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AN EVALUATION OF HIV/AIDS MINISTRY OF THE EVANGELICAL  
LUTHERAN CHURCH IN SOUTHERN AFRICA'S CONGREGATIONS IN THE  
UMHANGENI CIRCUIT OF THE SOUTH EASTERN DIOCESE (KWAZULU-NATAL)

BY

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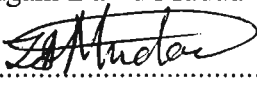
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## DECLARATION

I declare that this thesis, unless specifically indicated to the contrary, is my own original work. It has not been submitted before for any degree or examination at any other university.

Zwodangani David Mudau

Signed.....

November 2001

As the candidate's supervisor, I have/ ~~have not~~ approved this dissertation for submission.

Steve de Gruchy



November 2001

## **ABSTRACT**

The spread of HIV/AIDS in South Africa has evoked many responses from the national government, Non-Governmental Organizations and the church. There are many reasons why the church should respond to this challenge of HIV/AIDS and join hands with the worldwide effort to provide care and support for people living with HIV/AIDS in our society. As the epidemic increases, many people in South Africa are falling sick, suffering physically, emotionally and spiritually and many are abandoned and desolate. Men, women, young people and children are dying; families and communities are severely affected socially and economically.

This thesis examines the response of the Evangelical Lutheran Church in Southern Africa (ELCSA) to AIDS and suggests a more adequate strategy to deal with HIV/AIDS. First, it examines the incidence and impact of HIV/AIDS, noting the emotional, physical and socio-economic impact of HIV/AIDS. Secondly, this thesis develops a theological response to AIDS. The involvement of ELCSA is examined via research into six parishes in the Umgeni circuit of the South Eastern Diocese (Kwa-Zulu Natal). It argues that a seven-fold framework best describes the sort of strategy needed to fight against the spread of HIV/AIDS. This seven-fold framework includes the following: AIDS education, AIDS counseling, Livelihood support for people living with HIV/AIDS, Advocacy for the people living with HIV/AIDS, Pastoral and practical care for people living with HIV/AIDS, Helping the bereaved families during funeral arrangements and providing grief counseling, and Support systems for AIDS orphans.

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I would also like to thank my Church ( ELCSA ) for giving me this opportunity to further my studies. I know that if it were not through your permission, I would not have arrived where I am today. Above all, I thank God, who gave me strength and courage to work hard. I thank all who were supportive to my studies, to them I say, the peace of the Lord be with you always.

## **DEDICATION**

This thesis dedicated to all the pastors of the Evangelical Lutheran Church in Southern Africa and all Lutheran members, so that they can take the AIDS crisis as a challenge for their faith in Jesus Christ. I also dedicate this research paper to all the people living with HIV/AIDS in Kwa-Zulu Natal, who are experiencing pain and isolation; I want to say to them: “You are not alone”, the church cares about you.

## CHAPTER 1: INTRODUCTION

### 1.1. MOTIVATION

The incidence of HIV/AIDS is very high in Kwa-Zulu Natal and many people are dying of this disease. This disease affects us in different ways and, as a result, we must find a way in which the church can deal with this AIDS crisis that threatens everybody in our society. Many people who are dying of this disease are young and they have a lot to offer to our economy in the future. At the Ecumenical conference which I attended in Durban in December 1999 about the involvement of churches in the HIV/AIDS crisis, the Lutheran church in South Eastern Diocese was found to have done very little in the struggle against HIV/AIDS in Kwa-Zulu Natal. Therefore, this thesis explores and offers strategies that can be used by the Lutheran Church in Kwa-Zulu Natal to fight against the spread of HIV/AIDS.

#### **Definition:**

In this thesis, I will not use terms such as “AIDS sufferers” or “AIDS victims” because they seem to be too negative. Instead, I will use the terms “people with AIDS” or “people living with AIDS”.

### 1.2. HYPOTHESIS

Through a range of strategies, the Evangelical Lutheran Church in Southern Africa (ELCSA) congregations can make a contribution to the struggle against HIV/AIDS.

In this thesis, I will argue that ELCSA congregations should use a seven-fold framework of action, namely:

- i). AIDS education
- ii). AIDS counseling
- iii). Livelihood support for people living with HIV/AIDS
- iv). Advocacy for people living with HIV/AIDS
- v). Pastoral and practical caring for people living with HIV/AIDS
- vi). Helping the bereaved families during funeral arrangements and providing grief counseling
- vii). Support systems for AIDS orphans

### 1.3. ISSUES INVESTIGATED

The HIV/AIDS pandemic threatens the whole nation and the church. This study investigates how the Evangelical Lutheran Church in Southern Africa parishes of the Umgeni circuit have been involved in ministry to people living with HIV/AIDS. This research investigates the problems that pastors and lay people in the Umgeni circuit encounter in fighting against the spread of HIV/AIDS in our community. I explore if the congregations of ELCSA have any role to play in fighting against this killer disease. Our research includes six parishes in the circuit. I investigate what these parishes have done in the struggle against HIV/AIDS and their experiences in the struggle against HIV/AIDS, in the light of the seven-fold framework. These six parishes are: Nhlankakazi, Mpumalanga, Pietermaritzburg South, Pietermaritzburg North, Georgenau and Applesbosch.

#### 1.4. METHODOLOGY

I use published and unpublished literature, journals, newspapers and interviews. This provides the larger social and theological background to the issue.

My field research focuses on the above-mentioned six parishes of Umgeni circuit. I interview pastors and lay leaders (women and youth included) of the above-mentioned parishes, asking questions about the parishes' involvement in the seven key areas of AIDS ministry.

## CHAPTER 2: THE AIDS CRISIS IN KWA-ZULU NATAL

### 2.1. INTRODUCTION

HIV/AIDS is spreading very fast in South Africa, and especially in Kwa-Zulu Natal.<sup>1</sup> Many people are raising questions (which have not yet found an answer) as to why HIV/AIDS is escalating so quickly in Kwa-Zulu Natal. This chapter is an attempt to gain an overview of the problem of HIV/AIDS infection, particularly in Kwa-Zulu Natal.

### 2.2. WHAT IS HIV/AIDS AND WHAT IS ITS ORIGIN?

**Let us first look at what AIDS<sup>2</sup> stands for:**

A: Acquired- this means that you get the virus from someone else.

I: Immune- the disease attacks the body's immune system (the system, predominantly in the blood, that enables your body to fight against sickness and infection).

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<sup>1</sup> See Doyle (1998:86), PACSA Factsheet, No 46 November 1999, AIDS statistics compiled by Doctors for Life in December 2000 ([www.hbc.dfl.org.za](http://www.hbc.dfl.org.za)), Lovelife (2000:7).

<sup>2</sup> AIDS is caused by a virus called HIV. By killing or impairing cells of the immune system (the body's defence system against germs and infections), HIV causes immune deficiency, as it destroys the body's ability to fight infections and certain cancers over time.

When a person's immune system is very weak or their HIV-related immune deficiency is so severe that various life-threatening, opportunistic infections (they take the opportunity provided by the weakened immune system) and/or cancers occur, a person is said to have AIDS.

Once a person has become infected with HIV, it takes on average 5-8 years, or more, for them to develop AIDS. People can be infected with HIV but look and feel well for many years, as their immune system continues to fight the virus. However, even though the person may look and feel well, they can still spread the virus. Only later, when the immune system is weak and unable to defend the body, do signs and symptoms occur. People who have chronic illnesses like TB, or who suffer from poor health will develop AIDS more quickly because their immune system is already weak ([www.mrc.ac.za](http://www.mrc.ac.za)).

D: Deficiency- your body's defense system is broken down.

S: Syndrome- as your body's immune system is broken down, so a number of different illnesses attack your body.

One's body is protected by the immune system, the "soldiers" of which are the white blood corpuscles. When germs, bacteria, or viruses enter the bloodstream, the white blood corpuscles attack them. Our immune system eventually kills the antigen, although we may feel ill or sick for a while. The AIDS-virus enters the bloodstream and attacks the white blood corpuscles. The AIDS-virus eventually kills the white blood corpuscles. This means that when other antigens attack our body (e.g. colds, flu, TB, etc), the body is unable to defend itself.

There is confusion about what causes AIDS. There was a report on TV news, radios and in newspapers that the president of South Africa, Thabo Mbeki, denied that HIV causes AIDS. At the 13<sup>th</sup> International AIDS conference, held in Durban, the President of South Africa said that the biggest killer and the greatest cause of ill health and suffering across the globe is poverty. Thabo Mbeki said that poverty is the reason why babies are not vaccinated, why clean water and sanitation are not provided, why curative drugs and other treatments are unavailable and why mothers die in childbirth. It is the underlying cause of reduced life expectancy, handicap, disability and starvation (9th July 2000). From what Thabo Mbeki said, one can say that many poor people die soon after they have been discovered to be HIV positive because they cannot afford drugs nor can they keep the right diet. It is clear that poverty is a serious problem in African countries, but it can be argued that it is not the

cause of HIV/AIDS. Poverty only makes infected people not to live longer than they could, because they do not have enough money to afford the right diet.

### **What does HIV stand for?**

H: Human- this virus only lives in humans, it cannot survive in insects, animals, birds or fish.

I: Immunodeficiency- infection with this virus results in the body's immune system breaking down.

V: Virus- a microscopic organism that causes disease.

The virus enters the blood stream, and attaches itself to a white blood corpuscle. The virus "injects" its own cellular material into the corpuscle. Using the cellular material of the corpuscle, the HIV "manufactures" hundreds more HIV's: it turns the white blood corpuscle into an "HIV factory". When the virus has killed the corpuscle by using all its cellular material, the corpuscle breaks open, spreading the "new" HIV's into the bloodstream.

Infection with HIV does not necessarily mean that a person is sick. A person with HIV can remain otherwise healthy and without symptoms for a number of years. He or she can live without notice of infection. I know of many people who are HIV positive and are playing important role in the community. These people continue to do their work fruitfully because they are living positively with the virus. For a person to remain healthy, it also depends on whether the person is keeping the right diet or not. According to the South African Law Commission, HIV infection during this

period is called 'asymptomatic infection'. During 'asymptomatic infection', a person is capable of performing all of his or her daily activities and can, thus, lead a full and productive life. Such a person does not have AIDS (1998:5). A person has AIDS only when he or she becomes ill as a result of one or more opportunistic illness. AIDS is the final clinical stage of HIV infection.

There are many myths about the origin of HIV/AIDS.<sup>3</sup> For me what is more important is not to know where AIDS came from, but how we can respond to it.

### 2.3. THE INCIDENCE OF HIV/AIDS IN KWA-ZULU NATAL

Issues of HIV/AIDS are often discussed in the media and in daily conversation and, yet, it is surrounded by myths and ignorance. AIDS is a reality in South Africa and especially in Kwa-Zulu Natal. HIV-infection is a reality in all racial, economic, and

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<sup>3</sup>According to Crewe, "myths abound concerning the genesis of AIDS". Because of the ignorance and fear surrounding the disease, Crewe believes that tales of its origins are irrational and often reflect the need to blame some individual or group of people for the epidemic. One of the most lurid myths regarding the origin of AIDS claims that the virus came from the central African green monkey. According to the story, the monkey has a related strain of HIV in its blood and this blood is used for circumcision in central Africa. In this way, the virus was 'transmitted' from monkey to man, mutated, developed into HIV and spread to the rest of the world from there via prostitutes, airline stewards and missionaries. Another myth of the origin of the disease weaves cold war political machinations into the topic. According to this tale, a group of American scientists was requested by the CIA or the FBI to develop a virus capable of destroying the body's immune system for use in germ warfare. The virus then 'escaped' and soon developed into the AIDS pandemic. Crewe states that "the Soviets (academy of sciences) understood AIDS to be an American biological weapon gone berserk and destroying its creator" (1992:8-9).

The myths of AIDS are also politically motivated. For in stance, some black people believe that AIDS came from white people in order to kill the black population. In the same way, there are some white people who believe that AIDS came from black people. It is clear that this politically motivated myth about the origin of AIDS is a racially motivated attempt to blame others for the disease.

There are many myths about AIDS and its origin. Some people say that it came from the Monkeys and Baboons. Others say it came from homosexuals. Culturally, people see AIDS as a result of witchcraft. Some Christians on the other hand see AIDS as a punishment from God for sin. Frankly, we do not know for sure where AIDS came from. The mythology surrounding the origins of HIV/AIDS reflects both the fear of the unknown and the need for a satisfying scapegoat. Perhaps it should not matter where the disease came from, but, more importantly, where it is going.

social groupings, but is more prevalent in the various economically and socially disadvantaged communities. Kwa-Zulu Natal has the highest number of people living with HIV/AIDS in South Africa. The population growth rate of Kwa-Zulu Natal will slow considerably as a result of the HIV epidemic. According to Doyle, with the most likely projections, the total population of Kwa-Zulu Natal in 2001 will be approximately 9.5 million as opposed to 10.4 million, a difference of 7 percent. By the year 2016, the population without AIDS would have been 14.3 million and with AIDS it will be 10.3 million, a difference of 27.9 percent (1998:86).

According to the AIDS statistics compiled by Doctors for Life in December 2000, South Africa has the fastest growing epidemic in the world. About 20 % to 30% of South African citizens are HIV positive. There are 1700 new infections daily in South Africa today. Within five years, one South African will die of an AIDS-related illness every minute unless action is taken now to curb AIDS and treat people with AIDS. This report shows that 33% of pregnant women in Kwa-Zulu Natal are HIV positive. Statistics state that in South Africa, up to 70% of hospital beds are occupied by people with AIDS. In Kwa-Zulu Natal, 75% of hospital beds in the children wards in Midlands area are occupied by children with AIDS-related diseases, while more than 50% of childhood deaths were AIDS-related. Reports from Kwa-Zulu Natal, where around 33% of the population are infected, are that the disease has pushed the death rate higher than the birth rate (Medical Research Council ) (MRC), 2001).

According to the Medical Research Council report which was formally released on the 16<sup>th</sup> of October this year (2001), 40% of deaths of people between 15 and 49 years

of age last year were caused by AIDS and 25% of all deaths last year were caused by AIDS (MRC, 2001).

Chetty reports that projections show that without cure for AIDS, the number of AIDS deaths can be expected to grow within the next 10 years to more than double the number of deaths accountable to all other cause, resulting in five to seven million cumulative AIDS deaths in South Africa by 2010. Chetty further reports that the MRC president, Dr Malegapuru Makgoba asserted that the MRC report is a chilling reminder of how powerful stereotypes across society have colluded in creating the most explosive epidemic in the history of South Africa (2001, Sowetan News).

