

**A PENTECOSTAL RESPONSE TO  
THE CHALLENGES OF HIV/AIDS IN TUMAHOLE.**

**by:**

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**NOVEMBER 2000**

**DECLARATION.**

**I declare that "A PENTECOSTAL RESPONSE TO THE CHALLENGES OF HIV/AIDS IN TUMAHOLE" is my own work and that all the sources that I have used or quoted have been indicated by means of complete references.**

Signed by:  .....

**TJ SKHOSANA**

Date: **NOVEMBER 2000.**

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**This dissertation would not have been possible had it not been through the support of the following persons; Pinkie, my wife, Bafana and Lerato, my kids, for their tremendous support and tolerance for being absent when I was needed the most in the family.**

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**To those living with AIDS, this paper is not just about passing my exams but also about coming up with the real solution from the church's point of view. "While you are waiting for the solution, may God help to speed the cure".**

**To those who have died of the 'disease', "may your souls rest in peace". We who are left behind and are alive, promise 'to fight until the cure has been found'.**

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**Above all, I dedicate this dissertation to God, the Almighty, for being so good to me.**

## A Psalm of Life

By: Henry Wadsworth Longfellow [1807-1882].

*Tell me not, in mournful numbers,  
Life is but an empty dream!-  
For the soul is dead that slumbers,  
And things are not what they seem.*

*Life is real! Life is earnest!  
And the grave is not its goal;  
Dust thou art, to dust returnest,  
Was not spoken of the soul.*

*Not enjoyment, and not sorrow,  
Is our destined end or way;  
But to act, that each tomorrow  
Find us further than today.*

*Art is long, and time is fleeting,  
And our hearts, though stout and brave,  
Still, like muffled drums, are beating  
Funeral marches to the grave.*

*In the world's broad field of battle,  
In the bivouac of Life,  
Be not like dumb, driven cattle!  
Be a hero in the strive!*

*Trust no Future, howe'er pleasant!  
Let the dead Past bury its dead!  
Act,-act in the living Present!  
Heart within, and God o'erhead!*

*Lives of great men all remind us  
We can make our lives sublime,  
And, departing, live behind us  
Footprints on the sands of time;*

*Footprints that perhaps another,  
Sailing o'er life's solemn main,  
A forlorn and shipwrecked brother,  
Seeing shall take heart again.*

*Let us, be up and doing,  
With a heart for any fate;  
Still achieving, still pursuing,  
Learn to labor and to wait.*

## **EXECUTIVE SUMMARY.**

**This dissertation is a challenge to the Pentecostal churches, particularly, the Apostolic Faith Mission Church in Tumahole, to take an action in meeting the challenges posed by HIV/AIDS.**

**This disease, HIV/AIDS, is the latest enemy to human life that the nations are faced with. In the newspapers like Sowetan, there is an article almost daily about HIV and AIDS.**

**In this dissertation, I have tried to show shocking figures of how this disease is spreading in Africa. The seriousness of the disease, unlike other diseases, is its incurability. The secular organisations are far ahead of the churches in as far as the relevant programmes on combating HIV/AIDS are concerned. Despite these massive programmes, the disease is spreading like the wild fire. Deducing from this background, it is no longer the question of whether the Pentecostal churches have any role to play, but what specific role should the church play in this challenge.**

**In this challenging times, many people look at the church as one of the most important institute that would play a positive role in bringing hope to the hopeless.**

### **KEY TERMS:**

- 1. AFM: The Apostolic Faith Mission Of South Africa.**
- 2. AIDS: Acquired Immunodeficiency Syndrome.**
- 3. ARC: AIDS Related Complex (sicknesses).**
- 4. AZT: Zidovudine Drug.**
- 5. HIV: Human Immunodeficiency Virus.**
- 6. SIV: Simian Immunodeficiency Virus (virus with the same characteristics as HIV, but found in chimpanzee).**
- 7. TB: Tuberculosis.**
- 8. TLC: Transitional Local Council.**
- 9. PCP: Pneumocystis Carinii Pneumonia.**
- 10. WHO: World Health Organisation.**

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# A PENTECOSTAL RESPONSE TO THE CHALLENGE OF HIV/AIDS IN TUMAHOLE.

## 1. INTRODUCTION.

This paper is an attempt to look at the role that the Apostolic Faith Mission (Tumahole Assembly) can play in the community for people who are infected and affected by the Human Immunodeficiency Virus (hereinafter HIV) and Acquired Immunodeficiency Syndrome (Hereinafter AIDS) epidemic. My focus in looking at the effects of the epidemic would mainly be focused on the African people of Tumahole community. It's a fact that HIV/AIDS in South Africa affects mainly young African people more than other populations. If there is anything that the church or any other community organisation can do in helping to bring a solution to our ailing nation, that could be done by being engaged in our different communities. When all people from different immediate communities are involved and engaged in the struggle to bring down the rate of HIV/AIDS, then the end results would be positive for the whole country. The best practical model in involving the churches other community structures can be found in Uganda. According to the World Health Organisation (WHO), because of engaging all the affected structures, Uganda is the only country in the world where the rate of HIV/AIDS is declining.

The fact that blacks are proportionally affected more than other populations in South Africa, compels me to look at the history of our land and how Africans have been subjected to human depravity and dehumanisation by the social, political and economic power of the past system.

Since the coming of the Dutch settlers to South Africa in 1652, Africans have been forced to suffer by loosing their humanity and property; land and livestock. At the ultimate end, the beggar (settler) became the owner, and the owner (African) became the beggar. The introduction of legislation of the Land Act of 1913 and also in 1936 witnessed further humiliation of the Africans through the confiscation of their land. The resulted to the struggle by the Africans to reclaim what was rightly theirs. The introduction of the racial laws through the Apartheid system in 1948 when the Nationalist Party came to power, alienated blacks further in their own mother/fatherland. The black people were segregated and pushed to the homelands. As a result, they had to come to towns

as the aliens who were good for working for the whites. While the towns were becoming richer and tidier through the sweat of the blacks, back home it was different, poverty was fast taking its course. The men who left their wives and children behind to come to towns and work for the families, experienced life in a new way. Some ended up 'marrying' the 'town women' and spent their wages with them. Thus depriving their homelands spouses. Because of migration, this situation in the mines was even worse.

At the same time some people, mainly men, had to leave their families because of their political convictions and the political cross-border migration. As 'men would be men', they too got involved in love affairs.

The unbanning of the outlawed political organisations and the release of Mandela and other political prisoners on 11 February 1990 ushered in new hope to the oppressed masses. This hope was realised with the first democratic elections on 27 April 1994. The long struggle of political emancipation was over. The apartheid regime was finally dealt with and South Africa was finally politically free.

Politically we were freed but the new struggle of HIV/AIDS and poverty had begun. Those who fought for freedom are back in the fold and are now fighting the disease that has and still destroys and kills many young people more than all the killings orchestrated by the apartheid regime (Sowetan, 4 June 2000).

In a leaflet for June 16, 2000, the National Youth Commission has as its theme for the day "**HIV-AIDS: The new enemy**". And as its introductory remarks it stated: "*24 Years ago brave young people fought against apartheid and defeated IT! 24 Years later there is an unseen enemy attacking youth – HIV/AIDS!*" The message in the leaflet continued to say, "*Like the system of apartheid once did, HIV-AIDS threatens the survival of generations to come... We could all see apartheid being enforced at schools, workplaces and wherever we went. We cannot see HIV/AIDS with the naked eye, but unless we join in the fight we will all be affected by it in some way*".

The worse thing about this disease is that it has got no cure, no mercy and respect for persons' age, status and class. Its victims range from innocent newly born babies, victims of rape, innocent and faithful partners who got it through their partners' unfaithfulness, and reaches to those who were irresponsible with their lives.

The effect of the HIV/AIDS virus is more dangerous and more deadlier than war. It is said that Vietnam war caused 50 000 lives in 10 years in America while HIV/AIDS infection has risen to more than one million in 10 years.

*"AIDS challenges the church to look again at its attitude to judgement, to morality and respectability. The challenge for the church is to work on itself, to create its own communities where people can learn to move forward and grow with each other"* (Woodward 1990: 70). When the secular ideas fail to bring a solution, *"the church is where people seek solutions, but the church has in fact being shying away from the realities of everyday life. The church is slow in reacting to social issues...Moreover, many priests are poorly informed about HIV/AIDS. Their only source of information is what they read in newspapers or see on television"*(WCC Study Documents 1997: 84). This dissertation on the one aspect will serve as resource material to such priests and the lay people who have been affected by the same ignorance.

People and leaders of different faiths and denominations have received the issue of HIV/AIDS differently. To many fundamental Christians, HIV/AIDS is the direct intervention of God's response to immorality taking place in the world. While there are debates about the morality and immorality of this dreadful disease, people are dying without us coming with an answer. Woodward (1990:51) is right in saying *"sickness is not a theatre in which to rehearse arguments about blame and divine retribution"* .

The church has a legacy of distancing itself from issues affecting the broader community as if it s not part of it. *"Often it is only when someone close to us becomes ill with AIDS that we first begin to understand the sheer scale of suffering involved"* (Nicolson 1996: 15).

I won't forget the story of the woman who came to me for counseling. In the process I managed to convince about bringing her husband with because it was evident that he was unfaithful in their relationship.

While discussing with them, I told them, especially the husband, about the consequences and the fruits of unfaithfulness that can later bring about the sexually transmitted diseases such as AIDS. At the mention of these facts, the woman started to cry. On the insistence to know how I can be of an assistance to her and the family, she then informed me that for the past 18 months she and her husband were diagnosed positive. In the presence of the husband she proved beyond reasonable doubt that she was innocent and faithful in the relationship.

I shall also not forget the many people I met and prayed for and many of them have passed away. Among these was my own sister whom because of her good behavior I never thought she could become a victim of this disease. She passed away in December 1998.

These are the people who challenged me through their sicknesses to do something as a Pentecostal pastor to the challenge brought about by AIDS in my community.

This dissertation is for the good memories I have had with these people. The church cannot remain silent while so many people are dying. I must admit that before beginning with this dissertation, I thought that I had all the information I wanted about the disease, but since starting with the research, I have realised how little I knew. If in 'all my knowledge', I had such little knowledge, what about those uninformed or with little formal education?

It is against this background that I would like to make this dissertation. My audience is not only the academics who would be marking this work, but I would also like to include those who are uninformed about the disease. To do so, I would, under analysis of HIV/AIDS, touch on topics such as what AIDS is, prevention, prior and post test counseling. This is for the purpose of helping my immediate community in order to see how far their contribution has impacted in this work. At the end, the final product will also serve as an information brochure to the community and the church.

## 2. RESEARCH PLAN.

### 2.1. Research topic:

“THE PENTECOSTAL RESPONSE TO THE CHALLENGE OF HIV/AIDS IN TUMAHOLE”.

#### 2.1.1. Central research question:

WHAT SPECIFIC ROLE CAN BE PLAYED BY THE LOCAL APOSTOLIC FAITH MISSION (AFM) AS A PENTECOSTAL CHURCH RESPONDING TO THE HIV/AIDS CHALLENGES IN TUMAHOLE ?

#### 2.1.2. Motivation for the research question.

As already indicated, HIV/AIDS is affecting all people regardless of age, colour, greed, sex and education. Though blacks seem to be the hardest hit, the epidemic infects indiscriminately. In case of death and suffering, the question for the church is not whether it can play a role or not but what specific role can it play.

In the past, any topic related to sex was regarded as a taboo in the churches. Thus, the church did not take HIV/AIDS seriously as an issue that needed its urgent attention. My church in particular, regarded the epidemic as a punishment by God to fornicators and adulterous. I as a minister in the local assembly also preached using the epidemic to scare the people from indulging in sexual sins.

But, the more I got involved in organisations which put the epidemic in its agenda as a matter of priority, my perspective has changed. This happened in the year 1993 when I was working for the South African Council of Churches as field worker. I was responsible for the department that dealt with Youth, Education, HIV/AIDS and Development. The council undertook training for its personnel on the subject of HIV/AIDS. I want to admit that the way the facilitator was so good and informed about the subject, and I was ‘converted’. Returning from the workshop, I was highly motivated. I organised and invited ministers from the Vaal Region to workshops on HIV/AIDS. The ministers were very skeptical. Though the workshops were good, not many results were seen from the grassroots. This lack of action from churches demotivated me. When I left the SACC in 1994, I also quitted being involved in the HIV/AIDS related issues.

I was reintroduced to the HIV/AIDS related issues between 1997 and 1998, when I was invited by the newly formed organisation in my community, Partuma AIDS Awareness Group, to their activities to address the community on my capacity as a minister on HIV/AIDS and the role that churches, particularly local AFM can play in bringing down the rate of infection while caring for those who are already infected.

The death of my sister, and another member from the church, death of those I knew who had been infected, meeting people who are infected seeking a message of hope compelled me to do something from the immediate community which I had the direct influence, i.e. the church.

## **2.2. Unit of analysis:**

### **2.2.1. Members of the congregation, especially the youth between ages 14 and 30.**

The reason for this is that the majority of people infected with HIV/AIDS are at this age group as it would be seen later. The majority of the members of our local congregation are also in this age group.

### **2.2.2. Health personnel and the agencies dealing with the HIV/AIDS,**

These are the people with first hand information on people infected as they are the once who do the testing. Their information would be more reliable than any information since HIV/AIDS is a health issue.

### **2.2.3. People living with AIDS (PLWA's).**

As this paper is trying to come up with role that can be taken by the church, we can't do anything for people without their full participation or else this would be a futile exercise. These people can direct the agenda of the role that the church could follow.



#### **2.2.4. Family members of people living with HIV/AIDS:**

HIV/AIDS does not only affect those who are infected but affects family members of those infected. In some cases the family because of the fear of being associated with and the stigma attached to this disease, rejects the infected people. The emotional response of the family members has got to be taken into consideration if the church would like to do justice in counseling these members too.

#### **2.3. Research methods:**

2.3.1. **Interviews:** a person whose three relatives died of AIDS, Health personnel (nursing sisters at two of our clinics), leadership of Partuma AIDS awareness Group, and a woman whose husband was unfaithful.

2.3.2. **Participatory observation:** being part of December 1, AIDS Day, observing while taking part in the discussion on AIDS, visiting the offices of the Partuma AIDS Awareness Group observing how they conduct their daily activities, visiting youth services where the youth in our church were deliberating on HIV/AIDS related issues.

2.3.3. **Questionnaire:** two sets of questionnaires were made (see addendum k and l). Questionnaire k was directed to personnel on health centres (e.g. clinics), and members of Partuma AIDS awareness Group. Addendum l was directed to members of the church.

2.3.4. **Documentary analysis:** documents of church's constitution, Greater Parys Transitional Local Council (TLC) Strategic planning document, newspapers and relevant books on HIV/AIDS, Workbooks 1-4 on MTH course.

### 3. THEOLOGICAL RESEARCH METHODOLOGY.

#### 3.1. Different approaches of doing theology;

##### 3.1.1. Contextual Approach.

In the past theology was mainly done by the professional elite at the universities (De Beer and Venter 1998: 32) or at the theological seminaries and/ or institutes. There has been a great shift from that approach in this age. Theology can and is also being done by ordinary people. Theology is not only about theory but more of praxis. It is about experiencing God in one's own practical situation.

The context of the poor, needy and the suffering are the starting point in this approach. The God of the Bible, has always identified himself with the poor and the suffering. This could be seen by the Israelites' liberation from Egypt and the return of the exiles (even where they were exiled because of their disobedience), and also with the coming of Christ who incarnated Himself in the human body and suffered with people to the point of the cruel death of the cross. The context, in this approach and not the church, is our point of departure.

The goal of this approach is transformation. *"God's vision is about transformation... of our present reality into his kingdom vision... This is an ongoing process to which we are invited to become participants"* (De Beer and Venter 1998: 41). This transformation begins with oneself, then our churches and later our communities.

In this approach other sources of doing theology apart from the Bible are used; i.e. social context, spirituality and the church, personal experiences, training and education.

##### 3.1.2. Confessional Approach.

This approach differs with the above in the sense that it 'maintains that the Bible is the only source for doing practical theology (De Beer and Venter 1998:34). Theology from this perspective focuses on the church and its ministry.

### 3.1.3. Correlational Approach.

In this approach the activities of the church and the believers in spreading the Gospel are a central point. The Bible is not the only source of doing theology. Unlike the contextual approach, in the correlational approach, the church remains the main focus (De Beer and Venter 1998: 34).

For the purpose of this dissertation, I prefer to use the contextual approach for its flexibility and emphasis of the context in doing theology. This will relate more relevantly to the context of those living with HIV/AIDS.

### 3.2. Methodology.

*“My theological method is how I construct my theology, how I obtain theological knowledge, and how I allow the various sources to interact with one another sothat my praxis will be transformative (De Beer and Venter 1998: 48).* In this way, it is evident that theology does not happen in a vacuum but within a specific context.

In this dissertation, I have used the pastoral circle or four-phased method of Holland and Henriot (1984) which was adapted by Cochrane, De Gruchy and Peterson (1991). The four basic phases of this method are **Insertion, Analysis, Reflection and Planning.**

According to De Beer and Venter (1998), the first step in doing theology is insertion. This step has to do with my present experiences and the actions I take in responding to the challenges raised by the context and at the same time how I am relating that response to my faith. It is a response to the present challenges within a specific context. As a Christian, my response will always have its starting point from faith. Theology is the knowledge about God; how one understands God in his/her present situation. The way one understands God, is the way he/she will respond to the given situation. As situations differ, so will be the responses of the people. For the response to be relevant, it has to be contextual.

Insertion can also be understood in terms of the incarnation of Jesus. In incarnation, *‘we are challenged to enter the reality of the inner city as Jesus entered our reality, giving ourselves as Jesus did, becoming human for other human beings, showing solidarity with the pains of the city’*

(De Beer and Venter. 1998: 51). Incarnation means to be immersed into your community in every way, to be part of it through and through. It is God dwelling with and among us. It is Him choosing to identify with us. As Carr (1989:74) puts it, "*Incarnation is God's statement of His willingness to be used in the confused human dynamics of transference.*"

With this understanding, "*We can begin to see, therefore, that the doctrine of the incarnation is firmly located both in common human experience and in the particular experience which pastors themselves acquire through their ministering with people*" (Carr 1989: 83).

Two of the Scriptures which are quoted in the Workbook One (Venter and de Beer 1998) as the examples of incarnation or insertion are Ezekiel 37: 12- 15 and Philippians 2: 5- 8. In the book of Ezekiel, the Spirit took the prophet to the captives and **he stayed with them** for seven (7) days. Jesus was inserted or incarnated in human body. He became one with humanity and suffered with them. As a pastor and a theologian, I am also part of the community I stay in. Their suffering and their joys are mine.

After the insertion stage follows the analysis of '*the identified or described experience, reality, or action*' (De Beer and Venter 1998: 58). There is a shift of realms from that of personal to that of broader social realm. The analysis helps one to understand and explain the reality in which one is inserted. One of the questions to be answered in this phase is 'why' things are as they are.

My analysis won't be an end in itself. I would go further to reflect on my spirituality, as a Christian, personal, social, theological as well as denominational reflection. If things are as they are, and the analysis reveal the social injustices, the next question would be how do I relate my faith to my experience. What does the Word of God say in this particular situation? How does my particular denomination influence my response?

