A CRITICAL THEOLOGICAL ANALYSIS OF THE HIV AND AIDS POLICY OF THE METHODIST CHURCH IN SWAZILAND

BY

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Dedication

First and foremost, I dedicate this dissertation to my parents, Annette K. Namutebi Kisaalu and the late James Luwunge Kisaalu for their initial efforts towards my education. Secondly I dedicate it to my brother George Matovu Kisaalu for the support he gave me since the time our father could not afford any more. I also dedicate it to Vincent Luzira for financial support and input he gave me throughout all my studies at the University and to the rest of my family for moral and other kinds of support.
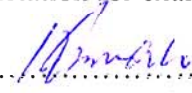
Declaration

I hereby declare that this dissertation is a product of my own original work unless stated otherwise.
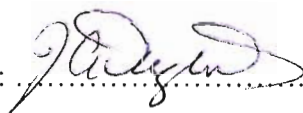
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Date: ...... 14 March 2008 ......

As Supervisor, I agree to the submission of this dissertation for examination.

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Acknowledgement

Abstract

Swaziland is one of the countries most affected by HIV and AIDS on the entire globe. The impact of the pandemic on the country is enormous with a prevalence of 42.6%. This has been so far the highest in Africa and possibly in the whole world. Due to this unbearable situation, a number of organizations, Church bodies, government and some individuals in the country are trying hard to counter the pandemic. This dissertation therefore seeks to outline the HIV epidemic in Swaziland and understand particularly the response of the Methodist Church to the epidemic. In dealing with the problem, the Methodist Church of Swaziland is using the Methodist Church of Southern Africa's (MCSA) HIV and AIDS policy document.

In evaluating the MCSA HIV and AIDS policy document, the thesis seeks to investigate the impact of the MCSA's response to HIV and AIDS. It also seeks to reflect theologically on the content of the policy document of the MCSA and to identify the strengths and weaknesses of the document and to establish whether it is relevant to the Swaziland context or not.

In general the thesis looks at the HIV and AIDS situation in Swaziland, the Shalom concept as well-being, the document summary and also presents a critical analysis in which it discovers that there are good things in the policy document. However due to the theological gaps in the document, there is need for a solid theological foundation for it to be used as a necessary tool or a *sine qua non* instrument. Conclusively, to strengthen the policy document the thesis recommends a number of things which include also a more solid theological base.

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List of Acronyms

AIDS	Acquired Immuno- Deficiency Syndrome
ANC	Antenatal Clinic
ARV	Antiretroviral
ART	Antiretroviral Therapy
EGST	Ethiopian Graduate School of Theology
FBOs	Faith Based Organizations
FDI	Foreign Direct Investment
GFATM	Global Fund to fight AIDS, TB and Malaria
HIV	Human Immuno-Deficiency virus
MCSA	Methodist Church of Southern Africa
MOE	Ministry of Education
MOHSW	Ministry of Health and Social Welfare
NERCHA	National Emergency Response Council on HIV/AIDS
OVC	Orphaned and Vulnerable Children
PLWHA	People Living With HIV and AIDS
SBIS	Swaziland Broadcasting and Information Services
SNL	Swaziland National Land
SNAP	Swaziland National AIDS Programme
SNAT	Swaziland National Association of Teachers
TASC	The AIDS Information and Support Centre
UKZN	University of Kwa Zulu Natal
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNICEF	United Nations Children's Education Fund
UNDP	United Nations Development Programme
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

It's nearly three decades into the AIDS pandemic and in spite of the progress made in increasing global awareness and commitment to overcome HIV, the epidemic continues to outstrip these efforts and remains a serious threat to humanity.[1] Coombe (2002) agrees with this view as he says;

> The rising prevalence rates world wide, indicate that most strategies to contain the disease have not been effective. As HIV and AIDS spread, the individuals, families, communities and nations must learn to live with the disease. HIV and AIDS, have moved from the level of a disease into a pandemic. The pandemic is a complex set of related problems which collectively constitute a phenomenon that needs understanding in very broad geographical, cultural, economic and social terms.[2]

Swaziland is one of the most HIV and AIDS affected countries on the globe. Generally the impact of the pandemic on the country is enormous with a prevalence of 42.6%[3]. Currently, due to this alarming situation in Swaziland, there are a number of organizations, bodies and individuals working hard in the country in order to make a difference by dealing with the pandemic. Surely this does not leave out the Methodist Church as a body that contributes a lot also in dealing with the pandemic. It was actually the first Church to start mission work in Swaziland in 1844.[4] The Methodist Church in Swaziland is using an HIV and AIDS policy devised by the entire Methodist Church of Southern Africa (MCSA). Therefore this thesis attempts to critically look at the theological analysis of the HIV and AIDS policy of the Methodist Church in Swaziland.

