

**HIV/AIDS IS NOT A THREAT TO THE CHRISTIAN INDIANS OF  
NORTHDAL/RAISETHORPE: IS THIS A MYTH?**

**With special focus on identifying the absence of Pastoral Care for  
those infected and affected by HIV/AIDS in this suburb.**

**By**

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**Submitted in partial fulfillment of the requirements of the degree of  
Master of Theology at the School of Theology at the University of  
Natal, Pietermaritzburg.**

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**Supervisor: Dr. Edwina Ward**

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## **ABSTRACT**

The essential question behind this thesis is: How can we respond to the pastoral needs of Christian Indians in Northdale/Raisethorpe, with regards to the HIV/AIDS pandemic, when there is this silence among those that are infected and affected and the lack of concern from the church?

This topic desires to research the silence among the Christian Indians of Northdale/Raisethorpe to look into the possibility that it is a myth that HIV/AIDS is not a threat to the Christian Indians of Northdale/Raisethorpe. Certain aspects of this problem need to be investigated to prove the myth and to open an avenue for pastoral counselling and care. In this investigation I intend to revisit and open a new dialogue with the clergy to set up combined structures that will alleviate the suffering in the Northdale/Raisethorpe community in regards to the HIV/AIDS pandemic.

The interview collections and research findings support the hypothesis that it is a myth that HIV/AIDS is not a threat to Christian Indians of Northdale/Raisethorpe.

## DECLARATION

I, Arumugam Perumal Chetty, the candidate for the Master of Theology Degree at the School of Theology, University of Natal, Pietermaritzburg, hereby state that the whole thesis, except where specifically indicated to the contrary in the text, is my own original work:

  
\_\_\_\_\_. (sign)  
Student's Name

12<sup>TH</sup> MARCH 2003.  
Date

As Supervisor, I have agreed to the submission of this thesis.

Dr Edwina Ward

  
\_\_\_\_\_.  
Supervisor's signature

## **DEDICATION**

I dedicate this work to my dear wife, Jaya and my family who encouraged me all the way. As I consider the tremendous pressure from research of this nature, I realise the sacrifice they made to allow me the peace and time to work. Aneurin and Adiel, my sons, stood by me all the way.

## **List of Abbreviations**

AIDS	-	Acquired Immune Deficiency Syndrome
CIA	-	Church in Action
ECAP	-	ESSA's (Evangelical Seminary of Southern Africa)- Christian AIDS Program
ESSA	-	Evangelical Seminary of Southern Africa
HIV	-	Human Immunodeficiency Virus
HIV+	-	Tested HIV positive
JPC	-	Journal of Pastoral Care
MWC	-	Men, Women and Children Counselling Centre
N/R		Northdale/Raisethorpe
PLWA	-	People Living With AIDS
UNP	-	University of Natal, Pietermaritzburg

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## CHAPTER 1

### **Overview of the problem of HIV/AIDS in Northdale/Raisethorpe**

#### **1. Introduction**

As the pastor of a local church in this Northdale/Raisethorpe area, I have come face to face with people in this community who have been infected and affected by HIV/AIDS. My preliminary research has shown that the church is silent on the HIV/AIDS issue. Christian Indians seem unaffected and unconcerned, in spite of all the publicity about AIDS. South Africa has the highest incidence of HIV/AIDS in the world. The writer does not feel comfortable with this and does not agree with either the silence or the denial aspects. The silence on the part of the church and the denial from this community prompted the writer to research this problem.

My hypothesis is that Indians are as infected and affected by HIV/AIDS as anyone else in Northdale/Raisethorpe (N/R) and that the church's attitude towards the suffering of people in this community is ill-considered, both in the educating and the caring ministries. In this research I aim to investigate and prove my hypothesis.

## **1.1 IDENTIFYING THE PROBLEM**

I have chosen to research the above-mentioned topic for two primary reasons:

1. My preliminary research has shown that Christian Indians in the Northdale/Raisethorpe (N/R) area have not accepted the fact that the threat of HIV/AIDS affects them too.
2. The churches in this area have not adequately responded to or recognised the need for pastoral counselling and care, which stem from this pertinent issue.

Currently there is growing concern about the alarming figures of those infected by the virus and the rapid spread of HIV/AIDS throughout the world and especially in KwaZulu-Natal. This research fulfills the need to bring about awareness and a concerted effort among all people to join the struggle against this pandemic. Therefore I attempted to investigate attitudes and responses towards HIV/AIDS among the churches in N/R.

One of the major problems that faces churches in this rapidly growing suburb of Pietermaritzburg is the lack of effective ministry among those persons infected and affected by HIV/AIDS, as far as pastoral counselling and care are concerned. The problem to be explored in this dissertation is that whether the modern Christian pastoral counselling and care paradigms can be effectively used to address the increasing needs in this community.

## 1.2 MOTIVATION

There are no combined efforts in the N/R area to provide pastoral counselling and care centres to alleviate the sufferings of people infected and affected by the pandemic. There is concern that this community continues in denial and silence concerning the effects of the pandemic. The meaning and purpose of any church is to take up the challenge of providing a holistic life for the members of its community. I am motivated, in this research, to focus on and to examine the ministry of the church to find out whether the church's ministry is community-based. Quite apart from the spiritual dimensions of salvation, the church has an obligation toward its members in the area of social upliftment through pastoral counseling and care in times of crisis.

Understanding the denial by Christian Indians, acknowledging the fact of the crisis of HIV/AIDS and the subsequent lack of adequate counselling and support for people infected and affected by the disease, makes the need for pastoral counselling and care seem all the more urgent.

Rescue the perishing, care for the dying  
Snatch them in pity from sin and the grave  
Weep o'er the erring one, lift up the fallen  
Tell them of Jesus, the mighty to save.  
Rescue the perishing, Care for the dying  
Jesus is merciful, Jesus will save (Ayers 1995:201).

### 1.3 METHODOLOGY

- 1) My primary research sources are books, journal articles and the theory of well-known counselling theorists such as Gerard Egan.
  
- 2) I will present case studies that show that Indians are infected and affected by the HIV/AIDS virus, hoping thus to arouse the attention of the church towards providing holistic care for this community.
  
- 3) The research depends on secondary sources such as interviews with religious leaders, medical personnel and caregivers. They may possess statistics pertaining to the HIV/AIDS issue in N/R. Their attitudes towards HIV/AIDS among the Indian community will be meaningful for this study.
  
- 4) Since there is no model for pastoral counselling and care among Christian Indians in N/R, I looked to the models used by churches in other areas of Pietermaritzburg.

I consider Egan's three stages as a model:

- Stage 1. Responding / self-exploring
- Stage 2. Integrative understanding / Dynamic self-understanding
- Stage 3. Facilitating action / acting (Egan 1975: 30).

I also consider Louw's stage model in a pastoral strategy (Louw 1999: 349-365).

The most significant aspect of each model will be applied according to the general trend of activities in N/R, since it would be foolish to apply models that

are not compatible with the context. In addition to the interviews, this research depends on factual data: books; journals; periodicals; pamphlets and newspaper articles.

In this dissertation I will demonstrate the hypothesis through

1. the research of pastoral counselling and care theorists
2. the presentation of case studies
3. interviewing the clergy and other religious organisations
4. interviewing medical personnel, and
5. examining written information.

#### **1.4 Delimitation**

There are contributing factors that limit a thesis of this subject matter. HIV/AIDS brings about fear, helplessness, panic, denial, the blaming of others, avoidance behaviour and despair among the sufferers. Diseases associated with the virus, such as Tuberculosis, Encephalitis, Meningitis, and Pneumonia etc., are often stated as the diagnosis and cause of death rather than HIV/AIDS. This lends support to the denial of and silence about people's HIV status. (Sutherland 2001:7-8)

Another obstacle in researching the effects of the HIV/AIDS pandemic is the moral censure and prejudice surrounding this syndrome. Negative stereotypes tend to characterise high-risk groups such as homosexuals, prostitutes and drug-users. Such stereotypes have influenced the general social perceptions of those infected with the virus. Effective education will eventually help to eliminate the

prejudices and misconceptions regarding the virus and those infected by it. But, until that time, a dissertation of this nature is limited in its research.

Confidentiality: In relating this story and reporting case studies, I have omitted all proper names and addresses of persons, as required by the law. Persons have a right to their confidentiality. "Any person with HIV/AIDS has the right to confidentiality. No one can give out information about a person's HIV status without their permission" (HIV/AIDS and Rights 1998).

## **1.5 Concluding Remarks**

In N/R, where silence and denial cover the HIV/AIDS pandemic from being exposed as a threat to the community, I consider that people here regard HIV/AIDS as a myth. The myth is that HIV/AIDS is not a threat to the Christian Indians of N/R. The silence and denial from the religious and church leaders show that the call to address the need is timely and that concern over the situation is long overdue.

We know that HIV/AIDS itself is no fable. The virus exists in N/R affecting the lives of the members of this community. Unless radical changes occur in the addressing and setting up of structures to battle the virus, N/R may produce statistics that rank as alarming. May this research bring about an awareness that will eliminate denial and lead the church into providing the required holistic care.

### **1.5.1 The Writer's Personal commitment**

This is not a case of the 'pot calling the kettle black'. I had to review my own ministry in the light of the HIV/AIDS pandemic rapidly engulfing our communities. I felt that, in my ministry, I must touch base with the people on the ground. I have taken the challenge of attempting several studies pertaining to HIV/AIDS to educate myself in the HIV/AIDS matter. In 2001 I completed two courses related to HIV/AIDS:

1. Clinical Pastoral Education, practical course in counselling patients at Grey's Hospital in Pietermaritzburg. This included coming face-to-face with people with HIV/AIDS.
- 2 Church and AIDS (UNP). This course dealt with the role of the church in response to HIV/AIDS.

To date I have completed two of these studies and attended several HIV/AIDS seminars. I am now in the process of educating community members through the church. I have engaged ESSA's Christian Aids Program (ECAP) to undertake the teaching and training program of Christian counselling and care ministries for our church members. This comprises fifteen weekly sessions of two hours each. In addition to this, my wife and I have completed the practical course of 'Home-based Care' offered by Gateway Project. I am confident that we can teach our church community and assist those infected and affected by the virus. In this way we could penetrate the community's attitudes and bring about awareness. I speculate that this might lead some people to break their silence on the HIV/AIDS pandemic.

In this dissertation I will research the following:

1. The reason for silence
2. Indian culture and sexuality
3. The response of the church

After investigating each of the above aspects I will proceed to make recommendations that could provide ways forward for what I think should be adequate pastoral care in this area.

## **Chapter 2**

### **An overview of Northdale/Raisethorpe and HIV/AIDS**

#### **2. Introduction**

To deal with the myth that HIV/AIDS is not a threat to the Christians of N/R one has a choice of either following the crowds in silence and denial, or of breaking loose and taking a stand for what is factual. My research has shown that the crowd refuses to accept the fact that HIV/AIDS is a reality and that it infects and affects the Christian Indians of N/R. They live in denial and silence.

#### **2.1 Northdale/Raisethorpe**

Initially, the suburb of Northdale was demarcated for the Indian community under the Group Areas Act. Raisethorpe became an added development as the suburb expanded.

##### **2.1.1 Location of Northdale/Raisethorpe**

Referring to the map in appendix 1, one finds that only municipal wards, not suburbs, divide the whole of Pietermaritzburg. From this map one has a bird's eye view of the whole of Pietermaritzburg. Northdale/Raisethorpe (appendix 2) has expanded in size over the years. As this area attracted more occupants it increased in size, eventually giving rise to the separate naming of every adjoining piece of land. Thus we now have Mountview, Belfort, Bombay Heights, Bakerville, Dunveria, Darjeeling Heights, Newholmes, Orient Heights and Allandale.

For the purpose of this research, I will refer to this whole area (appendix 2) as “N/R”. As already stated, it includes the adjoining extended areas because they are occupied only by Indians.

### **2.1.2 History of Northdale/Raisethorpe**

During the apartheid era Indians were forcibly resettled in this northern suburb of Pietermaritzburg, after being displaced from other areas by the then government. These areas were referred to as ‘Indian areas’ and make up part of the northern suburbs of Pietermaritzburg. From the early 1960s Indians were placed in Council homes in Northdale because they were being displaced from their former districts under the Group Areas Acts.

Raisethorpe comprises better homes for the more affluent Indians. This area was set aside for Indians who were able to invest in better houses by purchasing land and erecting homes of their choice. N/R houses displaced Indians, and is even today regarded as one area. Since the 1994 democratic election, this area has lost much of its race classification. This area has attracted numerous families from other race groups. However, the majority of people remaining here are still Indians.

Looking closer into N/R, one finds that these suburbs have undergone demographic transformation. Though other race groups have moved into this area, the Indian community still predominantly occupies N/R. Businesses, schools, wards, clinics, religious centres, etc. are still run only by Indians. The

churches in this area are still overseen by an all-Indian leadership.

Transformation is still some distance away.

Overall, this is a densely populated area of Pietermaritzburg. According to the 1996 census N/R has approximately 80,000 adults. The more recent 2001 census should show a much larger population, but statistics are not yet available<sup>1</sup>.

## **2.2 HIV/AIDS in Northdale/Raisethorpe**

Hospital statistics (appendices 3 and 4), the case studies presented in chapter three and interviews all show that HIV/AIDS is indeed affecting the Indian community of N/R.

### **2.2.1 Definitions of HIV/AIDS**

‘HIV’ stands for Human Immunodeficiency Virus, which are very tiny organisms which cause diseases such as colds and ‘flu. HIV leads to AIDS. ‘AIDS’ stands for Acquired Immuno Deficiency Syndrome. The virus attacks the body’s immune system which protects us from diseases. This virus can be present in a person long before they know they are infected. At any time the infected person can infect others (AIDS: Facts vs. Fiction 1993). This virus is unique and occupies many scientists and medical personal in searching for a cure. The limitation here is seen in the fact that a person can be HIV positive, can suffer with one of the symptoms and yet deny their HIV status.

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<sup>1</sup> Details provided by R Gounden, Forward Planning, Msunduzi Municipality, October 2001

## **2.2.2 Stigmas and Pride Issues attached to the HIV/AIDS**

### **Pandemic**

Associated with this virus is the stigma that HIV/AIDS is brought about by sexual promiscuity. In addition, Indians claim that HIV/AIDS is a disease of Africans and does not affect Indians. This creates an 'us and them' divide. The general feeling among Indians is that, if a person breaks the silence about his or her HIV status, it shows that they have had sex with an African person, which is regarded as an improper right. Fear and shame grip the Indian family and this gives rise to silence, which inhibits treatment as well as limits the research program. People do not want to talk about or to disclose their HIV status.

It is disappointing that all efforts to consolidate the local church in unity so as to address the needs related to the HIV/AIDS pandemic have failed to arouse interest from its various leaders. The general response has been that HIV/AIDS is not a threat to the Indian community. It was apparent that there was a lack of awareness in this ministry. This research will show that it is a myth that the Christian Indians of N/R are not affected by the HIV/AIDS pandemic. As elsewhere in the world, the virus does affect the Indians of N/R. An infected person could infect any uninfected person through sexual activity, blood and body fluids, as is widely evidenced in our society.

The national statistics are alarming. Figures quoted in the Natal Witness are significant indeed: An estimated 4,7 million South Africans – one in every nine – were infected with the HIV/AIDS virus by the end of 2000, according to a

government report (Natal Witness 21 March 2001). Formerly, many Indian men from N/R were truck drivers. Today it is difficult to find such drivers. They are no more, as many have succumbed to HIV/AIDS. Efforts to get truck companies to talk about the disease failed. They refused to disclose any details. Recently a study that was conducted to ascertain the status of truck drivers produced shocking results. This made headlines in the Natal Witness.

A study based on information collected by roadside sex workers in the KZN midlands has revealed disturbing facts on HIV and the sexual practice of long-distance truck drivers.

The study found that 56% of drivers surveyed were HIV- positive, that 34% reported always stopping for sex during journeys, and that 29% never used condoms. At one truck stop in Newcastle, 95% of truckers were HIV positive (Natal Witness 03/05/2001).

The background of such a shocking disclosure requires ministry to the infected and affected members of this society. This pandemic has opened up an avenue for pastoral care.

The churches in the city of Pietermaritzburg have already acted on their vision to care for those infected and affected by the virus. The Church in Action of Pietermaritzburg has already included AIDS amongst the 'Big Six' issues for the church in Pietermaritzburg to deal with. However, they work in areas where there are proven statistics of people affected by and infected with the HIV/AIDS virus. Among the Indian, Coloured and White communities, on the other hand, there are few statistics of persons living with the virus (Kocheloff, P (Dr) 04/10/2001: interview).

The stigma attached to the HIV/AIDS issue is that a person becomes infected through indulging in promiscuous sex. Sex outside marriage seems to be a common cause. Truck drivers are noted HIV/AIDS carriers:

...and large numbers of truck drivers and their crews (truckers) are infected with sexually transmitted infections (STIs), including HIV. Reasons for this high infection rate include unsafe sexual practices and lack of information on sexual health. (Southern Africa AIDS Action 2000: 5).

### **2.2.2.1 The reasons behind the myth**

Thus far it has been shown that it is a myth that HIV/AIDS does not affect the Christians of Northdale/Raisethorpe. The Leemings' definition of a myth helps me to project the cultural diversity in the call to ministry. The Leemings wrote,

A myth is a narrative projection of a given cultural group's sense of its sacred past and its significant relationship with the deeper powers of the surrounding world and universe. A myth is a projection of an aspect of a culture's soul. In its complex but revealing symbolism, a myth is to a culture what a dream is to an individual ( Leeming and Leeming1994:vii-viii).

On 07 March 2001 Stuart C Bate, of St Joseph's Theological Institution, presented a sermon entitled 'Good News in a world of AIDS' at Cedara, Pietermaritzburg, which I found to be crucial to this thesis. In his sermon he covers a section entitled "Good News for AIDS myths".<sup>2</sup>

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<sup>2</sup> Permission has been obtained from the author, Stuart C Bate, OMI, to quote parts of this sermon for reference. The sermon will be published in the journal *Missionalia* in 2002.

As concerns HIV/AIDS he examines four myths in order to identify the truths they are communicating. Some extracts of this sermon will help in understanding the myth among the Christian Indians of N/R.

(i) The myth of social disgrace and the myth of sin and evil caught my attention. (ii) The myth of sin and evil is that ‘participation in sexual behaviour which contravenes the sexual codes is participation in evil and, as a result, the ultimate outcome of the behaviour will be evil. In this myth, then, HIV/AIDS is the result of evil behaviour’ (Bate 2001:4).

Bate goes on to say that “In the Christian religion this is expressed as punishment from God...The disease HIV and the resulting illness AIDS are interpreted as God’s punishment” (Sermon SJTI 2001). This is the judgement being preached in the churches of N/R, instead of the church using HIV/AIDS as an opportunity to express the love of God through works of service. This is exactly the new course that my ministry and concern in N/R have taken. The new call is to ‘stop being judgmental and serve’ in an environment of Christian love and care. Bate also goes on to present a remarkable finding on the myth of social disgrace, which fits in perfectly with what we find in N/R.

The truth the myth communicates is that Aids is a shameful thing to be sick with and an even more shameful thing to die of. .... It encourages people to avoid [HIV] testing, since discovering that one is HIV+ condemns a person to the stigmatised group. It is best not to know. The spouse or sexual partners are deliberately excluded from knowledge, with the result that they too become infected. ...Then, as people develop ‘full-blown AIDS’, and it becomes clear to all that they are sick, the narrative of social disgrace motivates families to hide their sick away, abandon them to institutions or even worse behaviours (Bate 2001:4).

