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The discourse on the intersectionality of religion and HIV and AIDS with specific reference to Thulamela municipality, Limpopo province

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The human immunodeficiency virus (HIV) since its genesis has continued to affect a large number of the population in the African region and has caused exponential deaths. At the same time, new infections have been reported in South Africa. However, religion as a vehicle of change through the institution of the church has been acting on the contrary, since it discourages the use of condoms (one of the most effective ways to prevent HIV) and moralising the pelvic area in its characterisation against the commandment of God. Such a perspective has largely been drawn from the Christian doctrine(s). We argue that in its condemnation and moralisation of the virus, the church, through its pastors, engaged in biblical discourse (preaching).

Contribution: The article applies a qualitative phenomenological approach and system theory as theoretical lenses. Furthermore, the article locates the study within Christian communities located in Thulamela Municipality, Limpopo province. It proposes Christian practices that can be useful in combating the virus.

Keywords: HIV and AIDS; preaching; discourse; moralisation; religion; religio-cultural beliefs; communities and Christian communities.

Introduction

The response of the church across denominations to the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) epidemic has varied. Some denominations chose to be silent, while others engaged in a biblical discourse of public and private condemnation of the disease. As Kruger, Greeff and Letšosa (2018:4876) argued, such approaches have characterised those infected and living with the virus being labelled as 'immoral' and in need of repentance. It has been argued that part of the stigmatisation phenomenon has largely been how the various denominations engaged in biblical discourse through their condemnation of people living with HIV (PLWH). This resulted in those infected with the virus either knowing or unknowing to resist testing for HIV. Succinctly put, this led to those living and those not knowing to be unwilling to disclose their status or seek testing. The outcome of such an approach led to the delay in treatment for fear of judgement and rejection (Alio et al. 2019:3). We would argue that since the notion of sexuality is a taboo between the two technologies of power, namely the church and religio-cultural belief system that intersected around those infected and affected by the virus, contributed to their marginalisation and impacted on their mental health. As Kruger et al. (2018:4877) have rightly argued, we assert that those that disclosed their HIV status were rejected and stigmatised by their communities and Christian communities. The question then arises: to whom were these stigmatisation addressed? In the following section, we will briefly discuss the technologies (negative and positive) that the pastors engaged in regarding the HIV and AIDS epidemic.

The theo-politics: The negative and positive towards HIV and AIDS management

Pastors' negative practices towards HIV and AIDS

The theo-politics in relation to HIV and AIDS, particularly those infected, has varied as indicated in the previous section. Within this context, the analysis and the 'labelling' of the church leaders' negative contribution to HIV and AIDS has to be located. Scholars such as Adimora et al. (2019:560) argued that pastors have earlier constituted a part of the problem rather than being a part of the solution. This is evidenced in how they delayed in responding and failed to acknowledge the exponential impact of HIV in their communities. This includes failure to determine the scope and implication of the rising cases of HIV and AIDS, resulting in silence and secrecy (Adimora et al.

Note: Special Collection: Reception of Biblical Discourse in Africa, sub-edited by Itumeleng Mothoagae (University of South Africa).

2019:561). Agha, Hutchinson and Kusanthan (2017:554) maintained that the association of HIV infection with immoral behaviour has openly contributed to the stigmatisation and discrimination of PLWH within the church.

Paterson (2011:7) observed that although some churches have advocated the use of condom, there appears to have been a deadlock over condom use among the different denominations resulting in the lack of preventing the spread of HIV and AIDS. At the same time, Tiendrebeogo and Buykx (2012:2) conducted a study in Tanzania and Cameroon on the various campaigns on condoms. They observed that such campaigns were viewed and described as promoting adulterous behaviour, pre-marital sex, and condoning sexual activities within the church. It is essential to point out that these studies were conducted at fundamentally different cultural and religious locations. As Bradstock (2012) reminded us:

