandemic will be reduced. Personalising the crisis of HIV/AIDS will promote human dignity, and quality care when the church stop saying HIV/AIDS is out there, but not in here (Gunnar 2009:11).

The fact that we are a compassionate church gives confidence that the churches can manage to respond positively to the pandemic as Gunnar says "For the church is the body of Christ- and if one member suffers, we all suffer with them (1 Corinthians 12:26). In this regard if church leaders in Swaziland can reassess their mission of being a prophetic church, they will seek and tackle the root cause of HIV/AIDS, without inflicting pain, and stop proclaiming that HIV/AIDS is a divine punishment" (Gunnar 2009:27), but rather break the silence and engage people into open discussion on issues of sex and sexuality.

In addition, the churches have the moral ground and authority to address the strong cultural practices that act as an impediment to the reduction of the HIV/AIDS infection rate in the country.

This thesis maintains that the church can advocate for a prevention strategy for the pastoral ministry of an intimacy space of sexuality which will bring change within Swaziland‟s cultural setting and human behaviour (Louw 2008:363), instead of focusing on the ABC model when people deny the existence of HIV/AIDS "everyone knows he has got HIV/AIDS, and he is saying, „No no I do not have HIV, I just have TB" (Oppenheimer & Bayer 2007:90).

In this regard, church leaders and denominations in Swaziland should critically reassess their policy on human sexuality and its connectedness to the HIV/AIDS pandemic. The challenge to the church is to come up with a positive and appropriate understanding of human sexuality, its connectedness to an integrative spirituality, and the role of human sexuality within the development of human dignity and maturity.

1.5 Research goals

This research will critically analyse the appropriateness of the ABC model within the cultural setting of Swaziland. It is mentioned that the country has a number of potentially high risk traditions and practices of multiple sexual partners, changing sexual partners, having sex at social gatherings like the reed dance (*umhlanga*), a cultural traditional ceremony for young girls, gender inequality and female subordination (Ndlangamandla 2008: XX1).

The research will assess the theological value of the ABC model and how it deals with the notion of human dignity and a constructive understanding of human sexuality. The ABC model is often connected to prejudice; it is only meant for promiscuous people, sex workers and gays (Louw 2008:368). HIV/AIDS affect the body of Christ; if one member suffers we are all affected.

The research goal is to encourage churches to take a leading role in using the Scriptures in a sound hermeneutical way. A theology regarding human sexuality should guide and inform an appropriate hermeneutic. This study will challenge the church‟s theology in terms of the relevance of its teachings during the time of this HIV/AIDS pandemic and the application of a pastoral model which will create a space and place for intimacy and affirm human dignity and identity.

1.6 Motivation for the study

The fact that Swaziland has not reduced the HIV infection rate since 1986 motivates the study to seek the contributing factors that hinder the intervention of the ABC model in HIV/AIDS prevention which include safer sex campaign, and condom promotion (Ellison et al 2003:72). The impact of HIV/AIDS has had a devastating effect on the life and ministry of the church, as highlighted in the research background, as well as on the social and economic life of people in the church and Swazi society. The research done in the army in Swaziland revealed that about 99% of the interviewed people were aware of using a condom in HIV/AIDS prevention, but only 54% were recorded as practicing safe sex by way of putting on a condom in the sexual act despite the numerous intervention programs of HIV/AIDS going on in the country (Rupiya (2006:77).

Birdsall and Kelly (2007:167) reveal that a number of people have already died because of HIV infection; “One community member lamented that there is an increasing number of funerals and these are largely for young people. The elderly are left to care for children as the parents pass on.” A community member of Motshane (a small rural area 15 km north of Mbabane, the capital of Swaziland, situated close to the border gate to South Africa) raised this concern. The huge

impact of HIV/AIDS has resulted in a high mortality rate leaving communities suffering. HIV/AIDS tests done at antenatal clinics indicate figures of women who tested HIV/AIDS positive have grown by 38, 6% between 1992 and 2002 (Rupiya 2006:67).

In Swaziland, women between 25 and 29 years of age are the most vulnerable, with a recorded mortality rate of 49%, compared to men between 35 and 45, for whom the rate is 45%.[1] The ILO/AIDS report (Beckmann 2005:12) reveals that 73% of businesses in Swaziland have an employee living with HIV/AIDS. The escalating figures are reflected in the high numbers of elderly people caring for their orphaned grandchildren. Because many people have become victims of the HIV pandemic, the impact of HIV/AIDS is felt in many households and communities in the country. The high rates of infection and death in Swaziland have resulted in significantly reducing production in many companies due to the high rate of people infected and affected by the HIV/AIDS pandemic.

In his speech, Mswati the King of Swaziland, on 19 February 1999 declared that the overwhelming figures and terrifying situation of the HIV/AIDS infection rate in the country was a national disaster (Kathy *et al.* 2009:2). He therefore called for a multi-sectoral and multidisciplinary approach to mitigate the impact of HIV/AIDS infection among the people in the country.[2] As a result of King Mswati‟s declaration, the international community and NGOs responded with programs of action towards reducing the high infection rate. However the means done have not reaped good results, as Rosenow (2010:87) pointed out that multiple partnerships is one of the factors facilitating the spread of HIV/AIDS in Swaziland and the other countries in African.

Programs offering various HIV/AIDS prevention services were started, such as voluntary counselling (VCT), condom promotion, and access to information, education and communication. Subsequently, in the country, numerous preventative activities have been and are now found in many places, programs, including behavioural change, that mainly focus on adults and the youth (Swaziland Country Report 2008:25). In spite of His Majesty King

[1] Figures indicate that women are the most vulnerable to HIV/AIDS (Swaziland Country Report January 2008:15).

[2] The seriousness of the high infection rate was marked in the king‟s speech (Swaziland HIV/AIDS crises management (2000:7).

Mswati‟s concern expressed in his speech, the attempt to reduce the HIV/AIDS infection rate in Swaziland as described above has seemingly not produced substantive results (Swaziland Strategic Plan 2000:7).

In light of this background, it becomes imperative that a study of this nature be carried out to discover the contributing factor that raises the rate of HIV/AIDS infection in a small country like Swaziland. The impact of HIV/AIDS has led to a significant reduction in agricultural production. About 70% of Swaziland‟s population live in rural areas, supported by subsistence farming on Swazi National Land. Making a living has become difficult in this era of the epidemic.[3] Swaziland is faced with the challenge of 43% of households that are headed by children or grandparents.[4] Child-headed households have become so common in Swazi society that the desperate society has run out of options due to the increase in the number of orphaned children.[5] According to Iliffe (2006:120) USAID estimated orphans to be 35 million in Africa by 2010 and Swaziland‟s orphaned children by then would make 10% of the entire Swazi population, many of them would be without parents and grandparents.

These abnormal family frameworks have resulted in an increase of young people engaged in sexual practices before the age of 15 years, as highlighted in the National HIV/AIDS Response Annual Report (2009:16). It has become imperative to give young people the skills of protecting themselves from HIV/AIDS infection as urged by the Organization for African Union (OAU) summit of 1994 (Bond *et al.* 1997: 28). In the Swaziland Demographic Health Survey among young people between the ages of 15 and 25 years, it was found that many young people who engage in sexual practices at an early age may cause a high contribution to HIV/AIDS infection (Swaziland Country Report 2008:35).

The country‟s experience of a high rate of death caused by HIV/AIDS infection has resulted in a tremendous drop in life expectancy in the early 1990s – from 57 years to 39 years in 2007[6] and

[3] Poverty is also a contributing factor to the pandemic of HIV/AIDS (Swaziland Socio-Economic Impact of HIV/AIDS 2006:1).

[4] HIV/AIDS has resulted in children living alone, or with grandparents (Whiteside & Naysmith 1993:4).

[5] People in Swaziland are familiar with child-headed households (Whiteside & Naysmith 1990:5).

[6] Life expectancy has dropped as a result of HIV (Swaziland Regional Department South 2008:10).

in Botswana life expectancy has dropped to 36 years (Ellison *et al*. 2003: 3). The impact of life expectancy is not only the problem of the African continent but it is felt beyond Africa, like in Guyana the probability of becoming HIV-positive between 15 years and 50 years is 19% (Ellison 2003:3-4). From the (National HIV and AIDS Response 2009: 21) life expectancy in Swaziland has fallen from 57 years to 37 years mainly because of AIDS. Approximately 81, 4% of elderly women currently care for their grandchildren and, when they die, the children are left without anybody to care for them.[7] The HIV/AIDS crisis has posed many challenges to the government, faith-based organisations and communities. There are still many misconceptions regarding HIV transmission in Sub-Saharan Africa. As Jackson (2002:4) indicates, people are posing a number of questions:

- How? People want to know how one becomes infected with the HIV/AIDS virus.
- Where? People want to know the origin of the HIV/AIDS pandemic.
- Why? People think that HIV/AIDS is related to God"s punishment for sexual promiscuity. Others blame biological warfare experiments that released the virus into the world, either deliberately or accidentally.

In some communities, people are still in denial regarding the modes of HIV/AIDS transmission. They deny the facts on how the virus is contracted. They also think the cause of death is "human-related or human-made". Louw (2008:180) states: "Many traditional African communities still believe that illness or sickness never occurs in isolation: They are convinced that a human agent is always the cause of sickness. A traditional African does not think of germs (internal organisms) as the sole cause of an illness."

People in Zimbabwe indicated that when death occurs "there is always somebody responsible" (cf. Berglund 1989:104). In persistence sicknesses people are not suspecting of being infected by HIV/AIDS but rather think of being witched as stated in (Iliffe 2006:23), "in the next six months, diarrhea appears on-and-off. There is gradual weight loss and the patient is pale. Most patients at this point in time will rely on traditional healers, as the disease for many is attributed to witchcraft." It is a common concept that when therapeutic needs arise in a family or society,

[7] Elderly women in Swaziland are acting as parents to grandchildren (Whiteside *et al.* 2006:56).

help is searched from the prophets and divine healer‟s society (Louw 2008:169). This proves how difficult African countries find it to accept the realities of the HIV/AIDS pandemic without attaching it to their own worldview of understanding, the causes of sickness and death in human life. The ABC model in HIV/AIDS prevention faces a challenge because the awareness programs are not bearing positive fruits of reducing the high infection rate. It is hoped that the research will contribute towards suggesting the pastoral strategy model of understanding human sexuality and cultural norms of people before addressing the issue of HIV/AIDS prevention. The HIV/AIDS infection rate in Swaziland remains a problem.

Feldman (2008:187) expresses concern about countries that have not changed their cultural practices that contribute to HIV/AIDS infection. Culture always changes, and it is the people who change it. Making the correct personal choices to survive HIV/AIDS induce important changes in African cultures. The essence of the culture can be preserved when people live healthier lives and are not affected by the pandemic. The culture of practicing polygamy they take as a normal way of life, not a contributing factor for HIV/ AIDS infection.[8]

The author of this study maintains that the pastoral approach can assist by encouraging people to live purposefully and meaningfully without fear of death, but face death with hope. People continuously suffer the scourge of existential issues and the researcher would like to help people to find answers to the questions raised by the HIV/AIDS epidemic.

The history of the church in helping communities has inspired the researcher. It motivated her to think of ways in which the church can help the people of Swaziland in their present crisis of the HIV/AIDS pandemic. Some churches are still reluctant to teach the people about HIV/AIDS but insist that the answer to HIV/AIDS is acceptance of Christ who will empower the believer to abstain and live a holy life.

Therefore**,** Bate (2003:48) affirms that churches need to overcome their fear of facing the realities of HIV/AIDS in our continent and rather shift their position to acknowledge the presence of the pandemic and its threat to human life. The recently established Church body for HIV/AIDS prevention, the Swaziland Church Forum, is a body capable of playing a momentous

[8] The Swazi culture has not changed even in this era of HIV/AIDS (Whiteside A et al 2006:18).

role in addressing the local widespread HIV epidemic. They are strong because the church is respected in Swaziland. The Church Forum also helps to train pastors and laypersons in the importance of a holistic approach to human beings. After all, the church has been doing so for a decade. The church has constructed schools, hospitals, and clinics that are of great assistance to communities, even today. Against this background, a study of this nature will be conducted to find the reasons that hinder information to rural settlements in Swaziland. As a result church leaders, elders and church members are not empowered to address the cultural influences in Swaziland, and find the correct use of language in addressing HIV/AIDS prevention issues.

The researcher has observed that people in Swaziland are aware of the gravity of the pandemic. The hopelessness of the situation is noted from the frequent funerals conducted almost every weekend in many communities, a result of which, many households here have felt the scourge of HIV/AIDS. As a pastoral caregiver to bring healing and comfort during loss, the researcher‟s personal experience is that most of her time in the parish during this era of the epidemic is spent on visiting the sick at their homes, in hospitals and also bereaved families.

1.7 Methodology

A literature study, several publications and documents will be studied and critically assessed. Documents and publications will be used within a reference system in order to link the argumentation to existing data and available knowledge.

In a qualitative study, due to the fact that the ABC model is applied within the cultural setting of Swaziland, different concepts playing a role in the understanding of the pandemic will be scrutinised. Their meaning will be assessed against the specific paradigm functioning within the Swaziland setting and language. Being a hermeneutic study, the researcher will focus on the interpretation and meaning of texts within the relational dynamics of local contexts. It will try to link data to the notion of Christian spirituality. In this attempt the researcher wants to apply existing theological knowledge regarding the pastoral anthropology of human sexuality and Christian spirituality healing to the pandemic and the applicability of the ABC model.

Regarding participatory observation, the researcher is aware of the fact that coming from Swaziland, and ministering in the congregation of the Lutheran church, Hlatikulu parish will play a decisive role in the assessment of data.

1.8 Research outline

Chapter One: Research outline

This chapter will explain why it is necessary to do this research in Swaziland. The background of this study, the problem statement, the research questions, pre-supposition, research goals, motivation of the study and methodology will be included and followed by the structure of the chapter and conclusion.

This chapter gives an overview of the impact of HIV/AIDS in Swaziland and the role that the church, government and the NGOs play in the fight against HIV/AIDS. At present, Swaziland has a high mortality rate and a life expectancy of only 40 years (Kalipeli *et al.* 2004:3).

Chapter Two: Swaziland's cultural setting and its impact on HIV/AIDS prevention strategies

This chapter will discuss the cultural practices that contribute to HIV/AIDS infection in Swaziland.

Chapter Three: The ABC model: Theory formation and paradigmatic background

The historical background of the ABC model in HIV/AIDS prevention will be given in this chapter, and detailed information about the first country that adopted this model will be highlighted. It will discuss the failures and successes of the ABC model in HIV/AIDS prevention and conclude by evaluating the ABC model in the HIV/AIDS pandemic.

Chapter Four: The role of religious leaders in HIV/AIDS prevention, the non-governmental organisations and the Swaziland government

Chapter Four will describe various responsibilities of the religious leaders, non-governmental organisations, and the Swaziland government in response to the ABC model in the HIV/AIDS prevention strategy.

Chapter Five: Towards a pastoral approach: Human sexuality within a prevention strategy

This chapter will discuss the controversy of human sexuality which has become a difficult subject to discuss, especially for the church. This chapter also gives the definition of human sexuality and the biblical understanding of human sexuality based on both the Old and New Testament. The current challenges will be discussed as cultural norms surround the subject.

Chapter Six: Conclusion and recommendations

The conclusion and recommendations are included in this chapter. The researcher came up with recommendations and a hypothesis based on faith-based organisations, assuming that when the church takes a leading role in the HIV/AIDS prevention strategy, impressive results can be observed and the high rate of infection will be reduced.