A survey undertaken at the University of Durban-Westville, indicated that there is a high rate of HIV infection among female tertiary students. "The survey showed that approximately 26% of women and 12% of men aged between 20 and 24 and 36% of women and 23% of men aged between 25 and 29 were currently infected. In a further example that explored HIV infection rates among people aged 20 to 50, in a sub-provincial area, estimates ranged from 21% among people living in private houses to 36% among those living in informal settlements" (Lovelife, 2000:7).

Unless some precautions are taken against the spread of HIV/AIDS in South Africa, "one in every four South Africans citizens is expected to be HIV positive by the year 2010. The HIV/AIDS pandemic is spreading at such a high rate that deaths now outstrip births for the first time in Kwa-Zulu Natal" (South African Human Development Report, 2000:36).

The reasons for this high rate of HIV infection in Kwa-Zulu Natal are probably complex. Smith believes that the contributing phenomena to this high rate of infection in Kwa-Zulu Natal are:

- The province has two major seaports, Durban and Richards Bay.<sup>4</sup>
- Kwa-Zulu Natal has a population of 8.4 million, which represents 20.7 percent of the total population of South Africa, but with only 7.6 of the land area.<sup>5</sup>
- The employment structure.<sup>6</sup>
- The absence of the male parent for long periods from home adds to the risk of a dysfunctional family.
- Extreme poverty (Smith, 2000:6-7).<sup>7</sup>

A study that was based on the information collected by roadside sex workers in the Kwa-Zulu Natal midlands has revealed disturbing facts about HIV and the sexual practices of long- distance truck drivers. “The study found that 56 percent of drivers surveyed were HIV positive, that 34 percent reported always stopping for sex during journeys and that 29 percent never used condoms. At one truck stop in New Castle, 95 percent of truckers were HIV positive. All 320 drivers surveyed travelled to three or more provinces in South Africa and most to neighboring countries, while 70 percent have wives or girlfriends but few used condoms with these regular partners” (Regchand, 2001).

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<sup>4</sup> These seaports are linked by road forming major trucking routes to East and central Africa. Throughout Africa, the influence of truck routes on the spread of HIV has been documented and may well be related to the early introduction of the epidemic into the province.

<sup>5</sup> This high density is accompanied by population demographics that show a very high proportion of young people: 64.6 percent of the population is younger than 25 years of age.

<sup>6</sup> Despite the high population density, Kwa-Zulu Natal industry has never developed commensurate with the numbers of its residents. Many working men join the ranks of migrant labour and work most of the year in Gauteng province. These men, away from home for long periods of time, have their sexual needs assuaged on a commercial basis, with the eventual transmission of HIV to their partners at home.

<sup>7</sup> With the massive migration of people from rural areas to urban areas, following the collapse of apartheid and the institution of a democratic government, large informal settlements have grown on the periphery of major towns. The antenatal clinics serving these areas show a much higher HIV zero-prevalence than that seen in the metropolitan clinics.

Bishop L Sibiya<sup>8</sup> mentioned that every week there are two or three funerals of young people in his local congregation. He said that the pastor no longer has enough time to do house visitations and other pastoral duties because he must prepare for the funeral services every week. The Bishop is convinced that the cause of these deaths is HIV/AIDS. The Bishop is worried that it is never mentioned that the deceased died of AIDS and, as a result, many young people are dying and still people do not know what is killing these young people, who are the future of our country. Bishop Sibiya believes that the disclosure of the HIV status of the deceased can alert other young people and the rest of the community to the fact that AIDS is a reality and it kills.

#### 2.4. THE SOCIO-ECONOMIC IMPACT OF HIV/AIDS IN SOUTH AFRICA

An increase in the illness and death of people suffering from HIV/AIDS has economic and social consequences. For each individual and his or her family, the HIV diagnosis and its consequences are a disaster.

##### 2.4.1. The socio-economic impact of HIV/AIDS and national economic growth

As Whiteside says, “South Africa has experienced negative or very low growth for many years now” (2000:85). Whiteside is correct when he further says that the degree to which the factors will impact on national growth will depend on the people

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<sup>8</sup>Verbal interview held with the presiding Bishop of ELCSA who works in the South Eastern Diocese (Kwa-Zulu Natal) (held on the 23<sup>rd</sup> March 2001).

who are infected in terms of their importance to national production and to what extent money is diverted from savings to care (2000:85).

It is a harsh economic reality that not all lives have equal value. There are people who are employed and people who are not employed, and their life experiences are different. Therefore, if the majority of people who are infected by HIV/AIDS are unemployed, unskilled workers, then the impact on the national economy will not be as great as if they are skilled and highly productive members of society.

Hope states that assessing its socio-economic effects can positively identify the catastrophic impact of AIDS and, hence, its impact on the already elusive development processes in Africa (1999:8). It becomes clear that AIDS deserves special attention because a failure to control the epidemic will result in far more demanding and costly consequences in the future. This shows that the AIDS pandemic is much more than a health or medical phenomenon. HIV/AIDS, also, has very significant socio-economic development ramifications.

A 1991 study on the impact of AIDS on South Africa's economy indicated that the public health service would feel the major impact at first. In the long term, however, economic growth would be affected. The conclusion of the study was that while the South African economy could sustain the effect of AIDS for 15 years (i.e. 1991-2006), "the problem is still a desperately serious one for our society" (Whiteside, 2000:87).

The question is whether the increase in death and illness due to AIDS affects the prospects for economic growth in South Africa. The 2000 South African Budget Review produced by the department of finance suggests that “population growth may slow close to zero percent by 2010, with the growth of the working age population declining from over two percent in 2000 to under 0,5 percent by 2008” (Whiteside, 2000:87).

#### 2.4.2. The socio-economic impact of HIV/AIDS on the private sector

The private sector has a crucial role to play in achieving sufficient economic growth in South Africa and in raising the general standard of living. It is the major source of employment, creates wealth and supplies the population with food, clothing, housing and most essential goods and services. AIDS primarily kills young people and middle-aged adults during their most productive years. This obviously has a great impact on the private sector. “One sector that has been the focus of particular attention in developed countries has been the insurance industry. Almost all insurance companies refuse to sell life insurance to people with AIDS” (Broomberg, 1993:49).

It is clear that the insurance industry is directly affected by the AIDS epidemic. And because of this, most life insurers in South Africa have instituted HIV testing as a pre-requisite for life insurance cover. “The only reliable and objective way for an insurance company to check whether a prospective member is infected or not, is through an anti-body screening test. At present, most insurance companies test their

new applicants, where cover levels exceed certain amounts, depending on HIV prevalence in the area in which the applicants reside” (Totaram, 2000:4).

The rise of benefits and medical scheme costs for the employees who are living with HIV/AIDS will have direct costs on the private sector. “The cost of an average set of benefits is expected to double for many schemes by 2005 and triple by 2010. This could add around 15 percent to the remuneration budget of a manufacturing company by 2005 or alternatively result in member’s benefits being halved” (Moore, 1999:1).

The effects of HIV/AIDS on business are reduced productivity, increased costs and loss of customers. It can be argued that profits in private sectors are being depressed by a number of factors. Absenteeism from work by people living with HIV/AIDS has clear effects on the profits in the private sectors. It can be argued that absenteeism is increasing not only because of the ill health experienced by employees, but also because workers take time off to care for their families and for funerals. It is clear that sick workers are less productive at work and cannot carry out the more demanding physical jobs, and this has clear effects on profits in the private sector. Clearly, employees who die or retire on medical grounds have to be replaced. Their replacement may be less skilled and experienced and, therefore, may require training. It is clear that training less skilled labourers will demand more money from the private sectors. As skilled workers become scarcer, wages have to be increased for the limited pool available. And, finally, where companies have granted credit to customers for purchases and those customers are dying of AIDS, the balance of the loans has to be written off.

The bottom line is that HIV/AIDS will make it more expensive for a company to produce a given quantity of its product, unless it can reduce its costs in other ways. Should the increase in HIV/AIDS-related costs be large enough, the company may face the prospect of going out of business, causing all of its employees to lose their jobs and incomes.

#### 2.4.3. Poverty and the socio-economic impact of HIV/AIDS

The links between poverty and health are increasingly recognized and understood. While this epidemic is not an epidemic for the poor alone, and anyone can get it, irrespective of their social status, it is clear that there is a close relationship between poverty and HIV/AIDS.

In South Africa the poorest 40 percent of households receive only 11 percent of total income, while the richest 10 percent receive 40 percent. The poor (classified as the poorest 40 percent of households) are defined as those earning less than R355 per adult per month. The ultra poor (the poorest 20 percent of households) are those earning below R194 per adult per month. About 50 percent of the population (21 million) live in the poorest 40 percent of households and are, therefore, classified as poor. About 27 percent of the population (11 million) live in the poorest 20 percent of households and make up the ultra poor (Whiteside, 2000:91). It is clear that in these households, an AIDS case will decrease income and increase the demands on existing sparse resources. In effect, AIDS has the potential to push households even deeper into poverty.

We may, also, note that the cost of the disease is also being shifted onto households in various ways. For example, where workers who are too ill to work are retrenched, they lose most of their benefits. Ultimately, they have to rely on the state or their families. State hospitals discharge many people living with AIDS to be cared for at home, which places an extra financial burden on the households. People living in urban areas may return to their rural homes when they fall sick, and there they can no longer access health services.

It is clear that HIV infection not only thrives in an impoverished environment, but the disease is itself a potent cause of poverty. Clearly there is no doubt that poverty and lack of resources increases the spread of AIDS, and even more drastically, the treatment and care for people living with AIDS and related illnesses in Africa. It is clear that poor people are more vulnerable to HIV because they do not have enough food to boost their immune systems that are already weakened by poverty and disease. Halperin rightly states that the resulting scale of illness and death will, in turn, have profound effects on economic and social development (2001:1).

#### 2.4.4. AIDS orphans and the socio-economic impact of HIV/AIDS

HIV infection does not reduce fertility, and for this reason, infected women may continue to have children while they are infected with the HIV virus. As a result, we will have a large number of orphans in our country. One of the main concerns in South Africa is that the number of orphans is increasing as a result of people dying of AIDS.

South Africa's population is young, "54 percent are below 25 years of age and 12 percent are below 5 years" (Whiteside, 2000:95). The increasing number of orphans means that many children will grow up without the guidance of their parents. It is clear that in some situations, children will receive little or no attention from their remaining relatives. This may, also, lead to a growing number of street children.

Nearly one million South-African children under the age of fifteen will have lost their mothers to AIDS by 2005. This is estimated to increase to around two million by 2010 (Whiteside, 2000:95). Obviously, children who lose one or both parents to AIDS, suffer loss and grief like any other orphan. It is clear that their loss can lead to the loss of education and health care. It can be argued that the psychological impact in a child who witnesses his or her parent dying of AIDS can be more intense than children whose parents die from more sudden causes. It can be argued that an increasing number of AIDS orphans who grow up without parental support and supervision, may turn to crime. Children orphaned by AIDS will have no parents as role models in the future and they may resort to crime to survive.

AIDS orphans are also at greater risk of malnutrition, illness, abuse and sexual exploitation than children orphaned by other causes. They must grapple with the stigma and discrimination so often associated with AIDS, which can even deprive them of basic social services and education.

Caring for AIDS orphans is one of the greatest challenges facing our country. The orphans that AIDS will create is, without a doubt, the most serious social, economic, political and developmental challenge facing South Africa. The existing social

service system cannot cope. Generally in an African culture, there is no “orphan”. Africans believe that it takes the whole village or community to raise a child. It is believed that a child does not only belong to its biological parents, but also to the whole community. If a child loses its parents, the nearest relatives or neighbors will adopt the orphan and provide it with parental care. In African culture, an orphan is not supposed to be cared for by strangers in an orphanage. However, culture is not static, it changes with time. Due to the increase in the poverty rate in South Africa, many families cannot afford to take care of AIDS orphans, and new responses will be needed to the crisis.

## 2.5. CONCLUSION

The escalating rate of HIV/AIDS in our country, particularly in Kwa-Zulu Natal, brings a challenge to the whole society and the church, to see if there is something that can be done to stop the epidemic. The following chapter deals with the understanding of the church on AIDS. With reference to some biblical passages, this chapter clearly describes how the church should relate to people with AIDS.

## CHAPTER 3: SHAPING THE CHURCH'S RESPONSE TO THE HIV/AIDS CRISIS

### 3.1. INTRODUCTION

ELCSA as a church finds herself amid the AIDS crisis and people expect to hear what the church is saying about this pandemic that threatens everybody. Christians and non-Christians often come up with questions about AIDS. People ask questions such as, "How can God exist if there is AIDS in the world?" or "If God really cares about people, why is there so much suffering in the world?" These questions and many others are asked of the church, and yet we often do not get any answer from the church. The task of this chapter is an attempt to answer the question, "Why should the church be involved in AIDS ministry?"

### 3.2. THE UNDERSTANDING OF THE CHURCH ON AIDS

Even if the church cannot answer all questions asked concerning AIDS, it is clear that it should be involved in AIDS ministry, because the church is called to be a healing community amidst pain and suffering, whatever its nature and source. The church has a mandate to console (2 Corinthians 1:3-5), to reconcile (2 Corinthians 5:19), to love (1 Corinthians 13) and to minister to everybody (Matthew 25:35-37). As Samita rightly argues, "the fact that the church should be actively involved as an effective tool in the fight against AIDS is based on the fact that historically and traditionally, by its nature and mission, the church is community-centred and service-oriented,

preaching and practicing love, compassion and care for the disadvantaged and underprivileged in the society” (1999:177).

Christians are called to embrace all people in love and compassion. Christians are called to minister to all people in unconditional acceptance and to challenge the world to follow the example of Christ, our Lord. The church is also called to assist those who suffer. It is challenged to help people living with AIDS to cope with the reality of HIV and to support those who are close to them as the disease progresses. Having said all this, the question is, “What can ELCSA as a church say concerning HIV/AIDS?”

As Stone rightly says, “One of the chief advantages of the church in crisis intervention is its location. For centuries, the church has been known as a place where individuals in distress can receive help” (1971:69). However, with the stigma around HIV/AIDS, it is clear that the church is no longer a place where people with HIV/AIDS can get help.

Nicolson argues that the AIDS crisis shows where the church has failed, but also gives us reason and motivation to try harder. He states that people with AIDS do not always find the support and the love that they seek in the church. Fear and prejudice has caused Christians, just like anyone else to close their doors (1996:154). In the Creed, we confess that we believe in one Holy and Apostolic church. If we call the church “One”, then we stand in unity with all who suffer. If one suffers, we all suffer (1 Corinthians 12:26); if one has AIDS, all of us are affected. We may not be physically suffering from AIDS, but identifying ourselves with people with AIDS

makes us one with them. “When Zulu people say that they are well, they mean that their relationship with other people, with their ancestors and with God is normal” (Moila, 2000:21). In the context of HIV/AIDS, the church is challenged to be in solidarity with people living with HIV/AIDS. The church is called to be in solidarity with those who suffer.