> This omission appears even more stark when one considers the inordinate amount of time and energy the church has devoted to 'pelvic issues'-sexuality, reproduction, and abortion, which receive nothing like the same degree of attention in scripture. (p. 230)

The above citation indicates the type of biblical discourses that the church throughout history has been engaging in. For that reason, the outspoken position regarding condoms by the Catholic Church and most Protestant churches complicates HIV and AIDS prevention campaigns in reducing unsafe sexual practices. The observation by Tiendrebeogo and Buykx (2012:3) not only illustrates the theo-politics surrounding HIV and AIDS, but it also points to how the various churches engaged in the biblical discourse. Such discourses have led to the belief in fasting and praying as one of the modalities that can be used to overcome and combat the demon (Trepanowski & Bloomer 2010:2), in other words, HIV has been labelled as a demon. Such a labelling of HIV as a demon not only delayed the treatment but also functioned as a politics of association. In his study, Adogame and Williams (2019:11) argued that Redeeming Christian Church of God (RCCG) in its newsletter labels HIV as demonic or evils spirits and those afflicted by the illness as the victims of a demonic spiritual attack, and also the need for the fasting ritual as a machinery to counteract Satan's evil powers. We would argue that the church by labelling PLWH as being possessed with the demonic spirits was engaging in biblical discourse as well as the politics of association and erasure. This has resulted in PLWH being at risk of defaulting and complicating their already compromised health.

Pastors have further fuelled the stigmatisation and discrimination through claims that they cure HIV, while in the process exposing the identity of PLWH when coming for altar calls. The HIV prevention charity African Health Policy Network (AHPN) reported that a growing number of London churches have been telling people that the power of prayer will cure their HIV infections (Dangerfield 2014:10). The church, which is based in Southwark, South London, shows photographs on its website of people the church claims were cured of HIV through prayer, and a woman was seen proudly displaying her two different medical records confirming she is 100% free from HIV following that she was prayed for. The church pastor told her that God is a healer and there is no sickness he cannot heal. The pastor further reiterated that doctors treat and God heals. Three people in London with HIV died after they stopped taking lifesaving drugs on their pastors' advice that their faith will heal them. This made a lot of PLWH default from their medication, which is detrimental and dangerous to their health. However, all such stuff that the pastors are prescribing to their congregations, whether herbs, anointing oil, water, and cloths, are all fallacy and void of evidence of any efficacy.

In the following section, we briefly discuss the positive technologies and/or modalities that pastors have contributed to addressing the question of stigmatisation and rejection.

Pastors contributing positively towards HIV and AIDS management

Joinet and Nkini (2010:1) argued that although the churches do not have programmes that are put in place to combat HIV and AIDS, there are positive practices that the pastors are engaged in that they are encouraging their members to go and get tested, and adhere to medication and thus instilling further hope for the despondent and the hopeless (Streets 2014:3). For most of Africa, Christian organisations promote condom use, emphasise condom use, and abstinence and fidelity (Geisler 2018:11). A similar study conducted in Tanzania and Cameroon by Tiendrebeogo and Buykx (2012:3) endorsed condom use as a protective measure against HIV and AIDS. In a study conducted by Paterson (2011:7) in Uganda, pastors played an integral part in the combat against HIV and AIDS working side by side with the government. The church has been at the forefront of condom distribution. Through these efforts, Uganda has experienced the most significant decline in HIV prevalence (Parkhurst 2013:70).

In KwaZulu-Natal, Liebowitz (2011:17) found that churches and church organisations were involved in significant and positive activities in HIV prevention through condom distribution at the community level. Liebowitz further alluded that churches were involved in communication during sermons, conducting workshops, crusades and peer education (Liebowitz 2011:9). In addition, the position regarding condom use by the Catholic Church and most Protestant churches has resulted in hosting HIV prevention campaigns which contributed to the reduction of new infections (Tiendrebeogo & Buykx 2012:4).