Medical aid societies afford privileges to members who are HIV+ but who remain silent about their status. This makes it rather difficult to know the real statistics of persons with HIV/AIDS (Nicolson 1994:235-236).

Whilst Indian and African cultures differ, both face the same enemy. Today we learn of a large number of child rapes taking place in our society. This is perhaps due to the myth that having sex with a virgin cures one of the viruses.

Women's vulnerability to HIV was exacerbated by several factors. The culture of silence surrounding sex dictated that 'good' women were expected to be ignorant about sex. Virginitiy, paradoxically, increased young women's risk of infection; it restricted their right of access to information, they were in danger of rape because of the myth that sex with a virgin cleanses men of infection, and because of the erotic imagery that surrounds virginitiy (Sanders 2000:15).

There are several facets to the Indian silence on the pandemic. The churches in N/R have not been fully integrated. Father Lawrence (Lawrence 2001. Interviewed on 13/11/01) confirmed that this is a contributing factor. According to Pastor Victor Rhandran (Rhandran 2001. Interviewed on 19/10/01) integration between Indians and Africans will take a long time. Only a few local African Christians attend his church. There is a definite gap between these two race groups. This is also why Indians of N/R remain silent about the pandemic. A colleague of mine, Don Spencer, once told me 'that birds of a feather will flock together'. Those who have been infected or affected suffer the mindset of the Indian community in labeling them as same as Africans/Blacks (Colin Naidoo 2001. Interviewed on 01/11/01). The clergy and medical staff interviewed expressed the perception that Indians have regarding the HIV/AIDS, i.e. that it is associated with promiscuity. This creates a major problem in bringing about

some awareness in joint community issues such as the HIV/AIDS pandemic.

The associated stigmas restrain the clergy from openly declaring that Christians in N/R are affected by the HIV/AIDS pandemic (David Perumal interviewed on 06/11/01).

One can agree that the same stigmas could apply to all people in all places. Kaya (1999) has attributed the silence and denial to loss of jobs and rejection.

It is difficult for most people to admit that they are HIV positive or are suffering from AIDS. This is due to the risk of losing their jobs or to rejection by friends, relatives and the community at large. Martin (1996) elaborates that discrimination and prejudice against people who are HIV positive or who have already developed AIDS enforces the need for them to remain hidden and thereby spread the disease (Kaya 1999:42).

#### **2.2.2.2 Family Support System**

In N/R Indian families are close-knit units. The extended family has always demonstrated support for the weaker members. This is an advantage for Person Living with AIDS (PLWAs) among the Indian community here in N/R. In South Africa, caring for others seems to be the way forward in regard to AIDS. Among all South Africans, families or communities are caring for two thirds of the country's AIDS orphans:

In 2000, South African Welfare Minister Zola Skweyiya estimated that about a third of the country's 250,000 AIDS orphans were in foster care, and almost two-thirds were being cared for by their families or communities (Sarandon 2001:41).

The approach of caring for one another is very typical among Indian families everywhere and is visible in N/R. Several unemployed or disabled persons are

being cared for by family members. Indians can receive support from families in times of dire need. They know that they have somewhere and someone to go to. To this extent, Indians respect and fear those who support them. This respect and fear can cause them to deny or to remain silent about their HIV status until it is too late, as did Leila (Case study on page 31), who lived with her parents. Indians are often emotionally torn between the two i.e. Caring for the member with or without disclosing their status.

However, in the HIV/AIDS issue, a fear grips those infected or affected by the virus. This fear itself leads to isolation and unnecessary suffering. Disclosing their status fairly early can prevent this. In the case of Leila the family broke the silence too late, when full-blown AIDS had already taken its toll. Others react differently.

AIDS can divide a family. The brother of the late Saras, Cyril (Page 31) disclosed that his sister recently died of HIV/AIDS. Cyril was very open about this, but his mother and two sisters denied that she had died of AIDS. Cyril claimed that he knew that his sister lived a very promiscuous lifestyle. The medical staff told them that the patient was HIV positive and was dying of full-blown AIDS. Cyril's mother claimed that her daughter suffered from tuberculosis and died of pneumonia. She stated what was in the death certificate. It is commonly understood that tuberculosis and pneumonia are HIV/AIDS-related sicknesses. This denial caused the relationship between Cyril and his mother to become strained. It is almost a year now since the tragedy resulted in death.

This was a clear case where an Indian family, affected by the HIV/AIDS virus, is divided on breaking their silence. Whilst this family is divided on the issue, it makes one realise that there is a strong possibility that this is not an isolated case. Also, there may be families that live in total denial.

### **2.3 The Demography of N/R**

Concerns, as expressed above, have stemmed from the demography on the HIV/AIDS issue. The government and related organisations work tirelessly to present us with statistics to show the seriousness of HIV/AIDS. Though they try to respond positively with a plan to eradicate the suffering that ensues, it is a mammoth task to present reliable statistics as is confirmed by Saayman and Kriel (1991) “it is difficult to obtain statistics which can be described as completely reliable” (Saayman and Kriel 1991:154-167). However, such statistics are alarming. The World Health Organisation claimed that at the end of 2000 34.7 million adults and 1.4 million children worldwide were living with HIV (Sunday Times 11 December 2001: Love Life 2001). The same source claimed that in 2000 an estimated 600,000 children became infected with the virus. It also stated that over 90% of them were born HIV positive. Awareness of the facts about HIV/Aids must lead to joint action by all segments of society.

The churches in N/R need to proclaim the facts about HIV/AIDS. In N/R the churches share the blame for being either too slow to react or too silent about the crisis. HIV/AIDS is not purely a medical problem. The church can fulfill the

spiritual needs of the community for answers and actions. HIV/AIDS has now been in South Africa now for almost twenty years. According to historical evidence, "...the first cases of HIV/Aids were identified in South Africa in 1982 in homosexual men" (Partnership Against AIDS 1999:12-19).

On 15 January 2001, when the Youth for Christ HIV/AIDS Seminar was held at the Jesus Miracle Revival Church in N/R, we were presented with the following shocking statistics and projections:

	<b>1990</b>	<b>2000</b>	<b>2010</b>
HIV+ Adults	20,000	4.2 million	6.5 million
HIV+ Orphans	200,000	4-600,000	2-3 million
Annual Deaths	350,000	600,000	1 million

The statistics above and below were provided by Youth for Christ, (statistics for the Cape are not included). (YFC HIV/AIDS Seminar-15/09/01)

Estimate of total number of South Africans infected (2001): 4.7 million.

Provincial HIV prevalence: Women attending antenatal clinics.

<b>Province</b>	<b><u>Estimated % HIV+ in October 2000</u></b>
KwaZulu-Natal	36.2
Mpumalanga	29.7
Gauteng	29.4
Free State	27.9
National	24.5

(Statistics by Youth for Christ, 2001)

The HIV/AIDS epidemic in South Africa can be explosive. Statistics may be alarming and the effects of HIV/AIDS are frightening indeed. HIV/AIDS is plaguing our society. This was published in the local newspaper:

The Pietermaritzburg 2000 Aids Action Group believes that the formal health care system in Natal and KwaZulu "will be unable to cope with what will become a tidal wave of sufferers

in the second half of this decade” (ECHO 1999).

### **2.3.1 Medical Statistics**

How can these figures assist us in proving that the HIV/AIDS virus affects Christian Indians in N/R? The answer to that question could be quite simple. Inevitably these frightening statistics present a major social and economic challenge to our society. Whilst this is true, many people still believe that HIV/AIDS does not exist among Indians. Many Indian people feel that HIV/AIDS is not their problem. They do not feel compelled to do something about changing their attitudes. These are sensitive issues (Ka’opua, LS 1998:51-62). However the statistics show otherwise. But before continuing in linking these statistics to prove the hypothesis it is necessary to look closer at the statistics received from the Infection Control Department of Northdale Hospital (Appendix 3), which is situated at the heart of N/R.

Sister A Siveraman of Midlands Medical Centre, who is the Unit Manager for HIV/AIDS counselling, informed me of Indian patients from N/R who attend treatment and counselling, especially those who have medical aid. She was unable to give details but confirmed that it was far from true that the HIV/AIDS virus did not affect Indians. Mr VB Jogessar, Pharmacist of Jog’s Pharmacy (2001: interviewed on 31/10/01) confirmed that several Indians do purchase medication for treating HIV positive persons. Sister Vani Praag, Secretary for the AIDS Committee at Northdale Hospital, confirmed to me that Indians from N/R were among the HIV/AIDS patients at the hospital. The numbers were very few but they did come. Dr Paul Kocheleff, who heads the AIDS clinic at Grey’s

Hospital, confirmed to me that Indians from N/R do attend the clinic but they are few in numbers.

Throughout Africa tuberculosis has long been a killer disease. From the 1999 chart and graph of Northdale Hospital patients admitted ( Appendix 3, page 126) we see that sixty tuberculosis patients were admitted in January alone. We understand that tuberculosis is an HIV/AIDS related sickness. The chart shows that this figure rose sharply to between one hundred and twenty and one hundred and thirty patients per month by November/December of the same year. These figures were alarming to the staff of Northdale Hospital. These patients have not been tested HIV positive. They were admitted purely for tuberculosis (Appendix 3).

In 1999, the same year, a greater number of patients were admitted suffering from HIV/AIDS. These patients were tested HIV positive and were admitted for treatment. The figures show that in January of the same year the number of HIV/AIDS patients admitted was one hundred and thirty, compared to sixty tuberculosis patients. On the graph (Appendix 3) one can see that in 1999 the HIV/AIDS figures fluctuated. In April the number dropped to ninety-five, but in August it rose to one hundred and seventy-five. In 2000 we can see a distinct increase in figures (Appendix 4). Comparing the 1999 and 2000 figures we see a sharp increase in TB and HIV/Aids patients (Appendix 5). These alarming figures show that HIV/AIDS is making inroads into our society. Northdale Hospital is one of three provincial hospitals serving N/R, the others being Grey's

and Edendale hospitals. The staff at Northdale Hospital has confirmed that a few Indians from N/R were among their list of HIV/AIDS patients. Some of these Indian patients have attended Edendale Hospital while others have attended Grey's Hospital. The Sister in charge informed me that several HIV positive patients go to private hospitals. They come from affluent family backgrounds and can afford the fees charged by those hospitals. Statistics from private hospitals, however, are denied to the public. Private hospitals place a further stumbling block in attempts to derive at the actual figures of Christian Indians in N/R living with HIV/AIDS. Owing to their confidentiality rights, persons can choose either to disclose or conceal their HIV status. Among Indians, the stigma attached prevents them from disclosing their HIV status.

The following facts, summarised by Partnership Against AIDS, help us see the situation more clearly:

AIDS is a huge threat to the economic and social welfare of South Africa. The need for expanded response has been identified - collective action is imperative – and has been shown to be internationally successful.

- \*South Africa has fastest-growing epidemic in the world
- \*Estimated 3 million infected by the end of 1997
- \*Estimated 1500 new infections a day
- \*14-fold increase in HIV prevalence over the last six years

- \*Highest prevalence in KZN with 27% of pregnant women testing positive for HIV
- \*Youth most at risk with 60% of HIV infections occurring in 15-25year-old age group
- \*Projected 20% of the South African workforce will be HIV+ by the year 2000
- \*Projected 4million HIV+ adult infections by year 2000 (approaching 6.5million by 2005)
- \*3 modes of transmission:
  - ...sexual intercourse (90% of transmission)
  - ...mother-to-child

...contaminated blood directly entering the body

\*At present no cure – only life-prolonging drugs available - but cost prohibitive.

(Partnership Against AIDS 1999:12-19)

The demography and projections relating to the HIV/AIDS pandemic, which so alarm us, should be counterbalanced by our responses. But, what we see in N/R, and particularly in the churches, is the exact opposite.

Denominational differences contribute to the lack of joint efforts in tackling the HIV/AIDS pandemic. So it seems that, unless we address denominational differences, we will fail the needy people that God places in our hands to love and care for. Each denomination needs to be respected for their belief and practice, but surely we can join forces to combat any epidemic that confronts us.

(Pastor David Perumal 2001: interviewed on 06/11/01)

Since 1994 we have enjoyed democracy in South Africa, which has ushered in equality for all people. Democracy has brought in many changes from the previous laws of the country to the situation we enjoy now. Democracy has brought in human rights standards for the society that has emerged in our country. One of these benefits is the right to public health and medical care, which applies to all people indiscriminately, including those living with HIV/AIDS.

When the right to equality is applied to health care delivery, it becomes clear that vulnerable groups should enjoy special protection. This includes women, children and people living with HIV/Aids (Bekker 2000:1-20).

Recently the media have been flooded with articles on the debate as to whether the HIV virus causes AIDS. Many would agree with the statement that HIV causes AIDS. This is a fascinating debate. Subsequently this has become a political issue. Mr. Thabo Mbeki stands by the premise that HIV does not cause

AIDS. The challenge for everyone is to understand what causes AIDS. In 1990 Hoffman and Grenz declared that HIV causes AIDS: "Increasing evidence has firmly established that the Human Immuno-deficiency Virus (HIV) causes AIDS." (AIDS Ministry in the midst of an epidemic 1990:63). There is still no cure to combat the virus.

HIV/AIDS workers, religious leaders and those infected and affected by the virus have expressed deep concern that there are still some communities which have not yet broken the silence and have done nothing to alleviate the suffering of community members (Hoosen interviewed on 05/11/01).

Numerous books have been written expressing concern at the rate at which the virus is affecting human lives, including, for example, *AIDS Ministry in the Midst of an epidemic* by WW Hoffman and S J Grenz (1990) and *Sexual Behavior and HIV/Aids in Europe* by Michael Hubert (1998). It has become a world focus. "The AIDS pandemic became part of the agenda of international cooperation within about five years of the realization on the part of public health specialists that a new disease was at work."(Gordenker *et al.* 1995:27).

Expressing his concern about the HIV/AIDS pandemic, the president of South Africa, Mr. Thabo Mbeki said, at the opening session of the XIIIth International AIDS Conference held on 9 July 2000 in Durban: "One of the consequences of this crisis is the deeply disturbing phenomenon of the collapse of immune systems among millions of our people, such that their bodies have no natural

defence against attack by many viruses and bacteria” (AIDS Bulletin, September 2000).

The minister of education, Professor Kader Asmal, expressed the urgency for educators to know about the disease. He claimed

There is good evidence that well over three million people in South Africa have HIV right now. The disease affects men and women of all ages, occupations and races, living in all provinces. If the current rate of infection does not slow down, by the year 2010 one in every four people in the country will have HIV. In ten years the disease will have made orphans of three-quarters of a million South African children (Guidelines for Educators 2000:1).

Marlan Padayachee of POST reported the bizarre discovery of an Indian family whose four-year-old daughter had been tested HIV positive. It is HIV/Aids cases like these that had prompted me to pursue research into this problem among the Indian community of Northdale/Raisethorpe. Leila was a nurse who cared for others. She became a victim of the killer disease and, as such, died tragically. No one would care for her. Health Minister Manto Tshabalala-Msimang praised nurses who are in the frontline in the struggle against the disease, for their work against HIV/AIDS. She also said “...HIV/AIDS is rapidly becoming a stark reality for health care professionals. SA has one of the fastest growing HIV infection rates in the world and an estimated eight million people could be infected”(Natal Witness 6 Nov, 2000).

### **2.3.2. Interviews**

Recently a senior staff member and Aids Counselling and Unit Manager of Midlands Medical Centre revealed, through an emphatic 'yes', that Indians who are HIV positive were admitted for treatment for HIV/AIDS at the centre. They are either affluent or enjoy medical aid, enabling them to afford treatment in this hospital. Names of persons are a confidential matter. (Sister A.Siveraman 27:10:2001)

Sister Sivaraman also indicated that among the Indian community the silence and denial are attributed to the stigmas attached to HIV/AIDS. Indians are very discreet. For example, in the adult sex columns of newspapers and escort agencies, Indian women are advertised for subtle forms of prostitution. She felt that Indian truck drivers were also the carriers of the HIV/AIDS virus. Among Indian families there are the gender and social problems. The most common ailments that Indians come for treatment of are tuberculosis and pneumonia. Others come for HIV/AIDS testing for insurance purposes (Sister A.Siveraman 27:10:2001).

Navaindren Phillips, a leader of the Northdale Siva/Nyana Sabha, a Hindu temple in the area, informed me that they were unable to set up any structures to deal with the pandemic because of the stigma attached to HIV/AIDS. This stigma was met with silence, denial, and fear, whilst the thought of being disgraced in the community made it difficult to address HIV/AIDS issues. Navaindren admitted that Indians perceive HIV/AIDS to be a Black person's disease. From these

informed sources we conclude that there is nothing that the religious sectors are doing about HIV/AIDS.

## **2.4 Concluding Remarks**

From the overview we conclude that N/R is an interesting suburb with many challenges. In relation to the HIV/AIDS pandemic one finds that its location, history and demography have given some reasons as to why the pandemic is kept hidden. This area is not exempt from the pandemic. With the area being largely Indian, stigmas such as pride, fear, denial, silence and hate seem to thrive well. This is exactly what one finds in this suburb.

The hospital statistics show that the pandemic is prevalent in this area. This goes to show that the virus affects many families in some way or other. If this is true, then why is there no action from the church to combat the effects of the virus? This is what prompted the writer to research the effects of the HIV/AIDS pandemic among Indians in the N/R area.

1. HIV/AIDS is indeed affecting the Christian Indians of N/R. On the surface it does not seem so, but, only when one is confronted by someone affected by the virus one discovers that the virus has reached this area. This substantiates the point I am trying to make in my hypothesis; that it is a myth that HIV/AIDS is not a threat to the Christian Indians of N/R.
2. The Christian Indians who are affected by HIV/AIDS remain silent about their status until, under some extreme stress, they may divulge information. In these cases it took another problem to expose the HIV/AIDS status in these

families. This substantiates the concern that Christian Indians are indeed infected and affected by the HIV/AIDS pandemic, but remain silent about it.

3. Education about the AIDS pandemic is needed for Christians to dispel the myth and to seek help through pastoral counselling and care. This substantiates the call for the church to respond adequately to the need for pastoral care for those infected and affected by the virus.

## **CHAPTER 3**

### **Indians of Northdale/ Raisethorpe infected and affected by HIV/AIDS**

#### **3. Introduction**

##### **Case Studies and Evaluations**

The following case studies are presented as proof to demonstrate that Indians are infected and affected by the virus. There has been great difficulty in getting people to disclose their HIV status. Proper identities of those who disclosed their status have been avoided.

#### **3.1 A Father's Disclosure of his Son's HIV/AIDS Status**

Prem has two sons. On 11 November 2001, during a time of counseling Prem and his wife in their marital conflicts, his four-year-old son, Jeeva, was with him. Prem disclosed that Jeeva had been tested HIV positive. It was further learned that both the parents had been tested negative.

##### **3.1.1 Evaluation**

The above is not an isolated story. The concern for this child's future overwhelms one with grief. Jeeva looked as normal as any other child looked. HIV/AIDS, a broken family, or both of these could perhaps sentence this child for life.