This chapter attempts to give the background to the entire research, focus of the study, aims of the study, motivation and rationale of the study, key question, research

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[1] The UNAIDS report on 1986-2006 WCC and AIDS. 2006: 3.
[2] Coombe, C. *HIV/AIDS and the education sector: The foundations of a control and management strategy in South Africa. United Nations Commission for Africa (UNECA).* 2002: vii.
[3] Ministry of Health and Social Welfare Swaziland National AIDS programme Mbabane, Swaziland, May 2004: 10.
[4] Kumalo, R, S. 2006. Methodism in South Africa: The Teaching of Five native Mission Agents. *Studia Historiea Ecclesiasticae: Journal of the Church History Society of Southern Africa.* 22 (2): 7-8.

hypothesis, literature, research problem and objective, methodology and outline of the study which will be developed in depth in the following chapters respectively.

1.1 Background to Research

The AIDS pandemic presents one of the most significant challenges of our times. According to the UNAIDS report (2006) on the WCC and AIDS, 1986-2006:

> AIDS causes 8000 deaths every day, has left 13 million children orphaned, exposes the perilous state of many countries, communities, cripples their ability to be sustainable and productive, and shatters relationships due to the accompanying stigma and discrimination.[5]

Since the first appearance of the pandemic, 25 years ago, an estimated 65 million people world-wide have been infected with HIV of whom 25 million have died.[6] The UNAIDS statistics for 2006 indicate the increasing number of people living with HIV particularly in Sub-Saharan Africa.[7] By the end of 1999, in Sub-Saharan Africa, the number of adults and children estimated to be living with HIV and AIDS was 24.5 million, and since then until the present, the number has increased drastically.[8]

The pandemic in Swaziland is so intense that no one can ignore the reality and every life in Swaziland is impacted by it. Since 1987 when the first AIDS case was diagnosed in the country, the Kingdom of Swaziland now has one of the highest prevalence rates in the world. In 1992 the first antenatal clients (ANC) survey found an HIV prevalence of approximately 4% among women aged 15-49, while in 2004, the 9th round of national HIV serosurveillance survey recorded a 42.6% prevalence rate among ANC attendees.[9] This is an indication that interventions have had little success in slowing the spread of HIV in the country. Further still, this tremendous escalation in prevalence signals that Swaziland will have to deal with rising illness and deaths. The epidemic is currently a serious concern for the government and the

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[5] UNAIDS, *2006 Report on 1986-2006, The WCC and AIDS. 2006:* 1.
[6] Ibid: 2.
[7] UNAIDS, *2006 Report on the global AIDS epidemic: A UNAIDS 10th anniversary special edition,* Switzerland: UNAIDS. 2006: 8.
[8] Barnett, Tony and Whiteside Alan, *AIDS in the Twenty-First Century: Disease and Globalization,* New York: Palgrave Macmillan. 2002: 15.
[9] Whiteside Alan, et al. *The Socio-Economic impact of HIV and AIDS in Swaziland.* Mbabane: NERCHA. 2006: 1.

people of Swaziland, as they have realized that the epidemic in the country is on a drastic increase.

At this stage, according to my observation, something more has to be done urgently otherwise AIDS will have a long term impact on the country. More and immediate responses from all quarters to deal with the pandemic should be welcomed.

The socio-political and economic situation of Swaziland exacerbates the spread of the virus to unparalleled proportions. Swaziland is classified as a lower middle-income country with per capita GDP at $1660 in 2006. 69% of the Swazi population is living below the poverty line of US$22per month.[10] Swaziland is still a monarchy having, a closed system of governance which has no room for human rights nor activism of any kind. Consequently, there is acute gender imbalance in Swaziland as well as a high degree of ignorance over the AIDS disease among the general population.