It can be argued that to say the church is “holy” does not merely mean that the church sets its mind on spiritual things only and not on social issues. Nor does it mean that Christians are better human beings than others. The holiness of the church does not come from itself nor belong to itself. It is understood to come from and belong to God. “The church sees itself as relying on the Grace of the Holy Spirit, and in this sense is Holy” (Nicolson, 1996:61). It can be argued that the church that is filled with the Holy Spirit must be a loving church, a church that welcomes everybody, including people with AIDS. As a church, we are called to love and support those who are suffering. The church is Holy, but its members are not holy. We all need God’s forgiveness as sinners. For this reason, there must not be any discrimination against people in the church because of their health condition. Instead of discriminating against and isolating others, we must support each other and give one another moral support because, as the church, we have been called by God in his Holy service to look after each other.

It is clear that AIDS is a challenge to our compassion, if we are to be faithful to Jesus, who called us from darkness into his marvellous light and appointed us to follow His example in our attitude towards our fellow human beings. To do this, we must embrace everyone who suffers. And doing so is not our work, but the work of God-in

Christ and Christ-in-us-all. This kind of compassionate love embraces everyone irrespective of the kind of illness.

As Kirkpatrick rightly puts it:

The church, through the epidemic of HIV infection, is being called into initiating what might be called 'an epidemic of compassion', nurtured through compassionate action and empathetic counseling. A ministry to those affected by the different stages of this infection has a dual function: that of caring not only for those who are actually living and suffering with the infection, but also for those whose alienation, whether self-imposed or otherwise, is part of the epidemic of AIDS. The church must do all in its power to prevent the epidemic of alienation that the AIDS diagnosis could bring, leaving us standing as before a huge chasm of fear (1988:101-102).

To prevent what Kirkpatrick calls "the epidemic of alienation" (1988:102), it can be argued that the church can overcome this pain during holy communion and in the sharing of peace. In holy communion, though we are many, we are one body because we share in one bread. We are one big family of believers, sick and well, poor and rich, and we are all united with one Lord. In the passing of peace that has become common practice in the Lutheran church, our status as members of a family is affirmed. When we take each other's hand or embrace one another, it shows unity among Christians. Hugging someone with HIV may quickly confront and dispel the fears and anxieties that many people have.

### 3.3. THE THEOLOGY OF AIDS

When we talk of the theology of AIDS, the first question that arises is, "Can there be a theology of AIDS? What has God to do with AIDS?" The answer of whether there can be a theology of AIDS or not depends on how one perceives theology.

Yeoman argues, “if there cannot be a theology of AIDS, there cannot be a meaningful theology of anything because if God cannot be perceived in human reality, we are left with an abstracted view of God that would be meaningless and irrelevant to most human beings” (1997:27). Yeoman rightly says that there can be a theology of AIDS because AIDS is not just about a virus or a set of physical syndromes. AIDS is about intimacy, sexuality, vulnerability, pain, suffering, death, prejudice, and bigotry. If theology has nothing to say about these human conditions, Yeoman believes that it has nothing to say about anything (1997:28).

Christian theology is based very largely upon the twin pillars of creation and redemption. They remind us that God not only made the world but that He loved it enough to live in it. That prompts us to believe that God is to be found not simply observing His world but that He is to be found within it, sharing the lives, hopes, suffering and death of people.

Clearly, when people are confronted with a crisis, they ask whether God really exists or cares about them or not. They often ask, “Why me Lord?” AIDS is not just a mere disease, but it is a sickness that involves anxieties about becoming a burden to the family and, eventually about death. AIDS raises many questions and one of them is whether AIDS is a punishment from God or not. So theology must ask: “Is God above, sending AIDS down as a punishment on sinful human beings? Or is He above, powerless to help His people? Or Is He above, looking at it and failing to intervene in this human crisis?” It can be argued that as God was with Christ on Calvary, He is with those who have AIDS, with those who are suffering and crying with no hope. God is not above them sending AIDS to them. He is with them not only sharing their

pain but also offering His love and strength to help them bear it. He is offering His forgiveness, not for them having AIDS, but for all their human brokenness, because AIDS is not a sin, but a sickness like any other sickness. God allows suffering; he does not send it to human beings. But even in sickness God is there with the individual, then we as His people must be too. We must be in AIDS counseling, sharing despair, pain, isolation, offering hope and lending whatever strength we have.

Yeoman puts it like this:

There can be a theological response to AIDS: a theology of discovery, discovering God's truth and His presence, His actions and His words, in the human situations of which AIDS speaks. More than that, there needs to be a theology of AIDS to counter false theologies and in order to do God's truth in the world. Human beings are God's language - God speaks to us through each other, through words and action (1997:31).

If God is really speaking to us through AIDS, what is the message he is giving us and how are we to interpret it? It is clear that theology is one of the means of interpreting what God is saying through AIDS. As followers of Christ, Wood rightly says that we should model ourselves primarily after His life (1990:279).

In Matthew 25:35-36, Jesus challenges us to treat everyone as if he or she were Christ Himself. We also have to know that our attitude towards people with AIDS tells how we relate to Christ. We cannot claim to be good stewards of Christ and, at the same time, discriminate against people with AIDS. Our call as Christians is to welcome those who are not acceptable in the community and to embrace them with unconditional love. Jesus did not see disease as God's judgement, but as an opportunity to show God's glory and mercy (John 9:1-3). He consistently touched and ministered to people, even though he knew they were considered unclean by

Jewish law. Whatever we do, we must follow the example of Christ and his attitude to people throughout his ministry. If we believe that God is judging people who have AIDS, it is clear that we would judge them as sinful people. We would not even want to associate ourselves with them. And if we believe that God is standing back watching AIDS sufferers, we will also do the same and say we have got nothing to do with AIDS. It is clear that we must not use AIDS to try and prove or disprove the existence of God, which is not the purpose of a theology of AIDS. But the purpose must be to show where God is and where we must be.

Nicolson is right in saying that churches must say clearly that AIDS is not sent by God as a punishment for sexual promiscuity (1996:19). It can be argued, if God sent AIDS as a punishment for sin, what about other promiscuous people who do not have AIDS because they use condoms? Moreover, it is not everybody who has got AIDS who contracted it through sexual intercourse or any other ways deemed sinful by the church. Some are innocent children who know nothing about sex, yet they are suffering from AIDS.

Nicolson further argues that churches must not be afraid of pointing out that AIDS is often a consequence of having multiple sexual partners (1996:19). It is clear that if the church compromises its stand, we will not manage to prevent HIV infection in our country. We must not pretend that the majority of people with AIDS did not get the virus through unfaithfulness. The church must teach pure morality. Our understanding of AIDS calls into question our understanding of sexuality. Moral theology should surely teach us that sexuality is the gift of God and that Christian moral teaching is based on love. It teaches faithfulness within marriage and

abstinence outside marriage as the only way to avoid AIDS, rather than encouraging safe sex, through the use condoms.

### 3.4. AIDS AND THE BIBLE

AIDS raises many issues that are deeply religious. Once we talk of AIDS and the Bible, people argue that the Bible was written before AIDS was discovered; therefore, the Bible has nothing to do with AIDS. It is true that the Bible was written before AIDS was discovered and it is true that the word “AIDS” does not appear anywhere in the Bible, but it is clear that the Bible has something to say in relation to the AIDS situation. We can learn something from the Bible that can enhance our relationship with people with AIDS. And for this reason, we may also address the issue of AIDS from a Biblical point of view. Let us illustrate how the Bible may speak to AIDS, by examining three familiar passages.

#### 3.4.1. Sickness and sin: John 9

In John 9:2-3, the disciples asked, “Rabbi, who sinned, this man or his parents, that he was born blind?” In this story of the blind man, we learn that the disciples believed that everything that happens to us is sent by God and, in the case of the blind man, they believed that the blindness must signify that God had some reason to punish the man for his own sin or that of his parents. When Jesus answered them, He did not say, it is because of his sin or his parents, but He said, “it was made that the works of God might be made manifest in him” (John 9:3). Jesus makes it quite clear that punishment has nothing to do with the man’s blindness. We learn from Jesus that

sickness is not punishment, but a human condition.

Sickness and sin are often connected together in the Gospel of John. For example, the man healed of paralysis in John 5:14 was forgiven and healed simultaneously and told to sin no more lest worse befall him. Although sin may cause sickness, Jesus never sends sickness upon humans. Sickness is an enemy, and Jesus heals sickness by forgiveness.

It is clear that the question of the disciples was based on the Old Testament background. In the Old Testament, sickness and plague are seen as punishment. When Pharaoh was stubborn and refused to free the people of Israel from Egypt, God sent ten plagues. Then from this background, one cannot really blame the disciples for their question. What is interesting is that Jesus corrected their interpretation about sickness and taught them that God does not punish people for their sin with sickness. If God were to punish people for their sins, it can be argued that we would all be sick.

It is clear that AIDS is not a punishment for sin, although sinful human actions and attitudes are major contributing factors. As Christians, we are called to love those with AIDS, even though on some occasions they may be in part responsible for their own situation.

#### 3.4.2. The Good Samaritan: unconditional compassion: Luke 10:30-37

The story of the Good Samaritan is one we all know well (Luke 10:30-37). Arriving on the scene, the Samaritan does not ask, "Why is this man on the road?" He does not

blame the man who was stripped and say, “Why did you use this road because you knew it was dangerous?”

It is clear that AIDS spreads because many people are sexually irresponsible, yet the circumstances of how a person contracts AIDS are not as important as the fact that they are ill and need help (Nicolson, 1996:77). For the Samaritan man, the important thing is not what the man was doing on his way to Jericho, but how he could be helped in his circumstance. As a result, he did not waste any time making an investigation into the case: he just helped him immediately. It is said in Luke 10:34 that when the Samaritan saw him, he had compassion, and went to him and bound up his wounds, pouring on oil and wine, then he set him on his own beast and brought him to an inn, and took care of him. This is the attitude we should have when we encounter people with AIDS. We must help and care for them rather than trying to find out how they got infected with AIDS. We should learn a lot from the Good Samaritan. Our task as the church is not to make an investigation into how people got infected with AIDS, but to help and care for them.

As Russel rightly puts it, “if the person living with AIDS is represented for us as the injured person along the Jericho road, many of us are inordinately curious as to how it happened that the person first became HIV positive” (1990:176). We should not use the information of how a person became HIV positive to rank his or her worthiness for our friendship, or even for God’s love.

When a person is involved in AIDS ministry, one of the greatest challenges is to avoid using the language that stigmatizes people with HIV/AIDS. Some people often use

the statement, “we”, referring to themselves as people who do not have AIDS and use the statement “they”, referring to people with AIDS. This usage of words creates a clear distinction between human beings. This shows that those who are HIV negative do not want to be identified with people who are HIV positive. Pointing to people with AIDS as “they”, symbolizes that they are far away from us and we don’t want to be identified with them. It is clear that the usage of phrases such as “we” and “they” does not unite, but separates us from one another.

Other people use terms such as “AIDS sufferers” or “AIDS victims”, referring to people living with HIV/AIDS. This kind of language puts a stigma on the virus and on people living with the virus. The church should avoid using the language that victimizes people with AIDS.

#### 3.4.3. AIDS: Leprosy of our time

The analogy between AIDS and leprosy has been noticed by a number of people. In the Bible, leprosy was a disease for which there was no cure, though sometimes people could spontaneously recover. It caused fear and revulsion. People did not necessarily think that leprosy was a punishment from God (Nicolson, 1996:79). There are only three Old Testament references to leprosy being sent as a punishment for sin (Numbers 12:10, 2 Kings 15:5, which is paralleled in 2 Chronicles 26: 20). Rather than as a punishment, leprosy was a mystery that only the mind of God could explain. Lepers were not necessarily sinful people.

Before Jesus came, lepers were not cared for. They were the most neglected people in the Jewish community. They were seen as harmful to the community and for that reason they were banished until the priest certified that their skin was clear of active leprosy. This can be confirmed by Luke 5:14. When Jesus healed the man who was a leper, He charged him to go show himself to the priest. This was a way of getting a license to come back to the community.

There are many ways of dividing human beings. The Jews did this by excluding lepers from their community and sending them to their own isolated place, where they were not allowed to mix with healthy people. In the issue of AIDS, we create this distinction by using words like “us” and “them”, “clean” and “unclean”. AIDS is able to keep us apart like those who had leprosy. People do not want to socialize with or relate to people who have AIDS. Others are even ashamed to reveal that they are relatives or neighbors of people with AIDS. This makes it very difficult for people with AIDS to disclose their HIV status. They remain depressed and isolated for a very long period, unless they become open about their HIV status.

The Jews believed that when the Messiah came, leprosy would come to an end. In Luke’s Gospel, Jesus replies to John the Baptist’s query concerning whether he is the Messiah. “Go and tell what you have seen and heard: the blind receive their sight, the lame walk, lepers are cleansed”(Luke 7:22). Nicolson warns us to be careful not to push the parallel between AIDS and leprosy too far (1996:79). It is clear that AIDS is not being cured yet, but in his compassion for the suffering, despite their physical disfigurement, Jesus is surely a model for us in reaching out to people with AIDS.

We are told that instead of Jesus distancing Himself from the disease of leprosy like

many Jews, He touched the leprous person (Mark 1:41). This does not mean that Christians are required recklessly to ignore safety precautions in ministering to people with AIDS. However, touching and embracing people with AIDS do not expose us to infection. Rather, they allow a person with AIDS to feel that he or she is not excluded from human warmth and companionship. Touching, hugging and physical contact are very important in ministering to people with AIDS.

While it is true that Jesus went about “curing all kinds of disease and sickness among people” (Matthew 4:23), it is also true that AIDS is, for the moment, an incurable disease. As the church, we may be unable to say to people living with AIDS, “Be cured” (Matthew 8:3)! Instead, we can reach out to people living with HIV/AIDS in love. We may not cure AIDS, but we can “bring healing” to people with AIDS. We can reach out to people with AIDS in love by spending time with them and praying with them.

### 3.5. LUCSA’S ATTEMPT TO ADDRESS THE ISSUE OF HIV/AIDS CRISIS

We have now looked at what the Bible teaches in relation to HIV/AIDS. It is clear that the word “HIV/AIDS” is not mentioned anywhere in the Bible, but Christians can learn from the Bible how to meet the needs of people with AIDS. To lay the groundwork for the research undertaken in this thesis, we now turn to see how the Lutheran Communion in Southern Africa (LUCSA) has attempted to respond to HIV/AIDS in the light of the Biblical witness.