Recently there appeared in The Post (a weekly newspaper) a similar unfortunate story of an Indian family. It reported the bizarre findings of an Indian family that

discovered that their four-year old daughter was HIV positive. In this case the parents have been tested negative (Padayachee 2001:1).

This is a mystery because both of us have tested negative and we are at loss about how Denise has contacted this deadly disease' said Mr. Naidoo. Spurned by family members and relatives, this poverty-stricken family have resorted to begging in the streets of Phoenix after their landlord... asked them to vacate his outbuilding (Post 10-12 Oct 2001).

In the case of Jeeva it was circumstances outside the HIV/AIDS pandemic, i.e. the marital conflict, which led this family to seek counselling. It took another problem to expose the HIV/AIDS status in this family. It seems that, otherwise, there would have been no disclosure about the problem of HIV/AIDS and how it affected this Indian family. It is frightening to think how many other children may be HIV positive in the N/R suburbs of Pietermaritzburg.

### **3.2 Death of HIV/AIDS Couple**

Saras had two growing children, a daughter and a son, who were left behind in the care of her widowed mother. It was learnt from her family that her husband fell victim to the virus and died first. Saras' suffering was prolonged and she died without any counselling or care from the church. Though Saras informed the family that she was dying of HIV/AIDS, the family was divided in their reaction to her status. Whilst most of the family accepted her disclosure, the mother aggressively refused to accept that her daughter was HIV positive. There was a lot of anger displayed in her tone of voice when she was confronted about the matter. The church that Saras attended conducted her funeral on Christmas Day 2000 and all attempts to speak to the clergy about this case were futile.

### **3.2.1 Evaluation**

This is a sad case of blatant denial. The reason for such denial could be related to cultural beliefs and practices. It is noteworthy that the mother, having heard her daughter disclose her status, saw her daughter deteriorate and finally die without a cure, could still deny that her daughter was HIV positive. Here again pastoral counselling and care by the church could have alleviated the pain and suffering in that family.

### **3.3 Disclosure: a little too late**

Leila was a prospective twenty-six year old nurse who became a tragic victim of the virus. Her parents disclosed their daughter's status a little too late. Shocking pictures and disclosures of this young nurse first appeared in the local Indian newspaper, Post, on September 5, 2001. The writer had been visiting this family since the disclosure. According to the details published in POST, it was learnt that Leila was a trained midwife at a hospital in Pietermaritzburg. In 1998 she had been accidentally pricked with an infected needle while nursing a patient. After being tested positive, Leila felt that she had been sentenced to death and gave up the will to live. Her mother's concern over her daughter's deteriorating condition moved her to publish her daughter's status.

She said her daughter's condition had deteriorated over the past eight months after she had refused to continue taking AIDS drugs and other medication bought for about R2000 cash every month by her brother Kamal... (Post 5-8 2001).

### 3.3.1 Reasons for disclosure

During these difficult days, the writer and his wife made regular visits to counsel, care for and offer prayer for Leila and her family. The discussion between Leila's brother and the writer is recorded below:

Kamal 1: If only Leila accepted the fact she was HIV+, she would not have been in this condition. Her biggest problem was rejecting the truth instead of accepting.

Writer 1: Did Leila receive any pre or post- test HIV/AIDS counselling?

Kamal 2: No. Who can give the counselling? At the HIV/AIDS clinic in Edendale Hospital Leila got the shock of her life when she saw that she was the only Indian who was tested positive. We did not want to tell anyone. There was no place here that we could have taken her to. We Indians don't tell anybody about HIV/AIDS. Leila was deteriorating. She attempted suicide three times. Only when my mother got fed-up she began to tell others. The newspaper, POST, started to come here. Now that everybody knows, we feel better. What is the sense of keeping it a secret?

Writer 2: That is true. Is it okay with everyone that the silence is broken?

Kamal 3: Oh, no! We received threat calls from some people. They claimed that we Indians were not supposed to tell anybody. They said that it was a shame, a disgrace, and our name was going to go down; but it did not matter to us.

Leila was sick and dying. What can silence do? Now that we spoke, even Post is helping us. And you and your wife also help us. We should have broken the silence earlier and maybe Leila would not have been so bad. You know, she doesn't eat anymore. She gave up the will to live. Three times, already, she attempted suicide. Her body is disfigured. To be an Indian when you've got HIV/AIDS is no good. But now I tell everyone to speak it out. Don't be afraid for what the people will say. You don't have to die like this. (Kamal, Interview 12/09/01)

I thanked Kamal for being so open. Leila was lying on her bed in her mother's bedroom. It was evident that her condition was worsening daily. She became pathetic to look at. The only thing that could be done for Leila was to pray, which we did.

In this case study an opportunity arose to counsel the family and to administer home-based care to Leila. On 16 September 2001 the writer and his wife took a PLWA, a lady from Project Gateway, to help with home-based care for Leila. This lady has lived with the virus for the last twenty-one years. She was brought in the hope of reviving Leila's struggle against HIV/AIDS. This lady did all that was possible, but to no avail. She herself is still fighting heroically in the struggle against AIDS, whilst, on the 25 September 2001, Leila passed away quietly but slowly. "AIDS had claimed another life among Indians" (POST 26-28 Sept 2001).

### **3.3.2 Evaluation**

This disclosure came too late. This premature death could have been prevented and Leila could have been taught to live positively with the HIV/AIDS virus in her. It seems that, had Leila received pre-test and post-test counselling, she would have handled the pandemic and the stigmas in a far better way. She could have prolonged her life. She was unfortunate not to have received any counselling at all. Her initial denial and silence contributed to her tragedy. The silence was broken a little too late. Similarly, there are other Indians who have not broken the silence at all and who died in isolation and regret, just to maintain the culture status in N/R.

### **3.3.3 A Response**

It is HIV/AIDS cases like the above that had prompted the writer to research this problem among the Indian community of Northdale/Raisethorpe. Leila was a

nurse who cared for others. She became a victim of the killer disease and, as such, died tragically. No one cared for her. Health Minister Manto Tshabalala-Msimang praised nurses, who are in the front line in the struggle against the disease, for their work against HIV/AIDS. She also said "...HIV/AIDS is rapidly becoming a stark reality for health care professionals. SA has one of the fastest growing HIV infection rates in the world and an estimated eight million people could be infected"(Natal Witness 6 Nov, 2000).

On one occasion, during the writer's visits to Leila, Logan Govender the publisher of POST, was present. The writer (known to them as 'Albert') commended the family for breaking their silence. Post published the writer's interest in this.

During our visit to the home on Monday, Pastor Albert Chetty, who prayed for *Leila*, said her mother was courageous because she had displayed tremendous courage to break the silence about the killer disease. Many Indians think that we are immune from contracting HIV/AIDS and that it affects whites and Africans only. *Leila's* illness has shown that we need to take this disease seriously. By talking about her daughter, the mother has alerted others that HIV/AIDS is a painful and crippling disease (Post 12-15 September 2001).

From the publisher's comments one can gauge the way Indians of N/R face the HIV/AIDS pandemic. This should be a serious concern for the church and an opportunity to minister to the needs of infected and affected people in N/R.

In this case study, an opportunity arose for the writer to counsel the family and to administer home-based care to Leila. This death could have been prevented.

### **3.4 An open disclosure**

On Friday 09 November 2001 I visited PLWA (Sagren to protect his identity) and his family. Sagren is an Indian male not living in N/R. He claimed that he had been the victim of hijack and abuse in 1995 that left him HIV positive. He is a father of two. Recently, he painfully broke the silence on his HIV/AIDS status to who ever he was able to tell. The print and electronic media, including 'E TV', covered his story.

In 1996 Sagren took ill and was unable to go to work at the company he had worked for for eighteen years. He had spent a lot of money on medication. In 1997 he was tested HIV positive. This shocked him and he had to first break the silence to his family. At this point he did not fully understand about HIV/AIDS. In 1998 he lost the will and ability to work. He lost his job. In 1999 his health deteriorated and he was admitted into a hospice and stayed there for one month.

Sagren said that he too thought that only Blacks got HIV/AIDS and not Indians. He was surprised, when attending the HIV/AIDS clinics at King Edward Hospital in Durban, to find that there were quite a few other Indians beside himself. His family has accepted it well and has stood by him all the way. His wife, daughter and son spoke out. They loved him very much. His mother also lived in his house. On the day in question he was looking fine. He spoke about his commitment to God ever since the day he learnt of his AIDS status. He attends church regularly. With the help of the present pastor and members of their

congregation, Sagren and his family get on well. The church members responded well to his breaking the silence on his status.

Prior to this, the first church he attended received the news of his status badly. This was regrettable. They admission on the grounds that they did not keep HIV positive persons for fear of straightaway made arrangements for him to stay at Jeevanadi, a Christian Counselling and Care Centre in Tongaat. There they refused him others becoming infected. Arrangements had been made for him to stay at Kwa-Sizabantu near Stanger. The day he was to have left to go there he received a call from his pastor, who informed him that he could not go there either. That same pastor became unfriendly and treated him as if he was an outcast. Sagren could not stand the hostility any longer, so he and his family quit the church. His wife continued to seek out a church that would accept them together with Sagren. Her search was successful. The present pastor and church responded in quite the opposite way to the first church. They treated him and his family with a lot of love and care. They helped them pull through. As a result, Sagren and his family are now (2002) doing very well. The attitude of new church made a tremendous difference to their battle against AIDS.

### **3.4.1 Evaluation**

The evidence of Sagren and his family declaring their HIV status and receiving love, counselling and care, sounded the call for a review of the situation in N/R. If more people could disclose their HIV/AIDS status, and do that in time, surely they too can enjoy being in a Christian atmosphere with love and care.

### **3.5 Baby miraculously saved**

Ronny and Ruby are both HIV positive. They have three-year-old son. They live in extreme poverty. Ronny is unable to work as he feels very weak. His wife, Ruby, suffers from full-blown AIDS and is slowly dying. Miraculously, the baby is well and does not have AIDS. After much persuasion from the writer, the church they appealed to is helping them with basic food and rent. The father agreed to send the child to a care centre while something is being done to strengthen the couple.

#### **3.5.1 Evaluation**

It was learnt from this couple that they did try to get help. They were turned down by the hospital for further help and treatment, apart from basic medication. In turning to their church for help, the writer was called on to counsel them. It was a pity that they could not have been helped any earlier.

### **3.6 Some Parallels to be drawn**

The above case studies may be just a few of cases where HIV/AIDS has been disclosed. The writer knows of other case studies, but those people have failed to disclose their status publicly and have refused permission for their stories to be included. This gives rise to the question: "Why the silence?" Indians have also become vulnerable to the pandemic. Indians elsewhere too have become vulnerable.

### **3.6.1 South African Indians contrasted with those in India**

The writer interviewed both Rev. John Ayyala and Pastor Simon Karinjottazhikathie of South India (Appendix 6), who are exchange students at the University of Natal, Pietermaritzburg. They disclosed shocking attitudes amongst Indians in India towards HIV/AIDS. Both these members of the clergy from India informed me that HIV/AIDS is a common sickness among truck drivers and drug peddlers in India. People in India regard AIDS as a deadly shame. Family members would disassociate themselves from infected members. In fact, they will not even touch them. They have seen AIDS corpses being dragged onto the street with a rope to be cremated (Ayyala and Karinjottazhikathie 2001: interviews).

The people themselves will not disclose that they are HIV positive because of the fear of being treated in a brutal manner. Those infected will live with families in denial until they are too ill to worry any more. It is at this point that families throw them out. This is gruesome. As pastors, they themselves are not allowed to address this problem from the pulpit. If they do, violence will flare up and they will be stripped of holy orders and thrown into the street. In most quarters in India HIV/AIDS is a “no go” subject (Ayyala 2001, interviewed on 04/10/01). This is due primarily to the fact of the stigma attached to HIV/AIDS and to the caste system. High-class people will go to great lengths to maintain their status. When the newspapers get hold of news of an infected person they spread the

news in bold print so as to bring shame upon the infected and affected persons.

It is common to see infected persons lying on the streets (Ayyala 2001: Interview).

In India prostitution is the main agent whereby HIV/AIDS spreads to others, because prostitution is common. Poverty is an allied factor, aggravating the circumstances that lead to the spread of HIV/AIDS. People need to survive and prostitution has become a lucrative business. There is no control over prostitution and as a result even children are lured into prostitution (Karinjottazhikathie 2001: Interview on 04/11/01).

In India there are some AIDS Houses that provide counselling, social, and physical services. Both John and Simon felt that the authorities are doing too little to fight this pandemic. They also were of the opinion that Indians in South Africa may reveal the same traits as their counterparts in India. This may be seen in subtle forms, (Karinjottazhikathie, interviewed on 04/11/01).

### **3.6.2 Silent Epidemic in India**

The writer draws attention to this story to show the similar attitudes adopted by Indians elsewhere. The media draw attention to the ninety percent of those Indians infected with the HIV/AIDS virus who do not even know that they have the disease. The publisher of “ Silent epidemic in India” (Natal Witness 18 July 2002) claims that India has the second largest number of people with HIV/AIDS in the world. The epidemic in India is still a silent one. Though silent, the

statistics show that migrating men, on returning to their wives, have been tested positive and have become high risk. Clinics attended by women record that more than two percent of women have HIV/AIDS. India faces an uphill battle because of the enormous social and cultural stigma attached to HIV/AIDS. UNAIDS has projected that in a few years time India will have the largest number of people in the world infected with HIV/AIDS (Natal Witness 18 July 2002:14)

It seems that India also displays a slow pace in addressing the HIV/AIDS issue.

India has taken its first faltering steps towards tackling AIDS. But, nearly seven years after the first cases of HIV infection were detected, it is increasingly clear that ignorance, apathy and corruption are proving powerful allies to the virus (New Scientist 14 Nov 1992:6).

### **3.6.3 Indian family and lifestyles**

One can learn from what world leaders are projecting for the future and also see that Indians in India have similar problems to Indians in N/R. Unless the real issues are addressed, HIV/AIDS could outstrip us. Kathleen Cravero, deputy executive director of UNAIDS said:

There are clear warnings that the epidemic could escalate in many countries, if urgent action is not taken. HIV/AIDS infections in Asia could outstrip chronically-hit Africa in the coming decade, unless urgent action is taken to stop the spread (Natal Witness April 24, 2001:5).

As an Indian, the writer understands that numerous Indians throughout South Africa have adopted the same culture and attitudes as those of the Indians of India, even though they are South African and although most have never placed their feet on the soil of India. This focus on India and HIV/AIDS helps to show that Indians in N/R adopt the same attitudes and related cultures of India. This may be due to common <sup>cultural</sup> culture traits. India is the second largest country in the

world that is threatened by the HIV/AIDS pandemic (India Today 30/11/92).

The war against HIV/AIDS had begun.

For too long India had foolishly denied that it had a problem. Now the AIDS time-bomb is ticking furiously, and the nation must take rapid steps to defuse it before it explodes with epidemic force (India Today 30 Nov. 1992).

### **3.7 Concluding Remarks**

Local church ministers interviewed have confirmed that there is a stigma attached to the HIV/AIDS pandemic. Promiscuous lifestyles may be the main cause of people becoming infected but, because of Indian family bonds, infected persons are kept in secret. Leila's mother said that she had gone against threats to break the silence of her daughter dying of the HIV/AIDS virus. Many told her that Indians do not tell others that they are HIV positive.

On 21 August 2001 the writer spoke to Marlan Padayachee of Post (Durban) who has written several articles relating to the HIV/AIDS pandemic and Indians. Through that conversation the writer learnt that there are many Indian families that are infected and affected by HIV/AIDS. In areas such as Chatsworth, Welbedacht, Phoenix and Marianhill Post has discovered that HIV/AIDS has reached Indian communities. Marlan said that it was very difficult to obtain their stories from the Indian people because of the stigma of HIV/AIDS and also because the Indians are conservative. Dr John Sebastian of Chatsworth Community Care Centre, in a Post article reporting the suicidal death of an Indian father who was HIV positive, sent out a call for Indians to break the silence.

... while he understood the agony the family was experiencing as a result of this death, the 'wall of silence' could lead to

speculation rather than assisting the community to come to grips with the spread of the killer disease. Though Indians are conservative, they should be open and discuss the disease because young people from 18 to 25 years old stand to be hardest hit by the spread of HIV-AIDS (Post 20-23 June 2000)

Marlan was further convinced that Indians are both infected and affected by HIV/AIDS. He said that getting them to talk about it is the big problem. To address the needs in N/R, arising from the HIV/AIDS pandemic, people are needed who are concerned and care about the plight of those who have been infected and affected by the HIV/AIDS pandemic.

Coming face to face with a PLWAs justifies the call to break the silence and stop the denial among the Indian community of N/R. There was a general concern for change amongst AIDS workers (MWC) and the medical personnel. The statistics alarmed concerned persons, who warned that the figures would increase (ECHO 1999). The traits of Indians in the N/R area were similar to those of Indians in India. In South Africa, the call to break the silence and stop the denial must be heeded to win the battle over HIV/AIDS.

The facts of HIV/AIDS cannot be brushed aside. Indian people, as has been mentioned, have not escaped the virus. Unless the true statistics of victims of this pandemic are known, we will never know how best to enter into battle.

## CHAPTER 4

### **Gender, Church and HIV/AIDS in Northdale/Raisethorpe**

#### **3 Introduction**

##### **The call from the media**

The year 2001 marks a time of increasing awareness of this pandemic that is fast destroying human lives. There seems to be a noticeable increase in efforts from all segments of society to address this issue. Daily the media have something to report on the HIV/AIDS issue, be it good or bad. Reports of the World Aids Conference appeared regularly in newspapers. There was the political battle by President Mbeki as to whether or not HIV causes AIDS. The pharmaceutical companies went as far as taking legal action to force the government to allow expensive imported medication to be provided for the HIV/AIDS patients. Then there was the battle to release HIV/AIDS statistics. Letters from concerned citizens related to the HIV/AIDS pandemic could be read in daily newspapers. Now and again the news of a public personality affected by the virus appeared in newspapers. Daily the news informed society in general about the HIV/AIDS status of the country. The media have helped the church to understand that HIV/AIDS does exist among Indians as well. This has been done through reporting promptly on case studies. An example of this was the case of Leila, which received much publicity (Chapter 3).

Former United State president, Jimmy Carter, who was shocked at the twenty-five million Africans who are infected with the virus, gave a remedy to combat the virus. He suggested that the leaders should send out the right message.

First, heads of states and governments must lead...They must publicly acknowledge and articulate the gravity of the threat posed by the AIDS epidemic, despite the stigma, taboos and deeply personal aspects associated with the disease.  
(Natal Witness 17 Nov, 2000).

Buyanima-Afrika Mkhulise reported on the progress made in some schools regarding arming pupils with information about AIDS and commented on the progress.

All eight schools in the *Mpophomeni* area, both primary and high schools, were invited. However, only four pitched up... We wanted to make sure that, as the people who are most vulnerable to the disease, the youth, learn about the disease and avoid it. (Echo 30 Nov 2001).

A similar call was made by the ANC youth (ANCYL). "AIDS, rural poverty and gender inequity emerged as some of the main areas of concern addressed at the African National Congress Youth League's national congress..." (Natal Witness 09 /04/2001). The Inkatha Freedom Party Youth League (IFPYL) supported the ANCYL with a similar call, "AIDS, jobs the Youth Day focus" (Natal Witness 16/06/2001).

The monthly Indian newspaper *Satyagraha* published a shocking article on the HIV/AIDS issue.