Chapter 2: Swaziland's cultural setting and its impact on HIV/AIDS prevention strategies

2.0 Introduction

The impact of HIV/AIDS has greatly challenged and affected the Sub-Saharan region, as (Haddad 2011:110) mentioned that the continent of Africa is the mostly affected by the HIV/AIDS pandemic than any other region. Unfortunately looking at the state Swaziland presently is in, it shows that the people in Swaziland have not been motivated to change the cultural practice especially that contributes to HIV/AIDS. The chapter will give a description of those cultural practices that contribute to the HIV/AIDS pandemic. This chapter will discuss the cultural practices in Swaziland that have become an obstacle to a positive response to HIV/AIDS prevention strategies. The detailed names and descriptions of these cultural practices that contribute to the high rate of HIV/AIDS infection in Swaziland will be given. The chapter‟s ultimate aim is to identify cultural practices that are a contributing factor to HIV/AIDS prevention strategies and hinder the application of the ABC global model in HIV/AIDS prevention. The chapter will conclude by giving the strength and weakness of the Swazi culture.

2.1 Cultural practices of the Swazi people

The HIV/AIDS pandemic has had a devastating effect on the people of Swaziland, where cultural traditions and customs are found to be a contributing factor to the high prevalence rate of HIV. This poses a great challenge to the leaders of the country, communities of faith and health organisations in Swaziland. Therefore, the practice of cultural traditions calls for an intelligent mind to select and abandon those cultural practices that perpetuate the high rate of infection among Swaziland‟s people. Culture may be defined as "the collective programming of the mind which distinguishes members of one category of people from another" (Akande 2009:83). Green and Herling (2007:43) define the culture of polygamy as common practice among the African people, and the statement is supported by Buseh (2004:362-363) when giving evidence that young girls in most African countries start to initiate sexual intercourse before the ages of 13 years. Therefore, "Culture is polygamous, that Africans have numerous partners or that Africans

start to engage in sex at an early age." He further defines culture as a programming of the mind which becomes the memory of beliefs, attitudes, norms, roles, and values that have been in practice in the past, and which are passed on from generation to generation. The predicament of the HIV/AIDS pandemic has not changed the perception and paradigm thinking of the Swazi people and their society. In this era of HIV/AIDS, polygamous traditions are still being practised by many people in Swaziland.

The common practice in this tradition is that it allows males to have multiple partners before they choose one to marry, despite the evidence that polygamy and multiple partnerships are the core contributing factors to the spread of HIV/AIDS infection (Pan African Christian AIDS Network April 2010:7). Researchers indicate that Swaziland is among the countries that are seriously affected by HIV/AIDS (Rosenow 2010:7). As a result many people have died due to HIV/AIDS.

In spite of all the dissemination of HIV information, Swaziland is one of the African countries where people still believe in and adhere to their strong cultural practices of polygamy. However, Whiteside *et al.* (2006:18) indicate that polygamy in Swaziland is a cultural norm; it is accepted simply because it protects men from engaging in casual sex. This culture is implemented without consideration of its impact to the HIV/AIDS prevention strategy.

Presently Swaziland is rated among the highest with infection rate as mentioned in the problem statement. It is unfortunate that in the country even at this time there are no record showing some development programs in fostering change from polygamy practices of polygamy. A prominent person in the country continues to practise polygamy. The King of Swaziland is a practical example as he is counted among those people with many wives as Whiteside (2008:44) mentioned that polygamy is acceptable in Swaziland. In Daly (2001:24) it is mentioned that "Males in Swaziland are allowed to marry many wives as long as they can sustain them economically."

In reality family maintenance in the country has become difficult due to unemployment and drought (Whiteside *et al.* 2006:21). Even though the practice of polygamy has not changed, as a participatory observer, the alarming figures of HIV/AIDS infection have not challenged the mindset of people in the country to transform the cultural practices of polygamy in Swaziland.

Traditionalists do not believe that the culture of polygamy presents a threat to the HIV/AIDS infection. Even the slogan of "Stick to one partner" is not adopted in Swaziland (Whiteside 2008:44). By not accepting that culture is a contributing factor to HIV/AIDS infection, the Swazi society continuously denies the contributing culture factor in HIV/AIDS, instead they blame witchcraft as the cause of the disease, not the polygamous practice that curtails the prevention of HIV/AIDS (Bond *et al.* 1997:104). The African traditional culture has become an enormous challenge as illness is attributed to supernatural powers and evil spirits (Rohleder *et al.* 2010:18). Swaziland is a patriarchal country, men dominate the system; and that disempowers women, restricting them from taking decisive decisions and having equal rights.

Cultural practices force women to depend on men in making choices of marriages, the Swazi Custom which permits a man to marry many wives as he pleases and whereas in civil rite marriage does not allow polygamy. Women cannot advocate for themselves, even when they are aware of the husband‟s behaviour. They choose not to challenge their husbands as they believe they are maintaining peace (Rosenow April 2010:33). At present, the strong cultural practice of polygamy has contributed to the high numbers of orphaned children who have lost either one or both parents as a result of HIV/AIDS infection (Daly 2001:24). This is the result of Swaziland‟s cultural norms whereby women do not have the same privileges as men in making choices about their sexuality. Hence, the strong culture of silence allows men to detect (Rohleder *et al.* 2010:18). The women‟s status in society makes it difficult for them to protect themselves from HIV/AIDS infection, as the culture forces women to be tolerant towards men who engage in extra-marital affairs (Rosenow April 2010:33).

In Sub-Sahara Africa gender imbalances is high, that limit power for women and girls to resist pressure of protecting themselves from unsafe sex (4th global report 2004: 94). Therefore, in the polygamous tradition, men control women and their spouses often inhibit the use of family planning, which makes it difficult for them to protect themselves from HIV/AIDS infection (Buseh 2004:355-367).

The culture forces a woman to be submissive even when the man‟s behaviour is not acceptable. Women have been on the receiving end by becoming infected by HIV/AIDS due to the fact that men have not respected human life and dignity, but have lived irresponsibly (Chitando 2007:184). The economic power has even forced a number of young women to tolerate such

cultural practices due to their total dependence on their husbands, thus, men feel that women are their property to control (Swaziland HIV/AIDS Prevention Response 2009:42). The challenge of such cultural practices in the Swazi society is most unfortunate because leaders in "Swaziland have often been unwilling to admit openly that such a crisis exists" (Daly 2001:23). The cultural practices continuously neglect the reality and the seriousness of the HIV/AIDS prevention strategies among the people in Swaziland. Poku (2006:11) indicates that, in the next decade, Swaziland is expected to lose about 32% of their employees under the three named ministries: that of Finance, of Economic Planning and Development, and that of Public Services and Information.

Seemingly, the challenge posed by such cultural traditions in Swaziland calls for a mindset that selects the cultural practices that fully support and alleviate the infection rate of HIV/AIDS among communities. In his speech in 2001 at the United National General Assembly, King Mswati highlighted three crucial themes about HIV/AIDS policies: 1) the magnitude of the disease, 2) the inequalities that surround the HIV pandemic, and 3) the formal and informal institutions in shaping the AIDS policies (Patterson 2006:1). His speech was in solidarity with the suffering people, without addressing the cultural issues that hinder the model for the prevention of HIV/AIDS.

The norms and cultural practices in Swaziland have made it very difficult for women to protect themselves from HIV/AIDS and utilise the suggested model of prevention to reduce the HIV/AIDS infection rate. The inadequacy of available human resources in all communities of the country is currently observed. There are no systems in place that provide information that builds the courage and status of women in communities and empowers them to reduce the rate of the HIV/AIDS infection. The culture has created constraints to the prevention programs of HIV/AIDS.

Secondly, in Swaziland, there is a strong cultural belief that a woman‟s role is to bear children; the preferable choice is a boy. When woman is not giving birth to a boy child that results in a stressful situation for the woman in a big family (Rosenow April 2010:33). Unprotected sex is practised in this situation and some cases have contributed to the dilemma that the country is facing with its high infection rate. Thirdly, the Swazi culture considers children as offspring (Nhlapo 1992:51), especial boys and girls grow up with low self-esteem as the culture

encourages putting them at a lower status. The Swazi society cannot contemplate their Swazi culture without adhering to their cultural practices, even when it interferes with the norms of living in this challenging period of the HIV/AIDS pandemic.

Women are socialised for their principal duty as procreators and, in turn, they please the men who will take good care of them (Jele 2004:30). Their culture disempowers women and young girls in terms of sex and sexuality. Other contributing factors that affect women in this regard are their lack of education, economic power and legal rights (Terry 2006:25). Even though the culture undermines women and children, the Swazi people still consider their culture as a treasure from which they do not wish to dissociate. Unfortunately, in the country, because of loyalty to their culture, women have little autonomy to negotiate with their spouses on issues such as protecting themselves from HIV infection. Swaziland‟s cultural practices have turned into being oppressive to women, and liberal to men, as the latter have the freedom of recourse to multiple marriages and sexual partners (Daly 2001:25).

Women‟s economic dependence forces them to tolerate their husbands‟/boyfriends‟ sexual demands. They are afraid to ask their men to use a condom as the culture does not permit such practices. The other fear is of the bodily harm that the men can afflict as they may become suspicious when a woman suggests the use of a condom (Daly 2001:25).

The cultural dispositions place women and girls at a greater risk of constructing HIV/AIDS in Swaziland. For the effectiveness of the ABC model both females and males are to take responsibility towards prevention of HIV/AIDS so that no one carries the blame of being a perpetuator of the pandemic. Behavioural change should not be suppressed by gender inequality, men and women need to take responsibility by viewing individuality from the perspective of being an image of God: “the highest measure of self-realisation and congruency of the human personality” (Louw 1998:248).

In *The Times of Swaziland,* 16th February 2010, it was revealed that 70% of males in Swaziland were not in permanent relationships, where approximately 23% of men were in permanent relationships**.** The state of HIV/AIDS had reached an alarming stage; this was confirmed by the Prime Minister of Swaziland, Dr Sibusiso Banabas Dlamini, indicating that the situation of HIV/AIDS pandemic in the country had moved from an emergency into chronic management

mode. Some of the contributing factors to the high infection rate in Swaziland are the culture practices, as it will be mentioned in the next paragraphs.

- ***Bunganwa*** (male with multiple female partners): Both married and unmarried men practise this culture. It is part of the Swazi culture for a man to have as many girlfriends as he wishes, and this happens with the knowledge of the females. When unmarried men decide to marry, they choose one among the number of their girlfriends. Although married, the Swazi culture permits men to continue to propose love to other young girls for marriage purposes, or just for pleasure. Such a practice is done publicly, even the women sharing the men.

Poku (2006:73) supports the above-mentioned statement: "In most African societies, many people either do not, or cannot, limit their sexual activities to a single, infection free lifetime partner." Hence cultural practices of polygamy and multiple partners continue to be a challenge in the HIV/AIDS pandemic era.

- ***Kungenwa*** (levirate, or inheritance of a deceased brother‟s wife): The practice of wife inheritance continues as part of the strong Swazi culture of keeping the wife in the same family clan by way of preventing her from marrying elsewhere after the death of her husband. This cultural practice is done without negotiation with the widow. The family clan (in-laws) decides on behalf of the widow who from the family should marry her. Traditionally, women are not supposed to object to whatever the *labandzala* (elders in the family) have decided. Chief Madelezi Masilela admitted that he was infected with HIV/AIDS through the practice of widow inheritance (*kungenwa*) when he married his deceased brother‟s wife. From the above explanation, it is clear that this culture increases women‟s vulnerability to HIV/AIDS infection as women are raped by their spouses and strangers as they cannot defend against such a practice (Phiri 2003:15).

- ***Kujuma*** (occasional short-term or overnight visits between unmarried male and female lovers): The Swazi culture promotes these occasional short-term visits of unmarried lovers, as they believe that they need to engage in moments of sexual acts before they can take a decision whether to marry or not (they are lovers‟ experimental

sexual intercourse periods). This cultural practice is highly promoted among young men who prepare for marriage, especially those who want to marry through customary law.

- ***Kuhlanta*** (a young sister bearing the children of her infertile sister‟s husband): In the case of an infertile married woman, her young sister is allowed to marry the husband as a second wife, with the intention of bearing children on behalf of her sister. This culture is also performed in consultation with the two families involved. The young girl‟s joining her sister or aunt in marriage is openly discussed. According to the Swazi custom, this practice does not constitute adultery – it is acceptable in (Daly 2001:25).

  In addition, in consultation with the sister or aunt of the young girl, an agreement is made for her to join the family. Thus, the two families agree. The issue of HIV is never taken into consideration, yet figures show that the HIV prevalence rose from 18% in 1994 and reached a peak of 39,4% in 2002 between the ages of 15 and 24 years (Nercha Annual Report 2009:6).

- ***Kushenda*** (having extramarital relationships): The culture permits men to have as many girlfriends as they wish. In Swaziland, the mindset of people has not changed despite this crisis of a high infection rate of HIV/AIDS. We still find both males and females engaged in extramarital relationships. A publication of the World Council of Churches reveals that the perpetuators of this cultural practice of having extramarital relationships cause poverty and gender inequality. HIV/AIDS has impoverished some households due to the death of their income-earning adults. As a result about 70% of people in rural areas of Swaziland are in poverty below $1 per day (Rosenow April 2010: 32).

- ***Kulamuta*** (having a sexual relationship with the younger sisters of one‟s wife): This culture is commonly practised among rural communities. Older men misuse the girls by providing financial support, which can be interpreted as robbing the dignity of these young people by capitalising on older men‟s immediate needs.

  The high rate of HIV infection among the young people of 15 to 49 years is rated between 15-49%, as confirmed by Nercha Annual Report (2009:5). For that reason, the HIV/AIDS estimated figures in the epidemiological fact sheet of 27 July 2007 reveal that

the HIV infection rate in Swaziland seems to be on the increase. The prevalence rate of HIV is very high in Swaziland compared to other neighbouring countries, such as Botswana, South Africa and Mozambique.

- ***Sitsembu*** (polygamy): Here a man is married to more than one wife and those marriages are officially authorised in Swaziland and are called *sitsembu* (Swazi Law and Customs), despite, during this HIV/AIDS pandemic, it being clear that this culture contributes towards the high infection, as Whiteside[9] mentions. This Swazi custom promotes multiple sexual partners. Studies have shown that polygamy increases and contributes to the high risk of HIV/AIDS infection and creates an opportunity for being infected by other sexually transmitted diseases (STDs) but Swazi people do not view their culture as a contributing factor towards HIV/AIDS infection (Whiteside 2006:44).

  The system of polygamy in the Swazi culture brings about a serious implication for the increase of the HIV/AIDS pandemic. Poku (2006:73) says that polygamous associations create opportunities for entire families to become victims of the disease. As indicated, "Some thirty-fifty percent of married women in Africa are currently in polygamous marriages" (Hope 2001 in Poku 2006:73). Such polygamous practices demonstrate the challenges that the ABC model faces in conjunction with the cultural factors, in reducing the infection rate of HIV/AIDS.

In the light of this evidence, multiple sexual partners have been identified as one of the contributing factors towards HIV/AIDS infection, which has resulted in the rapid spread of HIV/AIDS and its high prevalence in the country.[10] The above-mentioned cultural practices promote male dominance, as has been mentioned earlier. Therefore, in support of the above statement, Green and Herling (2007:13) indicate that unfaithful men"s spouses or partners find themselves being infected by their men even if these women were practising abstinence and fidelity. In view of the practices of culture in Swaziland, the structures in place must be challenged, i.e. the traditional gender roles, and power relations within sexual relations in

[9] Polygamy that contributes to HIV/AIDS is not a taboo in the context of Swaziland (Whiteside Swazi Economic Report 2006:23).