At his consecration as a bishop of ELCSA in 2000, Bishop NP Phaswana spelt out his pain at knowing that millions of South Africans will die if precautions are not taken to prevent HIV/AIDS from spreading. He said that the rate of new infections is alarming and it is estimated that by the year 2010, nearly 6 million South Africans will be living with AIDS. “As the salt of the earth”, he argued, “we need to encourage the formation of support groups to help de-stigmatize the epidemic. Our congregants are the victims. Our future leaders at all levels are at risk.” He said that although we have no resources, such as a cure or finances, we should never give up. He said that ELCSA needs to support the establishment of a ministry that will give hope to those living with AIDS, identifying and training pastors to deal with the whole ministry of human sexuality at all levels. He argued that the myths surrounding HIV/AIDS should be demystified by facing up to the realities of the day. And he concluded by saying that we have no future as a nation if we do not protect our children from these myths.

To meet this kind of concern, LUCSA has proposed a programme for the churches in ELCSA to deal effectively with the AIDS crisis. The objectives of this programme are to enable churches in the Lutheran and Moravian traditions, at all levels, to recognize the spiritual, psychological, physical, social and economic needs generated by AIDS and find responses which are in line with the gospel. “This will entail involvement in the struggle against the spread of HIV, the care of the infected, the spiritual, financial and social support of both the infected persons and the affected families and communities, especially the orphaned and the widowed” (LUCSA unpublished).

For the LUCSA programme to have a meaningful impact, structures and agencies must be formed in every congregation, parish and circuit. This means that voluntary AIDS committees should be formed, and they must consist of a pastor, a doctor or nurse, a social worker, a youth leader and a person living with HIV/AIDS. Their involvement will help them to familiarize themselves with the facts concerning HIV/AIDS. They will also act as resource groups for the church and the entire community. They will also be able to conduct regular workshops on HIV/AIDS for other church members and their social environments. They will also need to set up an AIDS support group for each infected individual and affected family. The other task of the committee is to monitor the situation of AIDS orphans and widows and report back to the church leadership so that the leadership of the church can respond with necessary help. The final task of the AIDS committees is to encourage potentially infected persons to subject themselves to tests and of infected persons to break the silence of HIV/AIDS and join the campaign against the spread of HIV/AIDS. This means that AIDS committees should identify the infected persons in the community and establish AIDS support groups for each case.

### 3.6. THE SEVEN-FOLD FRAMEWORK FOR THE CHURCH'S ENGAGEMENT IN THE AIDS CRISIS.

The LUCSA AIDS programme only touches on two issues, namely, the issue of AIDS education and a support group as a mode of the church's engagement in AIDS ministry. It does not cover the entire seven-fold framework suggested in this thesis. The seven-fold framework follows the life-cycle of the virus and its impact on a person's life and it is as follows:

- **AIDS education**

AIDS education involves providing people with information about HIV/AIDS. This includes understanding how HIV is contracted and how to prevent it from spreading from one person to another. AIDS education also touches on the issue of sexuality and addresses the myths that abound around the issue of HIV/AIDS (eg, having sexual intercourse with a virgin can cure AIDS).

- **AIDS counseling**

Oates defines counseling as a non-medical discipline which aims to facilitate and quicken personal growth and development and provide wisdom for persons facing the inevitable losses and disappointments in life (1974:9). It is clear that AIDS counseling will mean empowering people living with HIV/AIDS to live positively with the virus.

- **Livelihood support for people living with HIV/AIDS**

Livelihood support involves projects (such as gardening, sewing, job creation and skills provision) in order to help the people living with HIV/AIDS survive from day to day and to continue to provide for themselves and their families.

- **Pastoral and practical care to the people living with HIV/AIDS**

Pastoral care means the ongoing care which the church or pastor provides to people or family of people living with HIV/AIDS after they have tested HIV positive. This

includes providing home-based care for people living with HIV/AIDS, providing them with prayer and other necessities for their life.

- **Advocacy and public policy**

In this thesis, advocacy means speaking for the oppressed, voiceless, victimized and ostracized. The thesis argues that advocacy means speaking for the rights of those who are oppressed, victimized and ostracized because of their HIV status. Advocacy means evaluating policies that discriminate against people who are HIV positive due to their HIV status.

- **Funeral services and grief counseling**

After the family has lost a person (through AIDS), they grieve for the loss of their loved one. In their state of numbness, the family has to make funeral arrangements for their loved one, and this is one of the most confusing stages in one's life. Grief counseling is an attempt to accompany a person or the family through the grieving process.

- **Caring for dependents**

Caring for dependents means providing care for those who are left behind after they have experienced death of their loved ones through HIV/AIDS.

### 3.7. CONCLUSION

The escalating rate of HIV/AIDS in our country, particularly in Kwa-Zulu Natal, brings the challenge to the whole society and the church to see if there is something

that can be done to stop this frightening disease. For this reason, the following chapter is an investigation of what ELCSA congregations in Umgeni Circuit have done in AIDS ministry.

## CHAPTER 4: PRESENTATION OF THE RESEARCH FINDINGS OF ELCSA CONGREGATIONS IN UMGENI CIRCUIT

### 4.1. INTRODUCTION

#### 4.1.1. The composition of ELCSA:

In the Evangelical Lutheran Church of Southern Africa, the combination of several congregations makes up a parish. The circuit is formed by the combination of many parishes. When several circuits are combined, they form a diocese. In ELCSA, there are seven dioceses, namely, Botswana, Cape Orange, Central, Eastern, Northern, South Eastern and Western. Our research focuses on the involvement of the Umgeni Circuit (which falls under the South Eastern Diocese) in the AIDS ministry.

#### 4.1.2. The focus of the research

As the previous two chapters have revealed, HIV/AIDS is no longer a problem that ELCSA parishes can ignore: it directly affects the church. For this reason, ELCSA parishes should not avoid dealing with the AIDS crisis and shift the responsibility to the government and non-governmental organizations. It is the problem of the church and we have to deal with it. This chapter portrays what the parishes of Umgeni circuit are doing in the fight against the spread of HIV/AIDS, using the seven-fold framework laid out at the end of the previous chapter.

## 4.2. THE INVOLVEMENT OF NHLANGAKAZI PARISH IN AIDS MINISTRY

*Name of the parish:* Nhlankakazi<sup>9</sup>

*Size of the parish:* 450 members

*Geographical location:* Greytown

*Average age of the parishioners:* Predominantly people from the age of 36 -55, few youth (35 years and below) and few pensioners.

*Educational level:* The majority of people who are middle aged do not have tertiary education. There are a few tertiary students and the majority of the youth is at secondary level.

*Income level:* There are a few teachers and nurses, policemen and farm workers, but the majority of people are unemployed, or unskilled labourers and pensioners.

*Language of the parishioners:* Zulu

### 4.2.1. AIDS education:

The parish conducts some AIDS education, but not frequently. The parish organized a conference where various issues were talked about and AIDS became one of the issues on the agenda of the conference. The parish does not have a project for AIDS education. The pastor also talks about AIDS in the pulpit and in this way, all members of the parish happen to know some facts about HIV/AIDS.

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<sup>9</sup>The following people were interviewed on the 20<sup>th</sup> August 2001: Mr LM Buthelezi (elder), Mrs KB. Zulu (elder), Mr. L Myaka (elder).

This kind of AIDS education does not have much effect on people because people are not allowed or given any opportunity to ask questions concerning the sermon.

As a result, people go home with unanswered questions from the pulpit on issues concerning AIDS.

The parishioners feel that it is important that they organize a workshop that deals specifically with the issue of HIV/AIDS. In this way, people will have more time to find out about HIV/AIDS. This kind of workshop should include the local community as well and not only church members, since AIDS affects the whole community.

#### 4.2.2. AIDS counseling:

The parish is not involved in AIDS counseling. The reason for this is because people who are HIV positive do not disclose their HIV status. For this reason, it is difficult for the church to be involved in AIDS counseling.

#### 4.2.2. Livelihood support for people living with HIV/AIDS:

The parish is not involved in livelihood support for the people living with HIV/AIDS. There is no specific project that has been started with the purpose of helping people living with HIV/AIDS. The reason for this is lack of finance in order to start a project.

#### 4.2.4. Pastoral and practical care for people living with HIV/AIDS:

The parish is not involved in pastoral care for people living with HIV/AIDS. The parish provides pastoral care to the sick, not necessarily to people with AIDS. It is difficult to know whether the person has HIV or not. People do not disclose their HIV status for fear of rejection. As a result, when a person is sick, the church provides pastoral care through visitation and by providing prayers. This is all the church can provide for those who are sick, irrespective of the kind of sickness.

#### 4.2.5. Advocacy for people living with HIV/AIDS:

The parish is not involved in advocacy for people living with HIV/AIDS. Some members of the parish may have been involved in advocacy for people living with HIV/AIDS in their work place.

#### 4.2.6. Helping the bereaved families during funeral arrangements and providing grief counseling:

The church is engaged in helping the bereaved families during funeral arrangements and in providing grief counseling. The moment death occurs, the pastor and other lay leaders visit the family in order to give them moral support and consolation. It is during this time that the pastor asks about the funeral arrangements. The pastor accompanies the family in the whole process of funeral arrangements. The church

also helps by conducting evening services during the week of funeral arrangements in order to comfort the bereaved family, relatives and friends. After the funeral, the pastor continues to visit the bereaved family, providing them with grief counseling. The pastor accompanies the bereaved family in their process of grief.

It is through helping the family during the funeral arrangements and by providing grief counseling that the family realizes that the church is a caring community. The bereaved family never feels lonely. They feel that the church is also sharing their suffering. This in turn strengthens the bereaved family in faith. The only problem encountered in providing grief counseling for the bereaved family is that the pastor fails to meet the needs of the bereaved family. The pastor fails to do so because in many instances, there are three to four funerals in one week and the pastor is expected to provide the same kind of grief counseling to all these bereaved families.

#### 4.2.7. Caring for AIDS orphans:

The parish has not established any institution for caring for AIDS orphans. The problem is financial constraints. The parish does not have enough money to start an orphanage.

### 4.3. THE INVOLVEMENT OF MPUMALANGA PARISH IN AIDS MINISTRY

*Name of the parish:* Mpumalanga<sup>10</sup>

*Size of the parish:* 600 members

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<sup>10</sup>Rev Z Nzuza (parish pastor) was interviewed on the 23<sup>rd</sup> of August 2001

*Geographical location:* Hammasdale

*Average age of the parishioners:* Predominantly middle aged and youth and few pensioners

*Educational level:* Few middle aged and youth have tertiary education.

*Income level:* Few people are employed in professional jobs and the majority of people are unemployed.

*Language of the parishioners:* Zulu

#### 4.3.1. AIDS education:

HIV/AIDS is talked about in the church, but not often. The issue of HIV/AIDS is talked about in the pulpit and in different leagues of the church.

#### 4.3.2. AIDS counseling:

The parish is not involved in AIDS counseling. Many people who visit the pastor for counseling are those who have marital problems and other crises, but not those who are HIV positive. Many people who are HIV positive prefer to keep to themselves and not to let other people know about their HIV status.

#### 4.3.3. Livelihood support for people living with HIV/AIDS:

The parish is not involved in livelihood support for people living with HIV/AIDS. The parish does not have any project that is aimed at helping people living with

HIV/AIDS. This is due to lack of finance, since any project needs money to succeed.

#### 4.3.4. Pastoral and practical care for people living with HIV/AIDS:

The parish is engaged in providing pastoral care to all members of the church. The problem is that there has never been any specific attention paid to providing pastoral care for the people living with HIV/AIDS. People who have AIDS receive pastoral care from the church like any other congregants. This is because people who have HIV/AIDS are not known in the parish.

#### 4.3.5. Advocacy for people living with HIV/AIDS:

The parish is not involved in advocacy for people living with HIV/AIDS. The church could be engaged in advocacy for people living with HIV/AIDS if they were able to reveal their HIV status in the church. The church could fight for their rights as human beings, but now that people are silent about their HIV status, it is highly impossible for the church to speak for people who are failing to face reality. The church can speak for those who are discriminated against because of their HIV status, but it is difficult to do so when people hide the truth.

#### 4.3.6. Helping the bereaved families during funeral arrangements and providing grief counseling:

The parish does help the bereaved families during funeral arrangements and does provide grief counseling. The pastor provides the family with grief counseling and

other members of the church help the family during funeral arrangements. The pastor and members of the church organize evening prayers with the bereaved family. The whole community is also welcomed to the service. It is through this service that the bereaved family is comforted by prayer and the word of God.

#### 4.3.7. Caring for AIDS orphans:

The parish is not involved in caring for AIDS orphans because of the lack of finance.

#### 4.4. THE INVOLVEMENT OF PIETERMARITZBURG SOUTH PARISH IN AIDS MINISTRY

*Name of the parish:* Pietermaritzburg South<sup>11</sup>

*Size of the parish:* About 500 members

*Geographical location:* Edendale

*Average age of the parishioners:* There are few pensioners. The majority of people are those in their middle age and the youth.

*Educational level:* The majority of youth don't have tertiary education and few of them are working. There are few people who have professional qualifications.

*Income level:* There are few professional workers and the majority of them do not have permanent jobs. The majority of people are not employed.

*Language of the parishioners:* Zulu

##### 4.4.1. AIDS education:

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<sup>11</sup>These people were interviewed on the 16<sup>th</sup> August 2001: Mrs K Nguse, Mr. Mavundla (elders).

The parish is involved in AIDS education. Some members of the parish and a few volunteers in the community, who are not necessarily Christians, do AIDS education. When the church becomes involved with the community in the struggle against HIV/AIDS, it shows that AIDS is a problem for the whole community. It shows that AIDS affects both the church and the community. People in the local communities still trust the church and, therefore, it is easier for the church to address the whole community on the issue of HIV/AIDS.

#### 4.4.2. AIDS counseling:

The parish is not involved in AIDS counseling. The outstations of the parish are predominantly in the rural areas. In these rural areas, people do not go for AIDS tests and, for this reason, it is difficult to know who is HIV positive and who is not. Many people in the rural areas still do not believe that HIV/AIDS is real. Instead, they believe that HIV/AIDS is a myth. This makes it difficult for the church to be involved in AIDS counseling.

#### 4.4.3. Livelihood support for people living with HIV/AIDS:

The parish is not involved in livelihood support for people living with HIV/AIDS. The reason is because the parish is not financially self-sufficient.

#### 4.4.4. Pastoral and practical care for people living with HIV/AIDS:

Many people who are HIV positive do not disclose their HIV status, and for this reason it is difficult for the church to provide pastoral care to people living with HIV/AIDS. The parish is involved in general pastoral care and not specifically for people living with HIV/AIDS.

#### 4.4.5. Advocacy for people living with HIV/AIDS:

The parish has not been vocal on this issue of advocacy for people living with HIV/AIDS. The parish has not committed herself to the task of speaking for those who are oppressed and victimized, who in this case are the AIDS sufferers. The reason behind this is not known.