Our clergy report that, every week, they are burying people who die of AIDS. Young workers are disappearing and dying from 'natural causes' in the prime of life, leaving their families behind with no income or support (Satyagraha, October 2001:4).

The Natal Witness and Children in Distress (Cindy), through the writing of essays, jointly called on youngsters to express how they wanted leaders to respond to the challenges of this virus. The essay writing attracted tremendous support from all segments of our society. On June 16 2001 community leaders of the city and councillors were invited to respond to the requests of the children, (Natal Witness 05/05/2001). This essay competition also allowed the youth to break the silence surrounding HIV/AIDS.

#### **4.1 The Problem and its Background**

One of the major problems that currently face the churches in N/R area is the lack of effective Christian ministry in the struggle against HIV/AIDS. Among the people there is evidence of ignorance, lack of any guiding word from the pulpit (sermon), and, in some cases, dead silence from those living with the virus.

##### **4.1.1 The Gender and Abuse Issue**

The church has to rethink its gender policy. This may be the heart of the problem. Gender issues and abuse are major factors in the Indian community and have a bearing on some women who have been tested HIV positive. Freedom for women from traditional marriage vows has been a contentious issue among Indians of all faiths. The call is now for women to be liberated from old traditions:

The interpretation of Islam by progressives is consistent with the Bill of Rights and goes against the notion of women as the silent keepers of the home and family. It is this bill, rather than the ability to freely practice one's religion, that will give Muslim women the opportunity to challenge the established conventions which disempower them (SARDC 1997:32).

The new South Africa is set to bring about some major shifts in the attitudes towards women. Muslim women need to be liberated as quoted above. In the same way, we find the need for Hindu women to be liberated.

Hindu women have mixed feelings as to whether Hinduism oppresses or liberates women. The overriding feeling is that Hindus are more open to change than other religions... Hindu women are challenging these roles and see themselves as active participants within the community, in business and career (SARDC 1997:33).

South Africa, since the arrival of democracy in 1994, has become free to address every form of discrimination and oppression. The country has become more open-minded and change is inevitable. Women bear the brunt of sufferings.

More than ever before, South African women need to foster spaces and places for a life giving spirituality to deepen and grow. Statistics of rape, domestic violence, and the gendered face of HIV/Aids and poverty continue to escalate... Pain and struggle for South African women is the order of the day, not only in society at large, but also within the patriarchal structures of the church (Haddad 2001:2).

This has been a carry-over problem from previous generations among Indian women and this is what we see in the N/R suburb of Pietermaritzburg. In the beginning, Indians settled mainly in Durban and then moved throughout the rest of the country. In the major cities like Durban I found that culture changes more rapidly, whilst in the smaller cities like Pietermaritzburg, change is slow, people are conservative and hold onto traditions of the past longer than those in the larger metropolitan areas. In this research, to find out whether Christian women of N/R have been affected by the HIV/AIDS pandemic, it was found that many Indian families were still conservative in their lifestyles, attitudes and their treatment of women. In large measure, Indian women have not been liberated.

Most churches in N/R still maintain male leadership and keep women in silence in the church, or allow them limited activity only in the recognised ministries amongst women and children. This research shows the need to change and to correct the discrimination against women, which will in turn lead to many benefits for the church. One such issue is the struggle against HIV/AIDS.

In addition, it is found that Indian women seem to accept the lack of status they receive from their male counterparts. Even more surprising is the finding that Christian women were made, by male clergy, to believe that the Christian Scriptures actually teach this gender inequality (SARDC 1997:33). This is what is taught in the churches. There is often the old mind-set of interpreting the Scriptures to suit old practices. In spite of all the awareness in the area of women and gender issues, Christian women in N/R have been gullible, accepting from the male clergy that God brought about this form of gender discrimination. They are made to believe that women are holy if they accept this. They are also made to believe that in submission to God they need to obey the teaching of the male-dominated clergy. The writer feels that this is erroneous teaching. Such is common practice in N/R.

The writer feels that a constitution that rejects discrimination and gender inequality should be in place. It will be then that the church at large can properly address community struggles such as HIV/AIDS.

To bring about such bold changes in an old-style organised church denomination will require going through the red tape of bureaucracy. This is not an easy task. The Christian communities in this area have long been taught that gender inequality is God's way of testing the submission of women to their male counterparts (Pastor David Perumal, interviewed on 06/11/01). Unless the church in this area liberates women to attain gender equality, the HIV/AIDS pandemic will continue to thrive through silence and denial among the Christian Indians of N/R. Nalini Naidoo published an article in the Natal Witness to the same effect. She published Karen Buckenham's impression of the church, women and violence issue when she (Karen) attended a workshop and learnt of their perceptions from women. Often the women would be blamed, or they would be asked what they did to provoke such-and-such an action. She said it became clear that, in many ways, the church, a patriarchal institution, has little awareness or understanding of the extent of violence against women and how to deal with women's suffering (Naidoo, interviewed on 01/11/01).

This perhaps is a reflection of the attitude of the church in N/R toward women's issues. This becomes a stumbling block in dealing with epidemics like HIV/AIDS. While there are numerous persons living with HIV/AIDS and affected by the disease, nothing or very little is heard about it because basically the women, who bear the problems that surface, are meant to be silent. This gives the reason why women are silent about the HIV/AIDS issue. Vicci Tallis argues that "the gender context has been missing from programs and interventions. A

gender approach, in which women's rights are a central concern, is vital and urgent" (Tallis 1998:6-14).

#### **4.1.2 HIV/AIDS as a Crisis for Women**

This research in N/R shows that women and children suffer AIDS the most. "AIDS is an issue that affects women more seriously due to their greater vulnerability to HIV infection resulting from their reproductive roles"(Tallis 1998:6).

Women are more susceptible to HIV/AIDS than men. The reason being that:

HIV is found in the blood, semen and vaginal fluids. If any of these fluids pass from an infected person's body into another person's body the virus may be carried with it. A woman may become infected through sexual intercourse or, if infected blood gets into her body (eg. through sharing blades or needles). A baby may become infected if the virus passes to it from its mother during pregnancy, at birth or through breastfeeding (Department of National Health and Population Development for the Pietermaritzburg AIDS Action Group [1998]).

One cannot disassociate HIV/AIDS from the impact it has on women. In N/R, owing to the Indian culture, women are not permitted to talk about their struggles but have to bear their pain silently. The women have become conditioned to such vulnerability (Tallis 1998:9).

By focusing on women's vulnerability to HIV, it is not suggested that men are not vulnerable, but instead that women are more vulnerable. Vulnerability refers to a lack of power, opportunity and ability (skills) to make and implement decisions that impact on one's own life...(Tallis 1998:9).

This shows that society at large is clearly divided on the matter of facing enemies like HIV/AIDS which are capable of destroying it. This division promotes destruction and, unless society addresses such issues as gender bias, we cannot

get a hold on HIV/AIDS in our communities. In this we must recognise that women are more vulnerable. It is good to note that the Deputy Mayor of Pietermaritzburg, together with Joanne Stein, a researcher, presented their view of this vulnerability in the hope that it will filter down to communities such as that in N/R.

The reasons for the disproportional infection of women, especially young women, include their physiological, social, economic and cultural vulnerability, which renders them more predisposed to HIV than males. Women also suffer the consequence and impact of the epidemic disproportionately, insofar as they are the primary care-givers in our society... Younger women who have undeveloped genital tracts are at higher risk than older women (Hlatshwayo Z, and Stein, J 1998).

Women should not be seen as sex symbols. Women who become sex symbols allow themselves to be treated as inferior. The different portfolios held by males and females should not determine whether they are inferior or superior.

Gender is not synonymous with sex - it refers to the widely shared expectations and norms within a society about appropriate male and female behaviour. Men are seen as being responsible for the productive activities outside the home, while women are expected to be responsible for reproductive and productive activities within the home. This tends to result in women being disempowered, subservient and excluded from decision making (Sanders 2000:15).

N/R is a culturally diverse area, and yet one might truly perceive that this is a totally integrated society. From a general perspective one can easily see groups across the racial lines working together and one can picture it as a multi-racial society. This is merely on the surface. The family and home life, sporting activities, businesses and, sadly, the churches are segregated. Looking closer into an Indian family, one would notice the cultural lifestyle and habits of the family. One would see distinct cultures that exist in India. In a lot of these homes there is

very little of Africa or South Africa. The homes would have a lot of Indian and or western culture images.

Now, this has an important bearing on what Indians in general believe about HIV/AIDS. The perception is that HIV/AIDS is essentially an African disease and that idea consoles them. When they do meet with persons of other cultures they tend to swing from one social practice to another but return to their home culture. This is where Indian women become confined to the home culture that restrains them from identifying with community issues. This pattern of swinging from one social practice to another is common also as we look for common practices in India, remembering that most of our patterns were inherited from India.

India presents a bewildering array of social patterns, strong religious influence, clearly-defined regional variations as well as the perennial suspicions between classes. The contradiction between constitutional and personal identity as against strong and emotional influences affect perceptions of women and the role and status assigned to them (Augustus 1998:56).

Working women face similar treatment from their husbands. They cling to biblical verses like the following, which presumably lend support to their beliefs "...the husband is the head of his wife" (1Cor 11:3). It is the church that continues to perpetuate such teachings that keep women disempowered. Though she is working and helps to finance the running of the home, a woman does not earn the same status as that of the husband. Even where the husband is unemployed or disabled he is the so-called family head and commands

leadership, with his wife remaining in a subordinate role. This is a typical pattern in N/R.

Even though the woman is an employee [?] on a par with her husband, she has to do all family chores and being harassed day in and out by both husband and officers. Even in the field of stage and cinemas the discriminatory attitude against women is very much evident (Rao 1998:86).

Will the HIV/AIDS pandemic help bring about some change in the way people perceive gender issues? It may take something as serious as HIV/AIDS to help break down gender inequalities and to elevate women to an equal status with men. This possibility of change may come about when every effort to discover a cure fails and efforts to reduce the spread of the virus become too costly and burdensome, then perhaps attitudes towards each other may change. This change will have to be attributed to realising that both male and female have become victims of this pandemic. Such a change is needed in N/R. Then mutual interest will be applied to the struggle against HIV/AIDS. Carolyn Baylies (2000) asserts that the HIV/AIDS pandemic will offer the possibility of change, and may necessitate it.

For those countries worst affected, AIDS represents a human tragedy and a development emergency of huge proportions. Yet, by exposing how prevailing gender relations and other patterns of structured inequality are implicated in its spread, the AIDS pandemic offers the possibility of change - indeed necessitates it (Baylies 2000:1).

Carolyn Baylies and Janet Bujra (2000) have summed up the gender struggles in stating that "...the epidemic in its turn has influenced the ongoing construction

and reconstruction of sexuality and the beliefs and behaviours which constitute it” (Baylies and Bujra 2000: 176).

#### **4.1.3 Cultural complexities for women with HIV/AIDS**

The Indian culture is very complex. At the heart of this complexity lie problems in Indian marriages. This, to a large extent, has been carried over from India. The women who marry are often ‘created just as an instrument to give birth to sons of a man, through whom the father continues his life.’ (Kumari 1993:153). In Indian culture a married woman sacrifices a degree of freedom and individuality. The caste system, in which there are upper and lower castes, impacts on marriages in a large way. Couples are required to marry partners from the same caste. This prohibits individuals from falling in love with someone outside their own caste. Women were obliged to marry a male of the same caste to please their parents, even to the extent of becoming his slave (Rao 1999:61-68). To this day it seems that “birds of a feather will flock together”. As a result, women who do not find a partner end up becoming promiscuous, while others go against parent’s wishes and marry cross-culturally.

Beyond doubt, major religions of the world have a dubious record with regard to women...For example, Buddhist women could not head the religious community. Hinduism usually held women ineligible for salvation. Islam made a woman’s witness only half that of a man. Christianity called a woman the weaker vessel, the more blurred image. Jewish men blessed God for not having made them women (Kumari 1993:153).

Times have changed and cultures are beginning to take on new forms, and the younger generations are exploring areas that have been avoided before (Rao 1999:66). These areas include the gender issues. All this is happening, and yet we

see that the some of the older folk still hold onto former ways. They still require their children to consider the old 'values'. These factors lead to silence among women and cultural bias (Rao 1999:61). From close observations one sees that trends from India still follow the Indians of South Africa including those of N/R. South African Indians *per se* do not follow the caste system or arranged marriages.

It is necessary to state again those barriers and power imbalances that hinder a right relationship between the genders, which must be broken down. These ought to include culture, gender and sexual inequalities.

Customs and practices which promote a cycle of illness and death must not be preserved. Gender roles that disempower women give men a false sense of power and are killing our youth. This must change (Sanders 2000:16).

Among the Indian women culture plays a dominant role. It is important to note that women are primarily concerned with 'bread and butter' issues. The present harsh socio-economic conditions put women in a disadvantaged position for disclosing their HIV/Aids status. Until recently, Indian women were dependent on their husbands to sustain the families. This has given men the dominant role to play in each home.

Many women in Africa are economically dependent on their spouses or partners and thus may find themselves unwillingly participating in sexual acts. Fulfilling immediate needs for food and shelter for themselves and their children may be a greater priority than the potential long-term consequences of unsafe sex (Hlatshwayo and Stein 1998:18).

The Indian culture does not help women in their struggle against the virus, but is designed in such a way that it allows for gender bias. The gender bias makes it

difficult for women to take a stand against HIV/AIDS. It places women at an unfair disadvantage and so deprives them of an equal opportunity to launch out against the virus. The cultural mindset is rigidly applied. Indians don't talk about sex (Sister Praag 2001- interviewed on 30/10/01).

Understanding the ways in which sexuality is constructed and gender relations configured is crucial for strategies of protection against HIV. The subordination of women's needs and desires in relations of intimacy came through in all of our case studies, expressed in a variety of ways (Baylies and Bujra 2000:176).

In South Africa, since 1994, changes to the old order of events were inevitable. Prior to this period, cultural norms were established where women were placed in positions of lesser authority. Women had to confine themselves to cultural dimensions for women and were not empowered to effect changes. Now that democracy has ushered in changes and equal rights for all, women are allowed to address issues pertaining to society, equally and responsibly.

Social democratisation is an expression of women's transition from subjugation to that of social equality and liberalisation of social institutions. The liberalisation implies the struggle of marginalised members to negotiate rules that will increase their equality, strategic actions, power and leadership (Kumari 1999:5).

The imbalances of the past created difficulties for tackling the HIV/AIDS virus head-on. This led to the rise of the myth that HIV/AIDS was not a threat to the Christian Indians of N/R. Some discrepancies of the past needed to be addressed.

In this the claim has been made that, to follow the righteousness of God, one must promote gender equality. The call to treat women with equality and respect must be adhered to, to fulfill scriptural teaching (Gal. 3: 28).

#### **4.2 Myths surrounding HIV/AIDS in Northdale/Raisethorpe**

The myth that HIV/AIDS does not affect the Christians of N/R rests heavily on the strength of certain inequalities. The church has to promote this new order of events. In this chapter we have seen that it is a myth that HIV/AIDS is not a threat to the Christian Indians of N/R. The Indian community of N/R hold onto a myth that HIV/AIDS is the result of sin and evil. This has led the clergy to focus more on the judgement of God rather than on the care of and concern for people with AIDS. The clergy have accepted the norm of silence and denial related to the AIDS pandemic in N/R. Stigma and pride have kept these Indians silent and in denial regarding the HIV/AIDS pandemic. Indians are more concerned about shame and disgrace than about facing realities. These have been examined and shown to come from the age-old caste system of India. Some Indians still hold onto these traditions. It has been shown that gender bias is a contributing factor in this area. It seems that women are faced with the struggle of coping with the pandemic by themselves.

Both the clergy and the medical personnel confirmed that getting Indians to disclose their HIV status would be a mammoth task. Medical personnel interviewed, both in private and state hospitals, have confirmed that they have treated several Indians who have tested HIV positive. Case studies have shown

that the virus affects Indians of N/R. In this chapter we have seen that the culture of Indians in this area has a bearing on why Indians, including Christian Indians, remain silent on their HIV/AIDS status.

### **4.3 Existing HIV/AIDS Church Ministries**

Although the HIV/AIDS pandemic has reached into this region, and case studies will be presented in this thesis to substantiate this, regrettably, the perception remains that HIV/AIDS does not affect the Indian community. The attitude encountered is that HIV/AIDS is an African disease. Until now, there has been no Christian ministry in N/R to address the community needs relating to HIV/AIDS issues. The writer's own church community has set up an HIV/AIDS awareness and education program to the level of home-based care for its members through the Evangelical Seminary of South Africa (ESSA) Christian Aids Program (ECAP) and Gateway Projects.

The volunteers have just completed the HIV/AIDS awareness and education program through ECAP in preparation for the implementation of services needed in this community. Men and women are being trained to respond to the call to serve people at the point of their need, namely HIV/AIDS. Unfortunately, other churches have not responded to the call.

#### **4.3.1 Other Christian Ministries**

The only ministry that the church can boast about is that HIV/AIDS is one of the Big Six Issues of the combined Church in Action (CIA). CIA is made up of some

of the city churches. This is a city-wide drive led by Pastor Craig Botha of Pietermaritzburg Christian Fellowship. The church in Northdale/Raisethorpe has not as yet set up an HIV/AIDS counselling and care centre. Pastor Victor Rhandran of Bethlehem Baptist Church in Northdale/Raisethorpe informed me during an interview that they do not have any HIV positive members in their congregation. Colin Naidoo of Patmos Assembly, Father George Lawrence of Holy Angels Anglican Church and David Perumal of Ephesus in Northdale/Raisethorpe said the same.

HIV/AIDS is the enemy in N/R, as elsewhere, that has come and destroyed the lives of so many. There is a need for church leaders and Christians to heed the call from the Lord to engage in the battle against this enemy.

#### **4.4 The Pandemic that targets Everyone**

HIV/AIDS is a world enemy that needs a worldwide, united front to consider a strategy to combat and eradicate it from the face of the earth. This is partly an expression of anger and a call for the killer to be killed. What is the cause of this anger? Besides those who brought it upon themselves through unprotected sex, there are multitudes of innocent victims. These include babies whose lifespans were undeservedly cut short. Some of them never had a chance to live their lives to the fullest. Such a cry for deliverance from this pandemic is justified.

The common reasoning: 'what about those who brought it upon themselves?' is an area where the church can help transform attitudes. This reasoning is selfish

and self-centred. Sometimes, the easiest way out is passing judgement on others. No offence caused would justify the mass killing of innocent lives. No matter whatever the reasoning, HIV/AIDS must be seen as a world killer. The battle against such a killer can be won if the world engages in this battle. No segment of society can withhold from this battle for the reason that the virus does not affect them. When one considers the innocent victims affected daily, then it is a war against every person.

Research of this nature has come across silence and denial by those who have been infected and affected by the virus. Persons that are HIV positive were reluctant to talk about it. Some PLWAs encountered made vague promises to return to tell their story, but failed to do so. Without their permission it was not possible to publish their stories, although these were known to the writer.

#### **4.4.1 The Churchs' Response: War against HIV/AIDS**

In its war against humans, HIV/AIDS takes more lives than inter-national wars have taken. This truth was recently expressed in our daily newspaper,

Ten times more people died of AIDS in South Africa last year than were killed in wars in the entire continent the year before, Natal University Professor Geoff Harris told the launch of the Coalition Against Military Spending (Cams) yesterday (Harris 2000:5).