[10] Multiple partners contribute to the high rate of HIV infection (Swaziland Country Strategy Paper 2009-2013:10).

Swaziland‟s communities. Findings reveal that the spread of HIV/AIDS among females is high compared to males, as cultural practices have contributed towards the disempowerment of women.

Hence there is a need to empower women who have been demeaned by cultural practices that have caused much suffering and have led to many deaths, especially among women and children. For example, women in Swaziland lack the power to negotiate for safe sex with their partners and some young people become infected even before they are married.[11] Young women in Tanzania fear that their boyfriends would regard them as prostitutes if they insist upon the use of condoms. Another study conducted in Kenya has revealed that a man‟s non-cooperation by refusing to use condoms consistently exposes women to high infection (Gibney 1999:51).

It has been said that a woman feels happier when she receives the man‟s sperm when he ejaculates into her. Thus, when a condom is used, they do not experience this happiness (Pope 2009:129). During a similar study conducted in Brazil, it was discovered that women were aware of the prevention model of using condoms, but that knowledge did not help as male partners were not supportive in condom use. Therefore, that led to the use of condoms being the last resort, as men are very much concerned about their sperms being destroyed in the condom. Secondly, due to the lack of the economic power the fail to negotiate condom use with males (Ellison et al 2003: 151). The culture in Swaziland oppressed women. Presently it does not seem practical for the Swazi people to change their cultural lifestyle, as polygamy continues to be allowed, despite the current HIV/AIDS pandemic. Louw (2008:417-418) supports this statement, “Despite the effect of modern life on tribal customs, polygamy and concubinage are still tacitly accepted as normal cultural practices among Africans.” According to Haddad (2011:60), the change of cultural domain will only take place when individual “members do or omit to do, whereby the beliefs and practices of the religion shape the societal understanding.”

The challenge towards changing cultural practices has not been successful in Swaziland, in spite of information dissemination on HIV/AIDS prevention programs that provide evidence that cultural factors obstruct prevention strategies. Secret lovers continue to be a common practice in

[11] The lack of bargaining power among women in Swaziland contributes to the HIV/AIDS infection rate (Beckman 2005:4).

Swaziland, while ignoring the fact that many sexual partners may contribute to high rates of HIV/AIDS infection (Iliffe 2006:45). Teenagers and women were at high risk of contracting HIV as routes for truck drivers that pass through Swaziland and Mozambique became more concentrated. This proves that knowledge should move towards action for more impressive results to be observed (Whiteside 2008:46). Another problem that the country faces is the misconception of the overestimation of condoms‟ effectiveness, which prevents people from using them for HIV/AIDS prevention (Green and Herling 2007:42). Secondly, people believe that the use of a condom promotes promiscuous behaviour, thus denying its cultural contribution to HIV/AIDS infection (Bate Omi 2003:38, and highlighted in the National HIV/AIDS Response Annual Report 2009:16). The fact that HIV/AIDS was identified in the USA early in 1980, creates a debate among the people in Swaziland to believe that a number of people who died earlier before identification of HIV was due to the HIV/AIDS infection (A pastoral letter from the Bishops of the Church 2008:9).

2.2 The strength of cultural practices of Swaziland's people

From the above-listed cultural tradition in Swaziland, it is acknowledged that cultural practices play a critical role in the high rate of infection and in the HIV/AIDS pandemic‟s prevention model. However, it is noted that some Swazi cultural practices have a positive impact on the people within the HIV/AIDS pandemic, as the culture promotes developmental life-support systems of relationships in community care (Taylor & Francis 2009:7). In times of illness, the extended family, together with community institutions, offers care and support. This caring spirit is extended to others who experience bereavement, widowhood, children being orphaned, poverty and other related needs. After the death of one or both parents as a result of HIV/AIDS, vulnerable children experience the unconditional love which they receive from relatives and others in their community. The Swazi culture is embedded within a network of caring. However, the caring spirit is found more among friends and family, as the family is perceived to be closest to the infected individual. But, this practice seems to be vanishing slowly due to the high death rate that wipes out the elderly people who have been foremost in introducing such practices to the younger generation.

A new cultural practice has been adopted as a way of reducing the rate of HIV infection. Males are being encouraged to be circumcised. Circumcision has never been part of the Swazi culture – it is only now that males are urged to have this done. Previously, individual choice resulted in circumcision. No pressure encouraged it. Parents are even motivated to circumcise their newborn babies in order to prevent the increase of HIV/AIDS infection (National HIV/AIDS Response Annual Report 2009:52). Since circumcision is performed in hospitals, it is safer for people to have it done there. Circumcision seems to be proving to be a safer mode in respect of reducing the transmission of HIV/AIDS, although it poses a challenge to the Swazi traditionalists, as some do not believe in medical doctors, but prefer traditional healers.

This poses a challenge to the medical communities, as they need to educate people about a safe and healthy way of performing circumcisions. Even though this has been encouraged, a number of people in Swaziland have not regarded circumcision seriously as a way of preventing the spread of HIV/AIDS. However, the researcher‟s personal observation is that young people have started to take this awareness of circumcision very seriously and some parents now encourage their young sons to be circumcised.

Swaziland is a country with strong developmental life-support systems with strong bonds of relationships. Communal life is emphasised and passed on to the next generation. This becomes an advantage during the times of need; especially during illness when people are affected and infected with HIV/AIDS, the support system is always there to give moral support and to care for patients or affected families. Even in the case of death in a family, the remaining relatives provide moral and spiritual support to the affected and take care of the orphans. As Nercha‟s report reveals, by 2008 Swaziland had 130 000 orphans and vulnerable children (OVC, which put the number of orphans in the country at 31%). The spirit of *ubuntu* has not lost its identity among the people of Swaziland – they care for one another, impart hope for the future even within the HIV pandemic, where the country is rated among the highest in the world with HIV/AIDS infection. Even the extended family has an excellent role in ensuring the stability of a family that strengthens the family life (De la Porte 2006:52-53).

However, the caring community in Swaziland occurs in diverse forms, as family members usually offer care to one another and adopt the role of the shepherd metaphor, which shows the

caring love of Christ for his people. Such a system is regarded "as family that provides a space for intimacy and a place for education and growth" (Louw 2005:61).

As a participatory observer it is the conviction of the researcher that the people of Swaziland have compassion with all humankind. Culture plays an important role in being present, which helps people to realise that they are not alone, but in a relationship with their family even in suffering, through which they encounter God"s presence. The narrative below illustrates how other families encounter God"s faithfulness in times of need. Caring for the affected and infected with HIV/AIDS is a common practice in Swaziland. The young heroes www.youngheroes.org.sz in the annual report of Whiteside and Naysmith (1990:41) report on how other families offer help to needy people in their community and show God"s care to the vulnerable.

A life story:

"The Dlamini family of Nkwene cares for 11 children in their homestead, two of whom have lost both parents. The two double orphans taken in are with Gogo and Mkhulu (grandmother and grandfather). Therefore, it is very important that there is some income to help feed these extra mouths. This family now receives a sponsorship through Young Heroes to assist the family to pay for food and clothing and lessens the burden of the double orphans living in their homestead."

(Source: Young Heroes 2007): www.youngheroes.org.sz

The above inset indicates the role of caring shown by some families in solidarity with the needy, while showing love to vulnerable children, in Swaziland. It has become common tradition for orphans to be left under the care of relatives or good Samaritans – people who have the spirit of caring and loving, as God"s images. The problem of orphans that Swaziland encounters is felt in almost all the regions of Africa. As a result, women in Uganda and other African countries have adopted a culture of developing various resources that create income, which they control. They produce reed mats, basketry and bark cloth accessories (Pope 2009:468). They do this out of concern for the HIV/AIDS crisis that affects all age groups of the society. From what has been

mentioned in the above report, it raises the concern that the crisis of HIV/AIDS is not a problem only for the Swazi nation, but rather a worry for the whole continent.

2.3 Weaknesses of the cultural practices of Swaziland's people

The modified change in the Swazi society has forced the community‟s network to shrink due to the child-headed families. The inequality between women and men promotes discrimination among them. Therefore, communal life is needed to break the wall of division and isolation that leads to suffering and loss of one‟s identity. Studies have indicated that women and children are serious victims of suffering, "Children may be more vulnerable because their mothers have lower literacy and are young. In all but a few countries, more than two-thirds of children have mothers who do not currently work for cash, but when they do they put more time into income generating work than men because their wages are lower" (Hunter 2000:111).

The Swazi culture limits the role of women in decision-making, norms, and values, and their worth is not considered much (Mcetywa 2001:38). This puts them at a high risk of HIV/AIDS infection and exposes them to poverty, as they lack the power of self-sufficiency. It is unfortunate that the culture oppresses women, which causes them to become silent about all sorts of abuse inflicted on them. According to the culture, men take a dominant role, leaving women with no opportunities to voice their opinions even on sexual issues. The AmaMpondo communities freely talk about sex and the Christian AmaMpondo women also oppose the cultural values that govern African society; the "general health of the whole community is the responsibility of every member of the society" (Mcetywa 2001:38). "Men are allowed to have multiple sexual partners. Polygamy, which exposes women to HIV infection, is legal in the African countries and is seen as a sign of true masculinity (Rosenow 2011: 57).

The Swazi culture oppresses women from both Christian and non-Christian communities, when women find it difficult to negotiate a condom use in HIV/AIDS prevention. There is still a strong desire to preserve the culture in the Swazi society. This is so even though there is a need to change the cultural influences, behaviour, and attitude towards the HIV/AIDS pandemic. Women need to be the focus point for HIV/AIDS programs of prevention, so that culture cannot abuse their human dignity. As culture assigns them a minor role where all decisions are made on their

behalf, they have no opportunity for objection. According to the culture, women are regarded as powerless to defend themselves against injustices. Hence, cultural practices have contributed much to the high rate of infection in the country, which is rated among the highest in Sub-Saharan Africa, as indicated earlier. However, this poses a challenge for the need to change society‟s traditions and calls for the people‟s willingness and flexibility towards cultural change. Negative consequences of the culture, such as polygamy, have been preserved without serious consideration of their influence on the success of the ABC model for the prevention of HIV/AIDS (Swaziland Human Development Report 2007:6). The culture has disempowered women by putting them at a risk of not negotiating condom use even when the men‟s bad behaviour is known of having multiple concurrent partners (Rosenow April 2010:35. Such behaviour impacts the ABC model in HIV/AIDS. According to Haddad 2011:67), the application of the HIV/AIDS prevention strategy has been opposed by traditional leaders.

2.4 Conclusion

This chapter has provided the names and explanations of cultural practices that contribute to the high rate of HIV infection and hinder the implementation of the ABC model. Upon examination of the impact of culture, it was discovered that the Swazi people have not been motivated to put plans in place to work towards practices for cultural change, especially those that contribute to the high rate of HIV/AIDS. The strengths and weaknesses of the culture have been discussed, in which the culture was found to be powerful in respect of support care systems for orphaned children who had lost one or both parents. The weakness of the culture entails that women are regarded as minors, making them powerless to defend themselves during this crucial time of the HIV/AIDS pandemic. Therefore, the third chapter will describe the paradigmatic background of the ABC model in the HIV/AIDS prevention strategy, the failure and successes of the model, and will conclude the chapter by evaluating the ABC model as an HIV prevention strategy.

Chapter 3:The ABC model: A paradigmatic background

3.0 Introduction

This chapter describes the historical background of the ABC model for an HIV/AIDS prevention strategy. Reasons as to why the model was adopted and considered suitable for use in the prevention strategy will be discussed. While examining the context of Swaziland and considering the fact that the ABC model was not originally designed for HIV/AIDS prevention, the researcher will highlight the successes and failures of the model based on the study‟s context. The gathered information will not only provide a framework of the situation in Swaziland, but will also reflect on how other countries have managed to utilise the ABC model to reduce the high rate of HIV infection. This chapter will conclude by evaluating the ABC model.

3.1 Historical background of the ABC model

The ABC model has been used for hundreds of years in the United States of America for pregnancy prevention (Gibney 1999:50). When the predicament of HIV/AIDS came, the "Condom use was advocated as a potential prevention tools", some stakeholders suggested that the condoms which was used as a prevention method of pregnancy can also be useful in the prevention of HIV/AIDS infection.

In Africa, Uganda adopted the ABC prevention model in 1990. This took place after success stories that the model has drastically reduced their infection rate (Pope *et al.* 2009:246). Although Uganda could not name it the ABC prevention model, this country instead emphasised prevention based on A = Abstinence, standing for abstinence from, or delaying sex, and B = Be faithful. "The condom option was for those who could not practice abstinence or be faithful in monogamy or polygamy" (Green & Herling 2007:5). In Uganda, they discovered that the effectiveness of condom-use was depending on an individual‟s preparedness to make a "correct decision about every issue in their sexual and reproductive health lives" (Green & Herling 2007:43). The leadership of the country, President Museveni, supported the prevention program as early as 1986. The President talked "openly and frankly about AIDS as he insisted that AIDS

be put on the political agenda at all levels, and set up the National AIDS Prevention and Control Committee" (Barnett & Whiteside 2008:345).

The global model of the ABC discourse creates tension among the people, as it challenges cultural practices that are sensitive to making changes as people believe that culture is part of their being, and (Haddad 2011:79) points out that "Christian churches adopted a very ambivalent attitude, with bishops divided or silent" while people on the ground discreetly promoting their use." The ABC model faces many challenges that create obstacles for implementation.

For an appropriate implementation of the ABC model in HIV/AIDS prevention Haddad (2011:79) suggests that "people need to be informed about the efficacy of correct condom use and about their church position on abstinence and fidelity." In applying the ABC strategy, we need to understand the worldview of the people from a cultural perspective. As in our African culture the message of condom use becomes very difficult for us to induce due to gender issues impact upon the sexual behaviours. Considering the women‟s self-esteem, violence they go through, coercion and limited choices they have.

It is very problematic in trying to promote abstinence in this social environment. If you tell people to abstain they say, "You were the people telling us to use condoms, and now you are telling us to abstain. Does this mean condoms were not effective and you were lying to us?" in (Higgins & Norton 2010:157). These are the challenges of the ABC model when trying to motivate people to integrate it as one of the HIV/AIDS prevention models. However, Uganda‟s good results were observed, but still the condom has never received the first preference as there is no one formula for applying the ABC model in HIV/AIDS prevention. The setting and socioeconomic environment need to be considered, norms and values and also sexual behaviour in order to better from the scourge of HIV/AIDS instead of being instructed to wear condoms while engaging in sexual intercourse (Higgins & Norton 2010:158).

In the continent of Africa, the success of the ABC model is hampered by denial, ignorance and misinformation. In Swaziland, studies reveal that people in the country are highly knowledgeable about the ABC model in the HIV/AIDS pandemic but, unfortunately, that knowledge has not been translated into the desired sexual behavioural change (Whiteside *et al*. 2003:14). However, this challenge requires major action of educating the country‟s leaders, government officials, and

church leaders, especially on the use of condoms, as that has been a major obstacle among faith-based organisations. The ABC model poses a challenge as the messages from this prevention strategy lies on the intelligent individual who can decide for themselves what to do in considering the people‟s cultural, social, economic and epidemiological context (Haddad 2011:322). Individual choice will play a crucial role in making an informed decision which will protect life.