#### 4.4.6. Helping the bereaved families during funeral arrangements and providing grief counseling:

The parish is involved in helping families during funeral arrangements and providing the family with grief counseling. The church visits the bereaved family and conducts some evening services in the bereaved family's home. In this way, the church shares the pain with the bereaved family. The parish also collects some money and gives it to the bereaved family and the bereaved family decides how to spend it.

The pastor, Rev. B. Nzama, and some lay leaders also continue to visit the family after the funeral, in order to strengthen the bereaved family in their faith. The parish

does this, irrespective of whether a person died of AIDS or not. In other words, when the pastor provides the family with grief counseling, the issue of AIDS is not touched on since it is never disclosed during the funeral that the deceased died of AIDS. Therefore, this makes it difficult for the church to deal with the reality of HIV/AIDS.

#### 4.4.7. Caring for AIDS orphans:

The parish is not involved in caring for AIDS orphans. The parish does not have centres for AIDS orphans and, for this reason, it is difficult for the church to be involved in caring for AIDS orphans.

#### 4.5. THE INVOLVEMENT OF PIETERMARITZBURG NORTH PARISH IN AIDS MINISTRY

*Name of the parish:* Pietermaritzburg North<sup>12</sup>

*Size of the parish:* 540 members

*Geographical location:* Bishopstowe

*Average age of the parishioners:* Predominantly middle aged, youth and a few pensioners

*Educational level:* Mostly secondary school students, a few tertiary school students, a few professionals and a few illiterate adults.

*Income level:* The majority of people are unskilled labourers, unemployed. There are a few professional workers and pensioners.

*Language of the parishioners:* Zulu

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<sup>12</sup> Miss H Khumalo (youth leader) was interviewed on the 12<sup>th</sup> May 2001

#### 4.5.1. AIDS education:

The parish is involved in AIDS education. On certain occasions, the parish conducts Bible studies on the issue of HIV/AIDS. In this way, the parishioners are provided with information about HIV/AIDS. One of the weaknesses is that the parish has not yet spread this AIDS education to the local communities around. The other problem is that the parish does not have the necessary equipment (such as AIDS posters) for AIDS education and especially to convey the message of HIV/AIDS to the youth.

#### 4.5.2. AIDS counseling:

The parish is not involved in AIDS counseling. The parish has not established any AIDS counseling centre and this makes it impossible for the parish to be involved in AIDS counseling. It is also difficult for the pastor to provide AIDS counseling because people in the parish do not want to disclose their HIV status.

#### 4.5.3. Livelihood support for people living with HIV/AIDS:

There is a gardening project in the Kenosis Lutheran Community that sustains the community. The parish provides skill training for people who will take care of AIDS orphans before they start their duty.

#### 4.5.4. Pastoral and practical care for people living with HIV/AIDS:

The parish is unable to provide pastoral care and counseling specifically to people living with HIV/AIDS. The pastor and lay leaders visit the sick and pray for them, including those who might be HIV positive.

#### 4.5.5. Advocacy for people living with HIV/AIDS:

The parish is not involved in advocacy for people living with HIV/AIDS. The church is not aware of anybody who is publicly known to be HIV positive in the church or in the community. The church can play its role of advocacy for those who are discriminated against because of their HIV status. Since the church is not aware of people who are discriminated against due to their HIV status, it is difficult for the church to show some advocacy.

#### 4.5.6. Helping the bereaved families during funeral arrangements and providing grief counseling:

The parish helps the bereaved families during and after the funeral arrangements. During the funeral arrangements, the church conducts evening services, where the family, friends and relatives are comforted by the word of God. After the funeral, the pastor continues to visit the bereaved family and continues to strengthen them in their faith with the word of God.

#### 4.5.7. Caring for AIDS orphans:

With the little resources that the parish has and through the assistance of some donors, the parish manages to provide a place of safety for AIDS orphans. The parish is involved in caring for AIDS orphans through the Kenosis Lutheran Community<sup>13</sup>

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<sup>13</sup> In Kenosis Lutheran Community, the first unit for a caregiver and up to 5 children has been erected. Two further units are planned, but this part of the project will start only after careful monitoring and evaluation of the first part has been completed. Thandekile Hlongwana was trained for three months as a caregiver at Pietermaritzburg Children's Home. She obtained additional practical experience with orphaned children by working with Thandanani organization at Grey's Hospital, which has been caring for abandoned children since 1989 and is trying to motivate for the care and assistance of children in distress in the greater Pietermaritzburg area. Presently, Kenosis has two care givers, that is Thandekile (with three children) and Noxolo (with two children). In February 2000, Thandekile Hlongwana moved to Kenosis and the first child was assigned to her care by the magistrate of Pietermaritzburg and Child Welfare who are also monitoring the whole project.

Kenosis is also a place a safety for children without parents. The social workers bring children to Kenosis community to be cared for. The social workers also look for foster mothers who will take care of the children. That foster mother goes to court to make a vow that she will be in charge of the child. Kenosis community also has an agreement form which the mother fills in which binds the mother. It is for one year. If the care giver wants to renew the contract with Kenosis, she is welcome to do so. People who want to adopt children from Kenosis are welcomed, but such a person has to follow the rules set out by the social workers. The relatives or mothers of children are allowed to visit them, but they are not allowed to know where the children stay. If they want to see the children, they need to talk to the social workers and the social workers will arrange with Kenosis community so that the care givers can bring the children in order that their relatives can see them. Once the baby is adopted, the parents and the relatives are not allowed to see the child because the child will be confused as to whom its real parent is.

The foster mother is allowed to go home for three weeks in the whole year and should go home with the child. If she goes home for two or three days, she needs to report to the social workers and look for someone to take care of the children. If she is to go home for a week, she is supposed to go with the children.

Kenosis community provides children with medical aid and a salary for the care-givers. Kenosis gets funds for the buildings from AIDS and CHILD organization in Switzerland. For the salary of the care-givers, Kenosis gets funds from individuals from Germany.

Orphans accepted must be under 7 years of age. This reduces initial problems as far as schooling and transport is concerned. The orphans' centre is integrated into the village community of Kenosis staff members and their families.

#### 4.6. THE INVOLVEMENT OF GEORGENAU PARISH IN AIDS MINISTRY

*Name of the parish:* Georgenau<sup>14</sup>

*Size of the parish:* 374 parishioners

*Geographical location:* Wartburg

*Average age of the parishioners:* Few Octogenarians, about 40 people between the age of 30-35 and the majority of people are under 30 years of age.

*Educational level:* Mostly primary school, a few nurses, teachers, police officers and clerks.

*Income level:* The majority of people are unemployed, pensioners and unskilled labourers earning less than R1000-00 per month. There are few professionals who earn more than R2500-00 per month.

*Language of the parishioners:* Zulu

##### 4.6.1. AIDS education:

There are no programmes on AIDS education in the parish because the pastor is still new in the parish. When the pastor arrived in the parish, there was no AIDS programme in existence, but he plans to start AIDS education in the parish.

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<sup>14</sup> Rev Dr MD Biyela (parish pastor) was interviewed on the 17<sup>th</sup> September 2001

#### 4.6.2. AIDS counseling:

The parish is not involved in AIDS counseling. The problem is that people with HIV/AIDS do not disclose their HIV status for fear of the stigmatization around HIV/AIDS.

#### 4.6.3. Livelihood support for people living with HIV/AIDS

The parish is not involved in livelihood support for people living with HIV/AIDS. This is something that the parish had never thought about. The pastor hopes to start it soon.

#### 4.6.4. Pastoral and practical care for people living with HIV/AIDS:

The parish is not directly involved in the ministry of pastoral care for people living with HIV/AIDS. The problem is that nobody knows who is infected with HIV/AIDS, because of secrecy. Any young person who is bedridden is a subject of gossip about HIV/AIDS.

#### 4.6.5. Advocacy for people living with HIV/AIDS:

The parish is not involved in advocacy for people living with HIV/AIDS. The parish does not know where to start on the issue of advocacy for people living with HIV/AIDS since the community does not know people who may be suffering from

AIDS.

4.6.6. Helping the bereaved families during funeral arrangements and providing grief counseling:

The parish is involved in helping the bereaved families during funeral arrangements and in providing grief counseling. The parishioners, especially women, visit the bereaved family and offerings are collected to support the bereaved family. In this way, the bereaved family is made to feel that they are part of the community. The pastor provides grief counseling to the bereaved family.

4.6.7. Caring for AIDS orphans:

The parish is not involved in caring for AIDS orphans. On the positive side, the extended family helps the orphans, but the unemployment problem has made this very hard. Rev Biyela believes that the church must initiate programmes for orphans in general and AIDS orphans in particular. This will be hard as the church has huge financial problems.

4.7. THE INVOLVEMENT OF APPELSBOSCH PARISH IN AIDS MINISTRY

*Name of the Parish:* Appelsbosch<sup>15</sup>

*Size of the parish:* About 570 parishioners

*Geographical location:* Appelsbosch

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<sup>15</sup>These people were interviewed on the 7<sup>th</sup> August 2001: Mr. NP Ngubane (elder), Rev Z. Duma.

*Average age of the parishioners:* Predominantly middle aged, youth and few pensioners.

*Educational level:* Few professionals. The majority of people do not have tertiary education. There are a few illiterate adults.

*Income level:* The majority of people are farm labourers, few pensioners, unemployed and few professional workers.

*Language of the parishioners:* Zulu

#### 4.7.1. AIDS education:

The parish is involved in AIDS education. The parish organizes workshops where information about HIV/AIDS is spread to the community. The church also invites the local clinic to talk about HIV/AIDS in order to provide the community with some medical explanation on the issue of HIV/AIDS.

Therefore, the church and the local clinic work together in the fight against the spread of HIV/AIDS.

The problem is that the church and the health department contradict each other on the issue of how to prevent HIV infection. The church emphasizes that youth must abstain from sex before marriage and those who are married must be faithful to their life partners. In contrast, the health department provides the community with condoms and tells the people that they must use condoms in order to be safe from HIV infection. The community becomes confused.

#### 4.7.2. AIDS counseling:

The parish is not involved in AIDS counseling. The reason for this is people who are HIV positive do not disclose to the community or to the members of the church that they are HIV positive.

Many people who are HIV positive believe that it is not safe to reveal one's HIV status. This is due to the stigma around the whole issue of AIDS.

#### 4.7.3. Livelihood support for people living with HIV/AIDS:

The parish is not involved in livelihood support for people living with HIV/AIDS. There is presently no existing project in the parish aimed at helping people who are living with HIV/AIDS. This is due to a lack of finance in the parish.

#### 4.7.4. Pastoral and practical care for people living with HIV/AIDS:

The parish is involved in providing pastoral care to the sick, but it is difficult to know whether a person is providing pastoral care to people with AIDS or not. This is because people who are HIV positive do not reveal it. The church provides pastoral care to all those who are sick and, in this way, those who are HIV positive are also provided with pastoral care.

#### 4.7.5. Advocacy for people living with HIV/AIDS:

The parish is not involved in advocacy for people living with HIV/AIDS. The

church's prophetic voice for speaking for those who are victimized and those who are oppressed is not practical in this issue of HIV/AIDS. The main problem is that many Christians do not know to whom they should voice their complaint. The government, together with the health department, seems to be big a structure to be reached by an ordinary person. One needs to be somebody in the country in order to be heard by the government when one speaks. As a result, many Christians are not heard when they speak for people with AIDS because their voices from the local communities are never heard. This makes advocacy difficult for the church to be engaged in, even though it is the task of the church.

#### 4.7.6. Helping the bereaved families during funeral arrangements and providing grief counseling:

The parish is involved in helping the bereaved families during funeral arrangements and in providing grief counseling. When there is death in the family, the pastor, together with church members, visits the bereaved family in order to offer them some prayers and words of encouragement. The pastor continues to visit the bereaved family in order to help them during funeral arrangements and the grief period.

#### 4.7.7. Caring for AIDS orphans:

The parish is not involved in caring for AIDS orphans. The reason is there are no orphanages in the parish and it is difficult for the church to start an orphanage due to financial problems.

#### 4.8. CONCLUSION

This chapter provided us with the information of what ELCSA congregations in Umgeni circuit are doing with regard to HIV/AIDS ministry. The following chapter evaluates what ELCSA congregations have done about HIV/AIDS ministry and tabulates the challenges that HIV/AIDS brings to the church.

## CHAPTER 5: ANALYSIS OF THE RESEARCH FINDINGS

### 5.1. INTRODUCTION

This chapter analyses the research findings from the parishes of the Umgeni Circuit as presented in the previous chapter. The analysis of the research findings will help us to evaluate what the parishes have been doing in AIDS ministry and also to see the main obstacles that parishes encounter in their involvement in AIDS ministry. This will also help us to come up with a way forward for the church, irrespective of all the obstacles encountered by parishes. The table below is a summary of the research findings of Chapter 4 and it will help us to analyze them.

Table 5.1

Names of Parishes	Nhlangakazi	Mpumalanga	PMB South	PMB North	Georgenau	Appelsbosch
1. AIDS education	Yes	Yes	Yes	Yes	No	Yes
2. AIDS counseling	No	No	No	No	No	No
3. Livelihood support	No	No	No	Yes	No	No
4. Pastoral care	Yes	Yes	Yes	Yes	Yes	Yes
5. Advocacy	No	No	No	No	No	No
6. Funerals	Yes	Yes	Yes	Yes	Yes	Yes
7. Caring for orphans	No	No	No	Yes	No	No

## 5.2. PARISHES INVOLVED IN AIDS EDUCATION:

Almost all parishes of Umgeni Circuit are involved in AIDS education except Georgenau parish. However, this education is not spread to all people in the community because many parishes provide people with AIDS education from the pulpit, when the pastor or the elder is preaching. The question remains about those who do not come to church. Does it mean that the disease does not affect them? It is clear that this dreaded disease threatens us all and the church should provide the whole community, including non-Christians, with the necessary information on HIV/AIDS. Furthermore, we can question the fact that most AIDS education mentioned in the research findings is done from the pulpit. This is because people who convey AIDS education from the pulpit may have not been fully equipped to educate people about the issue of HIV/AIDS and, as a result, many issues may be left untouched. The other problem is that the preacher may have nothing to say about HIV/AIDS if the sermon text (of that particular Sunday) cannot be related to the issue of HIV/AIDS. The issue of HIV/AIDS is very complex and if the preacher tries to address it in depth from the pulpit, he or she may end up losing focus on the sermon text of the day. Clearly, this remains a crucial area in which ELCSA congregations will need to develop a clear and adequate strategy.