This truly shows the devastating power of HIV/AIDS that targets human lives. Therefore the struggle against HIV/AIDS must be seen as war. This pandemic has declared war against humans. HIV/AIDS attacks the immune system of the human body.

HIV stands for the Human Immuno-deficiency Virus. In 1983 HIV was found to be the cause of the Acquired Immune Deficiency Syndrome(AIDS). It is unclear where the virus comes from or why it appeared...HIV attacks and slowly destroys the immune system by entering and destroying important cells that control and support the immune response...All this means that some of the most important cells of the body's immune or defence system are destroyed by HIV (Provincial HIV/AIDS Action Unit 2000:1).

With AIDS around, living on this earth is like living on enemy ground. The enemy is inside every territory and looks for the slightest opening in order to enter and attack from there. When we look at a person living with full-blown AIDS we can see the destructive element of HIV/AIDS.

In response to the enemy attacking humans, the call has been sounded to many sectors of society, including the religious sector, media, education, labour, business, Government, non-government and community based organisations, sport and entertainment, women's organisations and even to individuals to declare war on the HIV/AIDS virus (Partnership Against AIDS 1999:12-19).

Recently there was a call to the media by Clem Sunter, a prominent anti-AIDS campaigner, to treat the AIDS crisis as a war and aggressively to educate the public about it. He called on the media to give saturation coverage in their newspapers; "We are getting to a point where you are going to have to go for saturation coverage, whether it sells or not" (Sunter, 2001:2).

War demands caution. The role should be to take every precaution against the enemy, to join forces to combat the enemy and to assist and care for the

wounded. Besides caring for others, one should guard oneself with good morals. Having a promiscuous lifestyle can lead to being infected with the AIDS virus. Other means of contacting the virus are through blood from an infected person through transfusion, accidental piercing by needles etc. Faithfulness to spouses, abstinence from premarital sex, precaution with sharp instruments e.g. needles and the use of gloves when treating HIV+ patients are all means of keeping the virus at bay (KZN Cabinet AIDS Initiative 2000: 3).

Indians in N/R ought to follow the example of Indians in Durban, who are engaged in a war of words with each other in their attempts to break the silence on their HIV/AIDS status.

...A conservative estimate is that by the year 2005, four million South Africans will have succumbed to AIDS, of which close to 200 000 will be of Indian descent. Aids knows no class, thus many of these will be people of good standing in society who have caught the virus through infidelity. If we can get at least some of these issues discussed in the homes of such people, we may well save lives. We are heartened by the calls we received from men who upheld the sanctity of the institution of marriage. However, reality tells a different story (Premdev 18:11:01).

HIV/AIDS cannot be fought alone. Silence and denial lead to one being defeated by the virus. One cannot blame it on the government alone. The sectors of society that fight against the virus should be united and broadened. As identified by Partnership Against AIDS, the different sectors called to war against AIDS are:

The Religious Sector  
The Media  
The Education Sector  
The Labour Sector  
The Business Sector  
Government

Non-governmental and Community-Based Organisations  
Sports, Arts and Entertainment Sectors  
Women's Organisations  
and Individuals  
(Partnership Against AIDS: 1999)

When all of these sectors form a united front to combat the HIV/AIDS virus, then only will society be able to say that they are in control of the situation. This can be achieved through education, proclamation and networking. In N/R, perhaps the church could coordinate such an initiative.

#### **4.4.2 Education Ministries: Seminars**

There have been two HIV/AIDS seminars in the N/R region, one at Jesus Miracle Revival Church and one at Alpha Omega Church. The writer attended both these seminars. Both focussed on areas outside N/R, under the pretence that HIV/AIDS is not a problem in that area. Both the Jesus Miracle Revival Church and the Alpha Omega Church have called for the churches in this area to support those groups from outside of Pietermaritzburg. This was done without considering the possible affect that this pandemic is causing in N/R. The purpose of these seminars was to attract sponsors for their efforts to combat the virus in their own areas, one in Durban and the other on the outskirts of Pietermaritzburg. These seminars did not, however, address the possibility that there could be people in N/R who are infected and affected by the HIV/AIDS virus.

### **4.4.3 Caring Ministries**

Although other churches have not responded to the need for caring, there are other groups that have. Two people have begun a Men Women Children (MWC) Counselling Centre at Mysore Road in Raisethorpe. Sumaya Khan and Eric Chetty, social workers, offer free counseling to victims of sexual abuse, women and child abuse, poverty and those infected and affected by HIV/AIDS. This is a non-religious ministry. The writer was told that people living with HIV/AIDS (PLWA), including Christian Indians, do come for help but that they fear breaking their silence. All attempts to interview these persons failed because they claimed that they were not yet ready to disclose their status.

Regrettably, no religious organisation has set up any form of ministry to fight against the virus or to alleviate the suffering of people in its own constituency. In speaking to Mrs Zohra Sooliman, a Muslim who coordinates the Gift of the Givers organisation, about this she acknowledged and said that she knew that AIDS affected everyone. She expressed her disappointment that the religious sector of N/R have done very little to address the HIV/AIDS issue.

### **4.5 Concluding Remarks**

The church should lead and pave the way to enabling people to talk about the HIV/AIDS pandemic. It is possible to perceive that those who do not freely talk about this stigmatic disease label those who have HIV/AIDS as 'bad' people, who deserve such punishment. From a pastoral perspective it is important to note that the church cannot allow its people to become judgmental but instead needs to

deliver them from judgmentalism and to teach them to love and care for others.

The church cannot allow its people to be misinformed. These misinformed persons spread fallacies. The pulpit in these churches should be used to proclaim the Good News in its context to the people on HIV/AIDS day. The pulpit is a most significant platform from which to address the people on issues that affect them. The Bible has numerous answers to our struggles of today and how we should respond to them. In N/R, as elsewhere, there is a need for churches to talk about the facts and to inform people about HIV/AIDS.

Unless the members of N/R review their stand on the HIV/AIDS issue, many lives will be lost. Unless the church in N/R reviews its call to ministry, the dying and the bereaved will never know of the love of Jesus Christ. Every individual needs to do something about counselling and caring, and to see Christ in the faces of those infected and affected by the HIV/AIDS virus:

Jesus said "...for I was hungry and you gave me food, I was thirsty and you gave me something to drink, I was a stranger and you welcomed me, I was naked and you gave me clothing, I was sick and you took care of me, I was in prison and you visited me." Then the righteous will answer him, "Lord, when was it that we saw you hungry and gave you food, or thirsty and gave you something to drink? And when was it that we saw you a stranger and welcomed you, or naked and gave you clothing? And when was it that we saw you sick or in prison and visited you? And the king will answer them, "Truly I tell you, just as you did it to one of the least of these who are members of my family, you did it to me" (Matthew 25: 35-40).

In discussing the above verses with the clergy, it has unanimously been agreed that Christ spoke specifically to the church to address the diverse needs of its people. AIDS can be singled out to test the obedience of the church to the Lord's call. The relevance is to exemplify the call to care.

The call the Lord made to Church leaders and to believers in general was to engage in the battle against the enemy. HIV/AIDS is a threat to the Christian Indians of N/R. This makes HIV/AIDS our enemy. The church leaders in N/R have a platform to proclaim the good news of Jesus, to bring people to his saving knowledge and to instruct on current issues. Besides this, the leaders must also disciple and train Christians to become care-givers. Christians need to respond to the call of God to engage in this battle against the enemy and to assist our fellow human beings.

The passage quoted above (Matthew 25:35-40) could relate to this dissertation in finding a solution to the myth that Christian Indians of N/R are not affected by the HIV/AIDS pandemic. It seems that our Lord prophetically knew that the church would neglect people when AIDS struck its heavy blow. When he was on earth, the Lord saw the neglect of the people and the wrong focus of the leaders. In a sense, the Lord corrected the focus of the church, as we know it. Wars cause casualties. The battle that Christians in N/R should engage in should not neglect or reject those who have themselves become victims of the pandemic that waged war against them.

We have seen that a united front is needed to fight this battle. Similarly, no single church can succeed alone, neither could any church stray away from biblical rules, as the church sees them, in fighting this battle. The church in N/R needs to combine its forces through gifted and called-out persons who are willing to

engage in this battle. In proclaiming the truth, the church should serve through caring. The theology of truth and the role of the clergy, Christians and the church should bring about counselling and care for people infected and affected by the HIV/AIDS virus.

## CHAPTER 5

### **Pastoral Counseling and Care**

#### **5. Introduction**

Some people have such great needs that, if help cannot be found, then disaster strikes. This help can be received through shared responsibilities. It would be inhumane if no one cared for other people. HIV/AIDS is so destructive that it is no longer only a problem for individuals but concerns society at large. The aspect of caring for each other becomes necessary in combating HIV/AIDS. Society is divided into numerous segments. Religion is one of the segments of society that is further subdivided into many faiths. All religions promote the idea of care for their people.

People everywhere have a need for meaning that will transcend their daily lives and relieve the suffering they see about them. Religion is the social institution that answers that need (Levy 1994: 2068).

Christianity, as a faith, is twofold in relationship. One is the calling to relate to God and the other to relate to fellow human beings. A vital role of the church is to offer pastoral care to those in need. Therefore this chapter will deal with some aspects of pastoral care of the church for N/R.

## 5.1 Theology of the Church

Most of the churches in N/R are seen as spiritual institutions for worship purposes only. In contrast to the biblical purposes for the existence of these churches, it seems that in N/R the mandate in this community to offer pastoral care has been neglected.

Jesus Christ shows this in his call to care for each other:

For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came to visit me... whatever you did for one of the least of those of mine who suffer, you did it for me (Matthew 25: 35- 40).

In the above verses the founder of the Church calls His followers to care for fellow humans. The writer feels that this call to care for those who are in need has been neglected by the church in N/R. Several theologians have contributed much in writing about such negligence and have suggested some solutions. One such person is Parkyn. Compassion is demonstrated in the life of Jesus, and it is also

part of the instruction he gave to those who inquired how they might follow him...In biblical imagery, the antithesis of compassion is 'hardness of heart'. Here compassion is dried up; the person characterized by hardness of heart can no longer see and feel the pain and suffering of others. The Pharaoh of the Exodus is the clearest biblical example of this attitude, Exodus 8:15 (Parkyn 1995: 244).

This lack of unity in community care efforts prompts the writer to examine views of the theology of the churches at large in N/R. There seems to be a vast gap in the way Christians relate to each other. This gap has given birth to a neglect of pastoral care

for fellow Christians. Thus the whole purpose and character of the church changes from being a caring community to being just a spiritual one.

The role of the church is to be a 'new community' which witnesses to the coming of the kingdom of God in the midst of the world. Relationships between Christians are to be characterized by love, justice, mercy and peace as these reflect the image and character of God and also the coming community of the city of God (McCloughry 1995: 108-115).

The writer's view is that the church should be seen as a sector of the community project which plays a vital role in the larger community. While worship is a fundamental activity of the church, it should not be its only activity. The church can influence the community in the way it develops. Biggar, a Master of Christian Studies, promotes the idea that the church should play some role in its community to influence a suitable environment for growth.

It is the small community that plays this role because it provides a suitable environment for the growth of intimate friendship, and so for the exercise of fraternal accountability, confession, and aid. This is the ecclesial model that many contemporary evangelicals have primarily in mind when they refer to the church as a 'family'. The virtue of this metaphor is that it holds forth appropriate ideals of intimacy, care and responsibility (Biggar 1995: 231).

Here again one finds the call for the church to play the role it was intended for. The exercise of fraternal accountability to God and to the members of communities places a challenge for every leader to stay true to the call of caring for others. Such a call should direct us to the great need among those that are infected and or affected by the HIV/AIDS pandemic. The church will always have opportunities to

demonstrate right attitudes towards the needy. The writer believes that failure in such a ministry will lead to neglect of the needy and will eventually result in the church having to give an account to God and society.

### **5.1.1. Church and HIV/AIDS: The Role of the Church**

HIV/AIDS is a complex issue. It is necessary to restate here that, medically speaking, there is no cure or guaranteed remedy for sufferers of this pandemic. Stigmas attached to the sickness result in denial and/or silence, which fuel the pandemic. This could lead to attempted suicides or the loss of the will to live, and so to early death. The Christian Indians of N/R live in this denial mode because of the stigmas attached to HIV/AIDS (Sister Sivaraman and Sister Praag 2001: Interview).

The church has been criticised repeatedly for its lack of input in helping fight the HIV/AIDS pandemic. The church fails adequately to teach and train its members to develop a program of home-based care for those patients. The church can respond to such criticism by providing pastoral care for those infected and or affected by the pandemic. In the light of such negligence, the criticisms leveled against the church have been substantiated.

Belafonte yesterday again criticised the church and religious leaders for their perceived tardiness in helping to fight AIDS. He said South Africa is a religious country, but churches have not fulfilled their obligation in dealing with HIV/AIDS (Natal Witness 2001:3).

In the light of the discovery of HIV/AIDS, Ronald Nicolson, Dean of Humanities at the University of Natal, Pietermaritzburg, presented a Christian theology about HIV/AIDS in his book 'A Christian Response' as early as in 1995. HIV/AIDS does not affect only Christians. It targets all people, irrespective of their faith. The love, mercy, grace and hope of God are available to all persons and not only to Christians. Through the church and individual Christians, all persons that are infected or affected could be reached through practical means (Nicolson 1995).

A Christian theology about AIDS must include a theology of sexuality and a consideration of sexual ethics. It must consider Biblical teaching, not only about sexual behaviour but about grace and forgiveness, compassion, and solidarity in suffering... It must take seriously the role of the church as a facilitator of the coming reign of God and of the human fellowship implied by that reign. It must embody love. On the one hand, churches must say clearly that AIDS is not sent by God as a punishment 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).

HIV/AIDS is the worst plague yet to strike humans. Mainline churches have been slow to respond to HIV/AIDS, which has already wiped out so many people, with Africa being the hardest-hit continent. This should have been a wake-up call to all churches to respond with the utmost urgency. Sadly, this picture remains the same today and this research shows that the situation in N/R is just the same. The call for the church to respond to the outbreak of HIV/AIDS was timeous, but the churches were hesitant in their response.

Until recently, the response from mainline Christian denominations has been hesitant. The WCC Executive Committee's statement notes that 'churches as institutions have been slow to speak and act; many Christians have been quick to judge and condemn of the people who

have fallen prey to the disease; and through their silence, many churches share responsibility for the fear that has swept our world more quickly than the virus itself (Reidy 1987: 47).

Sound Christian theology directs the church in the role it should be playing in the world today. Every generation find new challenges for the church to display sound Christian theology. In this generation the challenge is HIV/AIDS. In several mainline churches in N/R one finds that churches serve only themselves and, meanwhile, fail to see the challenges beyond their own comfort zones. Those churches are accused of being unmoved by the pain and suffering that are experienced even in their own communities. This is true also of the position and practice of the churches in N/R. The church is sent and has a social blueprint to serve the world.

The church cannot afford to exhaust itself in self-serving. If it does, it smacks of death. It may have been called to worship the Lord: it has also been sent to serve the world. The Master says: 'As the Father sent me into the world, even so I send you into the world' (John 17:18; 20: 21). Herein lies the blueprint for the church's social responsibility in the world: to fulfill that for which Jesus Christ was sent in the power of the Holy Spirit (Adeyemo 1986: 165).

By taking a closer look at the role of the church in N/R, it seems that Adeyemo provides a clue as to what the church should be doing. The church has been called and sent to serve in the world. No one has been more forthright than Susan Rakoczy, has been in describing the position of the church in relation to HIV/AIDS. She claimed that the church itself is HIV positive:

As the HIV/AIDS pandemic infiltrates every corner of South African life, it has been said that the 'Body of Christ is HIV positive'. This stark statement challenges us to realise that it is impossible to do

theology as if things in this country were normal – with our endemic problems of poverty, inequality, racism and sexism. Instead, we are confronted by the magnitude of a crisis which will dramatically change life in South Africa in less than ten years. Theologians must assist those who cry ‘Why is God silent?’ or who have perhaps decided that God has abandoned them to the ravages of terrible suffering and an early death (Rakoczy 2001:5).

It may be justified to apply Rakoczy’s criticism to the church. The reason the myth persists in N/R is because the church is dormant in its approach towards HIV/AIDS, in spite of the obvious opportunities to serve. ‘I propose to you that HIV/AIDS is not a problem to the church. It is an opportunity for the church. HIV/AIDS is not a curse! It is an opportunity for us to see ‘God’s grace manifested’ (AIDS in Africa 1996:2). The only way to avoid the pandemic destroying the Christian Indians of N/R, or of becoming uncontrollable, is by the church actively engaging in projects which address the problem and which seek solutions. The response from the Indian community will help gauge the situation in N/R.

The writer feels that any community becomes dependent on the churches for spiritual guidance and growth. The churches, however, would be strengthened if and when their members become mature and begin to serve others. Therefore, the churches need to focus on community projects that attract people of all faiths. Everyone ought to be included, so as to benefit from God’s grace when the church provides a haven of love and care. God does not confine His love and care only to those who are Christians, but embraces all people. Thus the church in N/R will need to review its

position on education, training and creating opportunities for service to reach all people.

Christians are bonded by a common destiny to serve in their community. The community needs to accept and care for those infected by the HIV/AIDS pandemic. The HIV/AIDS pandemic also calls for transformed lives to understand the fear, anxiety, pain and loneliness of those infected with the virus. Under normal circumstances each person will consider their own family and themselves. Each person can contribute to the sanctity of life.

### **5.1.2 A model for Christian Marriages and Family Life**

HIV/AIDS is fast destroying family support. Christian marriage values must include gender equity and human rights as a prerequisite in order to reduce the effects of the pandemic. The church must value Godly principles for families. One of the ways one can become infected with the virus is through sex. The church must encourage every married couple to be faithful to their spouses and abstain from sex outside of marriage.

Faithfulness in marriage is rare. Women have become used to tolerating their husband's promiscuity which is seen as a male prerogative...Society collectively denies the problem of AIDS attributing it to the problem of gays, drug users or North Americans only (AIDS in Africa 1996:38).

More needs to be done for godly marriages, “There is no longer Jew or Greek, there is no longer slave or free, there is no longer male or female; for all of you are one in Christ Jesus” (Galatians 3:28).

The Indian families have a track record of being closely bonded together in times of hardship. In this close family support system, if one member has a need, the family steps in to assist. This has its advantages and disadvantages. In the HIV/AIDS issue, the advantages can be seen from the point of view that there is always a support system. Unlike the situation in India, here in South Africa an infected person can go to family members for help. It also has its disadvantages. The family can be secretive about HIV/AIDS because of the stigma attached. They will live in denial and will refuse to break their silence. This was why the statistics of the disease among Indians were so difficult to obtain. Indians will not disclose their HIV status. Like Leila’s family, Indians will eventually be pressured to break the silence (Chapter 3). Otherwise the pandemic will take its toll.

At a time like this, when the crisis of AIDS is posing a threat to the physical and emotional health and welfare of modern society, the human family needs to rally its resources as it never has before in order to care for and counsel those afflicted with Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or who test positive for the antibodies to the AIDS virus (HIV+) as well as prevent the spread of AIDS (Perelli 1991:11).

Perelli calls for support from society. Indians have always enjoyed the close family support system. In N/R in the area of HIV/AIDS, counselling must be directed

towards helping the families to accept their HIV status and how best to break the silence so that the pandemic can be confronted.