Communities need to be prepared by creating new or revitalised social norms which will increase the understanding and assess risk behaviour as a better way of HIV/AIDS prevention. In Swaziland, it has been observed that about 50% of young people, post school-age, do not use condoms (Swaziland Human Development Report 2007:60). The research reveals that the prevention strategy of the ABC model in HIV/AIDS prevention has not control the high infection as Swaziland with Botswana, Mozambique, Lesotho and South Africa are projected to experience negative population growth as adult lifespan is severely reduced(Omwami 2008: 53).[12] In fact, it shows that the epidemic has continued to increase in Swaziland. Here, this has resulted in life expectancy to be 37 years, which has dropped by half between 1990 and 2007 (Mngadi 2007:16). Whereas, in South Africa, the life expectancy has decreased from 62 years in 1990 to 47 years in 2007, and it is projected to drop even more to 40 years by 2010 (Pope *et al.* 2009:257). Regarding the fact that the first diagnoses of the HIV/AIDS pandemic in the United States of America was in 1981, whereas in South Africa it was in 1982, the ABC model of prevention has not yielded impressive results (Iliffe 2006:43).

The discovery of HIV in the United States of America (USA) resulted in the ABC model strategy to be opted as a means in preventing the spread of HIV/AIDS pandemic while no cure had been discovered.[13] Therefore, this calls for the reinforcing efforts to know when appropriate to apply the ABC‟s messages in eliminating the high rate of infection in our communities. Presently HIV/AIDS is the greatest disease that the whole world faces. According to UNAIDS, 42 million people worldwide have the virus that causes AIDS, and close to 70% of the global total of HIV-

[12] The lifespan in adult has been severely reduced (Omwami 2008: 53).

[13] Van Dyk‟s (2008:4) research revealed that HIV/AIDS is a problem of concern for the whole world.

positive people in Sub-Saharan Africa have already died from the epidemic, and Swaziland is one of the countries which is highly affected (Kalipeni *et al.* 2004:47).

The discovery of the HIV/AIDS pandemic has posed a great challenge to the people in Swaziland, and to the global community, to seek a solution that will overcome the pandemic. In a study conducted in Swaziland, the results revealed that abstinence and faithfulness are not realistic, as women are cannot negotiate safe sex in fear of mistrust by their husband, abandonment or withdrawal of financial support by the spouse. (Rosenow April 2010: 36). Therefore in the context of polygamous and strong cultural traditions in Swaziland, the implementation of the ABC model in HIV causes problems for the model to produce impressive results, because women are having difficulties to negotiate the condom use (Rosenow April 2010:35). It has been revealed from the human development report in PACANet that a woman in Swaziland was assaulted by a lover for negotiating the use of a condom during sexual encounter (2010:35). This shows the difficulties women experience in protecting themselves from HIV/AIDS infection.

People‟s misconceptions about the HIV/AIDS prevention strategy have resulted in them not taking serious safety measures on HIV/AIDS prevention by means of protecting themselves from infection as they believe that HIV/AIDS was a gay disease, it was a white man‟s disease and heterosexual women and men were believed to be safe and children safe because only adults were infected with HIV/AIDS (Amod 2000:21). As a result, many women have been infected with HIV/AIDS by their unfaithful husbands or partners.

According to Green and Herling (2007:44), the number of Africans who had multiple partners in previous years was 23% among men and 3% among women. This proves that the HIV model has not been taken seriously as a prevention strategy. Green and Herling further elaborate that consistent condom-usage in Africa is estimated to be 5%. This creates a question as how realistic does people in the country engaged themselves in the prevention strategy of HIV/AIDS prevention, as cultural norms and women‟s inequality dominate the Swazi society.

This crisis came at a time when Swaziland was classified as a lower-middle-income country; with 69% of the population who lived below the poverty line as indicate by Rosenow April 2010: 32). The ABC prevention model of the HIV/AIDS epidemic is complicated by a double tragic

crisis, as wealth and assets of the affected household are being reduced and families are broken and in most African countries half of the population is under the age of fifteen years (Ndinga-Muvumba A and Pharaoh R 2008:146). This shows how people have been affected by the pandemic.

Swaziland also encounters rural/urban and gender disparities, all of which fuel the increase in HIV/AIDS infection. Even though the history of the ABC model was successful in Uganda around the 1990s but according to Hunter (2003:21), the projection of the HIV/AIDS pandemic by the 21st century, is that about 52 million people already died by 2010, and 58 million will be remaining, but already infected by the virus. This raises a question about the effectiveness of the ABC model in HIV/AIDS prevention strategy. In Swaziland, the worst fatal disease that kills people in large numbers is HIV/AIDS. A recent vulnerability assessment found that 45% of deaths in Swaziland occur among those 16 to 35 years old, as cited by Hunter (2003:21). This has dramatically declined the child survival rate in the country; as such, these AIDS-related deaths are expected to alter the population structure. This brings the awareness that the ABC behaviour needs to become embodied in the development of new social norms on how individuals can be empowered to make informed decisions.

It is estimated that, by 2025, the country will be a population of both the very young and the old age groups (Swaziland Analysis of Prevention Response Final Draft Report 2008:11). According to the Draft National Multisectoral HIV/AIDS Policy, the epidemic in the country is general and primarily driven by heterosexual transmission, of which 20 000 are children under the age of 15 years, who are infected with the HIV that questions the abstinence messages, condom and behavioural change.

The history of the ABC model in HIV/AIDS has stirred up conflict in the Catholic Church as they threatened to withdraw its funding in 1998 as a result of condom use (Hunter 2003:32). Therefore, this indicates that, even though Uganda had good results in reducing the infection rate by using the ABC model, it has not convinced everybody to adopt the model of prevention as a means of limiting the infection rate. The low and inconsistent use of condoms is still a challenge to the Swazi community and globally, as it is revealed that the main cause is people‟s engagement in irregular heterosexual relationships. Young people start sexual activity at a

relatively young age. Yet, the intergenerational sex has limited recognition, or even denied personal risk of HIV/AIDS infection.

Ever since the ABC model was introduced in Swaziland, there has been persistent denial, which remains the greatest obstacle for the HIV/AIDS prevention in the country, as well as in the Sub-Sahara region, this is observed by a high number of community parenting, alcohol use as some of the important factors. The transfers of money, gifts and sexual relationships have not been reduced (National HIV/AIDS Response 2009:8).The people in the community have strong beliefs in witchcraft. That causes them to believe that the ABC model is irrelevant. The impact of the HIV/AIDS epidemic becomes visible as many companies in Swaziland start to note an increase in absenteeism among the staff due to frequent illness, which has reduced productivity and profitability (Muwanga 2004:20). The impact of HIV/AIDS on poor families and the subsistence farming is listed (Whiteside *et al.* 2006).

- Reduced available household income: to purchase farming inputs and hired labour, which are essential in areas with erratic rainfall and poor soil.
- Reduced labour: also within the household, as members‟ hired labour become ill and are no longer able to work.
- Loss of institutional memory: heads of households die leaving an increasing number of female-headed households and orphans without the knowledge vital for sustaining and maximizing production.

The paradigm of the HIV/AIDS epidemic has created an atmosphere of anxiety and trauma, not only among the people of Swaziland but world-wide, in spite of the information on the ABC model. The impact and tension is felt among government sectors, community-based organisations (CBOs), businesses as well as communities.[14] Many heart-breaking stories are heard from sick people who cry for assistance, “He is still reeling from an earlier encounter with an HIV positive mother who had come to see him, simply to ask: Will you look after my baby when I die” (Lawson 2008:15). Children suffer and become victims of all sorts of abuse because

[14] The HIV prevention model is not effective, as people continue to suffer in spite of the dissemination of prevention programs (Gibney 1999:xi).

of a lack of parental protection as parents have died due to HIV/AIDS. The following is a story of a small girl who left home after the death of her mother:

> I came to Manzini after my stepmother told me she did not want me at home. My mother died. I did not know my real father. My stepfather had other children. We were poor. I never went to school, even when my mother was alive. At home, they called me „Scraps", because I dressed in scraps of clothes. I am still Scraps. Because now I can fight. I get into fights. I am here outside Bhunu Mall most times. The shoppers have money. Sometimes they give me coins. I always go after white people. They are rich. They don't always give me money. But they don't say „Foesak" like some Swazis (Hall 2003:90-91).

This story reflects experiences that lead orphaned children to be sexually abused, despite the knowledge of the prevention strategy.

In view of the gravity of the epidemic in Swaziland, the National Strategic Plan (NSP) has embarked on an extensive consultative exercise in trying to evaluate the first conducted NSP and to review the study done between 2000 and 2005[15] to find ways that would enable people to familiarise themselves with the global prevention model. However, one cannot deny the fact that cultural practices seriously challenge the success of the ABC model in HIV/AIDS prevention in Swaziland, as mentioned in the second chapter. The model of HIV/AIDS prevention comes with mixed messages, as De Waal (2006:99) states: "Giving young people condoms is tantamount to giving them a license to be promiscuous."

However, this proves that the ABC model in HIV/AIDS prevention faces many challenges, as mentioned previously. The difficulty in implementing the ABC model is common practice in some communities in Swaziland. Lindiwe Dlamini, a lady working for the HIV/AIDS prevention program in Swaziland, confirms this: "We knew AIDS was there, we all knew about it, but it was on the other side, somewhere, over there" (Epstein 2007:146). This has resulted in the low use of condoms in spite of information distributed in a number of places and condoms being accessible in the country. The level of their use is very low due to myths and a conception about the epidemic, such as that condoms are for prostitutes and the church does not allow condem use

[15] Swaziland's review of the National Strategic Plan (National HIV/AIDS Monitoring and Evaluation Annual Report 2008:6).

(Chitando and Hadebe 2009: 65). That is why the use of a condom is still not fully accepted among the people in Swaziland, and worldwide. These constraints highlight the tension that the ABC model has in the HIV/AIDS prevention strategy. The concern that needs to be addressed in this model is the implications for HIV/AIDS transmission which had predominantly been known as a practice for prostitutes and immigrant male labourers (Herdt and Lindenbaum 1992:246).

3.2 The successes of the ABC model in HIV/AIDS prevention

It has been mentioned that the three elements of HIV/AIDS prevention (ABC), are equally important. The condom‟s effectiveness is estimated to be between 80 and 90% only when used correctly and consistently (Green & Herling 2007:10). Correct and consistent use of condoms has not shown effective results in Africa, because the use of condoms by men in Africa is very low (2007:32). The promotion of condoms alone does not have good results in lowering the infection rate. We need to understand that the use of a condom is a primary strategy of HIV/AIDS prevention. After the identification of the first victim of HIV/AIDS in Swaziland, NGOs have taken a leading role in addressing the crisis. As a result, centres for voluntary counselling were established to offer services to communities and for dissemination of information on the ABC model in HIV prevention. Figure 1 below shows the areas reached with information on the prevention strategy of the ABC model in HIV/AIDS.

Geographical areas covered where information on the ABC prevention programs is taught

Figure 1 = Sources: Population Census 2007

(Swaziland HIV Prevention Response and Modes of Transmission Analysis 2009:64)

Region	Total population	In-school youth	Out-of-school youth	Adults	Unspecified	Total 2007	Total 2006
Hhohho	282 743	7 249	6 645	7 132	18 334	79 988	14 974
Lubombo District	207 731	4 552	104	15 675		29 684	9 499
Manzini District	319 530	154	810	3 768		35 033	14 979
Shiselweni District	208 454	6 782	6 685	5 095		49 395	19 397
Total	1 018 449	18 737	11 244	31 670	18 334	194 100	58 849

The figure above shows the number of people who have been reached when disseminating information on the prevention strategy. In the country, the information on the ABC model is accessible, but what is lacking is the behavioural change. HIV/AIDS has been with us for a decade now (Cadwallader 1992: vii). During this time, the Church has not taken a leading role. However, some NGOs‟ efforts must be appreciated, as well as the effort of institutions, such as the University of Stellenbosch, which trained church leaders and other skilled people to be of assistance in meeting people‟s needs. Although faith-based communities have not successfully accepted the ABC model of HIV/AIDS prevention, in his book on sensitive sermon guidelines and liturgy, Dube (2003) encourages and motivates church leaders to prepare sermons that portray affected people and regard them as fully created in God‟s image, without discriminating against them because of their status. He further reminds church leaders about their mission to embrace people with loving care in situations where people are faced with existential issues of guilt and anxiety.

3.3 The failures of the ABC model in HIV/AIDS prevention in Swaziland

Despite a number of campaigns launched by different organisations working on HIV/AIDS issues as an alternative effort to minimise the spread of the fatal crisis continue in Swaziland. The frightening figures of the infection rate are reported in Swaziland, and "the burden of orphan care is increasingly transferred to the older and female-headed households. Grandmothers are left to look after the orphans yet they are too old, weak and poor to support the needy children" (Swaziland Human Development Report 2008:65). Statistics prove that the availability of information about the ABC model has not led to any change of behaviour among the Swazi nation as many orphans are left without parental care. Although the majority of people in Swaziland are aware of the HIV/AIDS epidemic, the prevalence still progresses. There are multiple factors that fuel HIV/AIDS infection in Swaziland and hinder the ABC prevention strategy, the anti-condom attitude which is a problem for both religious and non-religious communities; they believe that condom use promotes unfaithfulness. Rosenow (2011:50) mentioned that nearly all the faith based organisations in Botswana were not in favour of condom use. Other factors have been mentioned in Chapter two of this research. The HIV/AIDS crisis is felt in the entire region in Swaziland. According to the country"s local newspaper, *Times of Swaziland* (15 April 2010), figures in the Lubombo region indicate that about half of the population is affected by HIV/AIDS. Out of the population of 147 871, about 20% of the people in this district are reported to be HIV positive, which signals questions to the effectiveness of the ABC prevention strategy, as the affected people are making Swaziland the worst hit by the pandemic. The Regional Health Administrator of the Lubombo district in the Smart Partnership mini-dialogue held in Siteki discloses the heart-breaking news that almost half of the people in Lubombo were HIV positive.

This proves that the ABC model in HIV/AIDS prevention has not yielded good results. If ever the information about the model has been communicated to them, in helping to reduce the infection rate among the people in communities. There is a clear indication that there are still factors in Swaziland that fuel the spread of HIV/AIDS as Rosenow (2011:51) said that condoms are never used in sex as people understand that sex with a condom is like taking a shower while wearing a raincoat or "eating a sweet in its wrapper".

The kind of thinking indicates that people‟s mindset and behavioural character have not changed. As an observer to the situation, sexual debuts occur; trans-generational sexual relationships, multiple concurrent partnerships and gender income inequality have not stopped. We cannot deny the fact that a lack of knowledge and misconceptions about HIV/AIDS still prevail in people‟s minds. As they continue to engage in risky sexual behaviour. The two contributing factors on the table below influence the high prevalence rate of HIV/AIDS. The table reflects other contributing factors towards the HIV/AIDS ABC prevention strategy model in the context of Swaziland.

Figure 2 shows the individual and environmental factors that hinder the information implementation of the ABC model and indicate how many cultural norms have contributed to the high infection rate, as well as individual behaviour.

Figure 2

INDIVIDUAL FACTORS	**ENVIRONMENTAL FACTORS**
➢ **Comprehensive knowledge of HIV** = many are aware but misconceptions prevail. ➢ **Inter-generational sex** = responsible for infections in girls 15-24 years. ➢ **Multiple concurrent sexual partners** = widespread sexual networks. ➢ **Early sex** = on average age 5,9% of youth have sex before age 15. ➢ **STIs** = HIV prevalence high among STI patients. ➢ **Secrecy and denial** = many don‟t know and those who do know don‟t disclose to partners. ➢ **Condom-use (with higher risk sex)** = not consistent.	➢ **Cultural beliefs and practices with negative implications** = *Inhlanti, kwendzisa, kungenwa* are celebrated. ➢ **Male dominance** = *bunganwa* is celebrated. ➢ **Business as usual** = political commitment and allocation of resources. ➢ **Decline of moral values** = an emerging valueless generation. ➢ **High mobility of the population** = within and outside the borders. ➢ **Poverty (income inequality) =** those with money exploit those who don‟t have it. ➢ **Alcohol and drug abuse** = correlation between high alcohol intake and high-risk behaviour.