Plattner and Meiring (2017:241) found that the Christian religion is an essential framework used by PLWH to make sense of their illness and come to terms with it. PLWH have reported that since being diagnosed with HIV, the Christian religion had become very important to them, giving them a sense of meaning and purpose in life (Haddad 2013:51). Niitshinda (2014:15) revealed that many churches regularly undertake to counsel and provide advice and encouragement to those infected and others in need of advice and support

(Adogame & Williams 2019:4). People have built trust with pastors (Tiendrebeogo & Buykx 2012:9). Haddad (2013:47) reported that Christian faith-based organisations (FBOs) have played a pivotal role in providing treatment and care services in Africa.

Campbell, Skovdal and Gibbs (2015:1206) reported that the church stands on morality, behaviour, and belief for ages. The social control demonstrated by many church groups goes against the international criteria for HIV and AIDS control. However, some social controls imposed by many churches help curb the spread of HIV. Social and sexual control of church members has reduced high-risk sexual behaviours (Campbell et al. 2015:1206). In South Africa, Garner (2008:41) found that some churches influenced their members to reduce extra- and pre-marital sexual activity to minimise their risks for HIV. Similarly, a study conducted in Ghana by Trinitapoli and Regnerus (2015:504) revealed that churches preached against immoral sexual behaviours and encouraged faithfulness in marriages.

The following section seeks to focus on HIV and AIDS in local settings and the sampling criteria.

Locality and sampling criteria

The sample was comprised of all pastors from African Churches (Zion), Lutheran, Presbyterian, Roman Catholic, Methodist, and Charismatic churches in the Thulamela Municipality. The researchers used purposive sampling for pastors, and snowballing was used to recruit PLWH. As all leaders of these churches cannot be used, only lead pastors who fit the inclusion criteria were used, which includes being a lead pastor of the congregation and interacting with people living with HIV.

Methods

Data collection was done through in-depth interviews with both pastors and PLWH, and written informed consent was obtained from the participants. Pastors were assured that their participation was voluntary and they could withdraw at any time. Appointments for the interviews were made with each participant at a venue they identified as safe, private and disturbance-free. All interviews were transcribed verbatim, and transcripts were independently coded following steps for interpretative phenomenological analysis as described in Neuman and Reed (2011:113). The steps included: reading and re-reading a transcript, note-making and development of emergent themes. Clustering emerging themes into superordinate themes, forming a master table of superordinate themes and sub-themes.

To ensure trustworthiness in this study, the researchers applied Lincoln and Guba's model (as cited in Polit & Beck 2017:787). Prolonged engagement with the participants during in-depth interviews ensured truth value. The researchers reflected by writing field notes during and after the interviews. Regular discussions among researchers enriched the process and improved credibility. Applicability was ensured through a well-thought-through sample, and a dense description of the research methodology. The possibility of an audit trail and the use of an independent co-coder during data analysis ensured consistency. Replication is possible because of a dense description of the study and data. An audit trail and reflexivity ensured neutrality. Authenticity is evident in the quotes that enrich the findings.

Findings

Following thematic analysis, the superordinate theme on pastors practices concerning HIV and AIDS emerged with the following two themes: practices that contribute to the reduction of HIV and improve quality of life of PLWH, and practices that perpetuate the spread of HIV and related death (see Table 1 for details).

Practices that contribute to the reduction of HIV and improve the quality of life of people living with HIV

This theme focuses on pastors' practices that contribute to the reduction of HIV and improve the quality of life of PLWH. The following sub-themes have emerged from data analysis: encouraging positive living, working collaboratively with healthcare practitioners, challenging stigma and discrimination related to HIV and AIDS, and challenging cultural beliefs related to HIV and AIDS.

Encouraging positive living

Streets (2014:2) cited that pastors play a critical role among PLWH through their counselling and acting as mediators among PLWH and their partners to avoid unnecessary divorces. Pastors assume a pivotal role in providing soothing counselling that there is life after being infected with HIV. This offers them the opportunity to make a real difference in combating HIV and AIDS. Joinet and Nkini (2010:1) revealed that churches are believed to be pursuing transformational agenda, bringing healing, hope, and accompaniment to all affected by HIV and AIDS. Christian PLWH need reassurance, encouragement, and above all, acceptance from their church. Pastor derived the expression from the Book of Ecclesiastes 9:4 that says, 'but for him who is joined to all the living there is hope, for a living dog is better than a dead lion'.