Based on my faith, then I can take an action to remedy the situation. This is where the pastoral action comes in. This pastoral cycle is contextual in its approach.

### **3.2. PERSONAL AND DENOMINATIONAL ASSUMPTIONS.**

- 3.2.1. There are people living with AIDS but are not known either by me or members of the church because they fear being ostracised by fellow Christians.
- 3.2.2. Christians are not yet ready to take up the leading role in facing the challenges of HIV/AIDS.
- 3.2.3. Churches have got a specific role to play in contributing to the reduction of HIV/AIDS spread.
- 3.2.4. Christians will make prayer their priority in dealing with people living with HIV/AIDS.
- 3.2.5. Christians will see HIV/AIDS as their problem in which they can contribute for solution.
- 3.2.6. The church has the resources to face the challenge.

#### 4. MY INSERTION:

##### 4.1. The Local challenge: Tumahole township.

The name of the township, where the research is conducted is Tumahole. It is situated in the magisterial district of Parys in the Free State province. This town is right at the bank of Vaal River at the border of Free State and North West province.

##### 4.2. Historical background.

In tackling the history of the township, I can't exclude the history of the town, Parys.

Parys (according to Greater Parys TLC Strategic planning document), was declared a town on the 16 May 1882 and in 1883 the Town Management body was established. In 1887 the growth of Parys led to the replacement of Town Management by the Municipality.

The discovery of gold in Transvaal in 1886 caused major changes in town. Travelers and businesspeople who moved through the town caused the generation of revenue for the town. At this early stage the municipality already realised the potential of Parys as a holiday town. The constraint of little funds limited the development of recreational facilities.

On 2 September 1903, Parys received a magisterial seat. It's speculated that the historically black residential place (Tumahole) was established in the same period. The first blacks residents of Tumahole were domestic and gardeners who came with their masters.

##### 4.3. Tumahole.

This township received recognition and registration as a permanent residential area in the early 1920's. Later the place was incorporated into the then Oranjevaal town councils with the overseer of the indunas (township leaders), and later by the councillors.

Because of the lack of housing, people hired and lodged in the backyards of those who were fortunate to own the houses. These lodgers were double-taxed by paying the council and the landowner.

Staying at the backyards was unpleasant for the lodger as a result of the friction between the owner and his/her household, which later was blamed at the lodgers.

The burden of double taxation, being woken in the middle of the night by the municipality police to check for the lodgers' permit, and the need to own the piece of land before one dies, led to insurrection whereby the lodgers felt that enough was enough. In one community meeting in 1990, they decided to defy the authorities and to illegally occupy the open spaces and build their own shacks as squatters. This is how the present sections such as Mandela, Sisulu, Tokoloho, Lusaka and Zone 6 were constructed.

The failure of the authorities to take action led to influx of the squatters from inside and outside Tumahole. People from the farms who were also tired of the oppression by the farmers migrated to the newly established squatter camp. Those from the farms came to be free and also with hope of getting better employment. The other reason of migrating to town was the market character of the town. The town in itself attracts people. *"Towns are typically markets, markets of commodities, labour markets and financial markets"* (Shorter 1991: 10). It is a pity that when they arrived in town, they discovered that the town has no place and hope for them.

#### **4.4. The Apostolic Faith Mission in Tumahole.**

##### **4.4.1. My faith community;**

I belong to the Apostolic Faith Mission of South Africa Church. This falls under the Pentecostal churches with the emphasis of baptism in the Holy Spirit as it happened on the day of Pentecost. The church is the product of Pentecostal revival that took place in South Africa in 1908 under the inspiration of John Graham Lake from the United States of America.

After its establishment, it had three (3) mission fields. This means that the White church was the church while the Blacks, Coloureds and Indians were not registered churches, but the daughter-

churches of the mother-church. These daughter churches had a white missionary to coordinate their affairs.

### **Some of the fundamental teachings of the Pentecostals (Hollenweger 1972);**

#### **The Doctrine of the Holy Spirit;**

For the Pentecostals the Acts of the Apostles are regarded as a normative record of the normative primitive church. The apostolic church is its obligatory model. The Pentecostals' understanding of the Bible to question the lack of miracles in the present day church. In responding to the question, they (Pentecostals), believe that the reason cannot lie with God since He is unchanging but the problem is with the unfaithfulness of Christians.

#### **The Bible as the authoritative Word of God.**

To the Pentecostals, Bible does not only contain the Word of God, but is the Word of God. The critics of the Pentecostal movement who accuse it of neglecting the written word in favour of individual illuminations by the Spirit are ignorant of the role which the Bible plays in this movement. "*Pentecostals live with the Bible*" (Hollenweger 1972: 321). Most of the Pentecostals read the Bible daily and know many passages by heart. The words of the Bible are woven into their prayers and writings. The power of the church and the moving of the Spirit comes directly from the authority of the Bible. Without the Bible there is no church and no answer to modern problems facing the world like HIV/AIDS.

To someone who lives by the Bible in this way has only one desire: to experience the Holy Spirit in exactly the same way as the first disciples. According to Pentecostalism, the traditional churches are still stuck between Easter and Pentecost. Although they know that Jesus died and rose again, the lack the Pentecostal power which fell on the disciples when they were behind the closed doors, drove them out, and made them into courageous witness to the gospel.



### **The Healing power and the Doctrine of miracles.**

Once people are born-again, have baptised in the Holy Spirit, read their Bible and living a holy life, the biblical promises that 'greater works than these ye shall do', and 'these miracles shall follow those who believe', shall be experienced. In the evangelistic crusades, these miracles are experienced.

When looking at the experiences of miracles and healing happening taking place under the ministry of Prophet Joshua in Nigeria, one is left wondering what great things that God can do. In his church, people with certificates of being HIV positive are prayed for and later go for check-up, and return with the certificates of retesting but with opposite results.

The above background helps one to understand the AFM as the Pentecostal church. This same background will also help in shaping the AFM's response to HIV/AIDS challenges.

### **The church and the status quo.**

In its fundamental teaching of the Christians' non-involvement in politics, the AFM church made sure that the blacks were not in anyway involved in politics or any matter of social interest.

While blacks did not have the vote in South Africa, their counterparts (the white) had the vote and were able to invite the government representative to address the gathering of the White Workers' Council which is the highest policy-making body of the church.

In his book, Church and Politics, the then president of the church, Dr F.P. Moller (1976:7) says:

*"The apartheid policy was based on the vision of the parallel co-existence of different national groups. The idea was that each ethnic group would be an independent state. The apartheid policy was implemented by legislating apartheid laws. These laws were to serve as a guide to place the various population groups on the road to distinctive development and autonomy."*

In other words, the South African apartheid government was an ordained institution from God and all its laws were approved by Him.

This teaching was taught at the Bible colleges. The same book was a prescribed material at the whites, Coloureds and Indians' colleges.

To make sure that no one steps outside the teaching of the church, discipline and excommunication were applied. The victim of this was Pastor Frank Chikane. Chikane (1988) was suspended from the church in October 1981 and in November was arrested under the state of emergency for six (6) months.

His suspension took ten (10) years and was uplifted when the young people from the church began to resist. They formed the Reinstate Frank Chikane Campaign (RFCC) and forced the leadership to reinstate Frank. At the moment Frank is full-time pastor in the church. A year earlier (1986), the church had signed a 'Declaration of Intent' renouncing apartheid as a sin.

Finally, in 1996, the church united and became one. One of the current burning issues in the unity is the 'Clergy involvement in Politics' and non-affiliation of AFM to ecumenical bodies such as SACC because of the Council's support of inter-faith dialogue.

The above points are mentioned as a way of showing how the church in its fundamental teaching was able to miss God's truth of non-racialism in the church. It's my assumption that as much it could support apartheid, it is possible for the church to miss God's moment of kairos on matters related to HIV/AIDS. It is on this assumption that the church condemned the disease and the person infected without showing the difference.

#### **4.4.2. Ecumenism and the national office;**

National AFM has good working relations with movements such as Independent Fellowship of Christian Churches (IFCC), The Evangelical Association in South Africa (TEASA), World Pentecostal Movement, Pentecostal Churches in South Africa, Dialogue with Rome.

#### **4.4.3. Involvement in community issues.**

With its Welfare Department, the AFM is involved in poverty alleviation programmes. All the local branches have been requested to register with the department to receive assistance to help the needy.

In October 1999, a letter was secularised from the Head Office urging the local churches to be involved in community development in order to reduce the high rate of poverty that usually leads to crime. In the analysis of the situation the secular regarded poverty as the cause of the rate of crime in our land.

Unlike in the past, the church is busy waking up to the realities of our societies.

#### **4.4.4. Local AFM Church.**

As opposed to the national Church, we do not only preach against individual sin, we also preach against the structural sin. Though believing and accepting the Bible as the Word of God, we also refer to the context in order to make the Word relevant to the people in our community.

#### **4.4.5. Ecumenism and local assembly.**

The problem with many churches is that each has its own thing there and does not want to mix with others. This makes the church ineffective when coming to the matters of common interest where the lives of the people are affected. When people want to know the united voice of the church, it can't be found because of the division.

In his book John Perkins ( 1993: 24) says: *"The race has divided us so efficiently into separate churches, neighborhoods, relationships and agendas, that there is hardly the opportunity for the whole church to attack the problem of urban poverty"* .

In order for us to avoid this problem, we forged the working relationships with other Christian organisations and churches. We have a good relation with Gauteng Council of Churches, the affiliate of the South African Council of Churches (SACC). I worked for two (2) years for SACC.

We are part of the Tumahole Ministers' Fraternal (Tumifra). We are also part of the formation and the members of Tumahole Pentecostal and Evangelical Churches Alliance (TUPECA). In our

mission statement, we have included working relation with other churches as an obligation and something that we need to work for at any cost.

#### **4.5. MY PERSONAL LIFE.**

I started ministry 11 years ago at a small place called Refengkgotso in Deneysville. This was a very poor community with very few people working. I was the first person in this community to receive a degree.

The community lacked genuine leaders as a result of lack of education and due to passivity by he learned folks. This resulted into me taking leadership role as an attempt to empower the community for transformation and sustainable development. I was once arrested for trying to intervene between the police and the 'comrades'. This arrest necessitated my involvement in community activities.

I served in community structures such as South African National Civics Organisation (SANCO), Free State Health Department's Feeding Schemes, non-governmental organisations (NGO's), Local Adult Basic Education and Training (ABET) forum and the Early Childhood Development (ECD) committee. I was able to start and register an ABET Centre with Independent Examination Board (IEB). The centre also pioneered the breadbaking, brickmaking and candlemaking projects to create jobs for the unemployed .

I was part of the people who started the Reinstate Frank Chikane Campaign (RFCC) which forced the church (church) authorities to lift Pastor Chikane's illegal suspension. The campaign was successful and he was reinstated in 1990.

At the moment I am the Parys Town coordinator and the chairperson of Culture of Learning, Teaching and Service (COLTS) which exist for the sole purpose of restoring and bringing back the learning and teaching in our township schools.

At the present, I am the member and public relations officer of the Tumahole Ministers' Fraternal. I am also the chairperson of the Tumahole Pentecostal and Evangelical Churches Alliance (TUPECA).

My involvement in the community and their structures has made me to talk like the healed blind man who said 'what I know is that I was blind but now I see'.

I can't forget moments when people came in the middle of the nights to ask me to pray for the sick members of their families, or to ask for something to eat, or to ask you to bury their dead relative.

#### **4.6. HIV/ AIDS infection in the community.**

According to the responses to the research I made in July 1999 (see addendum K), there are 181 people infected with the virus. In this number, 66 are males while the rest, that is 115 are the females.

Age distribution is, below 19 years 11 are infected, between 20 and 29, 73 are infected, and those between 30 and 39 are 63. And those above 40 are 34.

In the concluding comment from one of the local clinics is that the number of the unknown far outnumber the known. The words of Dixon (1989: 14) are truthful in saying "so if you know that ten people in your city or town have died of AIDS, you know that maybe a hundred or more are walking around the streets everyday feeling fine but carrying the killer virus". The health centre states that between January and October 1999 there was a high death rate of young people between the ages of 20 and 40 suffering from diseases such as pneumonia, hepatitis, cancer, and meningitis. The report states that most of these victims were potential AIDS virus carriers that were not known to the clinic.

#### 4.7. My personal encounter with HIV/AIDS.

As implied in the introduction, South Africa has had a very bad history of violence and death. Whenever a number of dead people is mentioned, in most of the times, this is just a statistics. Even when the number of those infected with the virus is mentioned, it remains a statistics someone close to you is infected or affected. It is only then that the number becomes meaningful.

My real experience of a person living with HIV/AIDS was when my own sister informed me that she was diagnosed HIV positive in 1999. I realised later that she knew her status 4 year prior to the latest revelation in 1999. But decided to keep this secretive until she was very sick and after the doctor took her blood for testing, she informed us so that we should not be surprised with the results. I was with her on her last day before her death. More pain for me was when I was to inform people about the cause of her death. What we decided to tell people was that she died of pneumonia. This is what appeared on the death certificate. Loosing a member of the family because of AIDS brings psychological distress because of the stigma the community has placed on HIV/AIDS.

The other encounter was with one member of the church whose husband was diagnosed positive and when she went for testing, her results were also positive. As a faithful member, this was a shock to us and to her. But she is still in good health. Her fear at the moment is to tell people about her HIV status. She says that she was discussing the HIV/AIDS issues with other devout Christians and these were very negative to AIDS and showing no sympathy to people living with AIDS. In her mind she wondered how these people would react once they knew her HIV positive state.

Between September and November 2000, I was able to know about the death of three persons who were close to me and who were infected with the virus and died of the AIDS- Related sicknesses.

The following is the story of one member of my congregation about her encounter with HIV/AIDS as related to me:

### **The story of the 21 years old lady.**

This lady suffered the loss of a sister, aunt and a cousin.

#### **Her sister (28 years):**

*"The first time I heard that my sister was HIV positive I was very shocked. I could not believe it because she was the remaining person after the separation of my parents and the death of my mother. My sister was a nice and honest person who believed in having one partner at a time. My sister was not aware of her HIV status until very late when she was becoming very sick. She discovered this status after being hospitalised and when a doctor diagnosed her HIV positive, she was immediately discharged so that she could come home and die. This, she kept as a secret until she called me on her dying moments to inform me about AIDS status and that she was going to die.*

*"What is amazing thing is that her husband and a two year old baby are diagnosed negative. I believe that more than the sickness, my sister died of fear and shock of contracting the virus while she fought very hard to achieve her goals in life".*

#### **Her aunt (38 years):**

*"I was not surprised to know that my aunt was HIV positive. To me, it was that she deserved it because of how she conducted herself. She was a person who used to have many partners at a time.*

*"After being diagnosed positive, she was full of revenge and vowed to spread the disease. At some stage, old as she was, she was in love with a boy of 17 years. This boy was old enough to be her son but she infected her on her vengeful spree. One of her boyfriend died of the disease related to AIDS.*

*"On her dying moment she chose to accept Jesus as her Lord and Saviour".*

**Her cousin (32 years):**

*"My cousin was a devout Christian who belonged to one of the Pentecostal fundamentalist church (Assemblies of God). As I understand it he must have been infected before conversion and was unaware of his status until very late in his life. The lady who was in love with him before he was converted died of AIDS related sicknesses two years before him".*

It is after meeting the likes of this lady that one realises that the church cannot fold its arms, it has got to do something for both the sufferers and the members of their families. Should these three victims have been counseled, they should have been helped to be positive about life. Her aunt would not have resorted to revenge but would have been helped to take care of her life and forgive the one who infected her. As a result of what this lady has seen at her age, she also needs counseling.

**4.8. Emerging questions:**

- 4.8.1. What specific role can the church play in the midst of HIV/AIDS epidemic?
- 4.8.2. What is the message of the church about the love of God to the innocent infected partner?
- 4.8.3. How can we talk about the powerfulness of God when He has left His creation to be destroyed by AIDS?
- 4.8.4. Is AIDS the punishment of God to the promiscuous?
- 4.8.5. In order to prevent the spread of HIV/AIDS, should churches be involved in the distribution of condoms?
- 4.8.6. Who are mostly affected by HIV/AIDS?
- 4.8.7. Should Christians undergo an HIV test before engaging in marriage? *Amen*

These burning questions would be addressed explicitly in the process of this paper.



## 5. ANALYSIS.

### 5.1. THE BACKGROUND INFORMATION.

#### 5.1.1. AIDS: WHAT IT IS?

AIDS is an acronym standing for Acquired Immune Deficiency Syndrome. The virus is affecting millions of people worldwide. Most of the infected are the young people between the ages between 18 and 35. *"It is affecting people EVERYWHERE, of EVERY RACE, EVERY economic level and EVERY day"* (Tisdalle 1997: 5).

#### 5.1.2. ITS CAUSE.

##### **The (President) Mbeki debate (Sunday Times, 23 April 2000).**

For sometimes, the South African public has been confused by how the President has been handling the issue of HIV and AIDS. The debate about what causes AIDS has threaten to reverse the work done by organisations working with people living with AIDS.

This debate began in April 2000 when President Thabo Mbeki appointed an expert panel to investigate the cause of AIDS. It is understood that the President is not persuaded by conventional wisdom that HIV causes AIDS, but rather there are many other factors, such as poverty and malaria, which lead to AIDS.

The problem with this view of the president is as though he does not understand the difference between the causal and the contributory factors to the spread of the virus. There is no doubt that the poor are the most affected by the virus and as a result of their condition, they find themselves exposed to factors that can contribute to its spreading.

As a result of the debate and the view, the president lost his credibility even among his own tripartite allies supporters. The Congress of South African Trade Unions (COSATU), South African Communist Party (SACP), Nelson Mandela, South African Medical and Dental Practitioners (SAMDP) and the South African Medical Association (SAMA) have publicly differed with the president's view and all agree that HIV causes AIDS.

Defending his view during parliament debate, Mbeki stated that virus cannot cause a syndrome. This literally means that HIV cannot cause AIDS.

**Conventional view (Tisdale 1997:6).**

AIDS is caused by a virus called **Human Immunodeficiency Virus (HIV)**. This virus can only live in the blood, sperm and vaginal fluids.

The virus does not live outside the human body. The following are the virus' vital factors for survival:

**Correct temperature.**

The virus cannot survive in any temperature but only in the correct one. That's why virus cannot be inhaled or caught from outside the human body. This virus survives only in a human living body, hence Human Immunodeficiency Virus.

**Fluids.**

The HIV virus can only be passed from person to person through the blood and other fluids such as vaginal fluids and semen. If fluids are not exchanged, there is no way that one can be infected with the virus.

**pH (Acidity and Alkalinity base).**

The pH of the body must be balanced for the survival of the virus.

It is therefore almost impossible, under normal hygienic conditions, for the virus to survive for any length of time outside the human body.

Once it has been passed to the other person it begins to attack the body from the inside.

### 5.1.3. THE ORIGIN OF AIDS.

Many theories about the origin of the disease have been developed. But these cannot be of any help for this dissertation since HIV/AIDS is the enemy destroying our youth today. For interest sake, I came across Sowetan/Sunday World newspaper (18 June 2000:12). The title of the topic under discussion was “**Source of HIV found**”. The author of the article states: “*Researchers at the famous Los Alamos research institute in the US say they have pinpointed the origin of the Human Immunodeficiency Virus (HIV). Confirming early research, US scientists have traced the most common strain of HIV to an African chimpanzee virus known as Simian Immunodeficiency Virus (SIV). The Los Alamos study shows that SIV evolved into HIV between 1915 and 1941. Colonial upheaval and migratory labour systems brought the mutant SIV into urban environments, ultimately causing the HIV pandemic. The findings are published in the respected journal science*”.