According to the UNAIDS country report of (2010:18) the challenging issue in Swaziland on HIV/AIDS pandemic is poor condom distribution, absence of coordination in communities and the lack of appropriate behaviour change among the people. The issue of gender has not been addressed well, men are considered superior in strength and by the law in the country, and the upbringing of boys and girls is very different, which creates a barrier (Swaziland‟s human development report 2008:2). Boys grow up dominating girls as they imitate the role of their fathers while girls are encouraged to be submissive and engage in household chores (2008:2). Hence the customary law is liberal with the boys in terms of their sexual activities but very prescriptive when it comes to girls. Within the HIV pandemic, the attitude of Swaziland‟s people towards women promotes a lack of power in decision-making about their sexuality. Swaziland Government Report October 2007:9-10) mentions that, "Women‟s vulnerability to HIV/AIDS infection is increased by economic, social and cultural factors and by different forms of violence, particularly sexual, that place them at a disadvantage within relationships, and the economic security forces women to engage in risk sexual behaviour."

Economic power causes women to be dependent on men, and their high poverty levels and lack of access to opportunities and resources contribute to their vulnerability to HIV/AIDS infection. Because of women‟s economic dependence on men, they are unable to take control over their lives and protect themselves against HIV infection. Most cultural expectations and practices were found to contribute to women‟s vulnerability to HIV/AIDS, as mentioned in the previous chapter. Insufficient and sub-standard food renders many people in Swaziland vulnerable to the epidemic, and insufficient medical facilities, drugs, and unqualified health workers hamper the teaching on HIV/AIDS prevention programs.

3.4 Evaluation of the ABC model

The three pillars of the ABC model in HIV/AIDS prevention strategy need to be looked at from a perspective of a human needs therapy and encounter with God. Human beings are not objects but are sexual beings; therefore human problems should not be reduced to merely a psychological issue but the church should realise that humans need therapeutic intervention to experience an

encounter with God. When considering the ABC prevention model, one must remember that human beings are not objects – they are sexual beings.

Abstinence and the Swazi society: Abstinence is not achievable in any society, due to cultural constraints and behavioural change being impossible to bring about. In the Swazi culture, multiple partners are permitted which makes it difficult for men to use condoms consistently and to exercise faithfulness to one partner. The culture also encourages young boys to have as many girlfriends as they wish, for the purpose of choosing one for marriage.

Church and abstinence in Swaziland: Although the church has a long history of teaching abstinence, in practice it has failed. That is why the policy of excommunicating young ladies who fall pregnant is being implemented even today**.** One seldom observes people behaving as "sex only in marriage". The church and women‟s issues encourage celibacy to control the uncontrollable. Abstinence from other sexual relationships has not brought any happiness to women, as they find that their husbands/partners infect them, even if they themselves abstain from other sexual relationships. As stated in Bond *et al.* (1997:160), "Every day, just now there are one-thousand and five-hundred women who have no sexual partners other than their husbands who are becoming infected," therefore, abstinence for women is not within their control. Unless a great change occurs in power imbalances, women will still remain subordinate in relations, as well as in society, due to the "unequal balances of power between men and women having fewer legal rights and less access to education" in other communities (Haddad 2011:258). The situation women experience also hinders them from the access of information on HIV/AIDS resulting in creating opportunities of putting them in danger zones. The celibacy issue is to control the uncontrollable, as sexuality is a spiritual issue that touches "the very fabric of human life" (Louw 2008:353). The promotion or encouragement of celibacy has never been practical, as all humans are sexual beings. An explicit desire is "longing for a counterpart as the loving mirror of one‟s own identity" (Louw 2008:353).

Being faithful within the Swazi society: How relevant and appropriate is this message? Sexual relationships in the African context have been rife with domestic violence, and multiple sexual partners. The study of Cockcroft *et al.* (2010:956) highlights that Swaziland‟s multiple partners among the sexually active was 45% among men and for women it ranged at 62%. This proves that the "be faithful" messages are not being put into practice in Swaziland. The practice of

multiple partners is high among men in Zimbabwe, especially in the rural areas Cockcroft 2010:958). The church‟s advice to unmarried people is abstinence, yet it never happens the way the church expects. Teenage pregnancies that occur as a result of unprotected sexual intercourse prove this (Mngadi 2007:18).

Condomising within the Swazi society: The church has never supported the use of condoms. As discussed early in the chapter, condoms have been associated with promiscuity and sex workers, therefore, the church did not want to associate with something sinful according to its understanding. “Somehow it would then seem more “spiritual” to use A and B and not C” De la Porte (2006: 4), this are challenges the model of HIV/AIDS encounter. This statement becomes a challenge as the use of condoms has not been successfully adopted due to cultural factors and also being a foreign model. It also becomes difficult to condomise the genitals, which were not meant to be rubberised, but these challenging times force people to practice sex with a condom. As African people believe in having extended families, procreation becomes a stumbling block when sex is to be practised with condoms.

3.5 Conclusion

In Swaziland, the HIV/AIDS pandemic has caused much havoc and suffering felt in many communities with large numbers of orphans. The ABC model in HIV/AIDS prevention has not had much success in decreasing the HIV/AIDS infection rate in Swaziland. As the high infection rate continuously rises. However, its success in Uganda is acknowledged. The challenging part is that behaviour has not changed in Swaziland. The impressing results have not been observed. In evaluating the ABC model in the HIV/AIDS pandemic, it became clear that the use of the model encounters some resistance and denial as our communities continue to have teenage pregnancies, multiple sexual partners, and the death rate continues alarmingly due to cultural practices that contribute to HIV/AIDS infection.

The next chapter will discuss the role of church leaders, non-governmental organisations and the Swazi government in HIV/AIDS prevention, by adopting the ABC model for HIV prevention.

Chapter 4:The role of the religious leaders in HIV/AIDS prevention strategy, non-governmental organisations and the government of Swaziland

4.0 Introduction

Through the ages, the church is known as a trusted body that people rely on; especially when they encounter trauma and crisis they run to the church for pastoral care. In this chapter the three different organisations will be discussed. The role played by the religious leaders in the HIV/AIDS prevention strategy will be given, the non-governmental organisations and the role of the government of Swaziland with relation to the HIV/AIDS prevention strategy. The last part of the chapter will be the conclusion.

4.1 The role of religious leaders in HIV/AIDS prevention

Swaziland is known as a Christian country as about 60% of the population in the country are Christians (Sowazi 1996:25). The church leaders in Swaziland are faced with the crisis of the HIV/AIDS pandemic, which has brought silence, denial, shame, pointing of fingers/stigmatisation and blame on many infected and affected people, the stigma, silence and denial are experienced in Swaziland despite the sensitisation campaign and education that have spread throughout in many communities (Swaziland human development report 2008:8). This has prevented the church from offering services of counselling and being present in times when people are full of more questions than answers about their suffering, asking where God is in their painful situation. The expertise members of the churches in medicine, teaching profession, and diakonia work can be used in offering vibrant services of caring. The church needs to draw on its economic planners to run sustainable activities of hospital and home visits (Chitando 2008: 17). Where in the past such situations have prevented the church leaders from taking a firm stand in addressing the realities of the pandemic. According to Knox (2005: 12) issues of sex need to be addressed with care by the expertise without inflicting pain to others as the silence of the church

on the subject of sex and the HIV/AIDS pandemic has created a gap and stigma for the secular information to spread, hence, this has resulted in aggravating the situation of HIV/AIDS while the church based in communities has not taken a leading role in addressing the crisis. The fact that HIV/AIDS is viewed from a perspective of promiscuity and is associated with sin mainly causes the church‟s silence, as indicated in Hoffman and Grenz (1990:20).

Oppenheimer and Bayer (2007:69) support the statement as follows "Knowledge that the highest risk categories for contracting the virus include sexually promiscuous homosexual or bisexual males and drug abusers (i.e. sinners), even children could be stigmatised because they bore the sin of their parents." Dalu Ndiweni said the attitude of this colleague about the babies he saw was, "Mom and Dad behaved so badly." The above statement reflects the church leader‟s position in understanding giving support in HIV/AIDS prevention strategy. The impact pain of the HIV/AIDS pandemic is felt not only in Swaziland but to the world. The denial and blame has been widespread in all the countries and communities not realising that argument and blame do not solve the problem but instead perpetuate the situation as nobody wants to take responsibility of working towards a solution. Shifting away from solving the crisis but continuously blaming one another has led the church leaders in Swaziland to remain in silence and denial: "AIDS is being blamed on gays, or drug addicts or on Blacks, Britain has blamed African students, the USA has blamed Haitians, Africa has blamed Europe (and vice versa), Japan has blamed foreigners, and French right has blamed Arab immigrants" (Amod 2000: 22).

Mixed messages around the use of condoms are heard in the country from church leaders "The condom is immoral and destructive of the dignity of a person. „Safe sex‟ or „protected sex‟ means abstinence before marriage and fidelity in marriage" (Bate OMI 2003:39). The church leaders‟ are reluctant to talk about the HIV/AIDS prevention strategy due to the fact that, "There is a certain simplistic attractiveness in the notion that God is punishing mankind for sexual promiscuity that is rife in our age" (Bate OmiI 2003:3).

Unfortunately, religious leaders in Swaziland have had a long period of silence in taking a leading role in HIV/AIDS prevention. It is with evidence that "Christians and indigenous polarities of good and evil, holiness and sin, framed the dominant discourse" of HIV/AIDS with their own worldview version (Haddad 2011:267).

According to Baard (2008:369), the church needs to move away from misleading messages and attitudes, such as describing HIV/AIDS as "God"s punishment" of "a sickness of sinful people". In spite of the lack of church involvement and understanding, I am still convinced that the church leaders have a role to play in the HIV/AIDS prevention strategy. "The assumption is that the agency involvement of the church leaders in taking a positive response, the country will quickly equip a number of people in developing self-esteem that will enable them to fight HIV/AIDS and other related human crises of poverty, inequality, rape and other economic and social issues" (Froise 1994:17).

The HIV/AIDS pandemic challenges the church to break the taboo or its silence on the issues of HIV/AIDS and also to break the cultural norms of making the subject selective to individuals and, instead, to make it an open topic of discussion for all ages, while disclosing human sexual information to the entire society. The role of religious leaders is to facilitate self-determination and compassionate care by being present in a distressed and lonely situation due to the impact of the pandemic. The church to provide the climate of love, acceptance and support (AWCC study document1997: 107), and is expected to offer empowerment of faith in traumatic crises of pain and fear of death (Louw 1998:366).

The church leaders in Swaziland have not been heard openly challenging the traditional gender roles. Not many messages of hope have been given, especially concerning cultural practices that disempower women to negotiate for safe sex, thus preventing the spread of HIV/AIDS. Seemingly, the church has problems in successfully condemning the cultural practices that contribute to the high rate of HIV/AIDS infection. It is noted that some church leaders have started with HIV/AIDS programs on prevention strategy after the Council of Swaziland Churches (CSC) initiated and urged churches to be part of the struggle in implementing prevention programs in their denominational activities and in communities where the churches are found (CSC"s HIV Documentary Program of 1998). It is mentioned in Rosenow (2011:48) that the involvement of church leaders in a HIV/AIDS prevention strategy will help pastors from tending to "shun from the topic as it is possible to go for a whole year without hearing a sermon topic addressing HIV/AIDS". This happened in ignoring that the church is part of the people affected and infected by HIV/AIDS. Church leaders are to empower the people, and teach them the principle of life skills to equip them from misleading information.

There is also the unquestionable fact that the spread of AIDS has been facilitated by promiscuous sexual activity, and could be contained if sexual activity were limited to faithful monogamous relationships and if the HIV/AIDS pandemic were known as *mashayabhuce* (AIDS kills everything). Such information and teachings inflict pain and perpetuate stigma and denial to people affected and infected with HIV/AIDS. Therefore, the Swaziland Church Forum is ensuring that all church leaders are engaged in HIV/AIDS prevention programs to strengthen the religious HIV/AIDS programs. Since the church has not dealt devotedly with issues of HIV/AIDS prevention, it cannot be credible. The organisation working with churches (the Church Forum) was formed in 2006, to provide adequate teaching information on HIV in the country. The Church Forum works with church leaders in running programs of HIV/AIDS. Churches and the Swazi community should not underestimate the complex challenge of HIV/AIDS, which requires adequate commitment from all stakeholders to embody and express compassion to people infected or affected by the scourge of HIV/AIDS. The church needs to affirm people‟s dignity and worth even after being dehumanised and stigmatised by the HIV/AIDS pandemic. It is obvious that, although converted to Christianity, some church leaders‟ mindsets have not changed to understand the issues of HIV in relation to human sexuality, as Maticka-Tyndale *et al.* (2007:53) state. The church leaders must be caregivers and move away from all the stereotypical information that associates HIV with promiscuity. Instead they should make the church‟s presence visible to the society and avoid the wrong perception of connecting HIV/AIDS to sin.

In Rosenow (2010:88), Benedict Xaba the minister of health in Swaziland mentioned that there are some obstacles that hinder the church‟s effective role in overcoming the challenges of the HIV/AIDS pandemic, namely a) the inadequate accurate knowledge on the subject, b) inappropriate attitudes towards HIV/AIDS, c) insufficient skills to provide care and support services needed by the community, d) insufficient resources to pursue and sustain HIV/AIDS prevention, treatment, care, and put support program in place. However, this awakens the church seriously to maintain its stand on sexual matters, between modernity, religion and traditions, especial the ones that dominate people‟s identities among the faith-based communities. The church needs to “revisit its underlying concept of how the church relates to society in transition” (Louw 1998:13). In Swaziland, the religious leaders should meet and find a solution as to how the church can serve the community in a better way for the benefit of the people. In Uganda, the

Uganda AIDS Committee (UAC) brought church leaders together to play an important role. This happened drastically, as Ugandan experienced the declining rate of new infection due to the comprehensive approach of reducing sex partners (Omwami 2008:14).

One tends to believe that if church leaders in Swaziland can adopt the method Uganda used in HIV/AIDS prevention strategy, better results can come. Therefore, it is not appropriate for the church to associate HIV/AIDS as a disease for sinners. Hence, there is a need for religious leaders to adopt a Scriptural therapeutic text within the context of a pastoral encounter, not to mislead people with inappropriate messages. People need to be empowered by the words of Jesus "But take heart I have overcome the world" (John 16: 33), the church is supposed to say such empowering massage, to portray the church as a caring community. The church has a very specific therapeutic impact on human behaviour by not promoting segregation (Louw 1998:369). Christians have a history of being a potential source that can relate HIV to all communities (Bond 1997:144). The church leaders must be caregivers and move away from all the stereotypical information of associating HIV with promiscuity. Instead, they must make the church‟s presence visible in society and avoid the wrong perception of connecting suffering to sin. The only organisation that responded positively on prevention strategies in Swaziland was the Council of Swaziland Churches (CSC). They encouraged the religious leaders and church members to meet in solidarity with the suffering people and take a leading role in alleviating the high rate of the HIV/AIDS pandemic in the country. The effort of equipping church leaders with information was not done to unite the church in speaking with one voice, but to talk openly about the prevention strategy of the ABC model in the HIV/AIDS pandemic.