TABLE 1: Summary of the results.

Superordinate theme	Theme	Sub-theme
Pastors' practices concerning HIV and AIDS	Practices that contribute to the reduction of HIV and improve the quality of life of PLWH	Encouraging positive living
-	-	Working collaboratively with healthcare practitioners
-	-	Challenging stigma and discrimination related to HIV and AIDS
-	-	Challenging cultural beliefs related to HIV and AIDS
-	Practices that perpetuate the spread of HIV and related death	Involving HIV-positive people in fasting
-	-	Lack of involvement in HIV and AIDS issues
-	-	Discontinue the practice of awareness
-	-	Claiming to cure HIV

> 'But we encourage her. Even after we realised that she was hopeless, I told her that there is still hope. There is still life after being infected by HIV, the issue here is for you not to put yourself down after realising that you have HIV.' (Apostle Humbulani, 56 years old, male, 22 years in practice)

The finding of this study revealed that pastors are giving spiritual support to PLWH, a practice that provides them a haven to be nourished and flourished with their life. The finding further explains that pastors are preaching messages of hope to people affected by HIV and AIDS, citing that having HIV orAIDS is not a death penalty. However, there is hope even after one has tested positive for HIV. Most importantly, pastors remove the element of fear from PLWH and encourage them to live a positive life even after contracting HIV. The finding of this study concurs with De La Porte (2016:5), reporting that pastors are taking a much stronger role in making lives of PLWH bearable, giving them hope and providing them spiritual support.

Working collaboratively with healthcare practitioners

According to Kasomo (2017:3), there is a need to collaborate and share scarce material and human resources. On this account, various local churches have designed strategies based on the felt needs of their various circumstances to address the HIV and AIDS epidemic. For example, Tiendrebeogo and Buykx (2012:2) alluded to intensified collaboration between the church's various social structures, health, and education yielded positive outcomes.

The findings of this study concur with literature that pastors working with doctors, health practitioners, Department of Health forging networking and collaboration with other stakeholders to combat HIV and AIDS. HIV and AIDS do not need institutions to work in isolation but in an inclusive environment to promote information and knowledge sharing. According to Tiendrebeogo and Buykx (2012:2), it is necessary to intensify collaboration between the various social structures of the church, health, and education. The pastor supported the use of doctor in curing, referring to the story Jesus related to in the Book of Luke 10:34-35:

> 'I usually call my doctor and refer a congregant whom I suspect has HIV infection. I request the referred congregant to tell the doctor that I am the one who referred him.' (Dr Cedrick, 54 years old, male, 19 years in practice)

This study revealed that there is collaborative work that is in place already. This concerted effort will assist PLWH in benefiting in all spheres of their life, including spiritual and physical interventions.

Challenging stigma and discrimination related to HIV and AIDS

The pastors and church are challenging the stigma and discrimination associated with HIV and AIDS. Churches and pastors are looking at HIV and AIDS differently from what it used to be, where it was associated with adulterous conduct. According to Pastor Lithabo, the church needs to be educated so as to eradicate the stigma and this can be attested by the following excerpt:

> 'We must stop this stigma that the person who is HIV positive is because that person was involved in sinful activities, but we must take this sickness as any other like Covid-19, Ebola.' (Pastor Lithabo, 67 years old, male, 26 years in practice)

Trinitapoli (2011:253) found that many church groups in rural Malawi are involved in caring for the sick, sponsoring HIV and AIDS education programmes for congregants infected and affected and emphasising care as a religious responsibility practice to defeat the scourge of stigmatisation and discrimination. The finding of this study revealed that pastors are at the forefront of eradicating stigmatisation within the church.