Whether the statement is true or false, time will be the ultimate judge. But under current conditions of the West versus Africa on the origin of HIV/AIDS, one would wonder whether this is not the developed countries (i.e. Britain and US) to justify their claim that AIDS originates from Africa, and in this way to blame Africa for its widespread.

What we know is that HIV and AIDS came into the picture by the late 1970’s and early 1980’s. In the USA and UK the first people to have been diagnosed to be positive were the homosexual and bisexual men and intravenous drug users.

Gradually the virus spread to the heterosexual community. In Africa the majority of the infected are the heterosexual (Sunday Times 23/04/00) quoting President Thabo Mbeki in Parliament: 23/04/00). This fact is being reiterated by Green and Miller (1986:25): “*Since the early cases of AIDS has become the number one priority in health for many governments. Cases are no longer restricted to gay men, haemophiliacs and intravenous drug users, although they still bear the main brunt of this terrible disease. And it has become clear that AIDS is not limited to America and Europe: it is causing the massive epidemic in Africa, where heterosexuals are the main risk groups*” .

Further, trauma patients and hemophiliacs died after receiving untreated, contaminated blood during emergency transfusions. Also affected were the unborn and the newborn infants who were born by the positively infected mothers.

#### **5.1.4. HOW DOES AIDS MAKE ONE SICK (Tisdalle 1997).**

Our bodies have many different parts and each part has an important role to play. We have a very important system called the immune system. This system's role is to protect the body against the germs and diseases. It also heals the body after the sicknesses and injuries.

The immune system is like the body's 'army'. The body cannot defend itself against any sicknesses or germs when this 'army' gets weak. The virus enters human body and deposits its own genetic material inside the nuclei of the CD4 cells. Inside the cells it hides for several years while rapidly multiplying daily.

Once it is into a person's body, the HIV slowly damages the immune system. This means that the body starts to lose its power to defend itself against other germs, such as TB. It also loses its power and strength to heal itself. Slowly the HIV gets stronger and stronger. The person starts to feel sick when the virus has broken down most of his or her immune system. This may take several years to happen. The result is the full-blown AIDS, which sooner or later result to death. There is no cure for AIDS.

Medicine and scientists are trying hard to research cure for AIDS but to no avail. Drugs like Zidovudine drug (AZT), which is very expensive, is used to prolong life in an HIV positive person but it is also less successful as previously thought. Several drugs have been produced but none is effective in curing AIDS. Until cure is found, AIDS remains a terminal disease with no cure.

The only option left for us is **PREVENTION**.

### **5.1.5. STAGES OF AIDS (Green and Miller 1986).**

#### **ACUTE RETROVIRAL ILLNESS OR ASYMPTOMATIC PERIOD.**

In most cases this is called the window period. In this period which last from the first day of infection, until the 6<sup>th</sup> month, the virus lies in the body. Even if one undergoes testing, the results reflect negative. To about 70% of the infected there are no sign of the sickness. Even in this stage one is still capable of infecting others.

To some people, depending on the strength or weakness of the body, there are signs such as painful muscles, fever, shakiness and sweating. This last for 3 to 4 days and sometimes few weeks thereafter there is nothing at all.

#### **PERSISTENT GENERAL LYMPHADENOPATHY (PGL).**

This stage prompts a visit to a doctor. About 30% of HIV infected people have the swollen glands around the neck, armpits and groin. This is not painful. It is usually accompanied by mouth ulcers, fevers, night sweats and weight loss.

These symptoms can last for more than 3 months. Some of the people in this stage complain about the episodes of chronic tiredness.

#### **SYMPTOMATIC STAGE OR AIDS-RELATED COMPLEX (ARC).**

This stage is just before full-blown AIDS. At this stage, the immune systems are considerably damaged. The symptoms here are severe fatigue, mouth and genital ulcers, severe weight loss (more than 10% of the body weight), more than 1 month of the unexplained diarrhea. Some of the PGL symptoms are found here.

## **ACQUIRED IMMUNE DEFICIENCY SYNDROME (FULL-BLOWN AIDS).**

This result due to total collapse of the immune systems. Between 10- 15% of the infected people develop AIDS within 36 months.

This is the highly complex illness that involves infections and tumors (cancers). The symptoms included here are:

### **Chest infections in AIDS.**

Pneumocystis Carinii Pneumonia (PCP) and it is diagnosed to about 50% of all the people with AIDS at an early stage. 60% of the infected develop PCP at certain stage. It (pneumonia) is the major cause of death in AIDS.

### **Gastro-intestinal infections.**

The infections occur in the mouth, throat, stomach intestines and anus.

### **Skin disorders.**

This results in the skin cancer or Kaposi Sarcoma.

### **Central Nervous System (CNS) disorders.**

At this point, the brain tissues are affected. It causes mental disorders known as AIDS dementia complex.

### **Death follows soon after the stage of full-blown AIDS.**

## **5.2. HOW DOES ONE GET AIDS? (Tisdalle 1997)**

Before answering this I think it would proper to state that it would be highly unlikely for the virus to be transmitted through “*sneezing or coughing, casual skin-to-skin contact, insect bites, from ingesting food and/ or water, blood donation, ...eating utensils, bed linen, toilet seats, swimming pools, etc*” (Tisdalle 1997: 7).

As already mentioned, the virus only lives in the blood and can only be passed on to the other person through:

#### **5.2.1. Sex.**

The most popular way in which people are infected with the virus is sexual intercourse. The virus will be in the sperm or the vaginal fluids of the person who is HIV positive. S/he can in turn pass the virus to another person through sexual intercourse (vaginal, anal, and/ or oral).

A person with sexually transmitted disease may have discharge or sores on his/ her private parts. This makes it easier for the virus to get into the body during the intercourse.

#### **5.2.2. Blood transfusion.**

The virus can pass from a person to another through the blood. This can happen when one has lost too much blood and is been given blood through blood transfusion. Fortunately, in South Africa, blood transfusions are safe because all blood is tested before it is given to the sick person.

The other way the person can be infected with blood is during the accident when one has a cut and touches the blood of the infected person.

#### **5.2.3. Mother to child.**

The other way people can be infected is during pregnancy. The infected mother can pass the virus to a child at birth or by breastfeeding.

The amazing thing is that not all children born from infected mothers are infected. And again not all the breastfeeding babies are infected. But for precautionary measures, breastfeeding by persons living with AIDS is totally discouraged.

### **5.3. HOW CAN ONE KNOW IF S/HE IS BEEN INFECTED?**

#### **5.3.1. HIV test.**

One can look and feel fine for many years while the virus is in the body. The only way to tell if one has the HIV virus in the body is through the **HIV test**. Most HIV tests are not designed to track down the virus itself, but only to indicate the presence or the absence of the antibodies in the blood.

*"A blood sample is taken and analysed for HIV by the lab technician, using the so-called ELISA test. If the result is positive, another test (Western Blot) is done to confirm the result of the first test"*(Tisdalle 1997: 9).

It is one's individual right to decide to have such a test. Nobody, not even a doctor, has the right to do the test without one's permission or concern. The test results are confidential and remain one's secret. This means that it is against the law for a health worker to tell the result to anyone without one's permission.

Before and after the test it very important for one to undergo counseling by trained counselors. This is where the meaning of the result would be explained, and advises would be given should one be found to be positive.

One thing about the test is that it cannot tell when one contracted the virus and when one would become sick.

#### **5.3.2. WHO SHOULD BE TESTED? AND WHAT IS INVOLVED?**

Tough the test is an individual's choice. Still, it is recommended for people to undergo a test. The doctor will send the blood samples to pathology lab for testing and if one is positive the doctor will inform one personally. Heavy emotions are expected at the announcement of the positive results.



Talking to a pastor, Christian counselor could benefit one to deal with mixed emotions and feelings. The professional counselor's help would be needed to breakdown the news to the members of the family and/ or friends. These (the infected) are the people who need church's help more than the healthy.

### **5.3.3. WHAT IF THE TEST IS POSITIVE?**

Being positive does not mean the end of the world. One can be positive and still have many productive years to live depending on the attitude, conduct and the food one eats.

The positive person can infect others through sexual intercourse, pregnancy and/or blood transfusion. Therefore, s/he does not have to give blood for transfusion. It is advisable to inform one's partner about the HIV test and status. Talking to someone trustworthy is psychologically and emotionally therapeutic.

Even if one is positive, that does not in any way stop the feelings of love or the sexual desires. Life is and will be normal until after many years when the immune systems are being destroyed and one has started showing some signs of sicknesses.

Once a person is being diagnosed positive, it is not an easy thing to deal with. Different people react differently.

### **5.3.4. Four different stages of responding (Louw 1990:46):**

#### **The impact stage:**

The impact is very tremendous when one is diagnosed as being positive. "*Shock, denial, severe anxiety and helplessness can surface immediately*" (Louw 1990:46). The stage prompts the counselor to develop or show the art of listening. The person needs understanding, acceptance and love. Another thing that can help a lot is physical contact.

**The regression stage.**

*“Forced to deal with the reality of the situation many patients retreat in an effort to return to a psychologically more comfortable time. During this stage they usually experience isolation. They make use of escape mechanisms and are very reluctant to undertake any action” (Louw 1990: 46).*

At this stage it would be very important for a caring group to accommodate this person for healing. In a group it would in many cases be difficult for one to experience isolation and withdrawal.

**The internalisation stage.**

At this stage one works through the long term consequences of the situation and the results. *“It describes a mourning period and a process of acknowledgement and acceptance of reality” (1990: 46).*

The pastor can be of vital importance in assisting the person to deal with reality. This is where the message of the mercies and the grace of God are of vital importance. The discovery of God’s unconditional love helps one to accept the eternal message of God’s love and forgiveness.

**The reconstruction stage.**

The stage is directly linked to decision-making, future planning and target development. To the person who has accepted God’s forgiving love, this is where hope plays the prominent role. To the one at this stage, death is not foreign, but it is welcomed as a ‘good servant’ leading one to meet the Master. But in the meantime, one carries on with life. The same person can become more useful in educating communities about living with AIDS. The example of this is Lucky Mazibuko, the columnist in Sowetan Newspaper on AIDS Talk, and Mercy who was honoured by Wits University with the Masters Degree in her contribution to people living with AIDS.

## 5.4 IS THERE A CURE FOR AIDS?

Until now there is no cure for HIV/AIDS. Medical Researchers are working around the clock to find a cure but to no avail.

There has been many claims of cure by both the medical and the traditional healers. In December 1998, MEDUNSA published and televised how they have found a cure to HIV infection. But ever since that time the number of infections have increased and the claim is silent.

### 5.4.1. Traditional Healers.

At the beginning, many claimed that they could cure the disease but nothing occurred. A certain Maggie Ramaota said that AIDS baffles the ancestors. She claims that the ancestors say that they cannot cure AIDS.

Professor Patrick Bouic (Sowetan 21 May 1999), who heads the department of immunology at the Stellenbosch University, and Professor Ruben Sher, of HIVcare International, supported the idea that the African potato has shown the ability to increase CD4 counts, and decreases the amount of the HIV antibodies in the human body. Amidst these claims the number of the infected is increasing daily.

### 5.4.2. Nonoxyl 9 Microbicide Gel.

The research by the Medical Research Council (MRC) claimed the gel to supposedly kills the virus. In their research, they applied the gel to some prostitutes and said that it was safe and non-threatening to be applied to women's private parts. The results of the gel are expected at the middle of this year (2000).

### 5.4.3. Zidovudine drug (AZT).

Despite the expensiveness of the drug, it (drug) seems to be the one the public is seeking for. There was even a time when the AIDS activists protested against the USA's authorities to make the drug available to Developing countries at a cheaper and affordable price.

Dr Heather Brown of the Coronation Hospital in Johannesburg, said that the hospital opened the HIV-AIDS unit when realizing that the number of HIV-positive patients was increasing. He says that the number of infections of children born by positive mothers has decreased from 30% to 15%. At the moment, *“Coronation is the only hospital in this country that pays from its own funds for the supply of AZT to the infected mothers”*(Sowetan 2, December 99).

Despite these encouraging facts, the South African government has banned the supply of the drug to patients citing the after effects as the main cause. To emphasise the government's stance, Doctor Costa Gazi was dismissed from his position for supplying women with AZT against the government's policy and for bringing the Minister of Health into disrepute.

This action lives one with nothing but to wonder about the government's seriousness on combating the spread of HIV and AIDS. In South Africa, the issue of AIDS is more for political gain than for dying people. By the politicians finally agree about spending some more money to seek a right cure, many would be dead. Reasons for this being that in politics money is valued more than ordinary people's lives.

### 5.5. PREVENTION.

Since there is no cure, we are left with one option to stay alive. This option is **prevention**. This could only be done through usage of the effective weapon, which is change in **life-style**. This is possible through **Education**.

The church can effectively contribute to the change in life-style, behaviour and morality, because; *“Behaviour change is largely the responsibility of the churches in South Africa. Churches are*

*important community resources...If the churches fail in this responsibility there is no other institution in South Africa that can be able to provide the equal resources" (Nicolson 1995:17).*

In the statement, Nicolson emphasises the importance of the churches in changing the moral behaviour of the community. AIDS is about morality. The church can play a role in the community education.

In the change of people's behaviour, the church would be able to show the community that AIDS is not a punishment from God. The rapid spread of AIDS in Africa, among other things is due to the distorted human lives. The church needs to point these out.

It is not the duty of the church to pass judgement against those who have been infected by the virus. It is not true that everybody with the virus is promiscuous. The innocent infected babies, rape victims, and/ or a partner of the unfaithful spouse are a proof to this.

#### **5.5.1. The three most popular prevention methods:**

To all the workshops that I have attended the A, B and C method are being encouraged. But the letter C always takes the 90% of the discussions as the best preventive method.

#### **The meaning of the letters (A, B, and C) of prevention:**

##### **A= Abstinence.**

The method encourages abstinence as the safest way of avoiding problems which are related to sex; pregnancy, STD's and HIV/AIDS.

The method is not much encouraged by the media and popular role models. For the youth it is very difficult abstain because the media; through the films and commercial advertisement, sex receive the highest priority. The whole meaning of sex has and is being devalued.

Amidst this, there are those who say no to sex before marriage.

**B= Be Faithful.**

This method encourages faithfulness to one partner or partners without cheating on them. The strength of the method is the encouragement of partners to be faithful to each other.

**C= Condomise.**

This is the most popular method encouraged by the president, parliament, health workers, AIDS workers and the media. More than the first two methods, this receives a lot of support by giving free condoms in all the clinics and government hospitals.

What we do not have to forget is that condoms have been there long before AIDS became a national crisis. Still then, the rate of teenage pregnancy was very high. I think that this was one of the reasons abortion was legalised. When AIDS started to take priority in the national agenda condoms were still there but the rate of infection is increasing daily.

Although it is also been emphasised that condoms are not 100% save, the message of 'having sex when you need it with whoever as long as you won't contract the disease', brushes away any precaution.

The Sowetan (5<sup>th</sup> July 1999) published the investigation of the distribution of the condoms by the Health Department. According to the report, 40 million Kenzo brand condoms imported from India between 1996- 1997 were found to have been defective. When this was discovered, many had already been distributed and used by the public. Only 5 million of the distributed were retrieved (see addendum J). Now, the question that comes is how many of the condoms contributed to the spread of the virus?

The second question is if condoms are also faulty, what then would be the solution in the country where sex has become part of entertainment?

**D: Death.**

Recently, the ANC Youth League has brought this letter (D) as the fourth one in the prevention of AIDS. Their argument is that if the first three have failed, or one has failed to apply them, the fourth letter, D, would invite itself. With death, there is no turning back.

**5.6 HIV/AIDS CHALLENGE.****5.6.1. The Global challenge;**

According to the World Health Organisation (WHO) statistics of 1994 (Tisdalle 1997;5-6), there are 22 million people infected with the virus; 11.3 million are males, 8.7 million are females and 2.2 million are children. This number is estimated to increase by 10 000 new infections per day and redoubles every 12 months.

**Year 2000 WHO projections** (updated from the Chiang Mai, Thailand Conference: Sept. 1995).

In the year 2000, it was estimated that 40 million people would be infected with HIV/AIDS, 90% of these would be in developing countries. And of these 25% would be children under the age of 15 and 15 million orphans under the age of 15. The Sowetan (02 December 1999:6) has published the figures from the UNICEF and UNAIDS as 11 million and by the end of 2000 this would have reached the projected figure. *'Already 95% of those orphans are in sub-Saharan Africa'*.

This projection may rise since many people are not sure about their HIV status.

**5.6.2. The continental challenge:**

Out of all the continents of the world, Africa is the one that is hit the hardest by the HIV/AIDS epidemic. In the Sowetan (22 July 1999), it was reported that the HIV infection rate in Africa is the highest in the whole world. *"Africa has got the 70% of the people living with AIDS in the world, 83% of the AIDS deaths and 95% of the world's AIDS orphans"* (see Addendum B).

In places like Zambia, life expectancy has dropped from 56 to 37 years. More shocking facts on AIDS was published again in Sowetan (2 December 1999): “*Eastern and Southern Africa are home to 4.8 percent of the world’s population yet have over 50% of the world’s HIV-positive people and account for 60 percent of all lives claimed by, UN data shows*”(Addendum A).

To show how serious the epidemic is affecting Africa, Miller and Green (1996:40) say: “*In some of the main city hospitals in Central Africa, up to 40% of beds are occupied by patients with HIV related conditions*”. This was 14 years ago and the situation has increased incredibly since then.

### **5.6.3. The National challenge:**

South Africa is part of Southern Africa. The shocking figures indicated above also affect us. In one edition of the Sowetan newspaper, one professor was quoted saying that if we were in a war, he would advice us to surrender because the battle against AIDS has beaten us.

Charity Bengu (Sowetan 13/12/1999) says: “*South Africa should brace itself to cope with at least 100 000 orphans by the end of this month (December) as a direct result of deaths related to AIDS*”(see Addendum C).

“*It is estimated that in 2005, there would be more than a million Aids orphans in the Country...’within 10 years this figure could rise to between one and two million*” (Sowetan 13/12/1999 in Addendum D).

Mokgadi Pela on the Sowetan (18 January 2000:2) quotes the admission by the Department of Health that; “*we have dismally failed in controlling the spread of HIV in our country. Of the 20 million cases of HIV in sub-Saharan Africa, 2.8 million come from our country. This is despite the fact that the epidemic in South Africa started later than in other parts of Africa*” (see addendum J).

Based on the above facts, it is evident that unless something is done as a matter of urgency, we will wake up been too late to do anything meaningful to our community. Our struggle against AIDS should not be launched from the top (i.e. government offices) but from our localities. It should be launched from our respective immediate communities.



## **5.7. THE EFFECTS OF HIV/ AIDS:**

### **5.7.1. Psychological effects.**

To be informed that one is positive raises many ill feelings. It raises the feelings of anger, bitterness, guilt and rejection. In anger one can do many things which he/she would later regret. To the guilty party, in promiscuity, one chooses to withdraw and nurse the pain in silence. To the innocent party revenge seems to be the only option. In this case, one would say that 'since I got this sickness while I was not sleeping around, I can't die alone, I will revenge'.