As a participatory observer, the researcher noted that a number of Swaziland‟s faith-based organisations‟ activities on HIV go unreported and, in general, that gives the impression that the church is not doing anything. Yet, much has been done in some communities. By not producing documentation of their activities, the church remains a major absence in the HIV/AIDS prevention strategy. However, the strength and hope for the church is greater than the current challenge that it faces. In Uganda, the religious organisations and political groups had a different understanding of the HIV/AIDS pandemic; the promotion of condoms would undermine the prevention messages of abstinence and being faithful (Higgins & Norton 2010:156). This confirms the perception that the church views HIV/AIDS from the promiscuity point, "For too

long in the minds of some Christians, all sickness – especially HIV/AIDS – has been regarded as a result of sin" (Messenger 2005:19)

Messenger (2005:19) highlights that, "For many Christians it has not been enough to consider AIDS as an evil brought by the human immunodeficiency virus, they have identified AIDS as a punishment inflicted upon sinners by God." Therefore, it is imperative for church leaders to be educated on HIV/AIDS issues to avoid the dilemma of misreading the Scripture in John 9:1-3: "When Jesus‟ disciples asked, Rabbi who sinned, this man or his parents that he was born blind? Jesus replied, neither this man nor his parents sinned but that the work of God should be revealed in him." The church leaders are expected to promote messages of hope, by encouraging people that are infected with HIV/AIDS, and not neglect them but show them that they are being loved in spite of being infected, and stop spreading inappropriate messages that humiliate them. HIV/AIDS in Swaziland is also associated with a disease for promiscuous people and beliefs of witchcraft (Swaziland human development report 2008:8).

It is essential for church leaders to ask God‟s wisdom when responding to this devastating effect of the HIV/AIDS pandemic. In this regard, churches have not prioritised programs of HIV/AIDS prevention as a matter of urgency. The faith-based organisations do not fully endorse human dignity and quality of life. People still view God as a judge, the one who punishes sinners.

The church needs to understand HIV/AIDS suffering from the perspective of God‟s presence in their midst rather than promote stigma and discrimination to people. The church needs to approach HIV/AIDS from a spiritual Christian faith, and to relate God‟s goodness to the reality of evil and justify Him in relation to evil. The church should understand that people will always seek for meaning in their suffering. In Swaziland, the church is being encouraged to journey with the people even when there are no answers to their questions about suffering, and to encourage them to bear God‟s image in their innermost beings (Rosenow 2010:26).

The church in Swaziland has been quiet on the issue of HIV/AIDS prevention strategy solely because it touches sexuality, "women found it difficult to talk about sex with their husband as they would appear un-Christian." (Haddad (2011: 262). when there is discussion about sex one is told either that Africans do not talk about sex in public because they are Christians, or that it is not African to do so. Sex has become a thorn in the flesh (Nordic-Foccisa 2005: 23).

The Council of Swaziland Churches (CSC) has not been discouraged by realising that the church leaders are not putting effort into the HIV/AIDS prevention program but they continue encouraging them to give messages of hope. “It would appear the pressure of living is so much for everyone that the CSC no longer feels content or confident to concentrate on spiritual evangelism alone and no longer feels confident enough to answer the various man-made problems with prayers. That is why all along the CSC has been ministering to the needs of man, the needs that go into making him or her a ready and willing recipient of the message of Jesus Christ” (Sowazi 1996:21). The Council of Swaziland Churches (CSC) was the pioneer in the crisis of HIV/AIDS in encouraging other church leaders to take part in HIV/AIDS prevention, while other church bodies, such as the Conference of Churches, distanced themselves from social political issues; as such that involvement was “regarded as unchristian, if not sinful” (Sowazi 1996:41). The religious leaders in this crisis of the HIV/AIDS pandemic are expected to assure people that as human beings on our side we are more than conquerors through Him who loved us” Leaders of the church are expected to offer empowerment of faith to people confronted with the pandemic as it causes traumatic crises, pain, suffering, and the fear of death (Louw 1998:366).

The church, as a faith-based organisation, needs to exercise its leadership role in communities, and to help with an empowering message for women who lack the power to refuse risky sex behaviour that may lead to HIV infection (Green & Herling 2007:49). Churches must be viewed as pioneers of support for human beings created by God in his own image. In communal life between sexes, there is no distinction between men and women; all human beings are created in the image and likeness of God and are endowed with dignity and honour (Genesis 1:26). The challenging time of HIV/AIDS in Swaziland exposes little participation of church leaders in combating HIV/AIDS, as indicated by (Swaziland country report January 2008:8) Swaziland has made considerable efforts in prevention, care and support, but no contribution by the church has been mentioned in the study.

The SAFAIDS and OSISA (2008:22) report points out a number of areas, especially the rural settlements in Swaziland that still require action in terms of information, education, and communication. This challenges the church to reach out, and identify communities, to offer support by promoting_HIV/AIDS prevention programs and other related needs. In response to

human needs, Kanyandango (2002:182) says: "Charity and social services have probably been the most common outreach, which were emphasised by missionary churches." Much good was done, especially in the fields of education and health care. Immediate assistance was given to the desperately poor and skills were taught. As a caring community in this crisis of HIV/AIDS, the church needs urgent action of solidarity with the suffering to "demonstrate compassionate love of God through concrete action in the name of the risen Lord Jesus" (Hoffman & Grenz 1990:260).

4.2 The role of non-governmental organisations in HIV/AIDS prevention

Non-governmental organisations were the first to respond to the HIV/AIDS crisis, after realising the high number of deaths. Many Swazi homes were left child-headed after both parents had died. According to Jele (2004:26), the disease has killed many people, especially children and women, as they are more exposed to the pandemic compared to males. The crisis of the HIV/AIDS pandemic is the challenge of not only the non-governmental organisations in Swaziland. Zambia has been highly affected also, as the population has dropped from as 30 million are living with the virus (Mombe 2005: 30). That is an indication of the impact of the HIV/AIDS crisis, which has affected life expectancy of many countries in Africa.

Presently the country has a number of NGOs working on HIV/AIDS prevention programs. They help communities to reduce the infection rate, stigma and discrimination and other related issues to eliminate the high infection rate in the country. However sex continues to be the most common way which HIV spread in Africa (Rosenow 2011: 55). In spite of all the efforts and dissemination of information from non-governmental organisations and faith-based organisations, the infection rate of the HIV/AIDS pandemic has not been reduced. Instead, a new infection rate has been recorded, rating the country with the highest rate of HIV/AIDS, together with Botswana, South Africa and Zimbabwe (UNAID in Nercha Report 2009).

4.3 The role of the Swaziland government in HIV/AIDS prevention

Swaziland was the first country to respond to the epidemic by referring to HIV in its national development plans and first to commission a study on the socio-economic impact of HIV/AIDS in the early 1990s (Jele 2004:25). The SAFAIDS Report (2008:8) indicates, "The report states that Swaziland undertook a number of HIV prevention strategies, which include the voluntary counselling and testing (VCT), condom promotion, information, education and communication, prevention of mother to child transmission (PMTCT) and blood safety." This indicates that the country has made considerable efforts to employ the prevention strategy of HIV/AIDS, and care and support programs, but unfortunately has had no success.

The government has conducted a study on the National Multi-Sectoral Final Draft of 13 February (2009:29) where the researcher indicated that, by 2007, the prevalence of HIV/AIDS in the country was 26% among people aged between 15 and 49 years. The research done by the government in 2008 discovered that the highest HIV infection rate was among females with 31% compared to males at 20%. These findings indicate that the Swazi population was not willing to change their sexual behaviour (SAFAIDS Report 2008:6). The HIV/AIDS pandemic has remained a challenge for the government, as the Swazi National Strategic Plan‟s efforts have not contributed to much change in the HIV/AIDS infection rate, in spite of suggested ways of managing the infection rate, such as communication for behavioural change (Epidemic of Inequality Women‟s Rights and HIV/AIDS in Botswana and Swaziland 2007:72).

In 2001, the Emergency Response Council for HIV/AIDS was also established, specifically to coordinate the multi-sectoral response towards HIV/AIDS programs in the country (Swaziland National HIV/AIDS Monitoring and Evaluation 2008:12). However, the final draft of the 2009 National Multi-Sectoral Strategy discovered that there was a need to mainstream gender and human rights‟ approaches in the HIV/AIDS planning processes, as females recorded high with HIV prevalence at 22% compared to the males at 5,9% in the same age group of 15 to 24 years (Swaziland Country Report January 2008:40). The data collected by SAFAIDS (2008:6) rated women at 31%, and men at 20%, aged between 15 and 49.

Even though the data was collected in the same year, but targeted different age groups, results from both studies revealed that women were rated with the highest percentage of HIV/AIDS infection. This supports the statement that Swaziland has not changed its behaviour even during

this time of the HIV/AIDS crisis. In response to the crisis in Swaziland, the government made a survey of the HIV/AIDS prevalence rate in the country‟s four regions. In the Hhohho region, the lowest infection rate of HIV/AIDS was 36. 6% and Manzini was found to have the highest rate of infection – recorded at 42. 2% (Patterson 2005:99-100). Hhohho and Manzini are the richer and more urbanised districts of Swaziland, while in Shiselweni, a poorer and more rural district; the rate of HIV/AIDS was 38. 5% and in Lubombo 37. 9% was recorded (2005:100).

Swaziland‟s government faces the challenge of this epidemic, and the study that Patterson (2005:101) conducted shows that, since the first case of HIV/AIDS, the prevention programs in this country have not had any marked reduction in the infection rate due to cultural influences that place women and girls at a greater risk (Swaziland Human Development Report 2008:8). The findings of the Swaziland government from the regions were done by Whiteside *et al.* (2003:15). The infection rate has increased in all the regions as indicated in a table by Whiteside *et al.* (2003:15).

Table 3

HIV/AIDS infection rate among patients at antenatal clinics (ANCs), 1994-2002

Region	1994	1996	1998	2000	2002
Hhohho	15.5%	26.3%	30.3%	32.3%	36.6%
Lubombo	16.8%	26.5%	31.5%	34.5%	38.5%
Manzini	15.6%	27.7%	34.8%	41.0%	41.2%
Shiselweni	16.8%	23.9%	29.6%	27.0%	37.9%

In table 3, the government‟s findings indicate the high rate of HIV/AIDS infection in four regions of the country. The reason being that the settlement in Swaziland has placed communities far from mobile outreach services, making it difficult for rural communities to access services (National HIV/AIDS Response 2008:24). The figures from 1994 to 2002 have increased. However, the current crisis of HIV/AIDS reflects that all the government efforts to reduce the infection rate during the early stage of the HIV/AIDS pandemic in the country have not contributed towards lowering the infection rate. The state of the problem of HIV/AIDS in

Swaziland clearly indicates that the HIV/AIDS prevention campaigns have nothing to celebrate, regardless of the massive distribution of condoms and education in the country ever since the first HIV case was identified (Patterson 2005:97).

The government‟s effort is acknowledged as follows: “A number of key stakeholders from the UN, civil society and practitioners agree that there is a high level of political commitment to the fight against HIV/AIDS in Southern Africa” (SAFAIDS Report 2008:7). Secondly, it is the unwillingness for behavioural change, as indicated earlier. The condom teaching and demonstration how to use a condom have been conducted in many places in the country clinics and hospitals. The demonstration in Swaziland was performed to encourage people to use condoms (Swaziland National HIV/AIDS Monitoring and Evaluation Annual Report 2008:16). The effort of condom promotion has been made available to some clinics but that has not contributed to decrease the rate of HIV/AIDS infection. In the context of Swaziland, the use of condoms faces the challenge of culture and women‟s inequality, “Men dominate women in all aspects of life and culture. Women are not equal to men in society, and therefore, they are not empowered to stand up for their rights of preventing themselves from HIV/AIDS infection (Swaziland Human Development Report 2008:07).

In Thailand, the intervention of 100% condoms was implemented, as mentioned in Holtgrave (1998:111), and the program has had a profound effect on the level of unprotected sexual diseases, such as STDs. Due to the impact of the HIV/AIDS incidence, the program was expanded nationally with impressive results. The same intervention based on the 100% condoms was implemented in Nepal. Such an intervention_would be of great assistance in reducing the high infection rate of HIV/AIDS in Swaziland‟s context.

According to the Nercha Annual Report (2009:26), the country has only seven voluntary counselling centres (VCTs), which are not enough to meet the needs of the community. There are 178 health facilities that offer HIV testing and counselling (HTC), and 87 health facilities that provide community-based care and support (CBCS). The Manzini region has 13 HIV/AIDS centres, but has not managed to reduce the escalating figures of the HIV/AIDS crisis in the country (Nercha Annual Report 2009:31). So, the establishment of HIV centres that work on HIV programs has had no impact to reduce the high rate of HIV/AIDS infection.

Therefore, the context of Swaziland needs a pastoral approach whereby the holistic approach of prevention will be implemented of offering pastoral care and counselling, diakonia ministry where the needs of people affected will be looked upon. Pastoral care will bring God‟s compassion, justice and grace that will enable people to shift their position of being victims of culture, which the government has acknowledged as the stumbling block to the HIV prevention program. The issue of HIV/AIDS needs approaches from both the government and faith-based organisations to employ their perspective skills in working towards reducing the infection rate in the country. Table 4 reflects the infection rate in Swaziland by age groups.

Table 4 (Final report of Whiteside, Hickey, Ngcobo & Tomlinson 2003:15)

The government's report on the infection rate between 1994 and 2002 (among antenatal clinics' HIV/AIDS patients, by age groups)

Age group in years	**1994**	**1996**	**1998**	**2000**	**2002**
15-19 years	17.8	24.1	25.6	26.3	32.5
20-24 years	18.8	32.3	38.4	42.5	45.4
25-29 years	14.3	27.2	38.0	40.7	47.7
30-34 years	10.8	21.7	24.8	29.7	29.6
35-39 years	9.1	11.0	21.8	17.0	23.9
40+	18.3	11.0	25.7	26.9	25.0
Total	**16.1**	**26.0**	**31.6**	**43.2**	**38.6**

The above table is from the government‟s research as a means of finding the solution to the crisis of the HIV/AIDS pandemic by ages, which questioned the prevention model of the ABC in HIV/AIDS prevention (Nercha Report 2009).

4.4 Conclusion

This chapter shows that no impressive results of attempts to reduce the high rate of infection have been observed when considering the roles of the church, non-governmental organisations and the Swaziland government. The church‟s silence and not taking a leading role in HIV/AIDS programs have created a barrier of information. The church has not spoken openly about its stance on the model of HIV/AIDS prevention due to culture obstacles of not talking about sex in the public. The next chapter will bring a pastoral approach to human sexuality within the prevention strategy of the ABC model.

Chapter 5: Towards a pastoral approach: Human sexuality within a prevention strategy

5.0 Introduction

The crisis of HIV/AIDS has brought a new perspective to addressing issues of human sexuality. Sex in an African cultural understanding is a private matter; it cannot be a public topic as mentioned earlier in this research (Rosenow 2011:51). This chapter will address issues of human sexuality from various perspectives. A definition of sexuality will be given. The Biblical perspective of human sexuality will be discussed within the framework of a pastoral approach. The chapter will be concluded by introducing the summary, research findings and recommendations.