The monarchical system of governance is so autocratic that NGOs and other FBOs, which would otherwise create knowledge of AIDS as well as critique social evils, are manipulated by the government and are not allowed to question certain systems and practices in the country. This has led to an exacerbated spread of the virus and catastrophic living conditions which, in turn, increase the mortality rate due to the impact of HIV and AIDS. The level of AIDS awareness in the country is far below that of its neighbours.[11]

Without the exclusion of Swaziland the epidemic is affecting the larger society, and the Church is not at all spared. According to the report by the Joint Christian Association of HIV and AIDS: Guide for Clergy, "Many people are infected by HIV and Church members form a big proportion of the total number of infected people". This also includes priests, deacons, religious, pastors and ministers.[12] Parents are dying, leaving an increasing number of orphans vulnerable and helpless; hence the church can no longer afford to be passive and silent about the pandemic. Churches have a unique and critical role to play in stemming the tide and overcoming the pandemic. This is so because the Church collectively has a long tradition of reaching

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[10] Whiteside, A. *The Socio-Economic Impact of HIV and AIDS in Swaziland.* 2006:19
[11] Ibid, 2006: 1.
[12] *The Joint Christian Association on HIV and AIDS, Guide on HIV/AIDS for Clergy*, Enugu: CIDJAP Press. 2005: 10.

out to people not only in times of joy but also in moments of tragedy. Indeed the church has a well-defined history of combating social problems like unemployment, poverty, breakdown of family life and diseases such as HIV and AIDS among others.

Churches are faith-based institutions. These, together with other faith-based organizations, have played a central role and still play a critical role in the provision of health care in the developing world. Many hospitals and clinics, which constitute the backbone of the health infrastructure in communities, today trace their roots to missionaries and churches. This is particularly and evidently true in Africa where it is estimated that FBOs presently provide 40% of all health services, especially in remote rural areas.[13]

Realizing the challenge posed by the pandemic to the entire society, particularly in the Southern region of the African continent, the Methodist Church of Southern Africa (MCSA) responded by devising an HIV and AIDS policy in 2002 which was revised in 2006. The MCSA urged that the document should serve as the chief planning and implementation strategy to be employed by various Methodist churches in Southern Africa including the Methodist Church in Swaziland.[14] It was actually aimed at mobilizing the whole Church in the struggle to fight against HIV and AIDS.[15] However the Methodist church in Swaziland is using a strategy that was designed for the entire Southern Africa region. Arguably, the Swaziland situation dictates a unique and radical contextual response. The Methodist Church in Swaziland is part of MCSA which extends to five countries in the SADCC region which are; Mozambique, Namibia, Swaziland, Botswana and South Africa. It is under the administration of the annual conference and residing Bishop based in South Africa. Therefore the Methodist Church in Swaziland is more than a Swazi Church but partly foreign.

Historically, the Methodist Church in Swaziland, known as the Swaziland district of the Wesleyan Methodist Church began as early as the 1800s with the first mission established at *KaDlovunga* in 1844. In 1845 the mission was moved from

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[13] FBOs and Global fund, a report by UNAIDS, June 2007: 1.
[14] Sol Jacob, *The Methodist Response to HIV/AIDS in Southern Africa* (Johannesburg: MCSA Mission Unit) 2006:1.
[15] Sol Jacob, *The Methodist Response to HIV/AIDS in Southern Africa* (Johannesburg: MCSA Mission Unit, 2006): 2.

KaDlovunga to *Mahamba* near the Mahamba border post. The first Methodist missionary in Swaziland was Reverend J. Allison who came with a team of black assistants from Natal. In addition to his evangelical work, he started a school which was believed to be the first school in the country and was established at Sankolweni.[16] Methodism came to Swaziland following the dream of King Somhlolo. This will be explained in depth in the next chapter.

The king at the time, Mswati II, had accepted the teachings of the Methodist missionaries but refused to stay with them as he indicated to them that the nation required him at the royal residence. He granted the Methodist Missionaries permission to spread their faith. However he cautioned them not to try to change the people's customs and way of life.[17] The Methodist Church in Swaziland has currently got three circuits[18] throughout the country, namely; Hhohho circuit (Mbabane) which is under the leadership of superintendent Craig Bell, Mahamba is under Rev. Margaret Dlamini, and Central Swaziland or Manzini circuit which is under Rev. Skhumbuzo Ngema.