In her moving biography, Charmayne Broadway (1998:162-3) says: "*This disease not only strips you of your health, but of your dignity, sanity, your sense of being human, a person. I feel I've been stripped of my soul and my very existence. I've lost the small things that I thought one could hold onto in one's dying days. It's taken every last bit away from me. I feel like a dog, left on the side of the road to rot and die, or at times, like a pesky fly that has been swatted against the wall. It's sometimes hard to keep a sane and rational mind. No one can share my pain to the extent that I feel it. And no one can feel the degradation and depression to the extent that I feel it. Nobody knows and frankly nobody cares. They're living, making money, working, laughing, consumed by what they love the most. And mine is all gone. I've lost what I love the most*".

These are real painful and emotional words. This caption shows how the disease affect the emotions, mind and personality of an individual. According to those words, the reality of HIV/AIDS leaves a person with nothing but the mind focusing on one's grave.

### **5.7.2. Spiritual effects.**

More than health and medicine, AIDS also affects the morality of the individual and the community. Associated with the punishment from God for promiscuity the person with HIV/AIDS feels guilty and sinful.

On the one hand the disease raises bitterness against God. The question being raised here is “if God is the God of love why does He let this to happen to me?” “If He is the most powerful God who heals His children why does He let this disease to destroy His own creation?”

Questions like these may either alienate one from God or may lead one to discover the mercy and the grace of God and experience His forgiveness.

AIDS also brings a challenge to a Christian community on showing love to people living with AIDS.

### 5.7.3. Social effects.

Life is about interpersonal and social relationships. But HIV/AIDS affect one's relationships with the family and the society at large. There is a stigma associated with the disease. No matter how one tries to explain the fact, it's a fact that very few in communities accept and associate with people living with AIDS as they used to do before infection. Rejection and alienation from the community result, and at the same time withdrawal by the persons living with AIDS is the response. In one meeting I addressed (01 December 1998) on AIDS I said that HIV/AIDS affects the living more than it does the dead. The remaining members of the family would have to bear the pain of answering the question; ‘What happened?’ or ‘What was the cause of death?’ in order to keep the family's image, one would lie about the cause of death. In so doing, one's conscience makes him/her feel guilty.

Dr Robert Shell was quoted in Sowetan (13 December 1999) projecting the number of AIDS orphans to increase since 6 million of the parents would have died by the year 2009. “*AIDS orphans will always be a visible and permanent feature of South Africa's street life. No doubt some will see them as nuisance*” . He further said: “*The socio-economic impact of the growing epidemic on children and families are severe and has a disorganising effect on families...The health, development and nature of these children may be neglected as grandparents, extended families and even communities may not be willing or able to carry the burden of so many orphaned children*” (addendum C).

#### 5.7.4. Economic effects.

As indicated earlier, most people living with HIV/AIDS are the youth and the young adults. Most of the affected are in the working class and the breadwinners in the family. Death of these would mean that families would be left without breadwinners, or no parents and the state with no money for social welfare because of many orphans with no parents, home and shelter. According to Dr David Bloom, professor of economics and demography at the Harvard School of Public Health (Sowetan 2/12/99:6): *‘There is a multiplier effect because AIDS attacks men and women in their prime working and consuming years. In addition, AIDS orphans create a major financial burden for communities, particularly in the poorest hardest hit countries’* (Sowetan 2 Dec. 1999:6).

Among the public servants infected the most are teachers –23% (City Press 23/07/00:5), health workers (nurses)-21% (Sowetan 7/09/00:3) and soldiers –17% (Sowetan 19/09/00:2).

#### 5.8 Tumahole:

Tumahole’s population according to Greater Parys TLC’s Strategic Planning Document (1998) is 61 160 residents. The growth rate is 5% per annum. Woman forms 54% of the entire population.

##### 5.8.1. Age distribution:

Age category;	Percentage ( %)	Number
0 – 5	13,8	8 440
6 - 19	30,8	18 837
20 – 34	28,2	17 247
35 – 49	18,8	11 498
50 – 64	3,5	2 141
65>	4,9	2 997
<b>TOTAL:</b>	<b><u>100</u></b>	<b><u>61 160.</u></b>

The table in the above shows that the young people between the ages 14 and 40 are in majority in Tumahole. This is the age group that is mostly affected by HIV/AIDS.

### 5.8.2. Housing.

Tumahole has got **8474 serviced and occupied stands**. With the RDP houses which are 1320, we now have **4 721 permanent structures** or built houses. The remaining **3 753** are still **shacks**.

### 5.8.3. Economic Sector.

<u>Sector.</u>	<u>Percentage ( % )</u>
<b>Formally Employed</b>	<b>36,3</b>
<b>Unemployed</b>	<b>46,0</b>
<b>Pensioners</b>	<b>17,7</b>

The number of the unemployed increases annually due to the high failure rate of the Matriculants. The high urban growth rate means high concentration of the poverty in town. Thus the urban growth also means the increase in HIV and AIDS.

### 5.8.4. The Revenue Distribution.

<b>Salary</b>	<b>Percentage ( % )</b>
<b>R0 – R 1000</b>	<b>57,6</b>
<b>R 1001 – R 1500</b>	<b>37,48</b>
<b>R1 501 – R 2500</b>	<b>4,31</b>
<b>R 2501 &gt; x</b>	<b>0,63</b>

From the analysis of the above table, it is clear that 95, 08% of the working class in Tumahole earn a revenue between R0 and R 1500.

**5.8.5. AIDS SURVEY (see ADDENDUM K for questionnaire).**

Before responding relevantly to the challenge of AIDS in the community, I formulated a questionnaire that would give me a picture of the situation in my community. The questionnaire was sent to two health centres (clinics) in the community and the other was sent to a community organisation that deals with AIDS; Partuma AIDS Awareness Group.

**The following is the analysis of their responses.**

**Question 1.**

In the past 5 years (95-99), there has been 181 people diagnosed HIV positive. In 1995 there was no record in any health centre. In 1996 there were 8.8% of the 181, and in 1997 there was 15.5%. In 1998 and 1999 the number increased to 37% and 38.7 respectively. These are only the numbers of those who were known by being tested at the clinics.

**Question 2.**

Females are found to be more than the males. Females are 115 while the males are 66 in number. I think that this difference is because every woman is being tested when she comes for labor and or during her pregnancy. It might also be because women attend clinic more regularly than men.

**Question 3.**

The age distribution would help to see the group mostly affected. Those who are 19 years and below are 6.1%, and those who are 40 and above are 18.8%. The danger zones are those who are between 20 and 39. This group is makes 75.1% of people living with AIDS. This again confirms the UN's World Health Organisation that AIDS affect mostly those in the age group between 20 and 40 years. Although the above group is vulnerable, the group that is more vulnerable to great danger is those under the age of 19. Most of those between 20 and 40 run to this group because of its vulnerability to abuse if promised money and other materialistic gains. The other reason may be because they (men between ages 20 and 40) are afraid of the danger among those in their age group, so they resort to those with less resistant.

**Question 4.**

AIDS affects all the sections of the community, although not in the same degree. Although Mandela Section seems to be having more infection, this cannot suggest that it more at risk than other sections because the difference is minimal. Again people of all sections meet and socialize.

**Question 5.**

According to the responses, the top three priorities in programs combating HIV/AIDS are **education, AIDS Awareness campaigns and Counseling.**

It is from this position that we as the church can augment the existing programs rather than wasting the resources by doing the duplication.

**Question 6 and 7.**

The community participation in AIDS issues is neutral this means that it can't be classified as either good or bad.

The church's role on the other hand has been bad or negative. So far there is only one church, Roman Catholic Church, that is known to have a strong program on HIV/ AIDS.

**Question 8.**

The following is the way the church could be involved in the AIDS awareness as suggested by the respondents:

1. To train the volunteers who would spread the AIDS message in youth groups, choirs, and other youth related activities.
2. Invite health workers, AIDS workers and the HIV positive people who are prepared to let their status known, to give talks to special services.
3. Messages on AIDS be made in the preaching to make people aware.
4. Special prayer services be held for those living with HIV/AIDS.
5. Spiritual and material support to those who are known to be HIV positive.
6. Church members should be educated on HIV and AIDS.

**Question 9.**

The social effects of AIDS are;

1. It increases the number of the **unemployed**. Because of the sickness many are unable to work effectively as a result, retrenchment is the only option.
2. **Poverty** results from the loss of job by the breadwinners.
3. Number of **orphans** increase. The department of Social Welfare is unable to support all these orphans.
4. High rate of **crime, prostitution** and other poverty related social ills are the end results.

**Question 10 and 11.**

Question 10 did not require the response.

In question number 11 there was one additional comment. The comment was that while we concentrating on the HIV infection, there should also be a focus on the HIV negative youth. These would need to be encouraged and be affirmed and also be empowered against the disease and how they should take care of themselves.

**5.9. THE SOCIAL CONTRIBUTORY FACTORS TO AIDS.**

In South Africa, AIDS affects blacks more than it does to other populations. It also affects the poor communities the most. Poverty has much contribution to the ills the country finds itself in. According to the Department of Social and Development Minister, Zola Skweyiya (Sowetan 18/01/00:2), *'many of the social challenges confronting the country have their immediate roots in poverty. Crime, the spread of HIV-AIDS and domestic violence are not simply symptoms of dysfunctional community and family institutions but are a consequence of the pressures of poverty'*.

Most prostitutes (Sowetan 02/12/99) blame poverty for the situation they find themselves in. Many came from rural places, homelands and other African neighboring countries to cities to seek for the job, but when they failed to get one, they chose this degrading life of selling their bodies. *"Poverty, migrant labor and the prostitution in which women are forced, the closeness to major transport routes, refugee populations from countries where AIDS is already widespread, all create*

*conditions in which rapid partner exchange is likely*" (Nicolson 1995: 14). From this statement, it is evident that poverty contribute a lot in the spread of HIV/AIDS. Differing from Mbeki debates it contributes, but does not cause AIDS.

### **5.9.1. Socio-economic factors in Tumahole (Greater Parys Framework Plan 1997).**

#### **Education/ literacy level.**

The literacy level of the population is estimated to be 60%. The pass rate of the learners entering school from grade 1 to grade 12 is in a pyramid form. Very few of those who start their schooling finishes after 12 years as expected before going to tertiary institutes.

For the past three years i.e. 1996, 1997 and 1998, among the 28 schools in the Sasolburg Education District, the last three schools are from our community. This raises a question of how can schools from the same place follow each other at the bottom of the ladder. This implies that the problem is not only with the schools, teachers and learners but with the whole community.

All the four (4) high schools are platooning. Though this might have a great impact on performance, it can't be used as a scapegoat because most of the schools in the province are platooning but their results are far better than ours.

#### **CRIME.**

One of the burning issues affecting the present government is crime. South Africa is classified among the top five countries in the world where crime is very rife. One thing the illiteracy, unemployment and squatting have borne is the increase of crime. In this matter Tumahole is not exceptional.

According to the statistics on criminal activities reported in the past six (6) months, the highest activity is the housebreaking on people's properties followed by housebreaking on business. An amazing thing is that most of these occur in the shacks where we really say people are really poor.



The poor steal from the poor and sell among the poor. As a result the victims promote crime unaware.

The perpetrators range from the children from the age of 11 to the young people of 27 years. The young steal sweets from shops while the young steal valuable household- goods like TV's, Hi-Fi's, videos and other musical systems. The stolen goods are sold very cheap. Actually they are being thrown away. To the poor, these goods are the bargains, an opportunity never to be left to pass by.

### **Non payments of rents and services.**

The non-payment of services was one of the strategies of the liberation movements to make the then apartheid's local government and the entire country ungovernable. Truly, this tool was so effective that the entire country followed suit.

### **How it began?**

Contrary to the fact that the rent boycott started in the Vaal on the 03 September 1984, the truth is that it started earlier on the 15<sup>th</sup> September the same year right here a Tumahole. This was the same date that the first victims of rent boycott fell. The determination of the youth caught the authorities by surprise. It was this period that gave birth to Stompie Seipei; 'the one whom Winnie Madikizela-Mandela was implicated to have engineered his death'. This act of boldness then spread to the other townships like Sebokeng, Sharpeville, Evaton, Langa and consequently the whole country.

The rent boycott came as a blessing in disguise for the people who were paying their services. It did not take much strength to make people not to pay. Those who defied the call of non-payment of services were cruelly disciplined and as such, were forced not to pay. This culture was rooted in the social life of the people. Everybody was now used to it.

In 1992 when the government scratched the rent arrears, those who were secretly paying were very angry and they too decided not to pay and be like the rest.

When the democratically elected government and the local government came into power, the culture of non-payment was part of the community. This, the government inherited.

When the leaders of the present local government called upon residents to pay for rent and services, their words fall on deaf ears. Some go to an extent of saying that these leaders are the once who introduced and educated them in the culture of non-payment. Though the motive was good then, but it is being misused by the opportunists who are prepared not to pay any cent for services.

### **The financial realities of Tumahole and Parys Municipality;**

In Parys, the Whites' residence, payment level is 98%. Contrarily, in Tumahole, the average payment level is 24%. The figures would have been much lower had it not been of the metered electricity people had to pay via council with the payment of the rent. Those who use prepaid cards for electricity don't bother to pay the services.

### **According to the Strategic Planning Documents (1998), the non-payment results in:**

Maintenance, repairs or replacements of the equipments is virtually impossible. And funds for new developments are non-existent. This also result into the hindering of the upgrading of existing facilities. Worse of all, community projects like Masakhane cannot effectively function.

### **What has the local government done in its part?**

Since the introduction of new democratically elected local councils in 1995, the Greater Parys TLC was able to build 1 320 subsidy (RDP) houses, reconstructed the main roads in the township, more sites for residence have been approved and allocated.

Although meetings have been called, letters and warnings have been issued, the community in its part seem to be passive.

Some people say that they are unemployed that is why they do not pay services, but the number of the employed is far higher than those who are paying.

Non-payment is a culture. Like any culture it can't be easily overcome. For it to be overcome, it will take the popular and well supported and legitimate leaders. At the moment I do not think we have such people. The current support at the meetings where serious community issues are discussed bear a witness to this. After the elections our leaders abdicated their responsibilities. Now that the elections are coming, they are busy waking up but there is nothing they are offering except to repeat what the national government is saying without contextualising that to our present conditions in Tumahole.

### **Alcohol abuse.**

According to the research conducted by the Police Community Forum (1999), among all the infrastructures of Tumahole, on top of the list are taverns and shebeens which are 38 in number followed by tuckshops which are 30.

What do these numbers mean? Do they suggest that people drink more than they eat? These questions reveals the trend of community is following.

### **Health.**

Parys has only one hospital. Tumahole has three (3) clinics and one mobile clinic to meet the health needs of the community.

Most common problems faced by the community is the high rate teenage pregnancy, high rate of the sexually transmitted diseases (STD's) among the young people between the ages 17 and 25, and worse of all, health centres have reported the high rate of HIV infection. At the moment, more than 150 young people have been diagnosed positive. Remember that these are only the people who went to the clinics for the test. There are many people who might be positive but are not known or do not want to know.

In Shorter (1991:51), "*The absence of normal family relationships and the morally disorienting experience of the shanty-town favour sexual promiscuity*". The absence of the family live is also responsible for high crime rate, drunkenness, prostitution and drug abuse.

At the moment, the only hospital we have is closing down to the provincial government's lack of funds. To the poor, this is a double blow.

#### **5.10. Tumahole AFM Church:**

The questionnaire (see addendum I) was developed in order to get a direction on what role the church and the Christians can play in addressing the AIDS challenges in the community. There are 21 Christians who responded to the questionnaire and here is the analysis of their responses:

##### **Question 1. SEX.**

Male	52.4%
Female	47.6%

52,4% males and 47.6% females responded.

In the normal sense it is expected that women (females) would be more than the males but in this case it was the opposite.

##### **Question 2. AGE GROUP.**

AGE	%
<19	38.1%
20-29	61.9%
30-39	0
40-49	0
50>	0

The respondents were less than 19 years and others older, but none was older than 30 years of age. Those less than 19 years were 38.1% and those between the ages of 20 and 29 were 61.9%.

Most of the respondents are in their youthful or early adulthood stage. This is also the group which is mostly affected by HIV/AIDS.

**Question 3. WORKSHOPS ON HIV/AIDS ATTENDED.**

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
14.3%	19%	33.3%	14.3%	19%

The highest number of the workshops attended were two by 33.3%, followed by 19% of either one workshop or four and above. Then followed 14.3% of those who never attended any workshop or those who attended 3 workshops.

**Question 4: WORKSHOPS ORGANISED BY THE CHURCH.**

Were those workshops organised by the church?

yes	19%
no	81%

81% of the workshops were organised by secular organisations while only 19% were church organised.

This in itself indicates that Christians usually respond late to serious issues such as HIV/AIDS that needs their attention.

**Question 5: SERMON ON HIV/AIDS ON SUNDAY WORSHIP SERVICE.**

Have you ever heard your pastor or church leader deliver a sermon on HIV/AIDS on Sunday worship service?

never	seldom	regular
66.7%	28.6%	4.8%

The majority of the respondents, i.e. 66.6%, have never heard any sermon on HIV/AIDS. 28.6% say they have seldom heard a sermon on HIV/AIDS and 4.8% do hear regularly sermons on HIV/AIDS.

It is revealing again that the reason why Christians are ignorant on the issue under discussion is because the pulpit is silent. So, none wants to commit him/herself on the controversial issue such as HIV/AIDS.

**Question 6: SERMONS CONDEMNING OR SHOWING LOVE, CARE AND SUPPORT.**

All those who responded either seldom or regularly heard a sermon on HIV/AIDS say the messages were showing love, care and support.

**Question 7: KNOWLEDGE OF A PERSON WHO IS LIVING WITH AIDS OR HAS DIED OF HIV/AIDS RELATED SICKNESSES.**

Do you know of anybody in your township who is suffering/ or who has died of AIDS?

yes	42.9%
no	57.1%

57.1% have no knowledge while 42.9% have knowledge of persons who are living with AIDS or have died.

**Question 8: RELATIONSHIP TO THE PERSON ON QUESTION 7.**

The majority of those with knowledge of the victim or persons living with AIDS were either the relatives or close friends.

**Question 9: HOW DID ONE KNOW ANSWER TO QUESTION 8?**

For friends and relatives, it was through the confession of the persons living with AIDS while those of neighbours were mostly through suspicions.

Question 8 and 9 shows that though many people are dying, none is prepared to reveal his/her status. People are dying with their secrets on their HIV/AIDS status.

**Question 10: KNOWLEDGE OF THOSE LIVING WITH HIV/AIDS IN THE CHURCH.**

no	Don't know	yes
9.5%	90.5%	0%

90.5% of the have got no knowledge of people living with AIDS. Only 9.5% have knowledge of such people.

**Question 11: TREATMENT OF PEOPLE LIVING WITH AIDS BY THE CHURCH.**

Since very few people who are HIV positive are known in the church, and those who are known it's either through suspicion or those who have revealed their status in confidence to close friends or relatives, it is not possible for the church to avail treatment to unknown people.

**Question 12: HIV/AIDS: PUNISHMENT FOR IMMORALITY?**

yes	38.1%
no	61.9%

61.9% of the respondents see HIV/AIDS not as a punishment, and 38.1% see it as a punishment. This shows how the attitudes of many Christians have changed towards people living with AIDS.