## 5.3. PARISHES INVOLVED IN AIDS COUNSELING:

With the stigma around the issue of HIV/AIDS, the research findings show that it is difficult for parishes to be involved specifically in AIDS counseling. As a result, no parish is involved in AIDS counseling. Pastors conduct other forms of counseling,

but not specifically AIDS counseling. Perhaps people who are living with HIV/AIDS prefer rather to go to health centres for AIDS counseling, where they will be provided with pre and post-AIDS test counseling. It is clear that people avoid coming to the church for AIDS counseling for the fear of being stigmatized and ostracized. Some people in the church still believe that AIDS is a punishment from God upon those who are promiscuous. This means that if a person discloses his or her HIV status in the church, he or she is also reporting having been promiscuous. People who are HIV positive try by all means not to put their lives or those of their family members into danger by keeping their HIV status to themselves. The question is: “Who must break the silence of HIV/AIDS?” The research findings indicate that parishes are failing to provide AIDS counseling because people living with HIV/AIDS do not disclose their HIV status. As the story of Mrs. Ntombela<sup>16</sup> makes clear, the church is the one that must first come to terms with the reality of HIV/AIDS. The church is the one that must first change its attitude towards AIDS. If the church could begin to understand that AIDS is a sickness like any other sickness and treat those who are infected with HIV like any other person, it is clear that many people would disclose their HIV status in the church, knowing that they would find support from their fellow Christians. In this way the gifts and resources of the church in counseling would be made available to those in dire need.

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<sup>16</sup> Mrs Anne Ntombela is living with HIV/AIDS. She was tested HIV positive in 1992 when she was giving birth. She told me that she left her original church (anonymous) due to discrimination she experienced after she disclosed to her fellow congregants that she was HIV positive. Many congregants tried by all means not to come close to her and others decided not to come to church anymore because they believed that their church was cursed for having a person in it who was HIV positive (Oral interview held on the 22<sup>nd</sup> May 2001).

#### 5.4. PARISHES INVOLVED IN LIVELIHOOD SUPPORT FOR PEOPLE LIVING WITH HIV/AIDS:

The research findings show that due to lack of finance in parishes, many parishes in the circuit are failing to provide livelihood support for people living with HIV/AIDS. Among all six parishes in the circuit, only Pietermaritzburg North parish is able to provide livelihood support for people living with HIV/AIDS. The parish has started a gardening project that helps them to feed AIDS orphans. Kenosis provides people who are to take care of AIDS orphans with skills training on how to provide pastoral care to AIDS orphans. The question is: “What about other parishes?” Is money the only problem for other parishes to get involved in livelihood support for people living with HIV/AIDS? Does it mean that without money the church cannot do anything to provide livelihood support for people living with HIV/AIDS? Chapter 6 will provide us with some suggestions on this issue.

#### 5.5. PARISHES INVOLVED IN PROVIDING PASTORAL AND PRACTICAL CARE FOR PEOPLE LIVING WITH HIV/AIDS:

All six parishes are involved in providing Pastoral care to the sick, but not specifically to people living with HIV/ AIDS. Pastors and lay people in all six parishes do visit the sick, including those who may be HIV positive. When pastors and lay leaders visit the sick, there is a ‘possibility’ that they are also providing Pastoral care to those who have not disclosed their HIV status for fear of isolation and ostracism. Due to the stigma around AIDS, the church is unable to provide Pastoral care to those who

are living with HIV/AIDS. The same question must be asked: “Who must break the silence?” Should it be the church or people living with HIV/AIDS?

#### 5.6. PARISHES INVOLVED IN ADVOCACY FOR PEOPLE LIVING WITH HIV/AIDS:

From the presentation of the research, there is no parish that is engaged in advocacy for people living with HIV/AIDS and yet advocacy is a very important factor in Christian faith. In His ministry, Jesus spoke for the voiceless and those who were vulnerable. Through His prophetic message, Jesus defended the poor, the oppressed and those who were vulnerable in the society, such as women. In obeying its call for advocacy, the church should stand against all injustices and discrimination practiced against people living with HIV/AIDS. The research shows that behind the lack of ministry to the people living with HIV/AIDS is this real difficulty of knowing who is HIV positive. Yet, in the light of the AIDS statistics,<sup>17</sup> it is clear that there is a serious problem about the spread of HIV/AIDS. Looking at the statistics of HIV/AIDS should send a message to the church that there is a very strong possibility that some of the church members may be HIV positive. The church does not only have to speak for people who are known to have been discriminated against, but also for those who are not known. The church is the voice of the voiceless. Therefore, the issue of not knowing who is HIV positive should never be an obstacle for the church to be involved in advocacy for people living with HIV/AIDS.

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<sup>17</sup> See Doyle (1998:86), PACSA Factsheet, No 46 November 1999, Statistics compiled by Doctors for life in December 2000 ([www.hbc.dfl.org.za](http://www.hbc.dfl.org.za)), Lovelife ( 2000:7 ), Regchand ( Natal Witness, 03 May 2001 ), Chetty ( 17 October 2001, Sowetan ), MRC ( [www.mrc.ac.za](http://www.mrc.ac.za) ).

5.7. PARISHES INVOLVED IN HELPING THE BEREAVED FAMILIES DURING FUNERAL ARRANGEMENTS AND IN PROVIDING GRIEF COUNSELING:

All parishes presented in the research prove to be helping the bereaved families during funeral arrangements and providing grief counseling. From the moment death arrives in the family and after the funeral, the pastor of the parish and his or her lay leaders journey together with the family during their grief period. During this grief period, the pastor provides grief support to the bereaved family in order to strengthen them in their faith. The pastor provides this without considering the cause of the death of deceased. I think it could make a difference if the pastor knew about the HIV status of the deceased. It is clear that if the pastor knows about the HIV status of the deceased, he or she may be able to help the bereaved family to deal with the fact that one of their family members died of AIDS. For example, if the husband died of AIDS, the remaining wife obviously will be traumatized about the fact that she may also be HIV positive. Therefore, knowing the HIV status of the deceased may enable the pastor to help the bereaved family to cope with their crisis. The pastor may provide adequate grief counseling to the bereaved family and help them deal with their feelings of anxiety, anger, denial and depression.

5.8. PARISHES INVOLVED IN CARING FOR AIDS ORPHANS:

From the research presented, it is only Pietermaritzburg North parish that takes care of

AIDS orphans. Through the caring of AIDS orphans, Kenosis Lutheran Community has become a home for a few AIDS orphans. What about other parishes? The research suggests that lack of finance is the only obstacle to other parishes focusing on providing care for AIDS orphans. Is there nothing that other parishes can do which does not require money? Chapter 6 will provide us with some suggestions on this issue.

### 5.9. CONCLUSION

The task of this chapter was to evaluate how the parishes of Umgeni circuit are involved in AIDS ministry. It is clear that the parishes of Umgeni circuit are not actively involved in AIDS ministry. The following chapter clearly states how the church can be involved in AIDS ministry, based on the seven-fold framework for the church's engagement with HIV/AIDS.

## CHAPTER 6: A THEOLOGICAL AND PASTORAL FRAMEWORK FOR CHURCH'S ENGAGEMENT WITH HIV/AIDS.

### 6.1. INTRODUCTION

We have now examined the AIDS ministry of ELCSA congregations of the Umgeni circuit in the light of the seven-fold framework for the church's engagement in AIDS ministry. We have identified many shortcomings in this ministry and, therefore, the task of this chapter is to promote a broad vision of what the church can do in the light of this framework, in order to see development as a holistic task of the church. This can provide guidance for a strategic intervention by local churches in all ELCSA dioceses, and even churches beyond ELCSA.

### 6.2. AIDS EDUCATION

In the face of the HIV/AIDS pandemic, AIDS education becomes a key responsibility of the church. The church has an enormous amount of educational resources, such as Sunday school, baptismal or confirmation classes. Before people are at risk of HIV infection, they need to be made aware of how to prevent HIV infection. For those who are already HIV positive, AIDS education provides them with information on how to live positively with the virus.

Buckingham rightly argues that churches have played a major part in creating a culture of silence about sexuality, and need now to play a major part in breaking it down. Buckingham believes that it is indefensible for churches to fail to make their

members aware of the crisis. There is no justification for our traditional reticence about sexual teaching. Churches may assume that their young people are not involved in sexual activity, but Buckingham strongly believes that this would be very naive (1992:73).

The question is, “Who must be involved in AIDS education for it to be effective in the church?” It is clear that the church is not without resources to facilitate AIDS education. Among church members, there may be a few nurses or doctors who understand the facts about HIV/AIDS. It can be argued that a person who must be involved in AIDS education should be able to interpret relevant medical information. It must be someone who can explain the way in which the virus works in the human body. This should not be understood as if AIDS education is the task of medical practitioners only, but the pastor, together with other lay leaders (men and women), can be involved in AIDS education if he or she is provided with necessary information about HIV/AIDS. This means that medical practitioners should educate the pastor and other lay leaders about the facts of HIV/AIDS so that they can be effective communicators in AIDS education. It can be argued that in conducting AIDS education, the facts of HIV/AIDS should be integrated with issues of faith.

Whiteside says, “evidence suggests that a critical factor for successful AIDS prevention is leadership” (2000:138). This suggests that leaders at all levels of the church should be taking every opportunity to talk about HIV/AIDS and lead by example. It is clear that leaders of the church must be sufficiently trained so that their AIDS education may be effective for the community.

The youth are at high risk of contracting HIV because they are sexually active. As a result, the target group for AIDS education should be the youth. It is clear that the main purpose of teaching young people about HIV/AIDS is “to reduce the likelihood that they will later begin to engage in activities that could pose a health risk in their lives” (Kelly, 1988:66). This should also not mean that other members of the church, who may as well be at risk of contracting HIV/AIDS, should be excluded from AIDS education.

It is clear that the principal aim of AIDS education should be to provide people with the facts about HIV/AIDS, its modes of transmission and its possible consequences. After people have been provided with such information, they may be able to modify their behavior so that they may not put themselves and others at risk of infection.

For AIDS education to be effective, it must provide people with information on how HIV infection can and cannot be transmitted from one person to another. HIV/AIDS education should also emphasize the fact that the disease is preventable. Young people must be provided with understandable information about strategies for HIV prevention. AIDS educators need to provide people with information about the social, psychological and economic implications of the disease. Finally, AIDS education should provide information about “community sources of assistance, not just on HIV, but also on sexual behaviors, bereavement and other areas touched by the epidemic” (Doka, 1997:147). It can be argued that understanding these facts should help people to make responsible choices that will prevent AIDS transmission.

The youth should be taught about AIDS in Sunday school, catechetical class and also in youth meetings. As AIDS education touches the issue of sexuality, it is clear that sex education for young people is critical in the church, especially in the black community. The reason for this is because in African culture, sex is not to be talked about in public. If the church truly cares about the next generation, it is clear that it must begin to see that people have accurate information about their bodies and the impact of sexual activity. We must no longer live under the impression that if we provide the youth with sex education, then they will become sexually active and we are condoning sexual activity. It is clear that young people need this information to make responsible decisions about their bodies and their lives. It is clear to me that pastors and other church leaders who feel uncomfortable discussing sexuality and specific sexual behaviors, which they may consider offensive, are not likely to be effective communicators of frank, and open discussions.

The World Council of Churches underscores this educational work:

People should develop a realistic understanding of vulnerability and risk, know the effectiveness of different preventive options and relate these to their own personal values. People should feel motivated to choose preventive behaviors, to practice relevant skills and to develop attitudes of compassion and care (1997:84).

Garner argues that church discipline can help to reduce the spread of HIV/AIDS because it promotes real behaviour change. He further argues that if such a strategy around sexual behaviour were applied more widely in churches, it is conceivable that a meaningful reduction could be achieved in the spread of HIV/AIDS (2000:16).

AIDS education can involve the use of seminars, videos and posters. To promote the prevention of HIV infection, it is inappropriate to use frightening messages: images

such as skeletons, skulls, coffins and even open wounds, have often been transmitted in the hope of scaring people into behavioral change. Such messages are harmful. Not only do they suggest that unless one has open wounds one is not infected, but they add to the stigma attached to those who are actually infected.

The research findings prove that it is difficult for people who are HIV positive to disclose their HIV status because they are afraid of being victimized and discriminated against. Promise Mthembu,<sup>18</sup> who is HIV positive, challenged me when she said that people listen to her and her AIDS education becomes very effective because she becomes a teaching aid herself. She also acknowledged that she breaks the walls of those youth who deceive each other by saying that AIDS does not exist. I found her to be a very good role model because she has a positive attitude towards life irrespective of her terminal illness. She cares about other people; she does not want them to be where she is now. She is living positively with AIDS.

The church has always educated people, it is clear that we should now add HIV/AIDS to the things that we educate people about. We need to educate everyone we can about the truth of HIV/AIDS. We can do this through workshops, posters, pamphlets, etc.

### 6.3. AIDS COUNSELING

The first stage of AIDS counseling involves pre-test counseling. If the person is found to be HIV positive, pre-test counseling moves to the next step, which is post-

test counseling. It is during this time that those who are tested HIV positive need a friend who can empathize with them. They need someone who can restore hope back to them.

### 6.3.1. What is counseling?

Nolan defines counseling as “a relationship between two or more persons in which one person (the counselor) seeks to advise, encourage or assist another person or persons (the counselee) to deal more effectively with the problems of life” (1994:39).

It is clear that the aim of counseling must be to provide an opportunity for the counselee to work towards living in a more satisfying and normal way. The role of the counselor is to facilitate the counseling session and in this session, the counselor must respect the values of the counselee. It is in counseling that the counselor brings back hope and faith where there was despair. In counseling, the counselor does not argue, threaten or warn the counselee. Instead, the counselor should encourage voluntary growth and change of attitude. Counseling involves empathy, listening and information giving. It helps the counselee to make his or her own decisions and carry them out. It involves support and confidence building. The counselee should “dictate the direction and pace and be helped to define his or her own problems, prioritize them and plan to resolve them” (Snidle, 1997:45). Counseling must be confidential because privacy is important.

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<sup>18</sup> She is HIV positive and is presently working at the Diakonia Council of Churches. She is working on AIDS awareness and she often gives the example of herself when she is conducting AIDS awareness in schools (Interview held on the 23 March 2000).

Counseling requires receptive listening. In other words, we must listen with ears, eyes and brain.

We must listen to what is said and what is not said. We must listen to verbal and non-verbal expressions.

Counseling is acceptance and love of another. The counselor facilitates communication with the counselee, communication that is not just the use of words, but “the art of understanding and being understood. This includes emotional meaning as well as intellectual” (Switzer, 1974:19).

It is in counseling that a counselor offers a ministry of presence. Our being with the counselee is more important than what we can say to him or her. It is clear that listening heals, and many counselees want to be listened to. It is not good that the counselor speak more than the counselee, because the counselee wants only an “ear”. The counselee must feel that the counselor is not bored, waiting to go home or worse, furious about what is being said. It is helpful to remember the words of Jesus, “I did not come to judge the world, but to save it” (John 12:47). Therefore, the counselor does not listen to judge, but to save.