1.2 Focus of study

This study is part of a larger research project about theology and HIV/AIDS, commissioned by the Church of Sweden and conducted by the school of Religion and Theology in the faculty of humanities and social science in various institutions of higher learning in different developing countries. These include the University of KwaZulu-Natal and Stellenbosh in South Africa, Makumira University in Tanzania and Ethiopian Graduate School of Theology (EGST) in Ethiopia. The aim of the Church of Sweden was to train some people in developing countries, especially in Sub-Saharan Africa where HIV and AIDS is very widely spread, who will later help the Church world-wide to respond to HIV and AIDS.

The focus of my research study however is about a critical theological analysis of the HIV and AIDS policy of the Methodist Church in Swaziland. The policy in focus is

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[16] Times of Swaziland-Friday, 13, May, 2003: 25.
[17] Ibid, 2003: 25.
[18] A circuit is formed by a group of congregations within a geographical area.

that of the (MCSA) Connexional Task force on HIV and AIDS which was written by Sol Jacob in 2002 and endorsed by the bishops of the MCSA in the same year.[19] This policy document was revised in 2006 and this study is focusing on the revised version, which serves as the Planning and Implementation Strategy employed by various Methodist Churches in Southern Africa including the Methodist Church in Swaziland. As the Church's response to the HIV and AIDS epidemic in Swaziland, the study focuses particularly on the strengths and weaknesses of the policy, the theological framework. The study is both theological and critical in order to determine whether the policy adopted is relevant to the unique context of Swaziland.

The MCSA arrived at this stage of making a policy with regard to HIV and AIDS after realizing the tremendous challenge posed by the pandemic to the entire society, particularly in the Southern Region of the African continent. The MCSA's response towards HIV and AIDS is a reflection of both her spirituality of taking care of the sick and her doctrine of sanctification.[20]

1.3 Aims of the study

The aims of this research study are;
- To add to our knowledge of the impact of the HIV and AIDS epidemic in Swaziland.
- To investigate the response of the MCSA to the HIV and AIDS epidemic in Swaziland using the policy document.
- To identify the strengths and weaknesses of the MCSA's HIV and AIDS policy document in of the Swaziland context
- To reflect theologically on the content of the policy document of the MCSA.
- To investigate the impact of the MCSA's response to HIV and AIDS in Swaziland.

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[19] Sol Jacob. *The Methodist Response to HIV/AIDS in Southern Africa*. 2006: 1.
[20] Kumalo, R, S. *Theology and Education: The role of the Church in education for social transformation: A Methodist contribution*. Unpublished. 2005: 112-113.

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1.4 Motivation of the study and rationale

Research into the HIV and AIDS pandemic has always been viewed as a health concern by different schools of thought, however it should also involve understanding the nature of the pandemic and its influence on the entire society so as to respond appropriately.[21]

From the literature reviewed by the researcher, the focus of much of the research on HIV and AIDS in Swaziland was on the social impact which the pandemic has, upon the entire nation, and the role of the Church and FBOs in response to the Pandemic. No research concerning the verification of the relevance of the policy document of HIV and AIDS, that the Methodist Church in Swaziland is using, has been done before.

The researcher was also motivated to pursue this study because in this country (Swaziland) where the researcher has lived for five years, the incidence of the pandemic is on the increase by 6% per year. This has aroused an interest in the researcher to study the HIV and AIDS policy employed by the Methodist Church in Swaziland in order to suggest ways of improvement, since the Methodist Church has got the largest following in the country, and could easily make a big impact so long as the policy being used is relevant.

The policy document is the first prepared in 2002 by the Methodist Church in response to the HIV and AIDS epidemic in Swaziland and other countries in Southern Africa.[22] However, preliminary gaps emerged, therefore the reason for doing this study is to scrutinize the document in the light of the current contextual theological thinking on the response of the Church towards the HIV and AIDS epidemic.

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[21] Coombe, C. *HIV/AIDS and education. Perspectives in education.* 2002: 6.
[22] Sol Jacob, *The Methodist Response to HIV/AIDS in southern Africa.* 2006: 1.

1.5 Key research question

The study seeks to answer the key question below.

- How relevant is the MCSA policy document for the Church's response to the HIV and AIDS epidemic in Swaziland?

1.6 Definition of terms

In order to facilitate a common understanding, broad definitions of key terms used in this paper are provided.

- **Connexion:** This is the administrative office of the MCSA.
- **Circuit:** This refers to the group of Methodist congregation in a geographical area brought together for administrative purposes.
- **Society:** This refers to the local congregation.
- **District:** This is the number of circuits in a geographical area for administrative purposes.