5.1 Definition of human sexuality

Within the context of HIV/AIDS, human sexuality is connected to death, which has led to a debate on the meaning of human sexuality and sexual intimacy. Louw (2008:351) argues that:

> It is not only the HIV pandemic … that has stirred up a lot of questions about the meaning of human sexuality. Gene technology, new developments in medical care and a [homosexuality debate] have also reopened questions about the meaning of human sexuality and how it relates to human identity, human dignity and the origin of life, marriage, family, and the dynamics of human relationships.

A question around human sexuality has been of concern, even before the crisis of HIV/AIDS. This indicates a need for a theology of human sexuality, to equip people with knowledge and avoid negative interpretation and cultural influence on human sexuality. According to Dominian and Montefiore (1989:21), sexuality is a God-given pleasure, yet, at the same time, sex can cause great anxiety, and deepest unhappiness, it can also absorb a great deal of a person‟s inner life and, lastly, sex enables a person to realise his or her deepest identity.

Human sexuality is closely related to human dignity, human rights, and the equality of all human beings. Louw (2008:355) observes that, "Human sexuality is a special gift of God to humankind" – it was created for a common good. Dube (2009:10) concurs when he says, "Every special gift requires much care and protection so that it can maintain its virtue and continue to be useful." Because human sexuality"s main objective is supposed to be the preservation of peace and harmony, Dube (2007:9) further defines human sexuality as "the quality or state of being sexual or having sex." In other words, human sexuality is the capacity to express sexual feelings or an engagement in sexual activity. However, Dube"s definition needs to change our understanding of human sexuality, since human sexuality also involves the manner by which human beings express and experience the incompleteness of their individualities and relatedness to one another as male and female (cf. Genesis 2:18). But, some cultures and religious organisations are silent on the subject of human sexuality. Sexuality brings two people together in relationship as equal partners (1 Corinthians 7).

Regarding this, Louw (2008:353) defines "sexuality as part of our being human, it is the search and longing for a counterpart as the loving mirror of one"s own identity." Human sexuality is further defined as a spiritual issue, where it expresses a person"s innermost being that drives one individual close to another, and it "is an expression of the esthetics (beauty) of the human soul (wholeness of being)." By these definitions, people are encouraged to talk openly about their sexuality to avoid connecting it to fear and death.

According to Thatcher (1999:54), human sexuality "is viewed as a positive, joyous phenomenon. Its expression is connected to personal health, happiness, self fulfilment, and social progress." For that reason, human sexuality needs honesty, commitment that conveys trust to a continuous relationship geared towards life"s fulfilment, and healing in order to prevent estrangement, rejection and isolation (Louw 2008:354). In his merciful love, God expects us to be a caring communal community for one another, as He has made a dwelling in us. "He encourages us to create a living culture of love, a love that is to recall humanity to its true destiny and dignity" (Messenger 2009:11).

According to the church sex is limited only to those in marriage, whereas it fulfils a central aspect of being human throughout life and encompasses sex, gender identity roles, sexual orientation, eroticism, pleasure, intimacy and reproduction (Rosenow 2011:51). Sexuality is a

"sacrament, an expression and symbol of peace and God‟s presence and sacrificial grace (Louw 2008:355). It is experienced and expressed in thoughts, fantasies, desires, beliefs attitude, values, behaviour, practices, roles, and relationships. According to Nordic-Foccisa church2005: 21) sexuality refers to the totality of personality, it is God given ways in which life expresses itself. It is the quality state of being female and male. According to the Nordic-Foccisa Church Cooperation (2005:11) sexuality is to be celebrated, enjoyed and treated responsibly as it is an intrinsic part of everyone‟s life whether or not human beings have sexual relationships and it is about identity and self-esteem. Therefore human sexuality should not be a private matter concerned with our most intimate relationships; it should be an intensely public subject for all, because God created us as sexual human beings.

According to Maticka Tyndale (2007:67), "human sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships and it is broadly defined as the social construction of a biological drive." However, when human sexuality is about power, it moves human sexuality away from the understanding of woman and man as equals. Finally, human sexuality has been defined as the central core of being human throughout life, and it encompasses sex, gender, identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. The definitions of human sexuality need to be communicated to all of society to prevent the stigma and isolation from guilty feelings when people are infected through sexual encounter.

5.2 A Biblical perspective of human sexuality

Human sexuality is embedded in the Christian belief of sharing, as Christ Himself shared his life with us and He continues to be with us in the community of believers. Human sexuality is part of God‟s creation (Genesis 4:1). Human sexuality was never meant to be a communal affair but given for individuals to enjoy (Proverbs 5:15-20) and share. It meant to be enjoyed by two people in order for them to take pleasure in the satisfaction of life to its fullness, and that encompasses the companionship of one another. Therefore, the creation of Adam and Eve was for the purpose of each person finding his/her true self, as described: "The man said, this is now

bone of my bones and flesh of my flesh" (Genesis 2:23 NIV). Maticka-Tyndale (2007:6) concurs with this statement.

Human sexuality has become a difficult subject for the church to address, despite the fact that the Biblical emphasis of companionship is highlighted: "It is not good for the man to be alone, I will make a helper suitable for him" (Genesis 2:18 NIV). By this note, the Bible provides a safe space to condemn rejection, stigmatisation and all sorts of gender-based violence as the Kingdom of God is a focal point in the healing of human life. Human sexuality in a monogamous pattern has been considered as a sexual expression for women and men of all cultures.

But, for sexual issues to be discussed in public is against the norms and practices of some African cultures, "Yes, African traditions shroud sex with secrecy to the extent that we grew up being told that children are bought at the hospital" (Rosenow 2011:51). It is not surprising that about 90% of HIV infection in most African countries is transmitted through sex as information may be not clear on how sexual intimacy be a tool for infection.

As human sexuality is a gift from God, people must learn to glorify Him with their bodies for such a gift, and also learn to appreciate that they exist as sexual bodies. God created us as sexual beings, both man and woman, not in opposition, but in mutuality. Therefore, even though people are much influenced by their cultural practices and the challenges of the HIV/AIDS pandemic, it is of vital significance that human sexuality should not lose its Biblical perspective. The crisis that human sexuality faces today originates from a historical understanding and Christian tradition that has connected sexuality only and exclusively to marriage. The Catholic tradition connects sexuality exclusively to marriage. Hence this "opens debate on the meaning of sexual intimacy" (Louw 2008:351). As a result, many Christian traditions have "regarded celibacy as the most direct way to God, since those who choose celibacy thereby liberate themselves from the bondage to the world" (2008:351). In the light of HIV/AIDS issues, people need to be educated about sex issues not only to be limited to one idea or information.

5.2.1 Human sexuality in the Old Testament

Several texts from the Old Testament currently cause the challenge about an understanding of human sexuality as they relate human sexuality only to procreation as many Africans value children and take that as primary purpose of marriage (Rosenow 2011:53). In Genesis 4:1, the end result of the intimacy was for procreation as Adam‟s wife got pregnant after the sexual encounter. But, such texts need to be re-read by taking into consideration the cultural and economic background of the epoch, not only the literal sense of the Biblical text.

In the Old Testament, human sexuality was regarded as a covenant that was binding to the man to leave his father and mother and attach himself to his wife, and the two become one" (Genesis 2:23-25). Members of the Christian community should exercise mutuality in this challenging time of HIV/AIDS by not manipulating human sexuality to connect it to sin and promiscuity practice (Mcetywa 2001:33).

5.2.2 Human sexuality in the New Testament

Jesus promoted equality between women and men by opposing gender inequality. The notion of human dignity within the realm of sexual behaviour and the HIV/AIDS pandemic needs the compassion of God, recalling that the suffering people are the images of God. The pandemic of HIV/AIDS has created an atmosphere of despair and anxiety, especially when religious people regard HIV/AIDS as a punishment by God. This also happened in the New Testament when Jesus responded to the teachers of the law and the Pharisees, who wanted to stone a woman to death because she was caught in adultery. But, Jesus‟ response was, "If any one of you is without sin, let him be the first to throw a stone at her" (John 8:7).

In the present situation, Jesus‟ response can be defined as a type of support system to all people in spite of the crisis that they are facing. The crisis of HIV/AIDS continues to be a sensitive issue to be discussed because of its connectedness to sexual character. But that is done without considering the value of human dignity and identity and not thinking about choices, that being HIV positive is not the individual‟s choice, but circumstances had trapped the infected victims. Treatment that HIV/AIDS positive people receive drives away the perspective of compassionate caring and regarding people from the perspective of grace and being loved by God.

Instead, human sexuality creates anxiety, loneliness and fear of death to people whenever they think of their sexuality. HIV/AIDS is currently being connected to sin, just as the same attitude arose during the time of Jesus‟ ministry. The disciples connected illness with sin as they questioned Jesus about the cause for the man‟s blindness. Jesus responded by saying: "Neither this man nor his parents sinned, but this happened so that the work of God might be displayed in his life" (John 9:2-3). The dilemma we face needs messages of hope and a mindset to allow people to think positively about HIV/AIDS, especially about those already affected and infected.

5.3 Contemporary challenges of human sexuality

Sexuality is a subject that most Africans never discuss openly:

> In South Africa, sexuality itself is something that‟s hardly spoken about. When you are diagnosed as HIV positive, nine out of ten South Africans will think you are promiscuous.
>
> The subject is taboo. One of my tribe‟s men confirmed this recently when he said that traditionally, sex activity was performed in the house, at night when it was dark, when the animals and children were asleep, preferably under some cover. These are sacred and mysterious issues you know! In African culture, sexual matters are discussed in public only when there is a problem. Even then, they are discussed in figurative language and among equals in age. May the African ancestors forgive us for breaking the taboo here (Oppenheimer & Bayer 2007:69).

The world today is facing a challenge of finding a solution to the HIV/AIDS pandemic by preventing the virus from spreading. Human sexuality is at stake, because it is associated with the transmission of the HI virus. As nobody knew about HIV/AIDS, many things have been said about the subject. Some religious born again leaders in Nigeria, claim that the spread of HIV/AIDS "could be a form of punishment from God for sexual perversion, as was the case with Sodom and Gomorrah" (Chitando 2009:116). However, sexuality must be a subject of discussion at this time of HIV/AIDS and the church needs to provide counselling, and view human

sexuality from a positive angle that "all human beings are sexual beings from birth until death" (Louw 2008:354).

In some communities, sex has become a subject surrounded by much strong disapproval, legal sanctions and social taboos, for example when issues of men having sex with men (MSM), issues of sex workers, several sexual partners, the trauma of sexual exposure, and the presence of genital ulcers or other sexually transmitted infections. Human sexuality should be addressed from a perspective of building people‟s self-esteem, by paying high respect, offering tenderness and love in order to promote the quality of life during this time of HIV/AIDS prevention strategy When it engenders strong feelings of shame and guilt; as a result, such influences promote fear and silence about the subject of human sexuality. Some of the problems are that we really do not have an assessment model in a pastoral approach which can serve as a diagnostic and supplementary to the ABC model. For a hermeneutic tool in this regard the researcher wants to refer to the hermeneutical model on human sexuality (Louw 2008:359). This model could be implemented within a ministerial strategy which wants to focus on a prevention approach. The reason for positioning to this model is that it highlights both the Christian spirituality meaning of human sexuality and how sexuality is related to possible dangerous attitudes and inappropriate decision making.

5.4 Conclusion

When examining human sexuality in relation to the HIV/AIDS prevention strategy, there is a need for information to change the thinking which has influenced people‟s minds about sex and sexuality. Therefore, the church must be a trusted accurate source of information for human sexuality to be a subject open to all, without limiting the information to only premarital people. Re-reading of the Scripture is needed to avoid misinterpretation of texts. Such knowledge requires the wider understanding of who we are in relation to God and the pandemic of HIV/AIDS. Sexuality should be understood as a God given gift of grace within the realm of a covenant approach, human sexuality is designed to improve and to enhance human dignity. This is the framework of fidelity, mutual trust, unconditional love, and lifelong commitment. The

church is faced with a challenge of offering care and support to all the affected and infected and also to advocate for diakonia programs to support the needy.

Chapter 6: Summary, research findings and recommendations

6.0 Introduction

The research findings and recommendations will be given per chapter of the thesis. Eventually a few final recommendations will be provided.

6.1 Chapter One

In the first chapter, the researcher outlined the background of the research study. It served as an introduction to this research study. This chapter will find that Swaziland is rated as one of the countries seriously affected by the HIV/AIDS pandemic (Rupiya 2006:66).

Recommendation: Since the church is supposed to be a caring, loving, sharing, and listening community, the researcher recommends that the church in Swaziland embraces/adopts a pastoral strategy prevention program that will approach human beings from a pastoral view of caring and being loved.

6.2 Chapter Two

The second chapter stated that Swaziland is one of the African countries that still believes and adheres to its strong cultural practices. Swaziland has remained a society where cultural practices of polygamy are commonly practised. This chapter describes how the Swazi culture causes the status of women and children to be inferior, and further predisposes them to HIV/AIDS (Nhlapo 1992:51). Secondly, the cultural practices of polygamy, *kungenwa* (levirate/wife) inheritance, multiple partners and *kusheda* (extramarital relationships) are also described. Studies have shown that this culture contributes to the high risk of HIV/AIDS infection and creates opportunities for being infected (Whiteside 2006:18-19). Despite the fact of the appalling impact that the culture has had, it has not motivated cultural change in Swaziland, as well as in the African region (Green & Herling 2007:43).

Recommendation: The crisis of the HIV/AIDS pandemic challenges for change in cultural practices, and to be selective to the cultural practices that cause human suffering and contribute to poverty in the country and the ineffectiveness of the HIV/AIDS prevention model.

6.3 Chapter Three

In the third chapter, the ABC model in HIV/AIDS has been adopted worldwide as a model for preventing the transmission of the HIV/AIDS without considering the contribution that can be done by the faith based organisations. The effectiveness of the model for HIV/AIDS prevention has shown impressive results in Uganda in 1990 (Green & Herling 2007:5), but that has not consistently maintained the position. One should take a note that cultures are not the same, what has worked in Uganda the cultural obstacles‟ cannot permit the success in Swaziland where polygamy is permitted and prominent people are taking a lead on that. This chapter reveals that people in Swaziland are highly knowledgeable about the HIV/AIDS prevention model, but that knowledge has not been translated into the desired sexual behavioural change (Whiteside *et al*. 2003:14).

Recommendation: Therefore, the HIV/AIDS prevention model needs a *diakonia* approach in pastoral metaphors to advocate for a support system and offer care to communities infected and affected by the HIV/AIDS pandemic and communal cooperation of all and culture constrains be looked at with serious note.

6.4 Chapter Four

The fourth chapter describes how the roles of the church and non-governmental organisations have demonstrated in the issues of HIV/AIDS. The church has not taken a leading role in HIV/AIDS prevention. The church leaders being silent have created a barrier of information flow. Open discussion on sexual issues should be done in the church environment. Even after the formation of the Church Forum, the organisation which was formed to coordinate HIV/AIDS issues in churches. In this chapter, it was found that stigmatisation of, and discrimination against,

people infected and affected with HIV/AIDS are commonly found in churches, as they view HIV/AIDS as God"s punishment.

Recommendation: The church needs to be reminded about its mission of being called to offer pastoral care and counselling to all people despite gender, cultural status or health status. Therefore, the church needs to overcome its fear of the deadly disease that threatens human life, and face it with hope (Bate 2003:48).

6.5 Chapter Five

The fifth chapter discusses the pastoral approach to human sexuality as a prevention strategy. It has become a dilemma, as this is not a topic for open discussion – only for people in preparation of marriage. This chapter found that cultural women and young girls are expected to be naïve on the issues of sex and sexuality, while older and younger men are expected to be au fait about sexual practice. The inappropriate information of connecting sexuality to the transmission of HIV/AIDS has led to the subject of sexuality being avoided.