## **5.2 Theology of Pastoral Counselling and Care**

HIV/AIDS has put to the church the greatest of all challenges thus far. Considering the theology of the church as set out by Parkyn (1995), Mc Cloughry (1995) and Biggar (1995), i.e. that the church should make an impact on its community, this challenges the writer to examine what the church can do in the light of the HIV/AIDS pandemic. One such ministry is HIV/AIDS counselling and care. Alta van Dyk (2002) presents a multidisciplinary approach. She defines counselling as being 'a structured conversation aimed at facilitating a client's quality of life in the face of adversity'. She also defines the aim of counselling as the helping of a client. This must always be based on the needs of the client. The counsellor's role is to 'facilitate the client's quality of life by helping him or her to manage problems, to effect life-enhancing changes and to cope with the kinds of problems that will arise in the future.'(van Dyk 2002: 200- 201).

According to van Dyk (2002: 201), the importance of counselling is part of alleviating the suffering of those infected and or affected by the pandemic. This is vital for the church in its ministry. The church needs to fulfill the role of caring for the needy people in its community.

In 2000 all efforts by the writer to mobilise the church in N/R, to set up combined efforts and ways to provide pastoral care to alleviate the sufferings of the people in this area, failed. As a result, this community still continues in denial and silence over the HIV/AIDS pandemic.

Several churches in N/R have already seen the effects of the pandemic, since it has claimed the lives of some of their members. Saras (Chapter three), who died of HIV/AIDS, was buried on Christmas Day (2000). Members of her family have confirmed that she had died of HIV/AIDS. As in the case of Saras, pastoral care has been denied to those victims who died without the ministry of healing, sustaining, guiding and reconciling, as discussed by Lartey.

Pastoral care consists of helping acts done by representative Christian persons, directed toward the healing, sustaining, guiding and reconciling of troubled persons, whose troubles arise in the context of ultimate meanings and concerns has become more or less a standard definition of pastoral care (Lartey 1997: 1).

The writer believes that such a ministry is sorely needed in N/R because of the effects of HIV/AIDS. The WCC also places that responsibility upon the church.

We affirm that the church as the body of Christ is to be the place where God's healing love is experienced and shown forth...As the church enters into solidarity with those affected by HIV/AIDS, our hope in God's promise comes alive and becomes visible to the world (WCC 1996:156).

From the above quotation of the WCC it is evident that the church is the agent for pastoral care. The N/R community has indicated to the writer that there is a need for pastoral care from the church in the times of crisis. The church does have a spiritual

and temporal mission toward its community, 'pastoral care in the church should be holistic, attending to all levels of human caring i.e. physical (temporal), moral and spiritual. Good pastoral care does not ignore the physical needs of a person or community' (Mwaura, 2000: 84).

It is common knowledge that the meaning and purpose of any church is to take up the challenge to facilitate a holistic lifestyle for the members of its community. The ministry of the church today envisions the understanding and focus of a community-based church. In each community the church establishment has various responsibilities toward its members: be it in terms of spiritual growth, social upliftment programs or pastoral counseling and care ministries in times of crisis. The church needs to respond to the day-to-day crises that the people face and, in this sense, HIV/AIDS has become a major disaster.

The call should cause the church not to sit back and wait for the pandemic to spread in proportions that will become impossibly alarming before they join the struggle against HIV/AIDS. Ignorance, silence, denial and a lack of ministry will have a damaging effect on the community at large.

A deep concern, associated with erasing the myth that Christian Indians of N/R are not affected by the HIV/AIDS pandemic, is that counselling and care ministries have been denied those Christians who have been infected and affected by the pandemic.

This is the very essence of the church's responsibility: to demonstrate transformed lives that are prepared to care for those who are perishing.

The early church demonstrated the same example that Jesus left behind and obeyed his command, "Cure the sick, raise the dead, cleanse the lepers, cast out demons" (Matthew 10:8). Ever since then, the modern church has moved away from this call of pastoral concern for people towards modern styles of worship, "...that the healing ministry, which in the past has been one of the main functions of the Church, has been lost in modern times" (Mwaura, 2000:72). In N/R there is ample evidence of people suffering from diverse burdens. However, throughout the country, times are difficult, and people need help. The church seemed to have failed the call to demonstrate care for people. In this harsh climate that we now live in, the church should pave the way of response to people's needs. HIV/AIDS has created the climate for such a shift. The present spiritual life and the life hereafter are important, but so are temporal needs and our concern for our fellow beings here on earth. Mwaura also takes the stance that the church has a spiritual and temporal mission to go by,

We have seen that [pastoral care] covers all aspects of disorder, which affect all levels of being. As such, pastoral care in the church should be holistic, attending to all levels of human caring, i.e. physical (temporal) moral and spiritual. Good pastoral care does not ignore the physical needs of a person or community (Mwaura, 2000:84).

This pastoral concern is the task of the whole church. The sick will always be around for the church to care for. In the event of one being very ill, or at the point of dying,

there is room for this concern to be exercised. The outward nature may perish quicker than the inner nature, “So we do not lose heart. Even though our outer nature is wasting away, our inner nature is being renewed day by day” (2Corinthians 4:16). The church must acknowledge this truth and mobilise its members to undertake a campaign against HIV/AIDS, even where the persons have full-blown HIV/AIDS and are perishing away. “Unlike other life-threatening diseases, AIDS is a disease with moral, psychological, social, economic and political repercussions” (Mwaura, 2000:94).

### **5.2.1 The Importance of Counselling**

Wittenberg (1994:61) asserts that counselling is ‘to mobilise the spiritual resources to enable the patients to cope with their physical pain’. The church needs to mobilise its people to do the work of the ministry to alleviate pain and suffering.

Pastoral counselling ministries are a major component of Christian ministry. Men and women from the community need to be disciplined and trained in ministry to come alongside sufferers who desperately need counselling and care. HIV/AIDS is massive, and pastors alone cannot cope or deal with the problems. Counselling is an important aspect of the church’s ministry in its community.

HIV infection and AIDS can lead to ill health and often emotional, psychological and social problems. These problems can also cause severe difficulties with relationships...AIDS is very much a disease of families. The infected people, their

partners and members of their family or close friends often need support during this difficult time... We usually solve our problems through a process of learning and experience. Sometimes we may seek help from a family member, a friend or a respected colleague. There are times, however, when even these people cannot help because the problem is too big, too new, too much of a secret or too strange. When this happens, counselling can be very helpful... People are often too scared or ashamed to speak to their family or friends about their condition or about their feelings and concerns... The counsellor can offer help which is fair, objective and balanced... AIDS can cause much shame, guilt and embarrassment... The counsellor and the client together can explore the issues and problems and find new or different approaches to dealing with them (Evian, 2000:14).

What seems to be needed in N/R is educated and trained counsellors among the churches to tackle the mammoth task of care-giving. The important different areas to consider in HIV/AIDS counselling are:

- a. Pre Test Counselling
- b. Post Test Counselling
- c. Family Counselling

#### **a. Pre Test Counselling**

The sad case of Leila (Chapter 3) highlights the importance of pre test HIV/AIDS counselling. I learnt from her family that Leila had received no HIV/AIDS counselling whatsoever. When Leila went to Edendale Hospital to have an HIV/AIDS test done, she discovered the concept among Indians that that only blacks suffer from the HIV/AIDS pandemic. She was the only Indian patient there that day. The stigma that only blacks suffer from the disease struck her so badly that when she got home she made her first, unsuccessful, attempt at suicide. Pre test counselling

could have prepared her adequately for the results. The lack of pastoral counselling in N/R denied Leila the guided ability of making informed choices.

Pre test counselling is a sensitive issue and enables the patient to adopt the right attitude towards the test and its results. Correct information about the test must be available to the person preparing for the test.

The aim of pre test counselling is to provide information to the individual about the technical aspects of testing and various implications of being diagnosed as either HIV positive or negative...Testing should be discussed as a positive act that is linked to changes in risk behaviour, coping and increasing the quality of life(UNAIDS 2001: 7.2).

#### **b. Post Test Counselling**

When Leila learned that she was HIV positive she lost the will to live. She attempted further suicides, also unsuccessfully. Both Leila and her family went into denial and silence about her HIV status. As a result she and her family were not at ease and received no emotional support. This was when Leila decided to end it all. But the fact that she was being guarded at all times left her with no opportunity to commit suicide. She then went on an intake strike. She refused food, water and medication, resulting in rapid physical deterioration. She ended up with full-blown HIV/AIDS, which was rapidly eating her away. At this stage, the family could not take the suffering. The mother then decided to break the silence. She phoned the newspaper, POST, and allowed them to publish the story. This was how the writer was able to come into the scene for counselling and prayer. Leila had reached the point of no return. She deteriorated further until she finally died.

In reviewing the situation in N/R, post test counselling is the vitally important aspect of preparing people for the life that lies ahead for them. The MWC Crisis Centre in N/R welcomed counselees for HIV/AIDS counselling. Unfortunately, those under their counsel who were listed as living with the virus were unable to break their silence and, as a result they live in denial. If they had broken their silence the statistics would have been less shocking. Post test counselling helps, through networking with different health services, with the result that such persons can get help and can be attended to. Post test counselling can encourage such persons, in very sick conditions, to receive home-based care. That will enable such persons to receive maximum care and demonstration of love. Post test counselling has to cater for the person's dignity from the very beginning until the very end. People who are denied post test counselling have struggled to cope with the disease and have ended up tragically. Counselling would have made a difference in their lives as well as the way they finally left this world. They live their lives in isolation and denial until it becomes too late. They knew their status, but never disclosed it to anybody. Counselling is very necessary because the emotions of 'fear, anxiety, distress, depression, helplessness, hopelessness, meaningless and loneliness' can cause destruction in the lives of infected and affected persons (Louw 1990:37). HIV/Aids affects the whole person.

A pastoral approach should realise that it is the sum total of the effects – biologically, psychological and sociological – of the virus on the person. The important point for ministering to the person with AIDS is to know That, although the basis of the disease is physical, the sickness penetrates to the spirit and affects the patient's whole being. AIDS causes an

existential crisis and brings the whole question of humanity and human dignity to the forefront (Louw,1990:38).

Those who have been infected and affected by the HIV/AIDS virus cannot cope with the struggle against the disease without the help of others. It seems that this kind of battle is unique. Never before has there been a pandemic that hit the human race that demanded that every person join the army against HIV/AIDS. The human body deteriorates as the virus takes its toll on a person. Finally, malfunction sets in the person with HIV/AIDS and the person becomes incapable of caring for him- or herself and becomes dependent on others. “The fear of rejection and alienation on grounds of stigmatization creates acute psychological needs” (Louw, 1990:40).

Christian counselling aims to leave such persons with hope. Christian ethics and ministry are based on hope for the perishing. Take this hope away and it leaves Christianity with nothing but fanaticism. This hope is based on the resurrection of Jesus Christ.

Hope is closely associated with meaning and refers to an anticipated sense of continued availability, endurance and persistence of an activity which will provide meaning over time”(D Barton *op. cit.* p 34) Being aware of the latter, pastoral care should be a facilitator of hope which transcends death. It is the Christian’s hope, with its basis in the resurrection of Christ, which provides a meaningful framework in fulfilling the patient’s need for a “sense of aliveness”. It is the resurrection hope in Jesus Christ which can penetrate the struggle of the AIDS patient and assist him to restructure his situation to spiritual growth ( Louw, 1990:40 ).

Sagren Moodley (Chapter 3) was a good example of someone who was fortunate to have received both pre test and post test HIV/AIDS counselling. Sagren seemed

healthy to the writer when he was visited. He was receiving regular hospital treatment and enjoyed the full support from his new church. He testified that the love shown to him from the church helped him to survive thus far and he was confident that with that kind of counselling and care he could go a long way, instead of just giving up the will to live. From what was discovered through Sagren, it seems that his present church had successfully combined counselling and care.

### **c. Family Counselling**

Family counselling is crucial in providing holistic care for the sufferer. The family plays an important role in encouraging the sufferer to adopt a right attitude towards what is happening to him or her. The family needs to understand that there is no cure at present and that death is inevitable, until a cure can be found.

Coming back to Leila's case, it shows that the family did not know how to cope with the situation. Leila's death struck a heavy blow to the family. Sadly, the mother suffered the most. Her health deteriorated. She died within a few months of the death of her daughter. Family counselling could have prevented most of this. Molly's family have been torn apart after her death. Some members still live in continual denial, which has divided the family. Family counselling could have prevented this. Sagren's was the only fortunate case that is known. His family had undergone counselling on how to accept the tragedy. They still receive counselling on how to

cope. They are doing very well. Family counselling plays a major role in helping families to accept and cope with the HIV/AIDS situation.

### 5.2.2 A Model of Care

Egan's (1975) model of helping and interpersonal relating can be accepted as a model of care. His model is:

#### Stage 1: Responding/ self-exploration

*Helper's goal: Responding*

To respond to the client and what he or she has to say with respect and empathy; to establish rapport, an effective collaborative working relationship with the client; to facilitate the client's self-exploration.

*Client's goal: Self-exploration*

To explore his or her experiences, behavior, and feelings relevant to problematic in his or her life; to explore the ways in which he or she is living ineffectively.

#### Stage 2: Integrative understanding/ dynamic self- understanding

*Helper's goal: Integrative understanding.*

The helper begins to piece together the data produced by the client in the self-exploration phase. He or she sees and helps the other identify behavioral themes or patterns. He or she helps the other see the 'larger picture'. He or she teaches the client the skill of going about this integrative process himself or herself.

*Client's goal: Dynamic self- understanding*

Developing self- understanding that sees the need for change, for action; learning from the helper the skill of putting together the larger picture for himself or herself; identifying resources, especially unused resources.

#### Stage 3: Facilitating action/acting

*Helper's goal: Facilitating action*

Collaborating with the client in working out specific action programs; helping the client to act on his or her new understanding of self; exploring with the client a wide variety of means for engaging in constructive behavioral change; giving support and direction to action programs.

*Client's goal: Acting*

Living more effectively; learning the skills needed to live more effectively and handle the social-emotional dimensions of life; changing self-

destructive and other-destructive patterns of living; developing new resources ( Egan 1975: 31).

Such a model, if practiced by the church of N/R, would bring the church into line with biblical teaching on the subject of caring for each other (Matthew 25: 35- 46). This then is a disciplined model to follow. In the light of those who are infected and or affected by the HIV/AIDS pandemic, this model guides the church in the steps to follow in caring for them. The church would be wise to train caregivers according to this model, so that a high standard of caregiving could be maintained. The clients will gain confidence in the caregiver if such a high standard of caregiving is followed. This then will cause those who have been infected and/or affected by the pandemic to disclose their status willingly. This could in turn have an influence on the attitude of denial and silence that is so prevalent among those with HIV/AIDS in N/R.

The reason that the writer has titled this section 'Christian care', instead of 'Pastoral care', is because pastoral care can be misunderstood by the members of a church to be a task for the clergy and not one for the Christians themselves. All Christians need to express God's love and concern through acts of caring and serving.

Lartey's definition of Christian care is helpful, because it combines pastoral care with helping acts. To care truly is to be able to do something to alleviate the suffering of people. The focus should be on action. Secondly, pastoral care is a Christian term that calls for all Christians who represent the Christian faith to serve

others. This task is not reserved for just the clergy. The focus should be on getting every Christian involved. Thirdly, the troubled people need pastoral care. The focus should be on those persons who are troubled. And, fourthly, Lartey calls Christians to stay within the context of the troubled person. By this it is understood that the focus should be on the problem or need (Lartey 1997:1-14).

It is quite easy to drift away from the essentials in expressing Christian care. All along, the church in N/R has focussed much more on the spirituality of believers than on acts of service. This spirituality was determined by the way Christians worshipped, served in church leadership and gave to the church, even though the church did nothing for that community, and it identified more with the local church and the pastor rather than with Christ and the suffering masses. The service or care aspect amounted to very little, or nothing. Christians were not taught to serve. Now that HIV/AIDS has hit N/R, nobody knows what to do or how to do it. The Christian's focus should be for the good of the patient,

The framework for demonstrating this salvation is the community of believers (corporative dimension). The body of Christ is a healing community which is expressed as *koinonia* in Christian love (*agape*) (Louw, 1994:66).

It takes mature Christians both to understand and to implement Christian care for the needy. The culture of caring for others should be the focus. The apostle Paul gave the following advice to the church at Ephesus:

...to equip the saints for the work of ministry, for building up the body of Christ...to maturity...we must grow up in every way into him who is the head, into Christ, from whom the whole body, joined

and knit together by every ligament with which it is equipped, as each part is working properly, promotes the body's growth in building itself up in love (Ephesians 4:12-16).

We are called to witness the presence of God to those that are infected and affected by the HIV/AIDS virus. Many victims of certain circumstances demand to know where God is in their struggles and, as Louw (1994:77) claims, they "rant, rave and blaspheme". Unless Christians come alongside them and demonstrate God's love and care, they will never know that God is present at all times. This offers a challenge to us in N/R to teach the love of Christ, which is to be demonstrated in caring for others, to develop community projects that address and provide care for the struggling.

### **5.2.3 Basic skills for Christian Counselling**

Counselling is a service offered by the church to those that seek help (Vaughan 1987). According to Vaughan (1987: 16- 30) apart from other skills, counselling may include consoling the bereaved, visiting the sick, attending, listening and supporting skills, so that the needy person can help themselves in times of crisis.

Personnel trained in pastoral counselling are crucial. Pastoral counselling is not a pastoral conversation, not a time to give spiritual direction, not just giving advice or not just an analysis of the problem (Vaughan 1987: 16- 30). The task of counselling may be approached from one of three directions:

1. As an expert
2. As an interested and understanding helper
3. As a facilitator in the process of problem-solving  
(Vaughan 1987: 16-30)

From the writer's own experiences in counselling, the act of listening to the distressed can be a healing balm to them. The counsellor allows the counselees to empty themselves of the load of pain and sorrow. Sometimes the counsellors just need be good listeners.

In the counsellor's having to deal with those infected or affected by the HIV/AIDS pandemic, the writer refers to Louw's (1994) guidelines for pastoral care.

Pastoral care must deal with the problem of stigmatisation. When pastoral care is indeed an illustration of the love of God, the only way to break through the problem of stigmatisation is to practice an ethics of love. In the case of AIDS, pastoral ethics consist of the following components:

- a. *A realistic insight and understanding* which acknowledges reality and does not play games. The fact is: the disease can be fatal. An ethic of love operates with the reality of the AIDS patient's adaptation to mourning and grief.
- b. *Empathy*. The message must be brought home: 'I understand your loneliness, anxiety and feelings of guilt.' An ethic of love accepts the AIDS patient unconditionally.
- c. *Support*. The complete attitude of the pastor should be: 'I am here, I am available, and you will not suffer or die in isolation.'
- d. *Imparting meaning*. Adaptation and interpretation of meaning implies: Although these patients cannot change their illness, they can *change their attitude* by means of a constructive understanding of God. The image of the suffering and loving God conveys hope, despite suffering and pain. (Louw 1994: 129- 130)

To date, there is still no cure for HIV/AIDS. It would be futile for the caregiver to make promises that may never materialise, such as promising that the person will be healed from the pandemic. The caregiver is required to stay within the framework of caring, and not that of promising. Such caring, then, should display love for the infected or affected person. The patient must be accepted unconditionally. The caregiver should refrain from all forms of judgment of the other person.