**Question 13: CHURCH'S PROGRAMMES IN RESPONSE TO HIV/AIDS.**

The following is in the order of priority the suggested programmes the church could implement as a response to HIV/AIDS challenges;

1. Counseling,
2. Bible Studies,
3. Education,
4. Support Groups,
5. Prayer and
6. Care.

My assumption was that as the survey was conducted among the fundamental pentecostal believers, prayer was going to be priority number one. The new trend from the youth seems to be saying; "Faith without works is dead. To these believers, counseling is more practical because one meets the person in need and in this way one would be able to know the person's real needs. From this action, prayer would follow later.

**Question 14: POSSIBILITY OF HIV/AIDS STOPPING IN OUR GENERATION.**

Yes	57.1%
No	42.9%

57.1% were optimistic that the spread of HIV/AIDS would stop in this generation. Their reasons among others were the fact that prayer is the most powerful weapon that the church could use. They believe that if the church could take its responsibility of teaching on morality and sexuality, the people would listen.

42.9% of the respondents said that HIV/AIDS cannot stop in this generation because of sexual activeness among the youth, high rate of immorality, low moral and family values in the communities and the pleasures the youth are engaged in.

My personal opinion is that unless people change their life-style and God intervening, AIDS is still going to destroy many people before any cure could be found.

**Question 15: THE A, B and C OF PREVENTION.**

Abstinence	76.2%
Be Faithful	100%
Condomise	42.9%

Most of the Christians believe in **Abstinence** to the unmarried, **Faithful** to the married. 42.9% still believe in **condomising**.

These people who go for condomising say this would be done within a marriage whereby one partner is positive but the two are still in love or where both partners are positive, the condom will



help to avoid the reinfection. To those who are sexually active and are not believers, condom would be the only solution.

**Question 16: A CHURCH TO DISTRIBUTE CONDOMS?**

yes	23.8%
no	76.2%

76.2% of the respondents disagreed with the distribution of the condoms by the church. Their argument is that once the church distributes the condoms, it would loose its moral standard and would be misunderstood to be promoting promiscuity.

23.8% agreed with the distribution of the condoms because HIV/AIDS is no longer outside the church. Even the 'devout' could no longer stand boldly to claim sexual purity. HIV/AIDS has come to the church.

But some Christians argue this differently. One pastor was quoted on City Press Newspaper (12/03/00) saying that he supplies condoms to members of the community. He argued that if we truly want to contribute in reducing the spread of HIV/AIDS, we have to be practical in taking the situation of our youth into consideration.

Although his ideas were convincing, when one looks at the reality we are faced with, but my conscious and conviction does not allow me as a Christian to do as he does.

## 6. THEOLOGICAL REFLECTIONS:

Theological reflection is *“the phase where we allow the Bible, our contextual analysis, our own tradition, our spirituality and personality, to enter into dialogue with one another. This is the phase in which we listen to all these sources intentionally and in relation to one another, and on the basis of listening, we gain new insights and we make decisions”* (De Beer and Venter 1998:64).

### 6.1. AIDS AND OUR PICTURE OF GOD: DIFFERENT PERSPECTIVES:

In reflecting God’s picture in the midst of AIDS crisis, Nicolson (1996) deals with this under three hypotheses which I would also like to reflect on:

#### **HYPOTHESIS 1: AIDS is a punishment for sin.**

According to those who are for this view, they say homosexuality, drug usage and promiscuity bring about AIDS infection. This makes AIDS to be a punishment for sin from God. Because AIDS is a punishment from God, the conclusion is that churches do not have to interfere in God’s way of punishing sinners. The Moral Majority’s executive criticised Federal Government for spending moneys on research for AIDS vaccine- because this would encourage the *“homosexuals to go back to their perverted practices without any standard of accountability”* (Nicolson 1996: 29). Crowther 1991:1 quotes this fundamentalist notion in the Times magazine (7 January 1987) stating: *“...AIDS is neither the problem nor the central issue. It is a symptom of something deeper and more deadly. AIDS is but one of the many disastrous consequences of promiscuous sexual behavior. Promiscuity is the root cause of the present epidemic. It has always been sinful, it is rapidly becoming suicidal”*.

This view fails to see that AIDS does not only affect the homosexual and the sexually promiscuous, but it also affects the innocent partners and newly born babies. The cruelty of the propagators of the view is evident in where *“One pastor whose family contracted AIDS through*

*blood transfusion was forced to resign – and children with AIDS were sometimes forced to leave the Sunday School” (Nicolson 1996: 29).*

This view makes pastors to act hypocritically and forget their pastoral responsibility of taking care of God’s flock. Pretending to be loving, they hurt and destroy many people who are in desperate need of their help. One such minister is mentioned in Kubler-Ross (1987:7),

*“With a sweet smile on his face, a minister informed one of my female AIDS patients that she was no longer able to attend Sunday services as her presence would empty the church rapidly and he did not like to preach to empty pews”.*

This is how far the ‘better-than-thou’ attitude can lead up to. According to White, *“God has indeed, as of old, sent AIDS amongst us as a plague, a punishment, and a terror to recall us, when all else has failed, to God’s law concerning sexuality. In a world which is becoming increasingly permissive about sexual ‘vices’, God must warn and punish”* (Nicolson 1996: 33).

Another fundamentalist propagator of this hypothesis is Clarke. According to him, AIDS is related to immorality. *“The AIDS crisis is directly related to sexual immorality, therefore we must address this crisis with biblical truth... AIDS, unlike other sicknesses, is a sexually transmitted disease; its development and rapid spread have resulted from specific sins committed by men and women... The AIDS plague continues to spread rapidly throughout the world simply because men and women want to continue in their sexual immorality”* (Clarke 1994: 20). As for those who have contracted the disease not by their own immorality, Clarke says that they are in that situation because of other people’s sin.

Contrary to Clarke’s view, theologians such as Nicolson, Amos and others believe that those infected with AIDS shouldn’t be thrown away.

Those who stand by the hypothesis site exile as a case study of God’s punishment to disobedient nation. The problem with this view is that even innocent people like babies, partners and those who received blood transfusion die in the process. *“If we decide that AIDS is God’s punishment,*

*we are declaring that God is unjust, punishing the good along with the wrongdoers”* (Nicolson 1996: 32).

Seeing AIDS as a punishment from God is to miss the reality of its contributory causes in Africa. AIDS kills innocent partners and children alike. It is true that its rapid spread is due to distorted human life. This, the church does not have to overlook.

In some African countries like Kenya, those who died of AIDS needed to be buried immediately in a body bag. Churches refused them church funerals. Those who were known to be suffering from the disease were not allowed to attend church service (Nicolson 1995: 27).

In this situation, people try to take God’s position by judging others on their fallible mundane understanding of God. *“AIDS is a very terrible way to die. There is increasing disability, loss of body function, and increasing dependence on others for assistance with feeding and going to the toilet... This is punishment – and it would be spiritual blindness on the side of the church to add more punishment by judging the victims”* (Nicolson. 1995: 29). Although there is somehow a link between AIDS and promiscuity, that does not mean that we are not called to love those who have AIDS. The message that needs to be constantly echoed in the ears of the church is *‘let him with no sin cast the first stone’*.

God forgives those who contracted AIDS through behaviour and who later repent. A repentant sinner stand cleansed before God just as Adam and Eve were before sinning. *“Our message to people with AIDS and for society in general should be one of divine compassion, of forgiveness for any personal irresponsibility or sin which has led to such dreadful consequences, and of supporting one another in mutual responsibility”* (Nicolson 1995: 32).

The incarnational theology focuses on creating a presence on behalf of God in the lives of those dealing with AIDS. In their approach, issues such as acceptance, affirmation and belonging are very important. *“An incarnational response centres on the people who are dying rather than on how they became ill”* (Amos 1988: 53). This response understands the biblical reality that we are indeed in a brotherhood and sisterhood relationship..

The response also accept the fact that some people with AIDS is due to their irresponsible life-style, but it further says *“we must be careful to focus on people and not fall into the tempting trap of identifying them by groups and responding to that identity. Granted, it is much easier to let our theology focus on labeling people than it is to let our theology move us into authentic biblical ministry. We must not let labels determine our ministry”* (Amos 1988: 55)

**HYPOTHESIS 2: AIDS is not a punishment but a consequence of freewill.**

According to this hypothesis, AIDS is not a punishment for sin but *“a consequence of sin... AIDS clearly is, in part, a consequence of human’s disobedience to God’s life-giving laws. In this view AIDS became a killer disease because some human beings live such irresponsible lives”*(Nicolson 1996:38) To support this hypothesis, Sider says people are precious before God and AIDS is not a punishment from God. Because of God’s justness, there must be consequences if God’s laws are broken.

This hypothesis differentiate between God’s sovereignty and human responsibility in the sense that *“AIDS is not sent by God, but it is an opportunistic virus like any other which normally does little harm but became epidemic when conditions encouraged its spread”* (Nicolson 1996: 41).

*“The spread of AIDS has a great deal to do with swing to a more competitive, less caring, political and economic ideology”* (Nicolson 1996: 42) as a result, *“The more AIDS spreads, the greater is the cost to the economy in terms of health care, lost to personnel, lost time, the cost of orphans and in many other ways”* (Nicolson 1996: 42). The above supports the notion that AIDS is closely linked to poverty. As a result, many governments from the underdeveloped and developing countries are reluctant to use their little resources in buying expensive drugs such as AZT.

**HYPOTHESIS 3: God neither sends AIDS nor permit it but is powerless to prevent it.**

The hypothesis states that because of the free will that God has given to people, God must be held accountable for the misuse of that choice. It further says that if God has all power, then suffering must be viewed as part of His will. To put it clearer, the hypothesis states that; *“If all power lies in God’s hands, then AIDS is God’s fault, and will tend to think that only God can do anything about it. But if we see God and creation in a more interdependent relationship, if we see that suffering is not by God’s will, nor even by God’s permission, but happens because God has no power to prevent it, perhaps we shall understand how AIDS can have come about; and perhaps too we shall see more clearly that we have a shared responsibility with God to try to overcome AIDS. In the end, however initially dismaying, a concept of limited God perhaps fits our experience of AIDS better”* (Nicolson 1996: 53).

The process theodicy, which the hypothesis is based on, states that God does not allow freewill but it is part of reality. According to this theology, *“AIDS seems to be a virus that does its own thing in a random way which we cannot, and God cannot control”* (Nicolson 1996:57).

The hypothesis reminds me of the era of 1960’s concerning the emergence of ‘God-is-dead’ theology. This came about because of the calamities and crisis that happened in Biafra, earthquakes that killed thousand in Mexico, the poverty in third world countries and consequently the discoveries of cure of dangerous diseases such as leprous, the first man on the moon and many other scientific discoveries. Because of the human achievements, God was ‘left at the back seat’. This process theology is human being’s endeavor to air the frustration people find themselves in.

In responding to question whether AIDS is a curse or punishment from God, Nicolson says; *“AIDS is not a punishment although sinful human actions and attitudes are major contributing factors”* (Nicolson 1996: 73).

## 6.2. Biblical-Theological reflections on the issues of HIV/AIDS: metaphors informing our response.

It is very important for churches to develop a theology of AIDS as a response to the crisis. The failure to respond means that the God of the Bible and Christianity as a whole is irrelevant and offers no saving power. This would be a sign of failing to love His creation. *Nothing that has been created that was not created by Him.*

In their responses, "... churches must say clearly that AIDS is not sent by God to punish for sexual promiscuity. On the other hand, churches must not be afraid of pointing out that AIDS is often a consequence of having multiple sexual partners" (Nicolson 1995: 19).

*NB: Pre-marital sex and adultery are sin before God.*

### 6.2.1. AIDS and the Love of God.

In more than one instance, the Bible shows God not as among the condemning but among the condemned, the poor and the suffering. Jesus also showed preference to the poor, the sick, the outcasts and the 'unworthy' people in his ministry.

He healed them regardless of their background but because of their acknowledgement that they needed healing. In healing them, he restored them to God and also restored their human dignity. The purpose of Jesus' healing was to restore the fullness of life; at-one-ness between an individual who needed the healing and his/her true being, at-one-ness between that restored human being and his/her community, and at-one-ness between that individual and his/her God.

When He was asked by his disciples about who sinned for the blind man to be born blind, Jesus answered and said that neither he nor his parents sinned but all these happened so that the works of God might be displayed in his life (John 9:1-3). I think this is how we need to view AIDS; as an opportunity for the greatness of God to be revealed.

### 6.2.2. The healing of the man with leprosy : a metaphor for ministry with PLWA.

Related texts; Mark 1: 40- 45, Matthews 8: 1-4, Luke 5: 12-14.

The Bible clearly says that the man was full of leprosy. Anybody who suffered from this disease had to be isolated by the family, community and the religious institutions. This man, too, was isolated by people and probably was a nuisance to them (crowd). But the man appealed to Jesus for healing.

Jesus reacted by reaching out and touching the man. One thing that needs to be taken into consideration was that Jesus touched the man before healing him. The lesson here is that he accepted him as he was and then restored him to community with a touch. He touched him being fully aware about the law stating that he who touches an unclean (untouchable) person becomes unclean (untouchable) himself.

By so doing, Jesus was affirming the man, He was coming alongside him in his suffering and rejection and making himself publicly 'one with the man'. After this, the physical healing followed.

This is the attitude that we need to have and to display towards those with AIDS. We need to touch them both physically and with our lives. We need to get out of our comfort zones and reach out to those in real need: those who have been ostracized by the community. By reaching out and physically touching and embracing the one living with AIDS, that is a miracle in itself. There is a miracle behind the touch. The laying of hands serves a great deal in the healing of individuals. It is also part of Great Commission (Mark 16). *hag* 1004087

### 6.2.3. Restoring the adulterous woman (John 7:53-8:11): a metaphor for solidarity with PLWA.

Adultery is one of the sins God's people had been warned more about. To Jews, it was worse. The one found committing it had to be stoned to death. In this passage of scripture, the religious leaders, the Pharisees and Sadducees brought the woman to Jesus, presumably to trick him. It is true that the woman was caught in adultery. Though adultery is committed by two people, an



interesting thing about the passage is that only a woman is brought to Jesus for justice to be done, while man is left behind.

Jesus, without rebuking them, invited the righteous, those with no sin to cast the first stone. Religious as they were, none was found worthy to be declared sinless. Realizing their spiritual emptiness, all the accusers left.

When all had left, Jesus said to the woman; “neither do I condemn you. Go and sin no more”. Jesus saw in this woman a person who needed the grace of God. He forgave the woman’s sins and restored her relationship with God.

The self-proclaimed righteous religious leaders’ concern was to destroy the already destroyed person, to condemn the already condemned. But Jesus’ attitude differs with all other he reaches out and restores one other desperate life. He condemns not because ‘there is now no more condemnation unto those who are in Christ Jesus’. By this attitude, Jesus calls us to be like him to brothers and sisters who are in a process of being destroyed by our own pious attitudes. His attitude was ‘neither condemn nor condone’. We, as Christians, have been called to serve and “it is as we serve each other, help to heal and recreate each other that we shall find in AIDS not a curse but a true source of blessing” (Crowther 1991: 31).

Christianity is not an individual’s personal faith, it is a communal issue. We were called to be a community, to take care of others and ourselves. “The call to serve Christ in People with AIDS is a call to each of us as individuals and to us corporately as the community of believers... Community is built on coming together to share suffering, to offer each other acceptance and value, of staying together in the service of anyone who hurts” (Crowther 1991: 73, 75).

The message that has got to dwell in our minds is that we were called to be together. “But if we are found absent or against those with AIDS now, those without AIDS in the future will not remember whose we claimed to be” (Crowther 1991: 72).

6.2.4. Christian hope: the resurrection of the living.

The message of the church to the hopeless people is hope. When Jesus came to this world he associated himself with the hopeless, sinners and the downcast. His first message from the book of St. Luke 4: 18 was a clear message of hope to the hopeless: i.e. the poor, the blind, and the slaves. He came to proclaim the acceptable year of the Lord, the Year of Jubilee.

Those he met, the sick, he healed. And the dead, he raised. This is the same message that the church has got to proclaim among the hopeless; hope. To someone who has just received the message of being tested HIV positive, one feels lonely, alienated and hopeless. The Christian message to someone in this state is to give him/her hope in this world. After one has accepted his/her condition, hope sustains one for the next day. To the person living with AIDS, each day counts. One has to have the hope for the next day. Our God is the one who knows and controls our future. Accepting this fact of His omnipotence, gives hope.

*all powerful*

{ To be tested and diagnosed HIV positive, does not mean the end of the world but the beginning of the new life with purpose. }

*another  
he has come that the blind may see*

It is the duty of the church to bring this hope to the hopeless. Through its education and empowerment programmes, the church would be able to educate those living with AIDS to be engaged in empowerment programmes that would positively contribute to both the uninfected and those living with AIDS.

6.2.5. Christian hope: the resurrection of the dead.

To those with full-blown AIDS, there is no more future hope of survival for them. It can only take a miracle for them to be cured. And miracles depend on God and we can't control Him to heal us.

*He still is the Miraculous God.*

*→ Amen  
He is Sovereign -  
But He can heal us*

To the people of these conditions the message of hope that is needed is that of hope beyond the grave: the resurrection of the dead. This is not the pie in the sky type of Gospel but the message of

*Jesus is  
THE JUDGE  
THE OVER  
LIVING  
AND  
THE DEAD*

And unless we are born again we will not enter the kingdom of God (John 3)

hope to where there will never be pain or sorrow. This hope is only for those who have confessed and accepted the saving power of the Lord. Amen

This has been experienced largely by the members of the church. Our cell leaders are often invited to pray for the sick. Some of these are those who are in full-blown AIDS' stage. The messages preached at such occasions are based on the love, the grace and the forgiveness of God. To those we prayed for, confessions were made. And I believe that they are with the Lord. This is the hope as stated in Revelations 21: 1-3.

### 6.2.6. Church and Sexuality.

Secular agencies are reluctant to appear to preach or appear judgmental, or impose a particular view of sexual morality. In their campaign of condomising, they seem to be saying, 'do what you like about sex but do not get AIDS' (Nicolson 1995:19). To them casual sex is okay and harmless as long as condom is being used. "Although the World Health Organisation has said that sexual abstinence is the only way to control the spread of AIDS, AIDS education programmes do not usually mention this" (Lucas 1993:11).

The surest way of controlling the spread of AIDS is abstinence and faithfulness. It is therefore the responsibility of the church to teach and preach about these two methods.

### Church and condoms.

There are two ways to prevent the spread of AIDS, and that is eradication of open sex and/or the use of condoms.

In the church, particularly Pentecostal churches, condoms are still a problem because they are being associated with promiscuity. This idea was echoed by the South African Evangelical Consultation when they said that condom promotion is "medically dangerous and a means to promoting promiscuity" (Nicolson 1992: 51). Saayman and Kriel (1992:25) say that "condoms

*alone cannot prevent the spread of AIDS . The programme to contain AIDS must not rely on them to solve the problem”.*

Prostitutes in their desperation to get money will be unable to insist on condom's usage. In Addendum E, some prostitutes were interviewed on the risk of their activity without a condom. They confirmed that: *“we agree to unprotected sex with mine workers despite fears of HIV infection because clients refuse to pay for sex without a condom”.* One was also quoted (Sowetan 02/12/99) saying; *“We are just surviving here from day to day waiting for the day we have to make our funeral collection”.* This is the risk our people find themselves in. In this situation of health hazard, one even questions the wisdom of the government in giving constitutional rights to prostitution.