### 6. 3.2. Pre-AIDS test counseling

Many people may be HIV positive and not know it and they may have been infected many years ago, but still be in good health. Many people with this virus continue to be well and live productive lives for many years.

There are many reasons why people may need to go for an AIDS test. It may be after rape. Some companies need an AIDS test before they employ you and other insurances before you join. The test will alert people to their HIV status, but this is a very difficult situation. A positive result brings with it a level of fear and anxiety that must not be underestimated. The aim of pre-AIDS test counseling is to prepare the counselee to live positively after he or she has tested HIV positive. The counselor should clearly state that being HIV positive does not mean that a person is dying. It must be clearly stated that people with HIV/AIDS can live fruitful lives like those who are HIV negative. This will bring hope to those who may feel hopeless after the test and may attempt to commit suicide after they have tested HIV positive. In pre-AIDS test counseling the church should indicate to the counselees that it will give them moral support after the test. The counselor should also provide the counselee with information about other HIV/AIDS support systems. The counselor should also clarify the myths about AIDS. This is important because some people believe that having sexual intercourse with a virgin cures AIDS, and for this reason many infants have been raped.

### 6.3.3. Post-AIDS test counseling

When a person is given a positive result, we should always assume shock. It is clear that a positive result can lead to despair with a loss of interest in living and in normal tasks and activities. It is, therefore, important to give such people time and encouragement to express their feelings and to answer their questions. It is important again to ask them whom they would like to tell. They may need help in telling their

partner which can be very difficult for them to do. It is very important to help them to identify possible support networks.

The stigma of HIV/AIDS can give people who have tested HIV positive a sense of social isolation. They may feel a sense of meaninglessness and start to be uncertain about their future. The task of the pastoral counselor is to help people with AIDS to come to terms with the disease and, therefore, encourage them to live positively with the virus. After people have tested HIV positive, they can live very fruitful lives if they live positively with the virus. As Snidle puts it, “ post-test counseling assists the person in moving from immobility, perhaps through fear, to action nurtured by hope” (1997:84). Help can come from many sources: namely, family, friends, support groups or from professional help.

After realizing that someone is HIV positive, it is very easy to judge that person to be promiscuous. But we must also remember that the pandemic does not give the church or anybody the permission to judge or condemn others. The only important judgement will be that which those living with HIV/AIDS will make of the church, of not being the loving and caring community the church claims to be.

#### 6.3.4. On-going counseling for people living with HIV/AIDS

People with HIV fear being discovered, discrimination, rejection and abandonment from people. Unlike other life-threatening illnesses, persons infected with HIV experience stigmatization. The anxiety and depression felt by many people living with HIV/AIDS can be severe and long lasting and will have implications for the way

they behave. They have a number of fears related to their illness, including dying a slow, painful death isolated from the people they know and care about.

For people with AIDS, the feelings of anxiety and depression are caused by the stigma that surrounds HIV/AIDS. They start to wonder if their relatives, friends and community members will accept them. Misinformed media presentation programmes on HIV/AIDS sometimes create these feelings of anxiety and rejection.

When a person provides pastoral counseling to people living with HIV/AIDS, it is important to know that though the basis of their illness is physical, the sickness also penetrates the spirit and affects their whole being. Therefore, ministry to people with AIDS requires “a psychological component” (Buckingham, 1992:77). It is clear that a person with AIDS needs a good friend to talk to and to cry with and, therefore, the church needs to be there for people with AIDS. The church should provide comfort and show unconditional love to people living with HIV/AIDS.

It is clear that pastoral counseling involves consoling those in pain and showing them compassion. In counseling, “the pastoral counselor is called to participate in the inner turmoil, agony, frustration and hopelessness of the sick or troubled person” (Mwaura, 2000:92).

Within the process of counseling, it is clear that the counselee experiences healing, when life and courage are restored and the counselee is aided towards fuller existence. In counseling, the pastoral counselor attempts to help the counselee to re-establish the broken relationship between himself or herself and God. Louw rightly states that to

be able to provide pastoral counseling to a person with AIDS, the pastor must first deal with his or her own paranoia. He or she must first come to grips with his or her own fears, uncertainty and prejudice. When the pastoral counselor plans for his or her ministerial strategy, Louw states that it is important to make contact with the person himself or herself on the level of his or her basic needs. He adds that the pastoral counselor should encourage hope in the person living with AIDS, and that hope must be grounded in the faithfulness of God and the resurrection power of Jesus Christ. And this hope should be encouraged through Scripture (1994:43).

In providing pastoral counseling to the people living with HIV/AIDS, the counselor should realize that the disease often brings low self esteem to the counselee. This may be caused by the fact that the person living with HIV/AIDS can no longer provide for his or her basic needs, but depends on others. Christian fellowship (koinonia) must help to bridge the communication gap and to give back to the sufferer a feeling of dignity; it must provide the person with a sense of belonging.

#### 6.4. LIVELIHOOD SUPPORT FOR PEOPLE LIVING WITH HIV/AIDS

A person can be HIV positive for a while before he or she has AIDS. People who are HIV positive, and those with full-blown AIDS, continue to be people in the community. They are often bread-winners, and they all have skills and gifts that can be used to help themselves and others.

The majority of people living with HIV/AIDS in South Africa are poor and, as a result, they die quickly due to the lack of access to nutritional food. The AIDS crisis

also puts a burden on poor families that cannot afford to provide nutritious food for the person living with HIV/AIDS. The church can help people living with AIDS and their families by starting small business developments, such as gardening projects and other income generating projects. A gardening project can also provide nutrition to people living with HIV/AIDS and their families. Psychologically, doing gardening can be very therapeutic. As the plants grow up, a person with AIDS looks forward to the time of harvest and this in itself has some future meaning in it. There is hope in waiting for the harvest to come, and this may in addition bring hope for the future in the hearts of people living with HIV/AIDS.

Most of the Lutheran congregations have a variety of assets upon which to establish an income-generating project for the livelihood support for people living with HIV/AIDS. The variety of assets that the church has includes the gifts, skills and capacities of the congregants, including people living with HIV/AIDS. Every single person in the church has capacities, abilities and gifts that can be used to establish livelihood support for people living with HIV/AIDS. This means that the church should utilize the skills of its members and also encourage people living with HIV/AIDS to use theirs as well in providing livelihood support of people living with HIV/AIDS. Kretzmann strongly argues that living a good life depends on whether the capabilities and gifts which people have can be used (1993:13).

Each time a person uses his or her capacity, the community becomes stronger and the person becomes more powerful. It can be argued that strong communities are basically places where the capacities of local people are identified, valued and used. Therefore, the basic information needed to start a project for people living with

HIV/AIDS is an inventory of the capacities of the local people in the church. Every person in the church has some skill, ability or experience at doing something (even those who have little income). These skills and capacities can be utilized as important resources for the church to start a project for the livelihood support of people living with HIV/AIDS.

One successful project can lead to other projects. This simply means that when a certain project is successful, many more similar projects may be started. A successful project demonstrates to everyone that people who stand and work together can make a difference in life. It is clear that the starting point of any project is a need analysis. A project can only address a need if that need is properly identified, and if the people participating in the project are able to define in similar terms the need they are trying to address.

Clearly, no development can function without resources. And yet, there is no community (including the church) that can be entirely without resources to start any project. Swanepoel rightly says that there is a tendency for many of us to look for resources outside the community. He states that people are aware of their needs and they can identify many when they are asked to do so. But when asked to identify their resources, Swanepoel argues that people find it difficult to come up with more than a handful (1997:123).

In order to start a project for the livelihood support of people living with HIV/AIDS, the Lutheran congregations can use their empty space of land to start a gardening project. The church can use the talents, skills and capacities of people living with

HIV/AIDS for a project and this will also enable people living with HIV/AIDS to be actively involved in their development.

#### 6.5. ADVOCACY FOR PEOPLE LIVING WITH HIV/AIDS.

Like many ethical issues facing the church, such as debt relief, racism, the environment, HIV/AIDS is a political and public policy issue. While it seeks to counsel and care for people with AIDS, the church also has a prophetic ministry to address the leaders and the powerful in society, calling them to justice and compassion.

As Christians, we are called to present a prophetic vision for society in which the welfare of all people is equally important. Theunis and Gabriel capture this aspect of AIDS ministry:

The church's understanding of its witness in and to the world demands that we lend our voice to those who seek a swift response to HIV/AIDS, and transform public attitudes and policies so that adequate care, such as access to affordable medicines and treatment, and appropriate preventive measures will be available for all people (2001:23).

The church's advocacy work is directed to the powerful people of this world, who by virtue of their power exploit the powerless. While counseling is directed to the powerless, the church's call for advocacy is directed to the powerful. In the context of HIV/AIDS, the government, the private sector and the employers are the most powerful ones to whom advocacy for people living with HIV/AIDS must be directed.

In the late 1990s, a number of studies examined optimal regimens to reduce the risk of transmission in developing countries. In February 1998, for example, it was

announced that by providing AZT for only one month before birth, it was possible to reduce transmission in the intrapartum period by 54 percent, that is, to cut a 30 percent risk to about 15 percent. “If this regimen were to be used today in South Africa, approximately 40 000 infected with HIV could be prevented” (Heywood, 2000:6). Thabo Mbeki, the South African president refused to provide AZT to HIV pregnant women. Despite all the convincing arguments that AZT had shown efficacy in reducing material transmission and favorable cost analyses, Mbeki was steadfast in his refusal even to consent to trials. His argument was that in surfing the Internet he had found evidence that AZT was highly toxic and dangerous. Mbeki claimed that “there was evidence (from 5 trial sites) that AZT was dangerous and that the ‘consensus’ view ignored such dangers” (Crewe, 2000:10). For this reason, the government refused to consider AZT for women who had been raped, with the minister of health arguing that it would be unethical to give possibly uninfected women AZT due to the toxicity and side effects. The Department of Health has focused its opposition to AZT on the possible dangers of the drug. However, what the government has failed to comment on publicly are the benefits that would accrue.

In 1996, Mr. Hoffman<sup>19</sup> submitted an application for employment as a flight attendant to the South African Airways (SAA). On the strength of his curriculum vitae, various interviews and psychometric tests, Mr. Hoffmann was found to be a suitable candidate for the job. In a medical examination required by SAA, the examining doctor found him to be “medically suitable” for appointment. Interestingly enough, Mr. Hoffmann did not disclose that he was HIV positive, but a routine blood test showed that he was “an HIV carrier”. “SAA then performed a volte-face and declined to employ Mr.

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<sup>19</sup> The applicant in the matter.

Hoffmann as a flight attendant, offering him alternative employment as a ground staff member instead” (Du Plessis, 2000:12).

The two above mentioned stories indicate how the government also participates in discriminating against people living with HIV/AIDS. In his ministry, Jesus spoke for the rights of the poor and the oppressed of his time. Jesus continues to call the church to speak for the oppressed and those who are discriminated against. In our context, Jesus calls the church to be involved in advocacy for the people who are discriminated against on the basis that they have HIV/AIDS. While the church does counseling, pastoral care, etc, it should also send a prophetic message to the government. The church has a prophetic concern about justice for all people. The church needs to speak against government policies that discriminate against people living with HIV/AIDS.

It is also clear that testing for HIV antibodies for the purpose of employment is in general discriminating, because it stigmatizes prospective employees and infringes their human rights by excluding them from productive employment. It can be argued that pre-employment testing is not merely the exercise of a legal power by an employer to choose whom to employ. It is clear that it also closes the job market to persons with HIV, thus depriving them of the means to earn their living and achieve fulfillment through an occupation. Nicolson rightly argues that pre-employment tests specifically for AIDS are ethically unacceptable, since such a person may well have ten or more years of working life ahead. Nicolson rightly argues that it is unfair to exclude them from employment because they have families to take care of (1994:233). Due to our call for advocacy, it is clear that the church should speak against pre-AIDS testing as a pre-requisite for employment.

The recent legal case in South Africa of multi-national pharmaceutical companies making obscene profits from AIDS drugs also serves to illustrate how important it is for the church to bring its perspective to bear upon policy issues. Many pharmaceutical companies are taking the AIDS epidemic as an opportunity to make a large profit. As a result, the pharmaceutical companies make AIDS drugs unaffordable for poor people who are living with HIV/AIDS. “The poor people who are living with HIV/AIDS in South Africa charged that the pharmaceutical companies are putting profits ahead of their lives. And in the same way, the pharmaceutical companies argued that diminished profits would make it difficult for them to pioneer new drugs” (Ducasse, 2001). It becomes clear that the church should speak against policies that put profit as a primary issue ahead of human life.

Some insurance companies demand that people must undergo HIV testing before they are allowed to take an insurance policy. Because of the effect that HIV/AIDS has on the private sector, many employers have started pre-employment medical tests. People who are found to be HIV positive do not qualify for employment or take an insurance policy. The question is whether it is ethically right for employers to insist on a pre-employment medical test.

The church should speak out against AIDS testing as a pre-requisite for taking insurance. The church must speak for those who cannot speak for themselves. It can be argued that people living with HIV/AIDS have the same rights as anyone and, therefore, must not be discriminated against on the basis of their HIV status.

The critical question is: “How must advocacy take place and who must do it?” During the apartheid regime in South Africa, the Lutheran church was very vocal against apartheid. Many Lutheran pastors and lay leaders were imprisoned for speaking out against apartheid. Some, like Tshifhiwa Muofhe, were killed for exposing the evils of apartheid. Today in South Africa, we experience the freedom that many South Africans fought for. The challenge for the church in South Africa today is no longer to speak out for freedom, but for those who are discriminated against. As the Lutheran church was actively involved during the time of apartheid, it can be argued that the church should also be the voice of the voiceless in the context of AIDS. The church needs to state clearly in public that people living with AIDS must not be discriminated against due to their HIV status. This is not only the task of the bishops, but every Christian is called to be the voice of the voiceless. This issue can also be addressed to the government through the South African Council of Churches. Advocacy should not be understood to be the task of the bishops: every Christian is called to speak for the oppressed and the powerless.

#### 6.6. PRACTICAL AND PASTORAL CARE FOR PEOPLE LIVING WITH HIV/AIDS

The care that the church should provide for people with AIDS during the counseling phase, continues throughout the life of the person living with HIV/AIDS. When HIV develops into full blown AIDS, it becomes more difficult for people with AIDS to wash themselves, cook, clean their clothes and house and, therefore, the church once again needs to show its caring face.

The church does not only provide pastoral care to people living with HIV/AIDS, but also practical care. Pastoral care involves visiting, praying, bible reading and solidarity with people living with AIDS. Practical care involves helping people living with AIDS with practical things such as washing their clothes, cleaning their home, cooking for them and help them with shopping.