The patient ought to be told the truth. However, the caregiver should promise truly that he or she would be available to care regularly. Such a promise can be fulfilled. This will bring confidence to the patient. The caregiver should aim to help the patient to accept the illness and strive to live with a positive attitude. In N/R, such pastoral care could have a tremendous impact on those infected and/or affected by the pandemic. The church in N/R could be the source of such care giving, because it has been mandated to fulfill its purpose (Matthew 25:35- 45).

#### **5.2.4 Relating the Models to the needs in Northdale/Raisethorpe**

HIV/AIDS has ushered in an opportunity for the church to counsel and care for those who have been infected and affected by the pandemic. Egan's (1975) model of care (page 88) and Louw's(1994) model of counselling (page 91) could be easily applied in a practical way by the church in N/R.

Both the care-giver and the client could follow the steps in counselling and caring.

In this dissertation, it has been shown that the community in N/R has been denied access to counselling and care from the church. The silence, denial and fear contributed to such a failure. If applied, the models by Egan and Louw could also assist the church in the training of care-givers.

### **5.2.5 Death and Dying**

The church is often called upon to come alongside those who are dying or a family who are just about to lose a loved one. Under these traumatic circumstances, it is very difficult to counsel the dying or the affected persons. The situation in N/R is no exception at all. The case studies in chapter three show that there are persons who are infected and affected by the HIV/AIDS virus and are in need of pastoral care. The figures in KZN are quite alarming.

The mortality rate is ever increasing because of HIV/AIDS. If the percentages are translated into figures, then an estimated 1 115 000 adults in KZN are infected already. There are about 71 000 people living with AIDS and in 2000 there will be an estimated 53 500 deaths...many of these deaths and most of the orphans are inevitable as they are a consequence of infections that have already taken place. (Whiteside and Sunter 2000:71)

The HIV/AIDS figures for South Africa are the highest in KZN. N/R, as part of KZN, also needs the church to make itself available to provide pastoral care for those infected and affected by the virus, especially those that are dying. The dying may better cope with the reality of their situation if accompanied by caregivers.

Death is not an occasional nor an isolated occurrence in N/R. Death is common and people attend funeral services in large numbers owing to the Indian culture. Daily the undertakers are kept busy. To draw a parallel here, it is safe to say that if so many deaths occur each day then the church should be busy indeed in pastoral care for those that suffer grief. If such deaths are not sudden, then the church is also called to counsel to prepare such victims for death. Just officiating at the funeral services may be insufficient impact for the church to make in its community. The church needs to do much more. Both the dying and the bereaved need pastoral care from the church.

Louw (1994) describes four types of need for pastoral care for the dying, as follows:

- a. Terminal patients have *biological and physical needs* which are relevant to pain and their fear for deformation and discomfort.
- b. *Psychological needs* relevant to the conflict: continuation of life and adapting to the inevitability of death. In this psychological process, which alternates between contact and separation, continuing and ending, there are two central emotional reactions: denial ('It's so unreal') and anxiety ('I fear the loneliness and isolation of the dying moments'). The crux of the psychological crisis is helplessness. What the dying fear most is not death itself, but the process of dying.
- c. *Social needs* of the terminally ill revolve around the need for understanding people to be near. Their being there and being available is vital to the dying who have a need for stable relationships and the expression of love, tenderness and intimacy. The core of their social crisis is: Having to part from their loved ones. In the final analysis, facing death is a state of being completely alone.
- d. *Spiritual needs* of the dying revolve around the desire to die with human dignity, to die with hope and to enter into death meaningfully. Central to the spiritual crisis is doubt and despair. This experience of despair is exacerbated when the dying experience how their lives diminish to a minute speck, the so-called tunnel vision of life. This gives rise to anxiety, which is worsened by acknowledging the absence of a future and that time is running out. The future is telescoped into the present, creating a sense of urgency (Louw 1994:170-171).

### **5.3 Counselling and Care Centre**

The writer advocates that a community centre may attract either the infected or affected persons who would need counselling. Such persons need somewhere to go to with their problems and/or someone to talk to. In such a situation the church that uses its premises as a centre will impact upon the community by creating an opportunity to interact with people.

When a person has AIDS the pastoral counsellor or pastoral caregiver has a unique opportunity to interact with not only that person but also the entire family. The church offers multiple points of entry into the family- probably more so than any other 'system' (Perelli 1991:13).

It seems that suffering is an accepted process of life. It is best to adopt the stand that Jesus took when he saw those who suffered. He came alongside those who suffered and set the perfect example. He showed compassion to those who suffered, (Luke 7:13). He has called us to follow His example, reaching people at the point of their need. The HIV/AIDS pandemic creates the kind of opportunity to show compassion to those infected and affected by AIDS. Kirkpatrick expands on this, calling it a people's ministry,

The Church is expected to be a 'people's ministry' to all the people of God, and especially to the marginalised, the sick, the suffering and those who suffer with them. It is expected to support those involved in pre-bereavement and bereavement counselling (Kirkpatrick 1988:97).

Kirkpatrick shares the same views as those that the Christian must consider, in every situation, to do what Jesus would have done. In N/R there is a great opportunity for the church to engage in people's ministry.

The community becomes dependent on the churches for spiritual guidance and growth. The churches, however, would be strengthened if and when its members become mature and start to serve others. Therefore the churches need to focus on community projects that attract people of all faiths. Everyone, of all faiths, ought to be included in benefitting from God's grace whenever the church provides a haven of love and care. So the church in N/R will need to review its position on education, training and creating opportunities for service.

Christians ought to be bonded with a common objective to serve in community as a family of God. As a community, Christians need to accept and care for those infected and affected by the HIV/AIDS pandemic.

#### **5.4 Existing HIV/AIDS Church Ministries**

Although the HIV/AIDS pandemic has reached this region, and case studies presented in this thesis substantiate this, regrettably the perception is that HIV/AIDS does not affect the Indian community. The attitude observed is that HIV/AIDS is an African disease. Until now, there has been no Christian ministry in N/R to address the community needs related to HIV/AIDS issues. The writer's own church

community has set up an HIV/AIDS awareness and education program to the level of home-based care for its members through the Evangelical Seminary of South Africa (ESSA) Christian AIDS Program (ECAP) and Gateway Projects. The volunteers have just completed the program through ECAP in preparation for implementation of services needed in this community. Men and women are being trained to respond to the call to serve people at the point of their need, namely HIV/AIDS. Unfortunately other churches have not responded to the call. On the contrary, every sector of life has been affected by the HIV/AIDS virus, “Indeed, there is no sector of our lives that is not affected by this deadly virus” (Mfayela 2001:2).

#### **5.4.1. Other Christian Ministries**

The only ministry that the church can boast about is that HIV/AIDS is one of the Big Six Issues of the combined Church in Action (CIA). CIA is made up of some of the city churches. This is a city-wide drive led by Pastor Craig Botha of Pietermaritzburg Christian Fellowship. The church in Northdale/Raisethorpe has not as yet set up an HIV/AIDS counselling and care centre. Pastor Victor Rhandran of Bethlehem Baptist Church in N/R said that they have not had any HIV positive persons in their congregation. Colin Naidoo of Patmos Assembly, Father George Lawrence of Holy

Angels Anglican Church and David Perumal of Ephesus in N/R echoed the same sentiments.

#### **5. 4. 2 Christian Care**

This is the task for the whole church to engage in caring for those who are in need. Christians everywhere need to express love and concern, through acts of caring and serving. Christians were not taught to serve people. Now that HIV/AIDS is visible in N/R, nobody knows what to do or how to do it. The Church's focus is far from positioning itself to bring healing to its community.

In keeping with the mission of caring for others it takes mature Christians both to understand and to implement Christian care for the needy. The culture of caring for others should be the focus. This offers a challenge to all people, irrespective of faith, in N/R to teach love which is to be demonstrated in caring for others, to develop community projects that address the needs and to provide care for the struggling.

#### **5.5 Concluding Remarks**

The writer feels that, whilst suffering is an accepted part of life, so too should caring be accepted as part of it. The HIV/AIDS pandemic creates the kind of opportunity to show compassion to those infected and affected by AIDS. Kirkpatrick expands on this call as calling it a people's ministry,

The Church is expected to be a 'people's ministry' to all the people of God, and especially to the marginalised, the sick, the suffering

and those who suffer with them. It is expected to support those involved in pre-bereavement and bereavement counselling (Kirkpatrick 1988:97).

Kirkpatrick shares the same views that Christian must consider, in every situation, to do what Jesus would have done. In N/R there is this opportunity for the church to engage in people's ministry.

Indian families have a track record of being closely bonded together in times of struggle. If one member has a need, the family steps in to assist. This has its advantages and disadvantages. In the HIV/AIDS issue, the advantages can be seen in that there is always a family support system. Unlike the situation in India, here in South Africa an infected person can go to family for help. It also has its disadvantages. The family can be secretive about HIV/AIDS, because of the stigma attached. They will live in denial and refuse to break the silence. This was why, in this research, the statistics of AIDS among Indians were so difficult to obtain. Indians will not disclose their status. Like Leila's family, Indians may eventually be pressured to break the silence. Otherwise the pandemic will take its toll.

In N/R, HIV/AIDS counselling must be directed to help families to accept their HIV/AIDS status and to break the silence. People infected and affected by the HIV/AIDS need to be accepted and loved by their families, by friends and by members of their community. The family and friends can help ensure that a nutritious diet is followed. The church is a community project. From their

community the PLWA's will need to be assisted with home-based care to help them live longer and more comfortably. The clergy need to counsel others for pre-test and post-test depression, and spiritual needs such as repentance, forgiveness, guilt, shame and loss of will to live. The clergy are required to educate their members to respond as Jesus would have done to those infected and affected by HIV/AIDS. The victims will need friends to help them overcome loneliness and despair. "...good counselling assists people to make informed decisions, to cope better with their health condition, lead more positive lives, and prevents further transmission of HIV" (AJNM 2001: 7.1).

The silence, denial and lack of ministry by the church have been shown to be a pastoral concern. The church in N/R needs to provide a healing ministry. While this is not what we see at present in N/R, it is of great concern to those who are perishing. It has been shown that the church has moved away from ministries that demonstrate concern and care. The stigma attached to the HIV/AIDS pandemic forces the Indian dominated churches of N/R also to move in denial, silence and failure to provide a haven for sufferers. Unless some sort of transformation takes place in N/R, the HIV/AIDS pandemic could penetrate deeper into this society and result in alarming numbers of deaths, which could be avoided if the church acted promptly.

Medical institutions concern themselves with treatment for sufferers. The HIV/AIDS pandemic has highlighted a need for everyone to join the struggle to combat this virus. Again, sound moral teaching through the church would empower its members

to practice safe sex. In this the Christian standpoint would be to be faithful to one's spouse and to abstain from pre-marital sex. The church relies on the biblical teaching about marriage, i.e. of one husband to one wife. The church must discourage all forms of immorality.

In this chapter we have seen that the situation in N/R can change. The Christian Indians are being infected and affected by the HIV/AIDS pandemic. It has become apparent that Christians, clergy and the church could play a role in removing the myth and replacing it with positive counselling and care. It has been shown that pastoral counselling and care could lighten the plight of the sufferers and alleviate their suffering.

People infected and affected by the HIV/AIDS pandemic need to be accepted and loved by their families, friends and members of their community. The family and friends can help ensure that a nutritious diet is followed. From their community the PLWA's will need to be assisted with home-based care to help them live longer and more comfortably. From the clergy they will need to be counselled for pre-test and post-test depression, and spiritual needs such as repentance, forgiveness, guilt, shame and loss of will to live. The clergy will be required to educate their members to respond as Jesus would to those infected and affected by HIV/AIDS.

## **CHAPTER 6**

### **Conclusion: Till HIV/AIDS Do Us Part**

#### **6. Introduction**

There has been a lot of fear among Christians in N/R in welcoming a person living with the HIV/AIDS virus, let alone in making contact, sharing the communion cup or embracing. At Community Bible Church, Ruby, a Christian PLWA, was invited to share her testimony. This was the first time that this congregation came face to face with a person living with the virus. Her moving testimony of how the Lord sustained her in all these years was heard and captured the hearts of the people. The congregation were taken aback and felt guilty that they could have distanced themselves from her. All were convicted of their attitudes. This was a turning point in this church. Some of them cried. When Ruby had finished witnessing the congregation was called to pray a prayer of confession and to seek forgiveness from the Lord for themselves. A major breakthrough for the church resulted from this. Christians of this church went over to the infected person, hugged and kissed her on the cheek.

This resulted in a good turnout for the first HIV/AIDS Education Program. This comprised seven weekly sessions of two hours each. Each week saw a good turnout. Commitments were made to work together as a church in the N/R area to help counsel and care for those infected and affected by the virus.

This was a practical way to break down some of the barriers that hold back these Christians from accepting those infected with the virus. The clergy in N/R need to redirect their congregations by means of some practical theology. Just to pose as pious, sinless beings and by judging persons who are HIV positive does not help Christians to bear the suffering of others. People need to understand the fear, anxiety, pain and loneliness of those infected with the virus. This new approach should prompt us to do something for those who have been infected and affected by the HIV/AIDS virus. Each person can contribute to the sanctity of life.

### **6.1 Stemming from this research**

*'Till HIV/AIDS do us part'* was chosen as the title for this chapter because of the extent of the damage that HIV/AIDS is causing. HIV/AIDS is wiping out people at such an alarming rate that it becomes uncertain as to who is next and what we should be doing in the interim. The usual saying *'till death do us part'* has been changed to arrive at this title. The meaning of this title is that we question ourselves as to what can we do for our fellow beings until HIV/AIDS takes them away from us. This deals with the period in which an infected or affected person faces the sting of HIV/AIDS. This period is crucial for Christians and the church because of the opportunities it gives us to put into practice what the Lord would have us do.

## 6.2 The Church in Action

Is such a world not that which is transformed by the One whose heart was moved with compassion towards a creation in pain and suffering? Jesus Himself, as Savior and Lord, went visiting all towns and villages teaching, preaching and healing. Into this world He sends His followers to be a healing and restoring community. His body, the church is challenged to pour out all its resources into such a need as HIV/AIDS that is presently so much in evidence (Hackland 2000:22).

In the case of N/R and the HIV/AIDS issue, from the previous chapter, it is learnt that education and certain ministries need to be provided by the church. The people of N/R need to become aware of the details of this pandemic and know that the church cares for them even in times of crisis. The above quote lends support to the fact that even in N/R the church should be “pouring out its resources” into the struggle against AIDS (Hackland 2000:22). The writer feels that, if the church moves into action, then the myth about Christian Indians and HIV/AIDS in N/R would slowly diminish.

The clergy interviewed unanimously claimed that people perceived HIV/AIDS as a Black person’s disease, (Lawrence, Naidoo, Perumal and Rhandran, interview: 2001). The people adopt judgmental attitudes and blame the pandemic on promiscuity. The hope of establishing a counselling care centre to deal with all forms of community needs still remains a dream. Community needs include other social crises, such as women and child abuse; poverty; the homeless; the HIV/AIDS pandemic; and the high rate of teenage suicide in N/R. The church needs to fulfill the diverse needs of its community. The church requires answers to such needs and steps

must be taken to mobilise the community both to address and to provide guidelines for the infected and affected people. In N/R the myth that HIV/AIDS is not a threat to the Christian Indians calls for a response from the church. K. Wilson (1988) makes a meaningful contribution in this matter:

In a situation where a section of religious people is deprived of material conditions and thereby the possibility for human self-emancipation, and in view of the mythological world-view that constantly comes in the way of its progress, the most urgent and the best possible task we can think of exercising is to confront such people with contextual meanings of the outmoded mythological notions. This helps toward the disclosure of their false consciousness and their exposure to authentic human existence (A Reader in Dalit Theology [1988]: 151).

Wilson also looks at the church that fails to provide appropriate action in response to the people's needs as a church that fails to address myths among its members. In N/R the church needs to move into action to address the AIDS issue. The myth about the HIV/AIDS pandemic calls for the church to confront the people through education, in the hope of eradicating this myth. This would release the people from such myths and help them to establish the needed action against HIV/AIDS.

### **6.2.1 HIV/AIDS Training for Workers**

Through networking with ECAP and Gateway Projects, the writer, being influenced by the results of this research, has already embarked on a program for the church to engage in practical theology. This program started off with a major workshop to bring about HIV/AIDS awareness. The deputy mayor, Counsellor H. Zanele of Msunduzi Council, Benson O. Manu from ECAP and Pastor Mbulelo Hina of

African Enterprise were the guest speakers. They spoke on different aspects of the pandemic and how it was affecting even the society of N/R. The turnout was overwhelming, with majority of the audience being Indian pastors and church leaders. This was important because they could take the awareness further into the Indian community through their churches. This may result in changed attitudes towards the silence, denial and cultural stigmas.

This was a major breakthrough for the people of N/R. The HIV/AIDS awareness program has led to several persons coming forward to volunteer in pastoral care. A standard for quality Christian care has been created. The coordinator encourages professionalism and seeks persons that can be approached to be care givers. Through ECAP, seventy-two candidates have now successfully completed the Phase One HIV/AIDS Training. This seven-week course dealt with the theory part of HIV/AIDS. Out of that number of trained persons, twenty-six persons successfully completed the Phase Two HIV/AIDS Training. This five-week course dealt with the practical aspects of the HIV/AIDS training. Other groups are in line for training to engage in pastoral care for those infected and/or affected by HIV/AIDS.

### **6.2.2 Projected Ministries**

The above candidates, who volunteered and have been trained to engage in practical theology, will be used to exercise their gifts and talents in this ministry. This

ministry will also embark on recruiting workers and arranging training for them before enlisting them in ministries.

### **6.2.3 Counselling and Care Centre**

The northern suburb of N/R requires a venue as a centre where needy persons could come for help. HIV/AIDS in N/R has too many stigmas attached to it. Owing to these stigmas, those who are infected or affected may not seek help from an AIDS centre. If wisdom has to be applied then the care centre has to be seen as a centre for various community needs. Such needs may include a strategy to alleviate the plight of those in poverty. This can be achieved through feeding schemes etc.

The centre can also attract abused persons and others who need pastoral counselling and care. Networking with existing organisations could create a satellite ministry. There are places such as Child Welfare for orphaned children, SANCA for drugs and substance abuse, Bethany House to accommodate PLWAs, Gateway Project for life skills training, etc. People could be referred to the right place, according to their needs, for continued help so that the centre does not duplicate the existing ministries. Those that are infected with or affected by HIV/AIDS could feel more comfortable to approach such a community centre for help. In this way the church can interact with PLWAs and their families.

#### **6.2.4 Project Development**

A property has been identified that would be very suitable for a community care project. Community Bible Church has made progress towards purchasing this property. The project is called Entabeni Community Care Centre. Applications for a welfare number and registration are being processed.

### **6.3 Implications of this study**

Through this study it has been discovered that HIV/AIDS is taking its toll silently on the people of N/R. It has also been discovered that the church has not reacted speedily to the needs of those that were infected and affected by the pandemic. The church had neglected pastoral care for these people. Now that the discovery has been made, the stand that the church takes in dealing with this virus in its community is crucial. This dissertation has shown that N/R is not exempt from the sting of the virus. The only struggle encountered was that Indians were not free to disclose their HIV/AIDS status. This was discovered as we looked at stigmas attached to the HIV/AIDS pandemic. However, we encountered the families of people like Leila, Saras, Sagren, the Indian father of the HIV positive child, and those who felt that they were not ready to break their silence, and this helped prove that, in spite of their denial and silence, Indians were indeed infected and affected by the HIV/AIDS pandemic. The medical personnel interviewed, who regularly attend to HIV positive Indians requiring treatment for this very ailment, confirmed this. Statistics presented

showed that Northdale Hospital has an HIV/AIDS wing catering for numerous HIV/AIDS patients, including Indians from Northdale.