1.7 Research Hypothesis

The hypothesis of this research is that the document is not relevant to Swaziland since, it does not address the particular areas of need in the country's AIDS epidemic. First, the document is not theologically equipped to guide the MCSA clerics in a creative theological reflection on the disease and its consequences. Secondly, it does not take into consideration the dictatorial nature of governance that the Swazi people are subjected to. Thirdly, it does not take into account the cultural dynamics of the Swazi nation, for instance, polygamy and gender inequality. Fourthly, the prevention methodologies of the document assume individual responsibility whereas the Swaziland situation is wrecked by violation of human rights, gender imbalances, poverty, and a pathetic health infrastructure. Therefore the reason for its inefficiency is that the document was founded on a hasty generalization.

This research is informed by the premise that the Church is a vital and indispensable stakeholder for a fruitful response to HIV in Swaziland particularly because of the closed political system which is effectively penetrated almost exclusively by religious organizations. Indeed, the Methodist Church is an integral part of the Swazi society, being the first church to arrive in the country it occupies a special place in the entire nation and also within the royal family.

HIV and AIDS, is affecting the wider society, and the Church is not spared. Many of the people infected by HIV are members and leaders of the Church. "Indeed, some are priests, pastors and ministers."[23] Parents are dying, being outlived by an increasing number of orphans. Therefore the Church can no longer be silent and passive about the pandemic, yet the weaknesses of this policy document impacts on the efficacy of the response the Church makes to the situation.

1.8 Review of Literature

The literature that was selected for review was obtained from a comprehensive search of the Methodist Church of Southern Africa (MCSA) HIV and AIDS policy document, national databases such as Swaziland National AIDS Programme (SNAP), Ministry of Health and Social Welfare(MOHSW), National Emergency Response Council on HIV and AIDS (NERCHA) database on current and completed research in Swaziland, and international databases such as the United Nations Programme on HIV and AIDS (UNAIDS), World Health Organisation (WHO) and United Nations Development Programme (UNDP). The majority of the books and journal articles consulted in this study were obtained from the libraries at the Pietermaritzburg campus of the University of KwaZulu-Natal, Cluster libraries, University of Swaziland, TASC library in Swaziland and the Methodist Church library in Swaziland.

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[23] The Joint Christian Association on HIV and AIDS, *Guide on HIV/AIDS for Clergy*, Enugu: CIDJAP Press. 2005: 10.

1.9 Research Problem and Objective

Religious values require equal treatment and regard for all manner and strata of people, therefore human dignity as well as identity should be enjoyed by all types and classes of people. The values of our faith call us to be involved because of the notion of the image of God (*imago dei*). The total concern of God for justice is rooted in God's self intrinsic nature and character.[24] The purpose for justice as manifested in Christ is for the common good of all humanity and the ultimate well-being of all people who are created in God's image.

The role of the church in the epidemic actually raises ethical and moral issues particularly in the light of HIV and AIDS stigma and discrimination. The church and in this respect of the study, the Methodist Church in Swaziland, needs to mobilize available resources and to ensure a holistic response to meet the future challenges of the disease (HIV and AIDS).

This study is vital in that, it can offer a model of accelerated participation and engagement of the Church in response to the epidemic. It will compel a review of unhelpful perceptions towards people living with HIV and AIDS. The study further more deals with aspects of identity and human dignity as the rational grounding of the study and argues for the validity of applying these values to the HIV and AIDS epidemic. Since the stigma and discrimination attached to HIV and AIDS is so common in the entire society, the Church as a faith-based institution that emphasizes human dignity and identity therefore needs to make a tremendous contribution towards new theological thinking. This will bring about a suitable action to counter the epidemic. The broader issue of HIV and AIDS stigma and discrimination will be investigated through the critical analysis of the policy document.

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[24] Ajulu Deborah, *Holism, in Development: An African perspective on empowering communities,* California: Marc Books. 2001: 59.