#### 6.6.1. Pastoral care for people living with HIV/AIDS

Pastoral care is a supportive ministry to people in crisis and those close to them who are affected by the very same crisis. Pastoral care is “a dialogical ministry which is oriented to the healing process in pain and suffering” (Hulme, 1981:9). It is a long-term ministry that is practised by people who may not have been trained for counseling. Pastoral care does not necessarily have to be a ministry of ordained people alone, but even lay people can offer pastoral care. Pastoral counseling is a short-term ministry and it is practiced mostly in crisis situations, but pastoral care is rooted in human life, and can never be isolated as a professional or even especially spiritual or religious preserve (Wright, 1982:9). The attitude of unconditional love and reflecting on the love of God make Christians to continue caring for others.

It is clear to me that people living with HIV/AIDS should also experience mutual healing in the way the church relates to and treats them. It is the task of the church to relate the alienation and helplessness of the person with AIDS to Christ's forsakenness. AIDS gives us a new and compelling opportunity to be the authentic church that our savior Jesus Christ calls us to be. In its call, the church must realize that the person with AIDS needs the Christian community. Christian fellowship must

help to bridge the communication gap and to give back to the sufferer a feeling of dignity and identity. It must also provide the person with a sense of belonging.

According to Nolan, the word “Pastor” is simply the Latin word for “shepherd” and “pastoral care” means the care or love that characterizes a good shepherd (1994:4). In the Gospel of John 10:1-18, Jesus is the good shepherd. He is the one who knows each of the sheep by name, and the one who lays down his life for his sheep. It is clear that pastoral care to people living with HIV/AIDS should be related to what the good shepherd does for His flock (John 10:11). Pastoral care to people living with HIV/AIDS implies that we should always be there in times of need and give them the mutual support they need. In doing this, we must not do it to the extent that people living with HIV/AIDS will be dependent on us for everything. Instead, we must help them to get back their identity and dignity as human beings.

Louw strongly argues that the aim of pastoral care is to integrate the redeeming work of Christ into our being, via faith (1994:71). On the other hand, Ward argues that the primary aim of the care-giver has most often been that of enhancing coping capabilities and providing emotional support in this time of isolation, fear and loneliness. There is an increased need for reassurance of love and care from others (2000:27).

In pastoral care, the care-giver wishes to help people living with HIV/AIDS to integrate, via faith, God’s compassion into their situation of illness. The care-giver also reaches out to others in Christian love in spite of illness, thus witnessing the presence of God, and to direct their entire existence, in Christian hope, to a

meaningful goal and a new future (Louw, 1994:72).

Thus, pastoral care wishes to assist the sick, in the midst of suffering, to rely on the faithfulness of God. This means that pastoral care wishes to link believers by means of scripture to God's fulfilled promises so that, out of gratitude, they can accept their sickness as a challenge to exercise faith. The distress of sickness becomes an opportunity to live God's victory and to demonstrate faith, hope, love and joy.

As care-givers, Williams believes that our first task is to examine our own attitudes. We can only help others if we enter into this world of suffering at a humble level, assuming that we are there to learn (1990:171).

Furthermore, people who are very involved in providing pastoral care to people with HIV often become frustrated in seeing so many promising young people die of AIDS. These care-givers become very involved with persons with HIV and with their families and friends and they share with them their experience of pain. It is clear that where there is attachment, there will be experience of loss and grief when the person dies. The care-givers also experience the pain of loss and they, too, need to be ministered to. Unfortunately this is not feasible given the size of the pandemic, but there should be other support systems to help those who are emotionally affected by working with people living with AIDS. The establishment of the minister's fraternity can be of great help in this regard. When ministers are gathered together, they may talk about their experiences in HIV/AIDS ministry and, therefore, may also support each other spiritually. In ELCSA, the bishops can be informed about ministers who

are deeply involved in AIDS ministry and, therefore, need spiritual support. This is clearly one of the tasks of the bishops.

#### 6.6.2. Practical care for people living with HIV/AIDS

Mwaura states that pastoral care in the church should be holistic, attending to all levels of human caring, i.e., physical, moral and spiritual (2000:85). It is clear to me that good pastoral care does not ignore the physical needs of a person or community. Good caring should pay attention to physical comfort and economic necessity. God is concerned with human happiness that entails health, material benefits, peace and salvation. Therefore, the pastoral work of the church is to be seen in terms of healing, guiding, sustaining and reconciling the people of God. The Bible clearly indicates that God is the ultimate source of all pastoral care. This care involves deliverance from bondage-social, political and economic (Exodus 3:7-9). It also includes restoration of personal health (Exodus 15:26).

With the high rate of HIV infection in our country, it is unlikely that the health department will have enough beds to hospitalize all people who are living with HIV/AIDS. When people living with HIV/AIDS are brought back home from hospital, they will need someone to care for them. They will need someone to wash them and to give them food. The church should be able to offer all necessary help needed during this time. As the pastor, together with his or her lay leaders visits people living with HIV/AIDS for prayers and to give holy communion, he or she will be faced with the challenge of washing people living with HIV/AIDS before praying with them and giving them holy communion. As the AIDS epidemic continues to

grow, the church will have to move from theoretical preaching and do practical things for people living with HIV/AIDS. The church will have to come up with strategies of how to meet the physical needs of people living with AIDS. The church will have to meet both the spiritual and the physical needs of people living with HIV/AIDS. For example, as shopping may be a problem for the family, the youth may have to draw up a timetable for helping the families of people living with HIV/AIDS with shopping. The youth will, also, have to decide how to wash the clothes everyday of the whole family of people living with HIV/AIDS. This also includes cleaning the house of people living with HIV/AIDS and making sure that all the physical needs of people living with HIV/AIDS are met.

For the church to be a healing community, it is clear that it is supposed to meet the spiritual and physical needs of people living with HIV/AIDS. In the story of the Good Samaritan (Luke 19:30-37), we hear that when the priest and the Levite saw the man who was beaten and wounded, they passed by. But a Samaritan came where the wounded man was, and when he saw him, he had compassion for him and bound his wounds, pouring oil and wine. This story portrays the priest and the Levite as people who are only concerned about the spiritual well being of people. With this parable, Jesus is conveying a message to all of us that spiritual and physical needs are of equal importance to a human being.

#### 6.7. FUNERAL SERVICES AND BEREAVEMENT

Death usually means the end of the work for the medical fraternity, but it signals another important task in the holistic development ministry of the church. After the

family has experienced death, they grieve for the loss of their beloved one. This means that the church has to take up the challenge of counseling the people who are left behind, namely, the parents, the spouse and the children, the siblings and the close friends.

There is great hunger among people living with AIDS to hear of a loving and accepting God, a God who is weeping with humanity about this plague, and a God who does not judge, but only loves. There are many ways in which the church can reach out to those who are mourning, and funerals can be one of them. The funeral is not just a church function, but also an opportunity to face the reality of death together, and to remind ourselves that death is not the final word that God proclaims to humanity. Funeral arrangements are most often made during a time of numbness and grief. For this reason, it is hard for the grieving family to decide exactly what they want. The church also has an important role to play during the funeral. It can be argued that it may be helpful to the bereaved family if the pastor or other members of the church accompany the grieving family as they make funeral arrangements, even though it is supposed to be the task and responsibility of the family.

As Snidle rightly says, “grief is not an illness, but a natural process that must be allowed to run its course and this takes time. Each person will have to establish his or her own method of recovery” (1997:115). This means that there is no right or wrong way to grieve. No one can resolve grief for another; resolution can be gained only by experiencing and working through these emotions.

Grief is a process with different stages and it affects many aspects of a person's life.

In order to help to manage loss, it can be argued that the church needs to offer to the family complete and unconditional acceptance, empathetic understanding and congruence. Our support and prayers should continue beyond death and through the mourning period.

When someone dies, it is the survivor who suffers. People speak of having 'lost' a friend, brother, sister, mother, father, wife, husband, child, etc. The bereaved person very frequently is unable to come to terms with the loss. As the church accompanies the bereaved family in their bereavement, it can be argued that the bereaved family must be allowed to talk about themselves, their situation in which the person who has died was last seen, the days and hours prior to the death and the feelings and plans of the bereaved.

In helping the bereaved family, Kay and Weaver want us to know that psychologically, mourning is a helpful process. It is clear that if people repress their emotions and pretend that they feel no sense of loss, then, they repress all their emotions. Kay and Weaver argue that the reduction of one emotion blocks out other emotions. If people cannot weep, then they cannot laugh (1997:164).

Mc Donald states that to work with bereaved persons, the helper needs to come to personal terms with his or her own experience of loss (1993:544). It is clear to me that this, also, applies to death. It can be argued that a person cannot freely and openly talk with the bereaved family about death if he or she has not yet come to understand his or her own death. It can be argued that a person who wants to help the

bereaved family in their grief must first deal with his or her own fears and anxieties about death, before he or she attempts to help the bereaved family in their bereavement. Melges rightly argues that people who want to help persons in their grief need a “capacity for reflective review” on personal loss and grief as well as “preparation” for a journey that is difficult for all concerned (1982:212).

#### 6.8. CARING FOR THE DEPENDENTS (ORPHANS)

Sometimes, after the funeral service, the church walks away from the bereaved but, due to the growing number of AIDS orphans, the church will be forced to change. The church will have to learn ways of bringing up children and caring for them. The HIV/AIDS pandemic calls the church to establish sustainable support systems that will make a lasting contribution in the face of the HIV/AIDS crisis. Since many affected families are of lower socio-economic status, and AIDS further inhibits their efforts to be self sufficient and they may not be able to afford medical insurance, special needs arise for financial assistance and social services (Buckingham, 1992:97).

According to Lovelife, by 2005, there are expected to be around 800 000 orphans under the age of 15, rising to more than 1.95 million in 2010 (2000:11). Commenting on the statistics, Naidoo states that orphans in Pietermaritzburg were last physically counted in 1994. Although it is estimated that there are already 10 000 orphans in the Pietermaritzburg region, no one can be certain. There are 1 700 new HIV infections and 200 HIV positive babies born every day in South Africa. In Kwa-Zulu Natal, the death rate due to AIDS is higher than the birth rate. In the midlands, 75% of hospital

beds for children are occupied by children with AIDS related diseases and 50% of childhood deaths in the same area are AIDS related (2000, Natal Witness).

As the epidemic increases in South Africa, there will be more and more children who will be AIDS orphans and they also have to live with the AIDS epidemic. It is clear that caring for AIDS orphans is one of the greatest challenges facing the church and the whole of South Africa today. As the number of AIDS orphans increases, there is a possibility that some orphans will grow up as street children due to lack of parental guidance. Others will be brought up by grandparents with limited capacity to take on parenting responsibilities. It can be argued that as children grow up under these conditions, they may become less productive members of society.

One of the creative ways to meet the emotional needs of AIDS orphans is the establishment of the “memory box”.<sup>20</sup> The basic assumption of the methodology of the memory boxes is that “children who remember their deceased parents and relatives in a positive way are in a better position to cope with the hardships of the orphan condition.

They know more about their roots and can figure out what has happened to their parents” (Denis, 2000:34). Denis further argues that maintaining the memory of the

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<sup>20</sup> “Memory box is a metaphor. The term also designates a physical object: a box which can be decorated with photos or drawings and contains the story of the deceased person as well as various objects pertaining to the history of the family. The members of the family, both children and adults, take an active part in creation of the box. The more they contribute to the process of retrieval of memory, the more they benefit from it. The method followed by Memory Box Agency is to gather people living with HIV/AIDS or affected family members and to ask them to share their memories for the benefit of the children. The process is also offered as therapy for people living with HIV/AIDS themselves, whereby preferred and enabling family stories are explored. This approach presupposes that the participants are open enough about their HIV status to want to begin this journey. They benefit from the assistance of a trained psychologist” (Denis, 2000:35).

family helps the children to structure their identity and, in this way, they better adapt to their new emotional and socio-economic environment (2000:34-35).

With the growing number of AIDS orphans, “providing a home, medical care, education, psychological support and basic needs for the AIDS orphans will be one of the greatest challenges facing our generation” (Giese, 2000:38). It is clear that AIDS orphans need care and love from the community, including the church. We have to stand up and support these children as much as we can. We can support them by giving them shelter, food and any other necessity needed in life. The church can do this by encouraging people to adopt AIDS orphans and the other way will be to start a project aimed at helping AIDS orphans. The best example of this is the project of the Kenosis Lutheran Community.<sup>21</sup>

## 6.9. CONCLUSION

This chapter provided us with a theological and pastoral framework for the parish’s engagement in the issue of HIV/AIDS. It becomes clear that ELCSA parishes can effectively deal with the HIV crisis if they follow the seven-fold framework of the parish’s engagement in HIV/AIDS. With the seriousness of the HIV/AIDS crisis, the following chapter concludes by challenging the church to be involved in AIDS ministry.

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<sup>21</sup> See footnote 13

## CHAPTER 7

### 7.1. CONCLUSION

We have made it clear that HIV/AIDS affects the whole of society. It touches all spheres of human life. It affects us economically, socially, spiritually and psychologically. The issue of HIV/AIDS in South Africa, and particularly in Kwa-Zulu Natal, leaves the church with a challenge to think more about the issue of what strategies the church can use to manage the AIDS pandemic.

The research findings suggest that the Lutheran parishes in Umgeni circuit have not taken the issue of HIV/AIDS very seriously. The response of parishes to the AIDS crisis seems to give the impression that AIDS is the problem of the government and, therefore, the church does not have to bother with responding.

However, the statistics of people living with HIV/AIDS in South Africa and particularly in Kwa-Zulu Natal are alarming. It is clear that some of the people living with HIV/AIDS are our church members, who may be active members of the youth league, men's league and women's league. The church seems not to understand its role in social issues. Perhaps that is why the research findings show that there is no parish involved in advocacy for people living with HIV/AIDS or in livelihood support for people living with HIV/AIDS and only one parish is involved in providing a support system for AIDS orphans.

The church is the one that must break the silence by changing its attitude towards people with AIDS and, as a result, people with AIDS will find it easier to come out and disclose their HIV status. They will be able to disclose their HIV status, knowing that they will find support in the church.

This thesis argues that in order for the church to be effective in dealing with the HIV/AIDS crisis, it has to apply the seven-fold framework for the church's engagement with HIV/AIDS.

HIV can be viewed as a challenge and an opportunity for society. It offers us the opportunity to re-evaluate our lives and to consider the meaning of life itself and it challenges our compassion. The question is: "Are we prepared to follow Christ to be with our brother or sister in pain?" Christ calls us to be with those who are in pain, in fear or confusion. In sharing suffering, we minister to one another and we both gain and grow spiritually.

The church has the mandate to console, to reconcile, to love and to minister with unconditional acceptance. The church should be a loving family that sustains people with HIV/AIDS and their loved ones, without barriers, exclusion, hostility or rejection. We are challenged to protest against discriminatory policies and practices, to provide practical and spiritual help and consolation to people with AIDS. May God grant us the grace to live up to his high calling in Christ Jesus our Lord.

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