The church can no longer deny that the HIV/AIDS virus does not affect Christian Indians in N/R. Pastors and church leaders need to come to grips with this reality.

Strong leaders are needed to educate, motivate and stimulate interest among community churches of N/R to unite against the struggle. There are several seminars and talks on HIV/AIDS on offer. Youth for Christ, ECAP, Church in Action and Community Bible Church have made available free seminars to assist the local churches.

The church cannot be criticised forever. If every church in the community could actively participate in these programs, then criticisms leveled against the churches would be unfounded. In tackling this pandemic the voice of the church can make a difference. Acceptance, and a call for Christians to break their silence would take place if such a call came from the church.

#### **6.4 Concluding Remarks**

The plight of those infected and affected by the HIV/AIDS virus must be given priority. It has already been established that the task of the church is not to judge but to serve. To alleviate the suffering of those infected and affected by the virus, the community needs structures or projects to be set up. Counselling and care should be

the key components of such projects. Confidentiality must be adhered to. The project should welcome people of all faiths from the community. This may become an opportunity for some to get to know the Lord and the salvation of God.

Discipling and training would be essential in order to set up such a centre. The churches in the community have to send gifted men and women to undertake such training and skills programs in order to become fully equipped to do the task of counselling. Such a centre has to gain the confidence of the people. The centre is required in order to attract HIV positive persons, against the stigmas attached, to come forward for counselling.

From what the writer has learnt through networking with other institutions, the best way to bring maximum care to those infected and affected by the virus is to practice home-based care. Instead of starting another hospital in N/R, teams of caregivers must visit the sick and the afflicted in their homes. This could be cost-effective. People can be treated in their own homes.

The poor experience great difficulty in caring for themselves. Caregivers can administer funds for essential needs such as blankets, food, sanitation, and non-prescription medication. Much can be done to alleviate the suffering of persons living with the virus.

The church in N/R is obligated to the people to conduct a healing ministry. This, sad to say, is not what we can see at present in N/R. The stigmas attached to the

HIV/AIDS pandemic force the Indian-dominated church also to respond in denial, silence and failure to provide a haven for sufferers.

Medical institutions concern themselves with medical and psychological treatment for sufferers. The HIV/AIDS pandemic has highlighted a need for everyone to join the struggle to combat this virus. In this the Christian standpoint would be to be faithful to one's spouse and to abstain from pre-marital sex. The church relies on the biblical teaching on marriage, i.e. of one husband to one wife. The church must discourage all forms of immorality.

During the writing of this thesis I have gained much by way of education and exposure. I have also seen Christ Jesus our Lord in the eyes of those who suffer. HIV/AIDS may be the worst pandemic ever, but the I have been awakened to the fact that something can and must be done about it.

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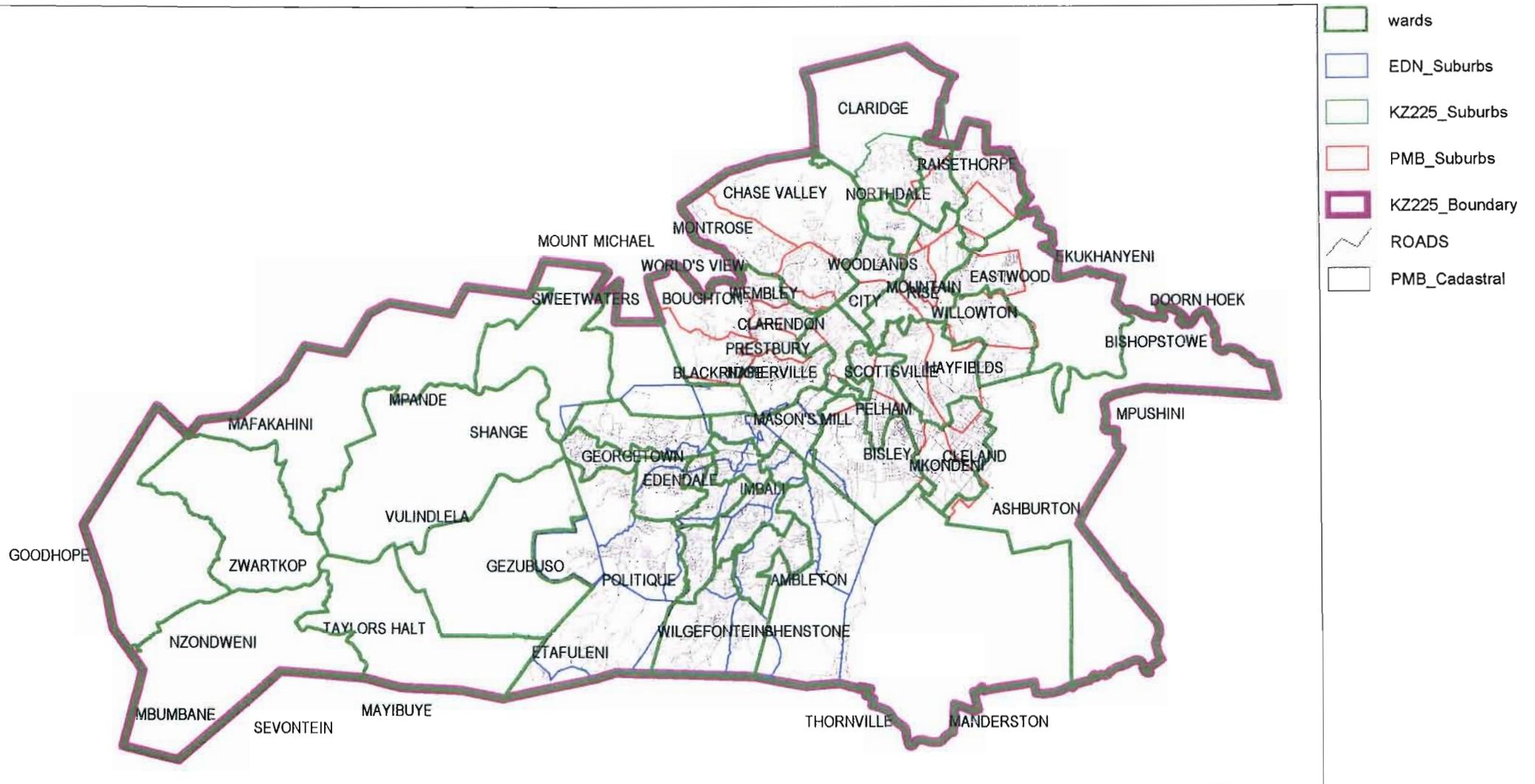
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**APPENDIX No 1**

**Map of Pietermaritzburg**

# Pietermaritzburg Borough



**Appendix No 2**

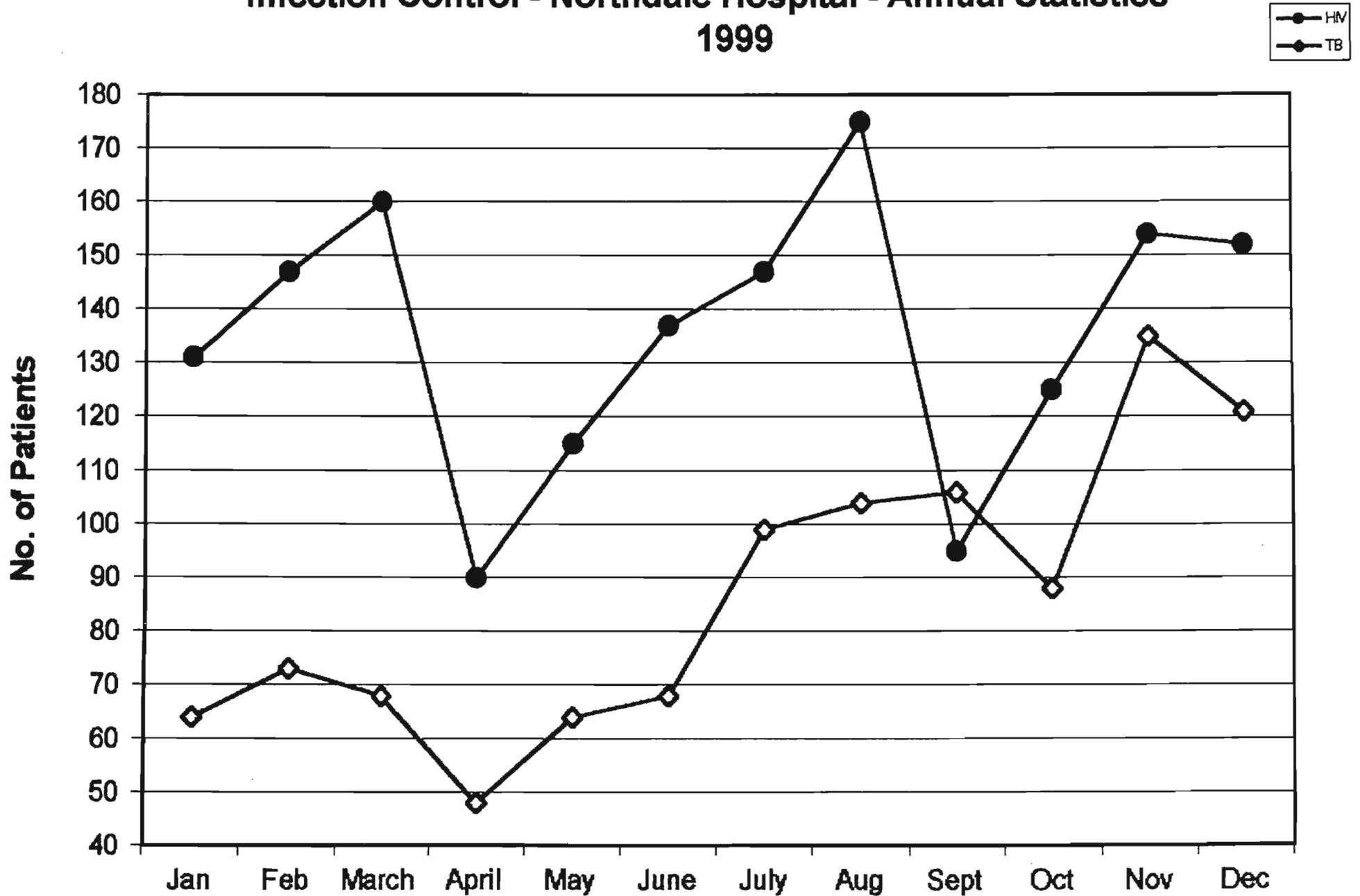
**Map of Northdale/Raisethorpe**



**Appendix No 3**

**Northdale Hospital: Infection Control Statistics**  
**1999**

# Infection Control - Northdale Hospital - Annual Statistics 1999

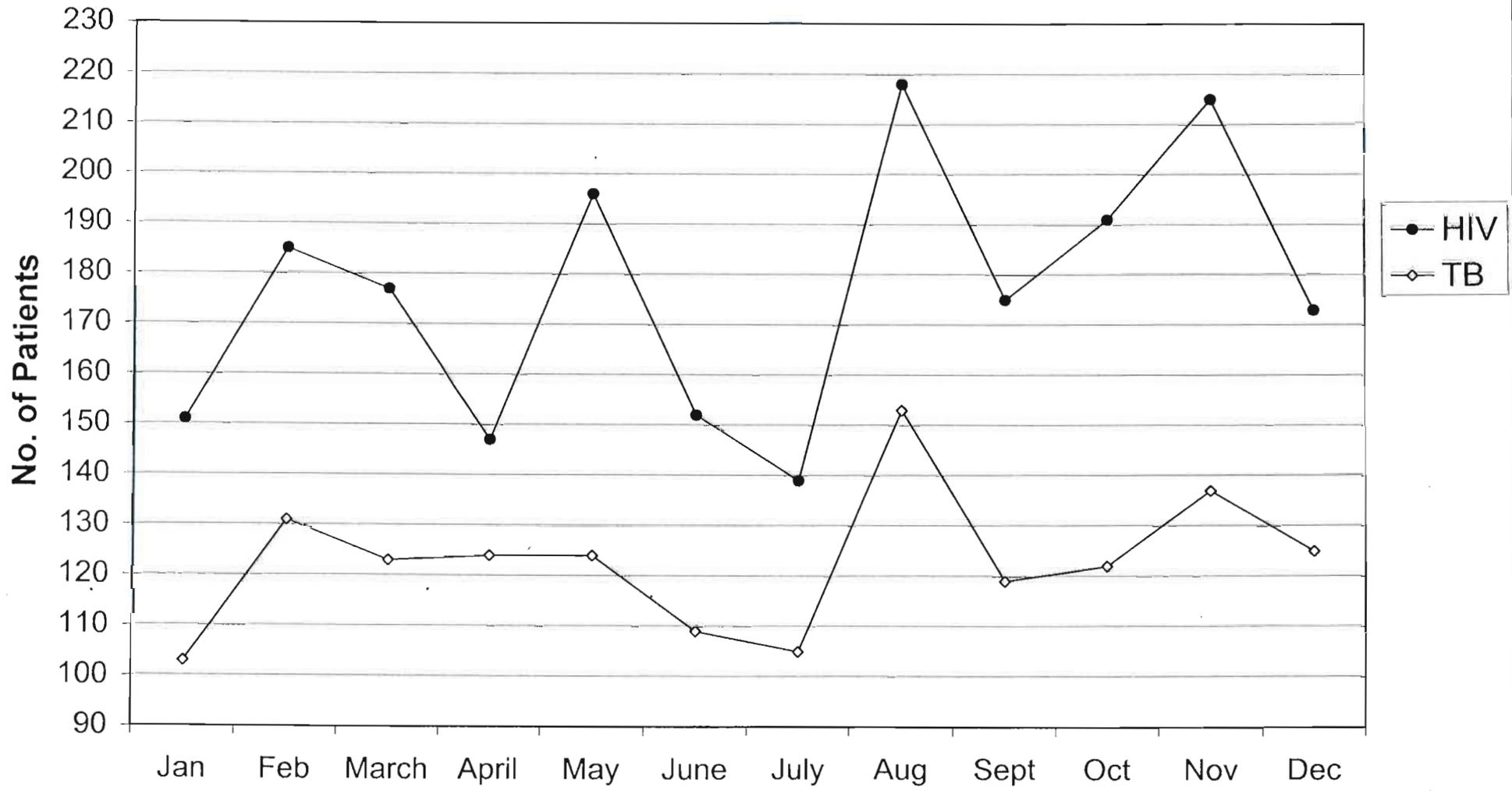


**Appendix No 4**

**Northdale Hospital: Infection Control Statistics**

**2000**

## Infection Control - Northdale Hospital - Annual Statistics - 2000



**Appendix No 5**

**Northdale Hospital: Infection Control**

**Yearly statistics for 1999 and 2000**

Northdale Hospital : Infection Control  
Yearly Statistics for 1999 and 2000

Month	1999		2000		% Increase	
	TB	HIV+	TB	HIV+	TB	HIV+
Jan	64	131	103	151	60.9%	15.3%
Feb	73	147	131	185	79.5%	25.9%
March	68	160	123	177	80.9%	10.6%
April	48	90	124	147	158.3%	63.3%
May	64	115	124	196	93.8%	70.4%
June	68	137	109	152	60.3%	10.9%
July	99	147	105	139	6.1%	-5.4%
Aug	104	175	153	218	47.1%	24.6%
Sept	106	95	119	175	12.3%	84.2%
Oct	88	125	122	191	38.6%	52.8%
Nov	135	154	137	215	1.5%	39.6%
Dec	121	152	125	173	3.3%	13.8%
Total	1038	1628	1475	2119	42.1%	30.2%

These statistics supplied by Senior Sister V. Praag who is in charge of the HIV/AIDS Clinic at Northdale Hospital.

## **Appendix 6**

### **INTERVIEWS**

Appointments were arranged and interviews held in Pietermaritzburg with the following persons whom I felt could make some contribution to my thesis, addressing the HIV/AIDS myth of Christian Indians of Northdale/Raisethorpe. I thanked each person for affording me the opportunity to interview them.

#### **Clergy from N/R**

Questions asked:

1. Do you think that the HIV/AIDS pandemic is affecting the Indian community of N/R?
2. Have you come across anyone from your church that is either infected or affected by the virus?
3. What do you think attributes to the silence and denials among these people?
4. Are you engaged in pastoral care ministries for such persons?

Naidoo, C. 01/11/2001 at 15h00. Pastor of Patmos Assembly of Mysore Road, Northdale/Raisethorpe.

Lawrence, G (Father) 13/11/2001 at 15h00. Priest of Holy Angels Anglican Church, Northdale/Raisethorpe.

Rhandran, V 19/10/2001 at 13h00. Pastor of Bethlehem Baptist Church, Northdale/Raisethorpe.

Perumal, D 06/11/2001 at 13h00. Pastor of Ephesus International Christian Fellowship, Northdale/Raisethorpe.

### **Clergy from India**

Questions asked:

1. Are people in India affected by the HIV/AIDS pandemic?
2. Are the figures alarming?
3. Do people freely disclose their status?
4. Is the church in India engaged in pastoral care for PLWAs?
5. Could you comment on the family support system in India?

Ayyala, J (Rev) 04/10/01, at 12h30. Baptist Church in Andhrapradesh, South India.

This interview took place at University of Natal, Pietermaritzburg, SA.

Karinjottazhikathie, S 04/10/01, at 13h30. Pastor of the Full Gospel Church in Poruvazhy, South India. This interview took place at the University of Natal, Pietermaritzburg, SA.

### **Medical Personnel**

Questions asked:

1. Are you treating any Indian patients or providing medication to those in N/R who are HIV positive?
2. Are the figures alarming?
3. Why the silence and denial by these people?

Kocheleff, P (Dr) 04/10/2001 at 10h00, Grey's Hospital. Currently Dr Kocheleff heads the AIDS clinic at Grey's Hospital.

Siveraman, A (Sister) 27/10/2001 at 11h00, Unit Manager for HIV/Aids counseling, Midlands Medical Centre, Pietermaritzburg.

Praag.V (Sister) 30/10/2001 at 09h00, Secretary for the Aids Committee, Northdale Hospital.

VB Jogessar (Pharmacist) 31/10/01 at 15h00, Jog's Pharmacy, Northdale.

### **People of other religions in N/R**

Questions asked:

1. Do you think that the HIV/AIDS pandemic is affecting the community of N/R?
2. Is your organisation offering any assistance to those who have been infected or affected by the pandemic?
3. Why do you think that the Indians of N/R remain silent and deny the effects of the pandemic?

Phillips, N 28/10/01 at 19h00, an official of Northdale Siva Nyana Sabha (Hindu Temple)

**Non Government Organisations**

Questions asked:

1. Are you assisting any Indians from N/R who have been infected or affected by the HIV/AIDS pandemic?
2. What do you think attributes to the silence and denials among the Indians?
3. Do you feel that the church is doing enough?

Khan, S and Chetty, E 15/10/01 at 15h00, Men, Women and Children (MWC) Crisis Centre for Northdale/Raisethorpe.

Hoosen, A 05/11/01. Marketing Officer, ATTIC, Pietermaritzburg.