*Wives in traditional African homes are culturally unable to make or even mention a demand of the usage of a condom and will be unable to insist that husbands returning from town employments should use them.*

Nicolson (1995) also argues that condoms do break and it is misleading to regard their use as safe sex. *What we need today is safer sex.* This is abstinence and/ or faithfulness. Condoms in themselves are technical and mechanistic Western type response to a health problem.

For long time churches have placed more emphasis on *moral issues such as teenage pregnancy above any other issues that demanded repentance and change of behaviour.* Teaching on sexuality has always been negatively perceived. Instead churches promoted simplistic and legalistic morality about premarital sexuality.

Because of the legalism *‘In sexual matters the church has lost its ability to demand effectively different attitude and behaviour from its members’* (Greely 1990:98). Instead of the people obeying the church laws, they hide and continue in the old life-style as long ‘as they cannot be found’.

The church needs to emphasise genuine repentance which will make people to lives on Christian principle such as loyalty and honesty. In this way, the church can play an important role in matters related to prevention on HIV and AIDS; *"If we can persuade people to change from high risk living to low risk living, then we can at least slow down the spread. Better still, if we can persuade enough people to change to no risk behaviour, those who do not may still eventually need care as they get ill and die, but the vast majority who change in time will be able to protect themselves from a similar fate"* (Dixon 1989: 17).

### **Sexuality as God's Gift.**

It is the responsibility of the church to affirm sex in all its respect, pleasurable, social, as well as procreational. Sex in itself is a good gift from God.

In this sense, virginity in both the males and females should be pursued at all costs. Sex needs to be located within the relationship of love, not legalism. This would be done once sex has been deculturised from being men's right and women's duty. *"Christianity must emerge as the champion of loving sex, yet insist that its proper place is only in the context of a loving relationship"* (Dominican 1987: 44). This relationship is proper in marriage.

*Not only that but a marriage relationship*

### **6.2.7. AIDS: exposing our fear and unbelief.**

Because of the fear of this disease, *"we have compounded our fears and in blind panic have sought not a solution but a scapegoat... It is therefore not AIDS we need to address but those fears which AIDS has reawakened in us, fears so great that even we who believe in a God in whom everything works to our good can see nothing but divine retribution"* (Crowther 1991: 16).

Fear has cast doubt to those who were supposed to be comforting the wounded. Crowther (1991:16) calls this kind of fear the fear of contagion. *"This is not just a fear of catching the disease but perhaps greater fear of being associated with the disease. And it is this fear, I suggest, that has made the church slow to respond, half-hearted in its pronouncements on the need to care for those with AIDS, and is quite unwilling to direct its many resources of people, skills, buildings*

*and money to the benefit of those with AIDS...". The church does not want to be involved in order to keep its reputation and integrity above reproach.*

The second kind of fear according to Crowther, is that of denial, pretending that AIDS could never affect us. We deny it in order to protect ourselves from it. We are forced by this denial to also deny reality to people living with AIDS. We convince ourselves that they do not concern us, failing to realize that we are 'our brother and/ or sister's keeper'.

We jump to conclusion that those who have contracted the disease are also responsible for its cause. We see them as responsible for their situation and so relieve ourselves of responsibility to care for them. They are no longer our brothers and sisters, so we are no longer their keepers. We refer to them not as people but as numbers, not as suffering human beings but as victims. We label them and thereby distance them.

AIDS is not a curse from God, but *"the true curse of AIDS is our lovelessness, a lovelessness that desires to deny the disease and to separate ourselves from those who have the disease... it is lovelessness that makes us want to point finger of blame for the disease on those who have the disease and to dehumanize and ostracize them to the extent of denying our common humanity with them"* (Crowther 1991: 20). It is this fear and lovelessness that has resulted to our failure to come to terms with our humanity. AIDS epidemic has really challenged our theology to its very foundations.

### **6.3. A CHALLENGE TO THE AFM IN TUMAHOLE.**

I am a pastor of the Apostolic Faith Mission Church of South Africa in Tumahole township. The AFM as the church is classified under the Pentecostal church. The Pentecostal is derived from Pentecost which is associated with the outpouring of the Holy Spirit as recorded in Acts 2.

The church believes the Bible to be the only inspired and authoritative Word of God. For any action to be taken in the church, whether in preaching, singing and testifying, we believe in being 'moved by the Spirit'. When the spirit moves, people are convicted of their sin and they, without

being forced by anybody respond to the altar call and there accepted the saving power of Jesus Christ.

When a person has accepted the Lord in this way his/her life changes. The change is not only being seen by the church but it is also been witnessed by the members of the community at large. There are some people who were known for their bad criminal records, but once in Christ their lives changed drastically. No sinner is above the saving power of Christ. → Amen.

### **Sexuality and sexual misconduct.**

In the church's fundamental teaching, sexual misbehaviour is viewed as a serious misconduct. Anybody found committing this act is being disciplined if the evidence proves the allegation to be truthful.

The church discipline is viewed and applied as *'God's way of insuring that the church helps Christians to move away from their sins and avoid enslavement to harmful habits... So church discipline should aim for the restoration of the individual'* (CLA publication vol.9 no 4, 1999).

The legalism of the church especially in the sexual matters does not seem to be very effective because yearly we discipline people for teenage pregnancy. These are those you can't think anything about them until the consequences of their secret love has been exposed in a shameful way. What seems to be the norm is that 'as long as I am not caught then I am holy'. People end up fearing people rather than the Lord.

In the traditional and black Pentecostal churches <sup>low</sup> sex is a taboo. Any study on sexuality is not easily accepted. When one preaches or teaches on the subject in the contemporary way, s/he is been labeled as 'fallen from glory'.

Premarital and extramarital sex is viewed as serious offences, in which the perpetrator needs to be disciplined. The church encourages abstinence and faithfulness. In the approach to marriage the pattern to be followed is { love, marriage and sex } - Amen

Based on this background it would be easy for one to image the church's stance on issues such as HIV/AIDS. Although it has never been an official stand of the church, most preachers have been preaching against AIDS as a punishment from God. I have personally attended crusades where preachers were attacking people who have contracted AIDS as being promiscuous.

Regardless of the situation, there is a change of heart in the official publication of the church in how to view AIDS and those who have contracted the disease. The Northern Free State regional chairperson of the church (AFM) brought the video on 'AIDS: Breaking the silence' and encouraged it to be circularised among the black churches for more input.

### **Divine healing.**

In its obedience to the Holy Spirit, the church believes in divine healing. When everything else has failed, then God takes over, if people allow Him. This healing is part of the great commission; *'they shall lay their hands upon the sick and they shall recover'* (Mark 16: 14-18; James 5: 13-16). Through the laying of hands, many people with incurable diseases are healed, the blind receive their sight back and crippled are walking. This is not just an old-time Bible story, but it is real. It is happening now in our time.

Incurable as AIDS might be, it can still be cured through faith in the healing power of Christ. In more than one place, we have heard of people who were tested positive, and after healing prayers were retested, only to be found to be negative. Amen

In response to whether God is biased by healing other while others die, T.D. Jakes says *'healing is from God. He is the One who decides who, where, when and why He should heal us. His healing is for a certain purpose'*. He further says *'even during the Bible time some leprous were healed while others died from the disease.'* That's true

In the video 'AIDS: Breaking the silence', in some places in Africa (eg. Uganda and Ethiopia) AIDS sufferers are dying and are being buried daily. In such countries the fastest growing business is coffin making. In that same situation, one Muslim priest was miraculously healed. He claims that he was given one month by the doctors to live. In the middle of one night, without been told by anybody, he saw a vision of Jesus who said He came to heal him. He was healed and today he preaches the saving power of Christ. This testimony and others of similar nature encourage us that AIDS won't have the last say. Healing will come. It might not be today or tomorrow, but it is coming. Our Omnipotent God won't be defeated by sickness, although for



some reasons beyond human comprehension, He seems to have allowed the virus to wipe out His creation.

#### **6.4. A CHALLENGE TO MY OWN PASTORAL IDENTITY.**

##### **My community involvement in HIV/AIDS.**

In this part, I am going to relate what I did to meet the members of the community and the local church to make this assignment what it is today.

##### **AIDS TRAINER.**

I, as the pastor of the church was trained as the trainer in AIDS and STD issues.

##### **AIDS DAY WORKSHOPS.**

On 01 December 1999, the community organisation on AIDS (Partuma AIDS Awareness Group), invited me to their meeting. To me this was an opportunity for more research on this assignment.

The meeting was attended by ministers, community leaders, teachers, health workers, learners and ordinary people. The average attendance was 600 people. Although the attendees were mostly youth, and children, it produced good fruits. Each speaker was trying to show the young people the true facts of how the disease was destroying our young people.

As it is usually done, this ended up as a condom promotion campaign. When I stood to speak, I tried to show how condoms have failed to in stopping the teenage pregnancy and how condoms cannot be trusted as the only weapon to fight against AIDS. Instead of C for condoms, used the letter for CHRIST. It is only Him who can save our world.

Surprisingly, more people supported the idea of abstinence, faithfulness and Christ.

## AIDS INDABA (28 DECEMBER 1999).

Just before the close of the century on the 28 December 1999, I organised the special service for the youth to look at issues which needs our attention in the year 2000, and do the planning on how to solve the problem arising from the discussion. On top of the agenda was the AIDS issue. Based on the facts on the table we realised that AIDS needs our serious attention more than any other problem in our community.

To facilitate the discussion for better understanding of the disease, we watched one video from the Go-TELL ministries entitled 'AIDS- Breaking the Silence'. The video was taken from Tanzania. In the video we saw corpses full in the mortuary about the people who died from AIDS.

One pastor there said that he is like a full-time burial pastor. He says he buries people daily.

The carpenter said that he has stopped to produce furnishes for production of the coffins. He said through AIDS his business of coffins has grown tremendously.

Bishop T.D. Jakes from the Potters' House ministries from USA explained how his church is involved in the ministry towards the people with AIDS. He said that AIDS was not a punishment but that it is through the disease like this where we can experience the power of the grace of God. He further said it could have happened to any of us so, no <sup>one</sup> ~~one~~ should boast. He concluded the message by making an altar call for those who would like to commit their lives to Christ.

After the video we made very constructive inputs and the resolutions are included in the way forward. One controversial issue mentioned in the discussion was the issue of HIV-test before marriage. The house did not accept this. It was seen as interfering in the lives of others. The thing to be done could be for one to wait years before marrying, trying to look for the partner to be. If one is positive that would be self-revealed in the process of waiting.

disagree

AND AIDS tests  
can best serve  
us to prevent  
surprises during  
the marriage  
relationship

## **A CHALLENGE TO MY SPIRITUALITY.**

I do not face the issue of HIV/AIDS on my own zeal, might nor power. My approach is purely because of my Christian faith. It is this faith that drives me not to pass a person in need without meeting his/her real need.

In this case, the person in need is the one living with AIDS, his/her relatives and or family members and the uninformed members of the church and the community on issues pertaining to HIV/AIDS. This faith experience is the one that keeps me going and that reminds me that by being hospitable, we will 'receive angels' as our guests.

As a Pentecostal, I also believe in the power of the Holy Spirit. This Spirit is the Spirit of Hope and Power. Where the Spirit of God is, there is liberty. It is this same freedom that frees me to take an action.

My Bible Studies, devotion and worship service shows me that our God is on the side of the poor, suffering and oppressed. Whenever He met a needy person, He met his/her need. Surely, I cannot claim to be a Christian until my heart is moved by what moves the heart of God.

## 7. PASTORAL PLANNING FOR ACTION.

### 7.1. Pastoral Care as Sacramental Ministry.

The church will train caregivers and counsellors for caring and counseling persons living with AIDS. These will also counsel families whose members of the family have been diagnosed positive. The church will also have to organise more material support for the widows and orphans of AIDS.

Visit families of the persons living with AIDS and the people themselves. The church's departmental divisions in the church will be empowered in the promotion of the culture of abstinence.

*"... good, solid and biblically based pastoral care is vital to ministry to persons and families dealing with AIDS. Good pastoral care begins with the reaffirmation of the need to respond to people with AIDS as persons and not see them primarily in the context in which their disease was contracted"* (Amos 1988: 94). How truthful is the statement to the persons living with AIDS? Our response must bring good news to them. In facing death, the presence of a minister can create acceptance to the sufferer. One's presence can offer hope that God does not abandon the person living with HIV/AIDS even in the face of hopeless situation. The presence needs to be strengthened by praying and reading the scripture together. More than just sermonising or giving a lecture, the caregiver needs to be a good listener as this can be of vital importance to the PLWA. Together, Christians need to pull their skills, experience and resources ecumenically in the face of AIDS. Whatever the caregivers do, they should begin with listening to those living with AIDS. They will also need to coordinate their united efforts.

On the other hand, collaboration with other churches and other Christian and non-Christian organisations dealing with AIDS is a must. It's at this score that the AFM will have to start encouraging ecumenical debate and discussions on the subject of AIDS and the churches.

The other thing that the church will have to take into serious consideration is to prepare itself for caring of the AIDS orphans. Having soup kitchen where these orphans could be fed could do this. In order not to stigmatise the children, other children from needy families will have to be taken into consideration.

By sacramental ministry I mean prayer services, laying on of hands to the sick, and the communion service as a healing process to those living with AIDS.

Prayer would be held for PLWA's and the members of their families. Laying of hands to the sick will continue being done for the sick in general and HIV infected people in particular. This ministry of laying of hands has an important psychological impact on the AIDS sufferer. Most people do not want to touch the infected people, let alone those with full-blown AIDS. When Jesus reached out and touched the leprous, he was calling on us for the ministry and the power of laying on of hands. In the book of Mark, He instructs His disciple to lay hands on all those who are sick because they shall recover. It's our call as believers to physically and with our lives to touch those infected by the disease. We need to come out of our comfort zones to touch and reach those in need.

The known full-blown AIDS sufferers would be visited and served with communion. The communion would only be to those who confess the Lordship of Jesus Christ. Those who do not confess this, will still be visited but on counseling purpose. But the church does not have to stop showing them about the love of God that reaches to all the people regardless of their conditions.

Services held for the sufferers would be for the purpose of reconciliation between them and God (salvation). The relevant Bible study lessons would be prepared and be discussed at the different cell group meetings as a way of conscientising the Christians for their responsibility towards the HIV/AIDS sufferers.

Message of hope in this world and/ or beyond this life would be the theme for preaching. Spiritually the person living with AIDS needs revival and assurance that beyond the here and now there is another life (Rev. 21:1-3).

One thing that the church can give beyond materials is to genuinely love those with AIDS as Christ has loved them (John 13: 33-34). *"The response of Christians and the churches to those living with HIV/AIDS should rather be one of love and solidarity, expressed both in care and support for those touched directly by the disease, and in efforts to prevent its spread"* (1997: 29).

AIDS brings a judgement to the church in the sense that the church fails to do what it was called to do; 'to love all of God's creation'. Those infected with the disease need not only to be cared for, they too have something to offer. *"If we treat them as objects of our pity, if we care for them only on that basis, we humiliate them"* (Nicolson 1996: 157). The church is been recalled to be able to hear what help the people we are concerned with require, not what they (church), with the bias of their needs, think is needed.

The church is called to love those who are hurting and sinners *"because AIDS is rarely spoken about in church, persons with AIDS have no way of knowing how acceptable they would be. There is a conspiracy of silence. People with AIDS only tell closest friends for the fear of ostracization"* (Nicolson 1996: 195). This was so shocking when I discovered that not all Christians are prepared to inform their churches about their HIV/AIDS status when they are being diagnosed positive. In one workshop we held, I asked whether any of them would be in a position to trust fellow Christians to reveal if they have been diagnosed positive. All of them denied and said they do rather trust those outside because Christians in most of the times cannot be trusted with confidential things. The AIDS crisis shows where the church has failed, but also gives us reason and motivation to try all the harder.

## **7.2. A PASTORAL CARE STRATEGY AND PLAN FOR TUMAHOLE.**

### **7.2.1. EDUCATION.**

According to the respondents to the questionnaire, education in as far as HIV/Aids is concerned, is in the top three priority after counselling and Bible Study. Without information or knowledge, 'the people perish'. As a proposal to churches to act as witnesses in relation to long-term causes and factors encouraging the spread of HIV/AIDS, the WCC Study Document (1997:90), has this to say: *"We ask churches to educate and involve youth and men in order to prevent the spread of*

*HIV/AIDS*". Lack of proper information is one of the most contributing factors in the spread of the disease in our generation and in my community.

The family of the sufferer and the sufferer need information about the disease. *"Regardless of how well read people may be, the presence of a crisis often calls for the introduction of information"* (Amos 1988:77). According to Amos, medical personnel do not always take time to go into details about the information needed. The pastor's relationship with the family also has an advantage that goes beyond that of doctor patient relationship.

In most of the communities, the church is regarded as educational agency. In Tumahole the AFM church enjoys the support and the respect of the people.

The theological reflection on HIV/AIDS in our local assembly would have to be introduced to all the departmental divisions such as Sisters Fellowship, Youth Fellowship, Sunday School and Men's Fellowship.

Sex education and sexuality would be included in the syllabus church's teachings. *"Sex education needs to be about informative than what we must avoid. Children should be brought up with healthy attitudes from the beginning. They need to learn a positive attitude towards their bodies and themselves, and not merely be warned against the dangers of sex in their teens"* (Nicolson. 1996: 100). Many agencies in their education programme on AIDS encourage casual sex as long as condoms are being used. But the church in its teachings about sexuality will help to bring a change. Throughout the world, traditional sexual ethical norms are broken down. Thus, AIDS spread because of conducive environment. It is in this kind of environment that *"Christians have a responsibility to provide seasoned, sensible, achievable standards of sexual behaviour which may help the various societies and cultures of the world to provide the basis for personal and family stability which we have lost"* (Nicolson. 1996: 103).

In my preaching and announcements, the subject would be mentioned at least twice a month for not more than 5 minutes. To be more explicit, these 5 minutes are not the preaching but some sort of awareness before each actual sermon. In every conference we are to have, one service would be given for sermon on AIDS.

As part of the expertise, Christian AIDS workers would be invited for inputs. The main objectives of the education among others, would be; knowledge about the disease, the distinction between the facts and myths about HIV/AIDS, to learn about the psychological, spiritual, social and economic impacts of the disease. We will also include teachings on the spread and the prevention of the spread of the disease in the community.

### 7.2.2. SOCIAL RECONSTRUCTION.

As one of the recommendations to churches in their ministries as a witness to the world, the WCC Study Document (1997:90) states that; *"We ask the churches to recognise the linkage between AIDS and poverty, and to advocate measures to promote just and sustainable development"*. As indicated earlier, there seem to be a close link between AIDS and poverty. Some people because of the poor condition they find themselves in, they resort to prostitution, which puts many to high risk of being infected with this disease. In support of this fact, the WCC Study Document (1997: 13) states: *"Socio-economic and cultural contexts are determining factors in the spread of HIV/AIDS. Because these circumstances differ from place to place, countries, districts and even villages may have quite different HIV/AIDS stories and current profiles... But WHO currently estimates that nine out of ten people with HIV live in areas where poverty, the subordinate status of women and children, and discrimination are prevalent"*.

The church in trying to curb the social imbalances like poverty that encourage the spread of AIDS, will fight against the culture that leads to unfair sexual relation; where men are favored to dominate women.