Challenging cultural beliefs related to HIV and AIDS

The study discovered a cultural belief that is so rife in the church community that associates HIV and AIDS with witchcraft. This was orchestrated by the side effects that PLWH have when taking antiretrovirals (ARVs). People in treatment can sometimes have hallucinations, and these hallucinations are interpreted differently by people and they may conclude that the person having the hallucinations has been bewitched:

> 'Side effect of ARVs contributed to the belief that people who are on treatment are bewitched due to some hallucinate.' (Pastor Lithabo, 67 years old, male, 26 years in practice)

This finding reveals that there is a cultural belief that associates HIV with witchcraft. However, pastors are fighting it by telling congregants the correct information that will assist them and PLWH. According to Tiendrebeogo and Buykx (2012:4), this cultural belief system needs to be eradicated to improve the living conditions of PLWH. Besides the positive attitudes contributing to the well-being of PLWH, pastors have shown some negative attitudes that antithetically affect PLWH.

Practices that perpetuate the spread of HIV and related death

Pastors indeed are gunning for providing counselling and preaching positive messages contributing to positive practice. However, PLWH and other chronic diseases are exposed to practices that complicate their health. Practices that perpetuate the spread of HIV and related death are further divided into sub-themes, such as involving HIV-positive people in fasting, lack of involvement in HIV and AIDS issues, discontinue the practice of awareness, and claiming to cure HIV.

Involving HIV positive people in fasting

It is a standard practice that any medication that needs should be taken after the meal. The church is putting PLWH at risk by allowing them to partake in fasting prayer that they will go without food, although medication needs to be taken daily and religiously (Trepanowski & Bloomer 2010:3). This is a harmful practice, for when people partake in fasting, they go without eating food for days leading to PLWH defaulting in their medications, leading to severe health complications.

However, some pastors still perceive HIV as demonic in need of spiritual intervention such as fasting as enshrined in the Book of Matthew 17:21 King James Version (KJV):

> 'And she's ever also fasting and praying with us after encouraging to do so.' (Apostle Humbulani, 56 years old, male, 22 years in practice)

The findings of this study agree with the study done by Adogame and Williams (2019:11), who reported that fasting is being used for PLWH as armour against HIV since HIV is deemed a demonic spirit. However, involving PLWH in a spiritual exercise like fasting puts them at risk and further complicates their health. Other than PLWH being engaged in fasting prayer, the church does not seem to be involved in the matters related to HIV and AIDS.

Lack of involvement in HIV and AIDS issues

The finding of this study shows sentiments that are contrary to the above-mentioned. According to Kasomo (2017:2), churches are involved in many programmes that seem to combat HIV or AIDS in Africa and Sub-Saharan countries. However, pastors have demonstrated that there is a lack of involvement in HIV and AIDS issues. The following quote supports this sentiment:

> 'Most pastors are not that educated, and they cannot touch or be involved in HIV issues since they are not well capacitated on.' (Pastor Mudau, 60 years old, male, 22 years in practice)

This study's finding is congruent to the study conducted by Alio et al. (2019:17) that pastors have limited knowledge about HIV and AIDS. The study's finding shows that the church was earlier advocating some HIV awareness programmes that were later abandoned.

Discontinue the practice of awareness

The majority of pastors do not have programmes or services targeted at HIV and AIDS. However, some have initiated the HIV and AIDS programmes, but later abandoned those awareness programmes:

> 'Before we had people who used to come and talk to us, we call a nurse to come and talk to us about HIV awareness. But now we are no longer doing that.' (Apostle Humbulani, 56 years old, male, 22 years in practice)

The study's finding shows that there was some running programme; however, those awareness programmes came to halt over time. This finding contradicts the finding of a study conducted by Tiendrebeogo and Buykx (2012:14) that the church must set aside money for HIV ministry within the church settings.