Recommendation: The church leaders are to be equipped with skill to engage all age groups in pastoral care and counselling, where issues of sexuality and cultural practices will be discussed. In the encounter in pastoral care and counselling information will be disseminated on the equality and dignity of all human.

6.6 Research findings

This research has raised the prevailing problem of cultural practices that have been discovered to contribute towards the high rate of HIV/AIDS infection in Swaziland. It also found that many people in the country are currently aware of the prevailing cause and effect of the problem, but mindsets have not changed so far as cultural norms of polygamy and multiple partners are concerned. Therefore, the researcher proposes the hermeneutic model as mentioned by Louw (2008:359, 363) as this model addresses sexuality from a Christian perspective, where sex will be discussed openly rejecting the taboos of culture away to be examined, as it promotes

responsibility in people‟s actions. Therefore, a shift in the paradigm for viewing the HIV/AIDS pandemic is essential to comprehensively address the impact of the high rate of HIV/AIDS in Swaziland, and target special areas of concern that humiliate human beings and rob their human dignity**.**

The factors that contribute to the high rate of HIV will be highlighted. The fact that Swaziland being a small country of only a million population with the highest HIV/AIDS infection has resulted the researcher to do the study, to find the factors that contribute to the infection rate being so high. The knowledge about the ABC model in HIV/AIDS prevention is known among the people but cultural factors hinder the effectiveness of the global model for HIV/AIDS prevention. It has been already indicated that the death rate in Swaziland is at 45% between ages of 16-35 years. One of the bigger contributing factors that is an obstacle to the current HIV/AIDS prevention model is the cultural practice of Swaziland and being a hierarchical country plays a big role. The cultural factors that contribute to HIV/AIDS are *sitsembu/*polygamy; the king in the country is an example of polygamy as he is married to many wives. The culture of polygamy is commonly practiced in Swaziland. *Bunganwa/*multiple partners: this practice is part of the Swazi culture, which permits all men to have as many girl friends as one wish, which gives a big choice to choose when one decides to marry. *Kujuma*/occasional short term, overnight visits between the unmarried female and male. *Kungenwa/*levirate/inheritance, women after the death of their husband are forced to marry the brothers of the decease. Women have no choice and the matter is never discussed, it comes as an imposed decision. *Kushenda*/ extra marital affair, the culture permits that only for men, for women it is a taboo. *Kulamuta*/ having sexual relationship with the younger sister of one‟s wife, young girls are infected through that kind of sexual encounter. Due to the poverty situation, there is no resistance as the men usually give a token of appreciation.

The society of all age groups and genders must be educated on the issues that influence change in communities, in order for people to have a positive understanding that sex is a God-given gift to be enjoyed and it is a sacrament to be celebrated and worshipped. In the research, the appropriateness and effectiveness of the ABC model in HIV/AIDS prevention was critically analysed, based on the problem statement that Swaziland is rated the highest with HIV/AIDS infection in Sub-Sahara Africa (Rupiya 2006:66). The church‟s contribution was discussed,

based on the different associations with which churches are affiliated in the country. The fact that the church has been silent and has not taken a leading role in the fight against AIDS was also discussed. This was done in the light of the fact that Swaziland, with its population of only 1 129 000, has had so many deaths. Thus, the seriousness of the pandemic in Swaziland has led to children heading many families and being exposed to sexual abuse, not only in Swaziland, but also in other countries especially in the Sub-Saharan region. Hunter (2003:27) quotes a child in Malawi who said: "When my father and mother died, I lived with my uncle, and then my uncle also got sick and died, so I went to live with my granny. She could not manage to send me to school [so I] ended up on the street to work."

In view of the above, the research question in this research project was, how can the church, in its pastoral ministry, apply the ABC model in HIV/AIDS prevention? This is rooted in the researcher‟s conviction that the church must adopt an HIV/AIDS prevention model that complements the global effort to prevent HIV/AIDS from continuing to exterminate human beings and impoverish the African continent. The traumatic situation of HIV/AIDS has been highlighted in that it needs the church, as a caring community, to effectively take a lead in disseminating information on the ABC prevention model and reach out, with empathy, to HIV positive people in their respective communities, while emphasising the consistent use of condoms.

The problem of culture in Swaziland was identified as one of the contributors to its high rate of infection and unfortunately, despite awareness, there have been insufficient organisations to reach out to all communities with support programs of awareness to advocate for cultural change from, for example, multiple partners, polygamy and wife inheritance which still exist in the country even during this critical time of the HIV/AIDS pandemic. Ever since the ABC model was introduced in the country, the mindset on misconceptions about HIV/AIDS information has been persistent denial, which remains the greatest obstacle to HIV/AIDS prevention in Swaziland, as well as in the African Sub-Saharan region. This has resulted in Swaziland having the lowest life expectancy in the world.

The Africans‟ strong belief is that, when sickness occurs, witchcraft is to blame. This makes people feel that the ABC model is irrelevant, as they believe that they have been bewitched. Ignorance, denial and misinformation hamper the successful application of the ABC model in

HIV prevention. As discussed, the HIV/AIDS prevention model comes with mixed and confusing messages, as De Waal (2006:99) states to give young people condoms is tantamount to giving them permission to be promiscuous. The churches should openly discuss this problem so that the people can receive a clear message. It is mentioned that the failure of the ABC model in HIV/AIDS prevention poses a challenge to the church‟s pastoral care, as we believe that pastoral care and counselling gives hope, and changes the lives of many people in the community from meaninglessness to meaningfulness.

Churches in Swaziland are called to change their attitude of silence and to embrace openness towards fighting the pandemic while openly discussing socio-cultural issues, i.e. critically reassess the traditions and policy on human sexuality and its connectedness to the HIV/AIDS prevention strategies. The ministry of the church is faced with two major related crises, the HIV/AIDS and poverty. The relationship between these two factors challenges the church not to focus on one factor, but on both for successful results, and so meet the needs of human beings in totality. Therefore, pastoral metaphors need to be advocated for the support and care of those infected and affected by HIV/AIDS. Finally, churches and other organisations working on the subject of prevention should join hands in the fight to provide successful care to the affected and infected and to provide them with empowering and encouraging messages, for example: “If God is for us, who can be against us?” (Romans 8:31).

6.7 Recommendations

An urgent need exists for church leaders to be empowered with new skills in pastoral care and counselling, to make themselves available to communities, and provide necessary services. The new mode of Christian spirituality need to be applied when leaders have been equipped. The skills will give knowledge that HIV/AIDS is not a punishment for promiscuous people. In the research, it transpired that church leaders in Swaziland are not as effective as they should be, especially during this time when people need care and comfort. The lack of effectiveness among church leaders signifies poor ministry of not being present in crises that people encounter in their existential issues. Therefore, the theology of sexuality must be revisited, as it emphasises responsibility in every sexual engagement. For church leaders, the incorporation of training and

education on HIV/AIDS issues will prepare them, in future, to manage various challenges that arise in the ministry, without being judgmental.

Churches should not base their teachings only on the resurrection of Christ, but they should start from Christ‟s suffering in order to be contextual in the time of HIV/AIDS. The 26% prevalence rate of HIV/AIDS infection among people aged 15 to 49 years bring about an awareness that the future ministry of the church is at stake.

The faith-based organisations need to organise workshops and awareness programs for continuous HIV/AIDS teaching in churches and communities. These workshops will help to remind church leaders to choose not to respond to the HIV/AIDS pandemic with judgmental theology.

In understanding how the virus has impacted on our communities, the church needs to present metaphors of comfort to those affected and infected with HIV/AIDS. The metaphor of God as a shepherd is relevant in the Swaziland context, since our God is caring, protective and comforting. Although the country walks through the valley of HIV/AIDS, this God is there, with his people. Thus, as a foretaste of the kingdom of God, the church ought to bring spiritual care to the suffering so that they do not view life only from the perspective of their suffering, but also from the eschatological destiny, based on the resurrection of our Lord Jesus Christ. In addition, the church should be encouraged to educate its members to conduct their life in a way that will protect them from being infected by the threatening disease.

When they view human beings in relation to HIV/AIDS, church leaders should understand human beings from the light of grace and being free, as Baard (2008:368-381) says: “Sin is truly understood only from the vantage point of the human experience of grace.” The church need to move away from stereotype practices but play a visible role in the HIV/AIDS prevention programs. Therefore, the researcher advocates that church leaders take it upon themselves to encourage change in cultural practices in Swaziland, especially the factors that contribute to HIV/AIDS, such as multiple partners, polygamy and wife inheritance, which still exist in the country, despite this critical time of the HIV/AIDS pandemic.

The church also needs to advocate a policy that can protect women in taking decisions, as Patterson (2005:110) mentions: “The Swazi society expects women to be subordinate and

submissive; allow men to have multiple sexual partners; and polygamy, which exposes women to HIV infection, is legal in the country." The church needs various interventions with non-governmental organisations to enforce programs on HIV/AIDS prevention to strongly empower societies to openly address the crisis of the epidemic in the country. The church is to take the responsibility to maintain its stance on sexual matters and HIV/AIDS prevention, so that a difference can be seen to reduce the infection rate.

Apparently, the introduction of male circumcision has aroused great interest among men in Swaziland; 71% would want their sons to be circumcised, while 54% of non-circumcised men are reported to want circumcision. Therefore, the health institutions in Swaziland need to provide adequate facilities for this exercise to be successfully carried out to meet the demands of the people. When they view human beings in relation to HIV/AIDS, church leaders should understand human beings from the light of grace and being free.

Leaders of the churches need to familiarise people by delivering messages of hope from the pulpit to give comfort to HIV/AIDS victims. They should demonstrate commitment in bringing about change in the society, as communities prefer programs that the church administers (Chitando 2007:14). The church will probably remain the trusted institution that people respect and support, therefore steadfast and bold leadership is needed to disseminate appropriate information with respect to people‟s needs. According to (Rosenow 2011: 59) the church is the only institution that can take appropriate steps to offer pastoral care for action in pastoral ministry, educate and advocate for diaconic care, reach out to communities bring healing to the physically body and spiritually being. Therefore, church leaders are to be encouraged in taking their position of pastoral care and counselling to the high infection rate in the world.

Understanding how the virus has impacted on our communities leads one to understand how the people created in God‟s image suffer and are affected by HIV/AIDS. That challenges the purpose of being the church among people, who are supposed to bring spiritual care in times of need and comfort, when they face existential issues. The faith-based organisations should give good quality service to communities and enhance the quality of life of the victims of HIV/AIDS in the country. It is hoped that information received from this study will be a good instrument to revisiting the ABC model in HIV/AIDS prevention, both in Swaziland and worldwide, so as to reduce high infection rates, especially in the Sub-Saharan region.

The challenge is to speak openly and break the culture of silence among people, especially dedicated people in communities, such as faith-based organisations and other organisations that offer help, for example NGOs. Strong political leadership is needed for a strong response to the crisis of HIV/AIDS in the country. Swaziland needs to put policies and strategies in place, which will help to reduce the high infection rate of HIV/AIDS in the country. However, if the church can engage in HIV/AIDS prevention programs based on the ABC model, the researcher hopes that the irrational thinking about the HIV/AIDS pandemic will cease, as the approach followed in the prevention program will not degrade the dignity of human beings in any form.

The church leaders should know that God has called them to exercise special discernment. Their theology must not be based on the assumption that HIV/AIDS is simply God‟s punishment for promiscuous people. The church must not abandon its prophetic role in society of promoting life care (cura vitae).

Amos (1988:55) states: “The Bible record is clear that our identity is as minister of reconciliation, it is because of the reconciling work of God in Christ Jesus toward us that we are able to be God‟s children.” 2 Corinthians 5:18-19 supports the above statement: ”All this is from God, who reconciled us to himself through Christ and gave us the ministry of reconciliation; that God was reconciling the world to himself in Christ, not counting men‟s sins against them.” The leaders of the church need to understand that all human beings carry the image of God even when the body is in suffering. God accepts us as we are, with all our shortcomings and sinful doing, therefore, He expects us to act likewise toward all people, young and old. The churches should create a forum whereby they report on what they have achieved regarding HIV/AIDS prevention programs of the ABC model, and on their strengths and weaknesses, as a way of encouraging each other to work towards fulfilling one goal for the benefit of the communities and the country.

The study calls for a better pastoral care program that can promote *diakonia* work to assist the church leaders in meeting the needs of people and providing counselling centres where people live, as a way of bringing comfort and care in their situations. Louw (2008:216) emphasises the importance of human encounters in times of suffering, and to foster hope in the face of many problematic situations that influence images of God. The second chapter gives descriptive information on the cultural practices that contribute to the suffering of humankind in Swaziland.

6.7.1 Model of being there: ministry of being present

As a matter of recommendation, the researcher proposes that the pastoral ministry of presence needs to be implemented in the HIV/AIDS pandemic. Considering that humans are spiritual beings that need to be assessed with the perspective of salvation and grace in the framework of their worldview, and given dignity in all circumstances that concern their human souls.

6.7.2 The four metaphors

6.7.2.1 The principle of servanthood and the wounded healer metaphor

In assessing the prevention strategy from a pastoral point of view, we need to employ metaphors of the servanthood principle. The ministry of presence will empower the affected and infected by not losing hope in their experience of existential issues. The prevention strategy, to reduce the high rate of HIV/AIDS in Swaziland, seems ineffective, as no impressive results have been observed after all the efforts of prevention programs implemented by faith-based organisations, NGOs and the Swaziland government in the country.

Therefore, regarding the principle of the wounded healer, which the researcher presumes that, in all the suffering that people have experienced, they need to discover God‟s faithfulness which will not focus on the origin of suffering in their quest for meaning, but instead discover that God‟s will is not suffering, but his loving care, and unconditional love. However, God‟s presence confirms this, i.e. the means of pastoral care on which the church needs to base its departure point of caring and offering healing to all affected and infected with the HIV/AIDS pandemic. This principle will enable people to discover God‟s compassionate love and his faithful care and comfort when He identifies with human suffering.

6.7.2.2 The principle of the shepherd metaphor: care as a mode of pastoral ministry

This HIV/AIDS pandemic challenges the church to implement the spirit of charity in pastoral care ministry, which needs to manifest in daily contact with people in their suffering.

This principle implies pastoral care that meets the needs of the people, as Louw (1998:40) quotes Matthew 25:35-36: "For I was hungry and you gave me something to eat. I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came to visit me." This caring principle should reflect in the church leaders‟ behaviour by displaying the shepherding spirit towards human beings, without being judgemental or by stigmatising those because of their being infected or affected by the pandemic of HIV/AIDS. *Koinonia,* or fellowship and mutual care, must be encouraged. This metaphor expresses God‟s love for sinners. His compassionate love and mercy are expressed in Matthew 9:36: "When he saw the crowd, he had compassion on them, because they were harassed and helpless, like sheep without a shepherd."

6.7.2.3 The wise fool metaphor: pastoral discernment and understanding

In this metaphor, as a caring community, the Church needs to offer pastoral discernment and understanding. It must impart Scriptural wisdom as the source of life.

6.7.2.4 The paraclesis metaphor: comforting as pastoral mediation of salvation

The presence of a pastor who offers comfort in times of suffering is essential. *Paraclesis* will offer comfort and care in the pastoral encounter. People in such an encounter experience reconciliation with God and grow in faith as the Holy Spirit works within the person‟s innermost being. In this crisis of the HIV pandemic, people need to be guided and comforted. The rendering of *koinonia* should be a remarkable symbol of growth in mutual fellowship.

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