We will also introduce nation-healing programs like debates, open talks and symposiums on respect between people of different sexes.

For the reconstruction programmes, we have started the dressmaking school where women are taught to make clothes to generate their own funds.



Other income generating programmes envisaged are the breadbaking and the candlemaking projects to create jobs for some heads of the families to feed their children.

Our teachers have volunteered to offer their services to learners who have failed their Matric exams or those who have performed very poorly in the said exams. This will remove children from the street, and positively channel their energy towards social reconstruction and community building.

In the launching of the projects of the church to the community, one of the lines I wrote was: "the crime, unemployment and unemployability, abuse, illiteracy and aliteracy (ability to read and write but lazy to put the skill into practice), prostitution, HIV-AIDS, alcohol and drug abuse, challenge us, the educated and the enlightened, to take a stand and volunteer our skills for improving the living condition of our disadvantaged community".

The main target of our development projects is the disadvantaged youth and women between the ages 18 and 30. Being aware that this age group is vulnerable to poverty and HIV/AIDS, it will be very wise for the church to do something to better the lives of those in this group.

**The measurable objectives of the church's development project are:**

To create jobs for the 20 households who are estimated to support 4- 7 dependants.

To train 50 people in sewing to enable them to start their own dressmaking business.

To train 10 people, in candlemaking, 30 in brickmaking, 40 in breadbaking, and link them to funding agencies for start-up funds, to start running their own income generating projects.

The project hopes that in 5 years period it will expand and develop its donor base continually to raise the appropriate level of funding to ensure that the plans for the organisation are implemented and that the project achieves its strategic vision.

### 7.2.3. PASTORAL COUNSELLING.

*“Counseling is a process of empowering the person to make decisions about his or her own life”* (WCC Study Document. 1997: 85). In his fundamentalistic approach to counseling in the AIDS crisis, Clarke (1994) has this to say as the goals of counseling; **conversion** (Gospel presentation to prepare one for heaven), **repentance** (from negative damaging emotional responses such as, bitterness, guilt, depression and self-pity), **change** (of moral behavior), and **encouragement** (to sufferer to face challenges of life).

He further says that, pastors, lay people and church workers, who are filled with the Holy Spirit and have the Bible as the inspired Word of God, can do the above goals. AIDS sufferers are counseled to make peace with God before dying. In presenting the Gospel, one does not have to worry about offending the sufferer, because *“attempting to counsel the non-converted person is like teaching a dead man to get up and exercise”* (Clarke 1994: 90).

Amos (1988) warns against this kind of approach and says that it is better for patient or family to face death alone rather than the presence of insensitive, judgmental or overzealous minister.

I, personally, do not agree with Clarke’s approach of not counseling the non-converted person. His idea is also contrary to the Gospel message that he is propagating. When Jesus approached or was approached by the needy person, without judging he would ask: “What do you want me to do for you?” and after the miracle of healing, he would say, “go and sin no more”. Jesus always valued the person. And in this way of approach, many followed him. He never judged nor condemned a needy person.

The other problem with this approach is that most people when they are told of their HIV/AIDS status, they think of nothing but death. In that state one will also agree to ‘accepting Jesus’ as a way of ‘bargaining’ with God for healing. Once they come to reality, most return to their previous life-style. My personal experience is the man who was ‘just about to die’; who accepted Jesus, and he ‘recovered’ his health after spending more than four month in the hospital. After two weeks of returning home, he started sleeping outside and continuing with his old style of living. Since then, he vanished from church and told me never to come to his house again. Though I believe in

presenting the Gospel to all people, but I do not accept misusing it against a defenceless person and not to counsel him or her if he/she does not accept Jesus as Saviour. To me counseling is counseling and has got a specific purpose and Gospel presentation for proselytizing is another with its specific purpose too.

Contrary to Clarke's (1994) counseling strategies, I align myself to goals as presented and mentioned in the WCC Study Document (1997) among others as:

### **Caring for the living.**

As it has been indicated from the interviews I have had with people living with AIDS and their families, once one is been tested and diagnosed positive, he/she becomes bitter, vengeful, self condemning, guilty and many other negative feelings.

Knowing the negative reception one will be facing among the members of the family, friends and most regrettably the partner and the community, one is left with the option of suicide or revenge.

In the state of attempted suicide, the pastor can play a very vital role. It is at this stage that the pastor can help the infected to come to terms with the situation. The counseling does not only helps the infected but also the affected family and partner.

Failing to accept the situation, the other danger is that of revenge. The innocent partner would normally say that since I got this without being promiscuous, the only option for me is to spread this to others. This is evident at the story of Aunt A. who vowed to spread the disease before she dies. I believe that she is not the only one with this kind of thoughts. Most of some sufferers are the victims of revenge.

If one is properly counseled, and he/she accepts the situation and '*deal with it rather than blaming the partner because this won't help one to better the situation*' (Woodward 1990: 75), the revenge mentality vanishes.

### **Empowering to cope.**

Being tested positive does not mean the end of the world, though it might seem for a short time. After the denial stage has passed, one realises that he/she is as normal as any other person. One is still as healthy as anybody. Their lives and feelings do not stop after the test. Different from any person, one knows his/her status. It is this knowledge that has to influence one to change his/her lifestyle. It is at this stage that the condom has got to be used by the married couples to avoid the re-infections. Diet and daily bodily exercises would be a new way of survival strategy to prolong one's life.

Members of the family and/or partner would be prepared through the counseling to cope with accepting and caring for the sufferer especially in an hour of great need when one is in a state of full-blown AIDS. When one can't do what he/she used to do, the support from those close to the sufferer is very essential.

Mother Teresa was quoted saying that there is no greater pain than that of being rejected by the family. To support this, Lucky Mazibuko in his article on Sowetan/Sunday World newspaper of 14 May 2000, quoted one lady, Lucia Nhlapo, saying: *"I phoned my mother for moral support and she gave me a cold shoulder when I told her that I was HIV-positive.. When got home my two children became strangers. They were ordered not to come near me. They were not supposed to hug or kiss me or even touch me..."*

*"I had to have my special cup and plate that nobody will touch, and my clothes were kept in a coal box outside the house.*

*"The big blow was when my aunt told me to pack my things and leave because I was a health risk to the family".*

An amazing thing, according to Lucky, at Lucia's funeral, the same people who rejected her while she was alive, were there and were mourning as if they had lost an important member of the family.

I was also able to counsel one lady who was tested positive. She, too, was staying with her aunt. In my deliberations, I asked her to inform her aunt since she was the only person near her and who

was like a mother to her. What she told me was that she will never do that for the fear of risking her accommodation. True to her words, she died in three weeks' time without informing her aunt about her HIV/AIDS status. The role of the pastor cannot be overlooked in this regard.

The church has got to be a 'home' to the homeless, a place where love is found and given to those in need. It's unfortunate that most of the times things are not so. "...sometimes people with AIDS find more love and acceptance outside the church than within" (Nicolson 1996: 65).

#### 7.2.4. The Ministry of Funerals.

It is very expensive to die as a black person. Our value of ubuntu, of waiting for all the people to come to the funeral is costing us a lot. When a member of the family dies, say on Tuesday or Wednesday, the funeral would be held the following week on Saturday. This is meant for all the relatives and friends to come. The more people have attended the funeral, it is 'believed' that that person has been rightly buried and that s/he has entered heaven.

The problem is that for the whole week or more than seven days people will be coming to comfort the family, and they would be given refreshments while the relatives from afar off would be fed daily until the burial. Some people go to funerals for food more than to comfort the bereaved.

After the funeral the members of the family are left with debts they acquired when they were trying to 'impress' the mourners.

The person living with HIV/AIDS lose a lot of money during the sickness by attending a doctor or a hospital. Thus there is no need to waste further money and to leave the widow and/ or the orphans with nothing.

I cannot forget a story of one person who died with nothing and the members of his family made an offer to the community that whoever will give this person a 'full funeral', that person will be given the family site as a reward. A full funeral means dignified coffin, hearse and a family car,

and a cattle to be slaughtered. What is the use of all these things when after the funeral the family would be having no property (a home)?

It is high time that the funeral should be treated with the dignity it deserves. It should be seen more in its mournfulness and those attending do so to comfort and to be with the bereaved family. The simpler the funeral is, is the more it would reclaim its cultural humanness (ubuntu).

In the church, community gatherings and ministers' fraternal, this message of bringing down the cost of funeral for the sake of the living.

### **This is how we can implement the burial plan.**

Bringing in the background before, an average funeral in the township cost not less than R6000.00. This amount is made of:

- Catering: R2500.00
- Funeral Service: R3500.00. (this package is compulsory. Nothing is sold in singles).  
(hearse = R500.00, family car R450.00, coffin R1500.00, tent and chair R500.00, grave R550.00).

### **Bringing costs down.**

**Catering:** instead of buying a cattle and other expensive grocery, we will buy bread to make sandwiches and tea or cold drinks for an amount which is not more than R1000.00.

### **Funeral service:**

Buy a home made **coffin** for the amount of R600.00. On the other hand, this would generate an income to unemployed carpenter.

For **Hearse** we will use bakkies (vans) from neighbours or hired for R50.00. And for a **family car** hire a taxi for the amount of R60.00 for 15 members of the family.

Price of **grave** would remain the same R550.00.

**Tent and chairs** could be hired for R200.00.

This type of funeral would cost **R2460.00**. Which is would be less with **R3540.00** from the current services rendered. This remaining balance would benefit the remaining members of the family.

## 8. CONCLUSION.

It is quite exciting that the church, particularly Tumahole AFM heeded to do something to address the issue of HIV/AIDS in our community. This action should be seen as a matter of urgency. The AFM can't afford to be a bystander while the lives of God's people are being destroyed by this epidemic. Taking into consideration the contribution done by the Christian churches in Uganda for bringing down the rate of infection in that country, I am convinced that we too can make a difference. The facts in this research show us that it is getting late and we too are becoming late. These are the lives of people we are dealing with and an answer will have to be found. People can't just die for nothing. To those who cannot change their lifestyles, it has to be emphasised that there is more to life than sexual pleasure, which at the end kills us.

My approach in this paper was the contextual one in which my context played a very vital role. The research was done at this very community and church. Thus the results will be relevant to the situation and the context of Tumahole.

The approach used is pastoral cycle with the following steps insertion- in which I described the present action and faith in my community; the analysis of HIV/AIDS, my community, my denomination and my spirituality, reflection of the various sources which drive me into taking an action; followed pastoral action based on my reflection.

The first hypothesis stating that people living with HIV/AIDS are not prepared to divulge any information about their status was confirmed as seen in this dissertation.

The assumption that Christians will put prayer as the top priority was proven wrong since prayer was at the bottom of the priority list.

Taking into consideration the facts of how the church contributed in Uganda to the reduction of HIV/AIDS infection, is the motivation that here in South Africa and in my community (Tumahole), the church's role cannot be overlooked.

As there is no cure for now surely God cannot ignore the cry of His people forever. He is the God who hears, sees, heals and delivers. I believe that as did with the Israelites, He will answer us by giving us a cure.

While waiting for divine intervention, we the people need to come together and fight AIDS as we did with apartheid. But individuals cannot win this struggle, it will need the efforts of all of all concerned people of God. From our church the stage has been set, the cry has been heard and we have moved from armchair spectators to real actors.

Like leprosy, AIDS would be a thing of the past. I hope that this would happen in our lifetime.



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**10.**

**addendum.**

# World has 11-m Aids orphans

**T**HE United Nations (UN) marked World Aids Day yesterday with a sobering set of new statistics, including that 11 million children have been orphaned by the pandemic.

In a report Unicef and Unaid says the number of Aids orphans is expected to rise to more than 13 million by the end of 2000. Already 95 percent of those orphans are in sub-Saharan Africa.

"The skyrocketing number of Aids orphans is – in addition to the loss of life caused by Aids – putting a severe strain on traditional support systems in Africa," said Unicef executive director Carol Bellamy. "The grandparents, who in so many cases are taking care of their orphaned grandchildren, have limited resources."

Eastern and Southern Africa are home to 4,8 percent of the world's population yet have over 50 percent of the world's HIV-positive people and account for 60 percent of all lives claimed by Aids, UN data shows.

In developing countries, children who have lost one or both parents to Aids are at a higher risk of malnutrition, illness, abuse and sexual exploitation than children orphaned by other causes, the report says.

Additionally, Aids orphans in many parts of the world face stigma and discrimination, leaving them socially isolated and often deprived of basic social services such as education, the report found.

UN secretary-general Kofi Annan called for an end to the "conspiracy of silence" that surrounds Aids, con-

tributing to widespread ignorance about the virus and discrimination against its victims.

A host of Aids experts spoke out on Tuesday about the virus and the enormous economic impact it has around the world.

"There is a multiplier effect because Aids attacks men and women in their prime working and consuming years," said Dr. David Bloom, professor of economics and demography at the Harvard School of Public Health.

In addition, Aids orphans create a major financial burden for communities, particularly in the poorest, hardest hit countries.

Panelists called for a global information campaign to educate more people about the virus since "at the moment, information is the best vaccine we have."

The launch of the UN report comes a day after 400 Aids activists demonstrated in front of the White House to protest US policies which they say prevent poor countries from getting the drugs needed to fight the disease. Ten people were arrested.

The activists, mostly from the Philadelphia area, accused the Clinton administration of supporting US pharmaceutical companies by using the threat of economic sanctions to prevent poor countries from producing generic drugs vital in the fight against Aids.

Developing countries attending the World Trade Organisation talks in Seattle have threatened to walk out unless they are granted some relief from drug production restrictions. – Sapa-AP

# Africa under threat

ADDENDUM D

SW 32 July 98

**+** **ARARE** – Of the nine countries to suffer a 17-year loss in life expectancy as a result of HIV-Aids, seven are in Southern Africa.

The life expectancy of Botswana, Malawi, Zimbabwe, Namibia, South Africa, Zambia and Zimbabwe will be back down to the life expectancy of the 1960s, according to the 1999 United Nations Development Programme report. The other two are Kenya and Rwanda.

The life expectancy in Zambia has dropped from 56 to 37 years.

According to World Health Organisation (WHO) regional director for Africa, Dr Ibrahim Abubakar, Africa has 70 percent of the people living with Aids in the world, 83 percent of the Aids deaths and 95 percent of the world's Aids orphans.

More than half the children in Zambia have at least one parent to HIV-Aids, giving the country of 9,5 million the world's highest concentration of Aids orphans.

Ranked among the world's poorest nations, Zambia has a 20 percent HIV-Aids infection rate. If this rate of infection continues, international aid groups say the number of orphans will increase in the next 20 years.

According to the Southern Africa Information Dissemination Services, between 35 and 40 percent of all children under 15 years old in Botswana, Malawi, Zambia and Zimbabwe will have lost one or both parents in 20 years.

The vast majority of these children, between 80 and 95 percent, will have been orphaned through Aids.

While Aids in Southern Africa has become a major factor for development, few serious attempts have been made to either deal with the socio-economic structures feeding into the epidemic to understand and minimise its socio-economic impact, according to the service, a non-government organisation working to promote alternative development responses to the Aids epidemic in Southern Africa.

## Budgets for health

The introduction of structural adjustments programmes reduced real budget allocations for health. In Zimbabwe, government's real recurrent per capita expenditure on health peaked in 1991 at R19,20 and declined to R12,60 in 1994, just barely above its 1980 level. It has since worsened.

Training costs to replace skilled workers in Zimbabwe were estimated at R15 000 per worker in 1993. Applying this average to the number of people with Aids in the formal sector indicated that training costs would increase from R6 million in 1991 to R30 million in 2000. More than 33 million people were living with HIV-Aids at the end of 1998, and 11 people

The rate of HIV infection in Africa is the highest in the world. It is an epidemic that is threatening to engulf the entire continent, writes **Lewis Machipisa**



According to the World Health Organisation, Africa has 70 percent of the people living with Aids in the world, 83 percent of the Aids deaths and 95 percent of the world's Aids orphans.

PIC: PAT SEBOKO

are infected each minute around the world, according to the WHO.

Aids causes 2,5 million deaths a year worldwide. In Namibia, there is a prevalence of 20 percent among sexually active adults or one in five Namibians aged 15 to 49 years old.

In 1997, Aids was the number one killer of Namibians. But silence still surrounds the disease in the Southern African nation.

Besides, the health system in most of the Southern African countries has collapsed.

Even AZT, the most basic of Aids drugs, is unaffordable in most African countries, where R360 a month is considered good pay. The latest therapies for Aids being used in industrialised countries cost R60 000 annually. This is many times more than the gross domestic product per capita of most African countries.

Most of the poor African countries spend next to nothing on Aids and most rely on international support, which is on a downward trend.

The problem has further been compounded by the stigma and discrimination against those suffering from Aids or are HIV positive.

In the volatile KwaZulu-Natal, a woman was stoned to death when she publicly admitted that she was HIV positive in December 1998.

"She was killed because she openly disclosed her status hoping that she could educate others. But the community stigmatised and discriminated against her and that resulted in her death," says Aurora Staffy of the service.

When hotel management in KwaZulu-Natal found out that some of the 27 Aids activists attending a workshop at the hotel were HIV positive, they attempted to evict them.

Hotel dining-room staff at the hotel were instructed not to serve the activists together with other guests. The hotel denies this.

Despite having paid R27 000 to hold the workshop there, the Aids activists had their cutlery and cooking utensils separated and meals served in separate dining rooms in total obscurity from other hotel guests.

## Mosquito bites

"There has to be more openness in communication regarding the disease," stresses Stally. "A lot of the time it's the messages that we come across and the perception that people have of HIV-Aids, for example the myth that you can get it from mosquito bites, sharing the same toilet seat or cup.

"People should come up with ideas of how to accept Aids openly. Journalists should not so much put the negative stuff in the press, but also the positive or balance out the reporting. We have cases of some people who have lived for 15 years with HIV."

WHO has urged Africa to declare the Aids epidemic an emergency in the hope that the formal declaration will focus attention on the problem and help bring in additional international resources. – Sapa-IPS.

# Aids orphans problem grows

## Charity Bhengu

SOUTH Africa should brace itself to cope with at least 100 000 orphans by the end of this month as a direct result of related to Aids.

is according to Dr Robert Shell e population research unit at s University, who was speaking Third African Population Confer- in Durban, KwaZulu-Natal last is situation is expected to worsen

dramatically with expectations that by the year 2009 six million parents would have died as a result of Aids. According to Dr Shell, many of the children left behind might also end up being abandoned.

"Aids orphans will always be a visible and permanent feature of South Africa's street life. No doubt some will see them as a nuisance," he said.

Shell said one of the worst consequences of Aids was that large number of children, as young as 11 years old, were left to head households after

losing both parents.

He says: "The socio-economic impact of HIV-Aids and the impact of the growing epidemic on children and families are severe and has a disorganising effect on families. This is because Aids becomes a family disease in that children are directly affected by almost every adult case.

"The health, development and nature of these children may be neglected as grandparents, extended families and even communities may not be willing or able to carry the

burden of so many orphaned children," he said.

Supporting the study, the SA National Council for Child and Family Welfare said the increasing social and economic burden of caring for these children could not be adequately met by the extended family, which was already experiencing great stress and disorganisation.

Already, great demands were being made on the Child Welfare Movement to meet the needs of alternative placement for children infected, affected or

orphaned by Aids. "This system is already overburdened due to a lack of human and financial resources," said the council.