Pastor claiming to cure HIV

Despite this little involvement, the pastors are getting involved in the campaign to lure many people to their church under the pretence that they will be healed, which exposes PLWH to a lot of shameful practices. Many false prophets are claiming to cure HIV, which is an unsupported claim. Furthermore, it is impossible to pray for PLWH without revealing their identity, in other words we are further breaching their confidentiality and exposing their identity. The following quote has supported this kind of conduct:

> 'What is painful is when we are calling PLWH to say come, and you will be healed, and they are not healed. The other most painful thing is we are breaking the confidential oaths, exposing our PLWH and also embarrassing them with these ill-advised practices.' (Bishop Netshahulu, 60 years old, male, 25 years in practice)

Besides exposing their identity to the public, PLWH are being embarrassed by these lies. This practice of openly inviting PLWH to be healed through prayer violates their privacy rights. In addition, this practice negatively impacts the PLWH losing trust with a pastor and leading to a delay in disclosure (Alio et al. 2019:23). A study conducted by Nzwili (2013:7) in Tanzania revealed a retired pastor who claimed to have received instructions from God to make the medicine referred to it as a 'God-given gift', made from the roots of a tree known as 'mugariga' to be the solution to HIV.

These false prophets/teachers do not stop at claiming that they heal. Instead, they tell people to stop using the prescribed medication by the doctors and only take the medicine that they are selling – a practice that is very dangerous and harmful, and people are dying because of such ill-advises. One of the examples of the manner in which the pastors engaged in biblical discourse is in their usage of biblical texts. For example, one of the Pastors referred to the scriptures that support prescribing medicine/practices to augment people's faith and healing: 2 Kings 20:7 and said: 'Then Isaiah said, "Take a lump of figs." So, they took and laid it on the boil, and he recovered.' He also quoted John 9:6, 'When He had said these things, He spat on the ground and made a clay with saliva, and He anointed the eyes of the blind man with the clay.'

> 'Vulnerable PLWH are given holy water, anointing oils, stickers, and cloth under the pretence that they will be healed.' (Dr Cedrick, 54 years old, male, 19 years in practice)

This finding further concurs with the study done in KwaZulu-Natal, where the prophet insists on people to stop using ARVs and use the holy water with his photo on instead (Madlala & Dzanibe 2013:3). The finding further supports the results by Nsingo (2018:6), who cited that a lot of PLWH died because of health complications after being ill-advised by these false prophets. This practice affects PLWH negatively because most of them develop complications that ultimately results in them losing their lives.

Conclusion

In this article, we have attempted to map the technologies used to address HIV and AIDS in both local and Christian communities. In comparison, there have been great strides in addressing the stigmatisation associated with the virus. However, a lot still needs to be done to enable those living with the virus to be agents of change. At the same time, to achieve this, it appears that the church, through its leaders (pastors), has to engage in a new form of biblical discourse. In other words, using the biblical text as a tool for liberation,

not enslavement. Such an approach will impact how the church ought to respond to HIV and AIDS. This includes how religion as a technology of power can also be a vehicle of change in addressing the latest pandemic of COVID-19 and at the same time not neglecting those infected and affected by HIV or AIDS.

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Authors' contributions

T.S.N. and A.M-M. conceived the presented idea. T.S.N. conducted data collection and development of model and A.M-M. verified methods and results. Both authors discussed the results and contributed to the final manuscript.

Ethical considerations

Ethical clearance to conduct the study was obtained from the Higher Degrees Committee of the Department of Health Studies, University of South Africa Research Ethics Commitee. The researchers successfully built trust and healthy rapport by interacting with participants before and after the interview sessions to address any concerns they might have. The researchers engaged all the participants and spent sufficient time in the research setting before, during, and after the data collection and member checking. Participants were informed that their recorded interviews would be kept anonymous and confidential by marking them with a code instead of their names. Data were stored in a safe place with hard copies being locked away and electronic data on computers being password-protected. The data will be kept for five years. HREC Registration: REC-012714039.

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Data availability

Data sharing is not applicable to this article as no new data were created or analysed in this study.

Disclaimer

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