Chief director of the national population unit of the Department of Welfare Population and Development Mr Jacques van Zuydam said: "We must be careful of approaching the Aids orphanage thing from a Western nuclear family perspective and making it out to be a new phenomenon that is going to hit the families out of the blue."

4 JUNE 99

# Ways to improve care for Aids orphans

By Charity Bhengu

THE dreaded Aids scourge has turned thousands of South African children into orphans overnight.

Many of them end up in children or elderly-headed households if not on the streets, according to the Department of Welfare and Population Development.

Caring for Aids orphans has become one of the greatest challenges facing the department.

This is because half a million children under the age of 15 have either lost their mothers or both parents to Aids.

It is estimated that in 2005, there will be more than a million Aids orphans in the country.

Welfare Minister Geraldine Fraser-Moleketi says: "Already, extended family structures are caring for many Aids orphans and many South Africans no longer have strong

extended families."

As children under stress grow up without adequate parenting and support, they are at greater risk of developing anti-social behaviour and of being less productive members of society, according to studies. Caring for them is stressful work that few can manage.

Fraser-Moleketi, whose Department has gone into partnership with the Health Department against Aids, says: "South Africa has 500 000 orphans and within 10 years this figure could rise to between one and two million. Therefore there is an increasing need for alternative care for children affected by HIV and Aids."

Thanks to the Social Welfare Plan on Aids which has been developed by the department of welfare, there is hope for Aids orphans.

The plan has the following five strategic focuses.

- To reduce the prevalence of HIV-Aids through targeted preventative interventions;
- Managing the impact of Aids on social security;
- Developing affordable community-based care and support models;
- Forming strategic alliances or partnerships and; and
- Developing appropriate policy to enhance service delivery.

The department is also involved in the piloting of two projects, one called Children in Distress in KwaZulu-Natal and another Kerus Care and Intervention Programme for children and families affected by the Aids epidemic.

Children in Distress programme provides the following:

- The best possible quality of upbringing for large numbers of orphans within communities profoundly affected by HIV/Aids;
- Rapid identification and place-

ment of orphaned, abandoned and abused children into these models of care;

- Economic self-sufficiency for people who care for orphans, especially families headed by the aged or by children; and
- Motivation and support for people and organisations involved in social service delivery to communities profoundly affected by HIV-Aids.

The Kerus programme is an integral part of the professional health care service at the Kalafong Hospital and the Pretoria Academic Hospital, working among people infected and affected by HIV-Aids.

It is said to be an ideal combined hospital-community-non-governmental organisations model of care for people living with Aids.

Kerus has provided care to 2 000 HIV-positive children and more than 4 000 infected adults.



A 10-month-old Aids orphan sits at the door of Ethembeni Children's Home in Johannesburg. There are many children like her whose parents abandoned them after finding out that they were dying of Aids.

PIC: CLEMENT LEKANYANE

ADDENDUM D

because women want i



Sex workers endure violence and insults and as a result their self-respect deteriorates.

# Selling unsafe sex

**W**ITH the HIV-Aids epidemic threatening our society, the working conditions of sex workers may sacrifice the lives of many. This is due to the fact that they may not practice safe sex -- more from duress than out of choice.

One of the sex workers living around a squatter community adjacent to a gold mine confirmed that "we agree to unprotected sex with mine workers despite fears of HIV infection because clients refuse to pay for sex with condoms. Most of the sex workers in this community come from impoverished rural areas".

Poverty is the most feared economic condition by these workers. Most find their job extremely unpleasant and say they have been driven to it because of poverty at home, as well as the lack of job opportunities for unskilled and uneducated women.

This prevents them from turning away clients who refuse to use condoms.

An added problem is that their work is stigmatised and they do not enjoy any respect from the community. As a result, say the researchers, their behaviour can be seen as rebellion.

"Sex workers endure violence and as a result their self-respect

Researchers Catherine Campbell, Yodwa Mzaidume and Brian Williams highlight the failure of information reaching sex workers about Aids prevention. This article is based on their findings, first published in Agenda, a feminist periodical.

deteriorates. Their response to this highly stigmatised profession is to rebel against campaigns for safe sex," says the report.

"One of the sex workers tried to talk a colleague into using condoms and she told her to 'go away with your Aids story. Don't waste our time with it. We are just surviving here from day to day waiting for the day we have to

by sexual fidelity and sobriety.

"But being in this degrading profession they are less respected as women. They are subjected to abuse from clients. As a result safe sex can never be a priority for them."

The researchers say the sex workers have strategies they use to deal with their negative identities. They are normally secretive about the job they do and pretend to be helpless victims.

The solution, according to the report, may lie in cooperation among the sex workers. This is confirmed by the sentiment of one sex worker who attempted to advise her fellow workers: "If sex workers begin to work as a unit without having to watch our individual backs our working conditions may improve. It would eliminate sex workers' HIV-Aids risk. Prevention could be easier and accessible. Working as a collective may help develop the assertiveness and establish necessary agents to insist on condom use in difficult circumstances."

**6 Most say they have been driven to sex work by poverty at home 9**

make our funeral collection?"

Another consequence of their work is that their social life is compromised: "Few of the women have regular boyfriends. Remember that a woman's respectability is derived from the traditional roles of wife, homemaker and mother -- roles that were characterised

Sowetan 02/12/99.



# Aids baffles ancestors, say traditional healers

21 June 1999

By Susan Fox

IN HER 18 years as a traditional healer Maggie Ramaota has thrown the bones countless times, asking her ancestors to provide her with a cure for HIV-Aids – but the answer is the same every time.

"We have asked them, we have even begged our ancestors for a cure," she explained. "but the answer is always, 'we cannot cure it, we can only balance it'."

Ramaota became concerned about the large number of HIV-infected people coming to her and took the advice from her ancestors a step further. She started learning about the disease, using medical doctors as resources, in order to find a suitable treatment.

What she discovered was that a herbal remedy treats visible symptoms, such as loss of appetite or a running stomach, but the virus itself remains in the person's body.

So she takes a different approach from most traditional healers and,

instead of assuring her clients that they will soon be well, counsels them on the realities of the disease.

She also tells them what to do to avoid spreading it to others and always has a supply of condoms on hand to distribute.

But Ramaota's views on the treatment of HIV-Aids are the opposite of many of South African traditional healers who insist they can cure people with Aids.

## Testing positive

PT Mtolo, an inyanga in KwaZulu-Natal, claims he has cured as many as seven people who came to him after testing positive for HIV in a hospital blood test.

He determined that they were cured after a few weeks of treatment when they began to look and feel much healthier. So he gave them a clean bill of health and sent them on their way. He believes that counselling about condoms or contraception is none of his business.

The Mai Mai Market in Johannes-

burg is a popular place to seek herbal HIV cures. *Labatheka*, a tonic made from the African potato, is used to treat various ailments, including diabetes, kidney disease, asthma – and Aids.

Although researchers suggest that it may have adverse effects, it is often the biggest-selling herb at this market.

Thully Zwane works with her mother, who is a traditional healer at the market and frequently treats people with HIV. These women take a more proactive approach and advise HIV-positive clients about condoms and other ways to avoid transmitting the virus. Zwane also treats clients with *labatheka*.

The misunderstanding among some traditional healers about the disease facilitates the continued spread of the virus, Ramaota said. Giving clients a clean bill of health and false hope when their bodies still have the virus only increases the chances of their spreading it to others.

It is estimated that 85 percent of black South Africans go to traditional healers. Complete confidence and



Among the herbal HIV "cures" is *Labatheka*, a tonic made from the African potato, which is used to treat various ailments.

trust characterise the relationship between traditional healers and their patients, making their advice more accepted than advice from a medical doctor.

Ramaota also treats HIV-Aids with *labatheka* but realises that while in her opinion it "balances the soldiers", it is not a cure.

Realising the critical role traditional healers play in controlling transmission, Ramaota has joined a small group of traditional healers who work for the government, conducting workshops aimed specifically at others in the profession.

Instead of preaching to them about

the importance of condoms, Ramaota takes her students back to tradition, discusses problems and finds solutions with them. So far she has trained 437 of her peers, but there is still a long way to go.

Mercy Manci, another traditional healer trainer for the Department of Health, thinks that modern values need to be incorporated into traditional practices.

Traditional rules for the prevention of STDs and pregnancy, such as abstaining from sex before marriage, have had to change. As some rules have been discarded, new ones need to be put into place, Manci said.

ADDENDUM F

ADDENDUM 9 21 May 1999

# Scientists endorse African potato

By Mokgadi Pela

TWO leading medical scientists have endorsed the medicinal value of the African potato in the treatment of HIV as the world battles to find a cure for Aids.

Professor Patrick Bouic, who heads the department of immunology at the University of Stellenbosch, and Professor Ruben Sher of HIVCare International, said the plant had shown the ability to increase CD4 counts (the amount of white blood cells in the body).

Bouic said the African potato is known to:

- Stabilise the patient;
- Increase the weight of patients; and
- Decrease the amount of HIV in the body.

"The earlier it's diagnosed, the better the prognosis. It is safe and we have lots of data," he said, adding that more than 200 people have been tested on it in South Africa.

Sher said he often supplemented anti-retroviral drugs with the African potato. "It has shown the ability to increase the CD4 counts."

But he was quick to warn people against using the African potato after boiling it in water. "We do not know what other substances remain in the preparation. What we know is that those active ingredients may be injurious to health and result in allergies."

Bouic said the African potato was a medicinal plant traditionally used to treat chronic viral and bacterial diseases. It was originally used by traditional healers to treat cancer of the bladder and prostate.

He said the University of Stellenbosch started studying the properties of the plant 12 years ago and discovered that it boosted the immune system of HIV-infected people.

A problem, however, was discovered with the fats in the plant which suppressed the

immune system in HIV-positive individuals.

"Knowing that the immune-enhancing activity of the plant was linked to the plant fats, we stopped using the whole plant and instead used only the purified form.

"It is therefore crucial for people to obtain this medicine by purchasing capsules from health centres or pharmacies," Bouic said.

A month's supply of the African potato costs about R90.

Dr Des Martin, an HIV-Aids researcher at Witwatersrand University, said: "From preliminary research it is clear that the African potato boosts the immune system. Although the potato is not sufficient treatment on its own, it could be extremely helpful when used together with other forms of treatment."

He also emphasised the importance of combining Western and traditional medicines in treating terminal illnesses.

# Gel may save women from HIV

By Bhungani Mzolo  
Health Reporter

**T**HE increasing numbers of women infected with HIV could decline following the discovery of a cream that supposedly kills the virus.

The Medical Research Council (MRC) is investigating the development of a microbicide, a chemical substance in the form of a gel or cream, that is safe and effective against HIV and other sexually transmitted diseases

(STDs). It is applied to the vagina or rectum before sexual intercourse.

The study covers four countries – Thailand, Benin, Ivory Coast and South Africa – and forms part of a larger research project for UNAids.

Dr Gita Ramjee of the MRC said the study investigated the use of a microbicide called Nonoxyl 9 on sex workers in KwaZulu-Natal.

“The first phase of the study looked at its acceptability by sex workers, while the second phase concentrated on whether it was safe to use or not,” she

said. The results showed that Nonoxyl 9 was well-received and safe.

Ramjee said the third phase, which began more than two years ago, is looking at how effective it is in preventing STDs. The results are expected by the middle of next year.

Dr Helen Rees, chairwoman of the Medicine Regulatory Authority, said both the MRC and reproductive health research unit at the Chris Hani Baragwanath Hospital, which she heads, were part of HIV-Net, an international network of research centres focusing

on HIV-Aids prevention.

“There is a recognised need for vaginal products that protect women during unprotected sex,” she said.

Rees said the results were expected during the international conference on the development of microbicides in the US in March next year. They will form part of the discussions of the International Aids Conference in August in Durban next year.

Professor Abdul Karim, coordinator of the Durban conference, said many women become vulnerable to HIV

infection because they cannot make their partners use condoms. With Nonoxyl 9 women do not have to inform their partners they are using it.

Karim said other microbicides being studied were PC 515 and Pro 2000, both of which kill the virus or prevent its duplication.

Dr Peter Piot, executive director of UNAids, said: “The research for an effective and safe vaginal microbicide has been slow. We need to see research from the public and private sectors.”

# Hospital's Aids unit on a brave mission

**By Bhungani Mzolo**  
Health Reporter

WHILE the debate about the cost of the anti-Aids drug AZT continues, a small Gauteng hospital has quietly been giving the medicine to pregnant mothers for nearly two years.

Coronation Hospital in Johannesburg opened an HIV-Aids unit about 18 months ago after it realised that the number of HIV-positive patients was increasing.

According to Dr Heather Brown, in charge of the unit, the money to buy AZT comes from the hospital's budget and they have been able to sustain the pro-

gramme by cutting down costs in other areas.

"We have stopped doing some of the unnecessary routine tests in order to reduce costs," she said.

Brown said 140 women were currently on AZT, at a cost of about R600 a patient.

Based on a study done in Thailand, the women are given two tablets of AZT twice a day in the last four weeks of pregnancy.

"Babies that are born of mothers infected with HIV run a 30 percent risk of getting infected but with AZT this is reduced to 15 percent," she said.

The drug stops the virus from replicating itself.

However, Brown said that the unit had already been warned to stop the programme as it was becoming extremely expensive to sustain.

"Any minute now we may be told to shut down the project."

She said ideally women should be given the combination of AZT and 3TC and, preferably, be advised to give birth through a caesarian section.

"The reason for this is that there is evidence that most of the infection occurs during delivery."

Coronation is the only hospital in this country that pays from its own funds for the supply of AZT to infected mothers.

# Inquiry over defective condoms

**By Bhungani Mzolo**  
Health Reporter

**P**UBLIC protector Mr Selby Baqwa is to investigate the distribution of defective condoms by the Health Department.

About 40 million Kenzo brand condoms, imported from India in 1996-97, were distributed by the Health Department throughout the country before they were found to be defective. They were apparently damaged when stapled together with leaflets containing information on how to use them.

Although the department tried to recall the stock, it is believed that less than 5 million were actually retrieved.

"We have received a report from the national Health Department concerning the distribution of the condoms, and have requested further information from the health authorities," said Mr Ray Zungu of Baqwa's office.

Dr Liz Floyd, HIV-Aids director of the Gauteng health department, said about 400 damaged condoms had been distributed by mistake by the staff at one clinic.

Floyd said when the department discovered the damage to the condoms last year, it immediately with-

drew them.

The news of damaged condoms led to a widespread panic throughout the country, as speculation became rife that it would lead to increased HIV infections. At present about 1 500 people are infected with the Aids virus daily, with the figure for those who are already infected estimated at 3,5 million.

Floyd said there were 40 depots in the province which supplied condoms to 300 clinics.

She confirmed that claims had been made against the department by some people, including commercial sex workers, who said they had been infected after allegedly using the damaged condoms.

Floyd said the new supply of condoms was safe as the standard had been set "very high".

In the absence of a vaccine against Aids infection, condoms remain the only available means to stop an infection. The health department still refuses to supply the anti-Aids drug AZT to pregnant HIV-positive mothers. The drug reduces the chances of mother-to-baby infection.

Floyd said people must report instances where they come across packaged condoms that are damaged.

## AIDS SURVEY: (addendum k).

The purpose the survey is to determine to what an extent the virus and the disease has affected our community. This will inturn help the church to respond effectively and relevantly.

### 1. How many people have been diagnosed positive in the last 5 years?

YEAR	NUMBER	PERCENTAGE (%)
1995		
1996		
1997		
1998		
1999		
<b>TOTAL:</b>		

### 2. SEX?

SEX	NUMBER
MALES	
FEMALES	

### 3. AGE DISTRIBUTION.

AGE:	NO.	%
< 19		
20- 29		
<b>30- 39</b>		
39 >		

### 4. LOCATION; (*Where do these people stay*)

Location.	No.	%
<b>Ou location/ Phelind</b>		
<b>Zone 6</b>		
<b>Sisulu</b>		
<b>Lusaka</b>		
<b>Mandela</b>		
<b>Ghana</b>		
<b>Vuka/ Metampelong</b>		
<b>Tokoloho/ Skotiphol</b>		
<b>"B"</b>		

### 5. What are the programmes that your centre is involved with in combating AIDS? (*indicate 1-6 in order of priority*).

Education.	
Counselling	
Volunteer training.	
Road show.	
House visits.	
AIDS Awareness campaigns.	

6. How is the community's response to the programmes on AIDS?

5. Very good; 4. good; 3. Neutral; 2. Bad; 1. Very bad.

--	--	--	--	--

7. How is the churches' response to your programmes?

--	--	--	--	--

8. How can the churches be involved in assisting the centre in AIDS awareness programmes?


9. What are the social effects of HIV/AIDS in the community?


10. Your cooperation will positively empower our church to respond to the challenge and threats raised by HIV/ AIDS in the community of TUMAHOLE.

11. Any other comment;


Survey by Pastor TJ Skhosana  
For MTh programme.

Respondents: Two clinics in the community and community based AIDS group.  
Potfolio:.....

## AIDS SURVEY ON CHRISTIANS ( addendum L)

(Conducted to individual Christians).

The purpose of the questionnaire is to seek ways and means in which Christians could play a positive role in responding to challenges brought about by HIV/AIDS epidemic

**Question 1.**

Sex.

Male	
Female	X

**Question 2.**

Age Group.

<19	
20-29	X
30-39	
40-49	
50>	

**Question 3.**

How many workshops on HIV/AIDS have you ever attended?

0	1	2	3	4
		X		

**Question 4.**

Were those workshops organised by the church?

yes	X
no	

**Question 5.**

Have you ever heard your pastor or church leader deliver a sermon on HIV/AIDS on Sunday worship service?

never	seldom	regular
X		

**Question 6.**

If seldom or regularly, were the sermons condemning the victims or trying to show love, care and support?

Answer: Not applicable .....

**Question 7.**

Do you know of anybody in your township who has is suffering/ or who has died of AIDS?

yes	X
no	



**Question 8.**

If yes, what was your relation to the victim/ sufferer?

Answer: Cousin.....

**Question 9.**

If q7 is yes, how did you know about victim/ sufferer's status?

rumors	
suspicious	
Informed by sufferer/ victim.	
Other: <u>Informed by family me.</u>	

**Question 10.**

Are there people in your church who are suffering from HIV/AIDS?

no	Don't know	yes
		X

**Question 11.**

How does your church treat those suffering from HIV/AIDS?

Answer: Make visits and prayers for them; Even invite them to the Lord

**Question 12.**

Do you as a Christian see HIV/AIDS as a punishment from God for immorality?

yes	
no	

I think that it could be but not necessarily that it is a punishment from God depending on some some circumstances; but I know that God is the punisher of sin.

**Question 13.**

What programmes do you think can be implemented by the church in its response to HIV/AIDS challenges? (1-6 in order of priority).

Education	4
Care	3
Counselling	6
Support Groups	5
Bible Studies	2
Prayer	1

**Question 14.**

Can HIV/AIDS infection stop in our generation?

Yes	
No	X

Give reasons:

As long as people are continuing to be rebellious of God's standards of living the reduction of AIDS is at low percent

**Question 15.**

Which is the best preventative method that the church can encourage people to use?

<b>Abstinence</b>	
<b>Be Faithful</b>	
<b>Condomise</b>	

**Question 16.**

Should churches be involved in the distribution of condoms?

yes	
no	

# ADDENDUM M.

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