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1.10 Research Design and Methodology

The design or theoretical framework to be used in this study is the concept of "Shalom" as conceptualized by Perry Yoder.[25] According to Yoder, "*Shalom,* Biblical peace, is squarely against injustice and oppression. *Shalom* acts against oppressors for the sake of victims. It demands a transformation of unjust social and economic orders. In the Bible, *Shalom* is a vision of what ought to be and a call to transform society,"[26]

Shalom from the Hebrew text and *eirene* from the Greek text, stands for "material well-being and prosperity, justice and straightforwardness."[27] This implies that *shalom* in the Hebrew Bible is marked by the presence of physical well-being and by the absence of physical threats like war, disease (*like HIV and AIDS*) and famine. *Shalom* and *eirene* are also linked to social relationships. "*Shalom* depended on the relations among people within a society. Oppression meant no *shalom*, but rather judgement, while justice led to *shalom,*"[28]

In addition to this, in the realm of morality, *shalom* refers to the "absence of fault, guilt, or blame."[29]

It therefore means that *shalom* is dwelling at peace in all our relationships: with God, with creation, with other people and with ourselves. This is what the people living with HIV and AIDS need from society. Jesus proclaimed the gospel of peace or *shalom* as central to his mission on earth (Luke 4:18-19). God is involved in the well-being of the world God has created. Jesus goes to the lost and the outcasts, the marginalized and the excluded (like people living with HIV and AIDS). His death and resurrection is a profound proclamation of *shalom*. God has a particular concern for those who suffer. So it is the responsibility of the Church as Jesus' representative on earth to continue with this message of *shalom,* so that the hindrances towards an effective ministry to people living with HIV and AIDS (PLWHA) will be removed.

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[25] Yoder, Perry, *Shalom*, London: Hodder and Stoughton. 1989: 5.
[26] Ibid, 1989: 5.
[27] Ibid, 1989: 11-16.
[28] Ibid, 1989: 15.
[29] Ibid, 1989: 16.

Within this theological framework, there will be a focus on suffering and lamentation. "Suffering has sometimes been considered a given unavoidable destiny of individuals. On other occasions it has been regarded as punishment for sin."[30] However, Jesus showed compassion for the suffering, a compassion that involved both strong feeling for suffering individuals and a determination to help and empower them.[31] This is actually an act of solidarity.

Consequently, while lament primarily articulates the cries of suffering, it also calls for justice - an appeal for God to right past wrongs and to bring about healing in the future.[32] Thus lament can enrich Church liturgies and pastoral care in this context of HIV and AIDS, and contribute to a more truthful and intimate relationship with God by naming the 'un-nameable' to God.

1.10.1 Methodological Approach

A summary of the modus operandi employed in this study is presented. The methodology of this study is non-empirical. This research is primarily a library research frame work. The researcher's approach to this study involved an extensive conceptual analysis of the MCSA policy document on HIV and AIDS. It also involved an evaluation of the document which altogether enabled the researcher to identify the theological gaps in the document and to establish the strengths and weaknesses of the policy document which eventually provided ideas for a reconstruction.

The method of the researcher was divided into two phases. In phase one, the researcher had to read very carefully through the entire document of the policy and highlight areas of concern. In phase two, the researcher concentrated on addressing the areas of concern highlighted previously. The researcher primarily collected data from the national context of the Swaziland socio-political and economical situation.

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[30] Bauer, R.W., "HIV-and AIDS- Related stigma: A framework for Theological Reflection," in *A Report of a Theological workshop focussing on HIV-and AIDS-Related stigma*, Windhoek, Namibia: UNAIDS, 2005: 14.
[31] WCC study Document, Facing AIDS: *The Challenge, the Churches' Response*, Geneva: WCC Publications, 1997: 33.
[32] Ibid, 1997: 33

The researcher consulted a number of books, journals, articles, pamphlets of the Methodist Church in Swaziland and newspaper reports as secondary sources that enabled him to meet the objectives and to make a thorough analysis. The researcher also used his personal experience and observation on the issue of HIV and AIDS in the analysis and writing of this thesis. He also participated in a symposium at the University of Stellenbosch in July 2006 where the issue of HIV and the church were discussed. He learned a lot from this and he contributed by presenting a paper on the initial work of this research.

1.11   Research site

The research site selected for this study is **"Swaziland"** as shown in the figure below. The kingdom of Swaziland is located in Southern Africa and covers a surface area of 17,000 square kilometres. Swaziland shares borders with Maputo province (Mozambique) in the east, KwaZulu-Natal Province, Republic of South Africa) in the south and Mpumalanga Province (Republic of South Africa in the north and west).[33] The country profile of Swaziland will be dealt with, in detail in chapter two.

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[33] Kingdom of Swaziland ministry of Health and Social Welfare: *9th Round of National HIV Serosurveillance among women attending antenatal care services at Health facilities in Swaziland.* 2004: 14.
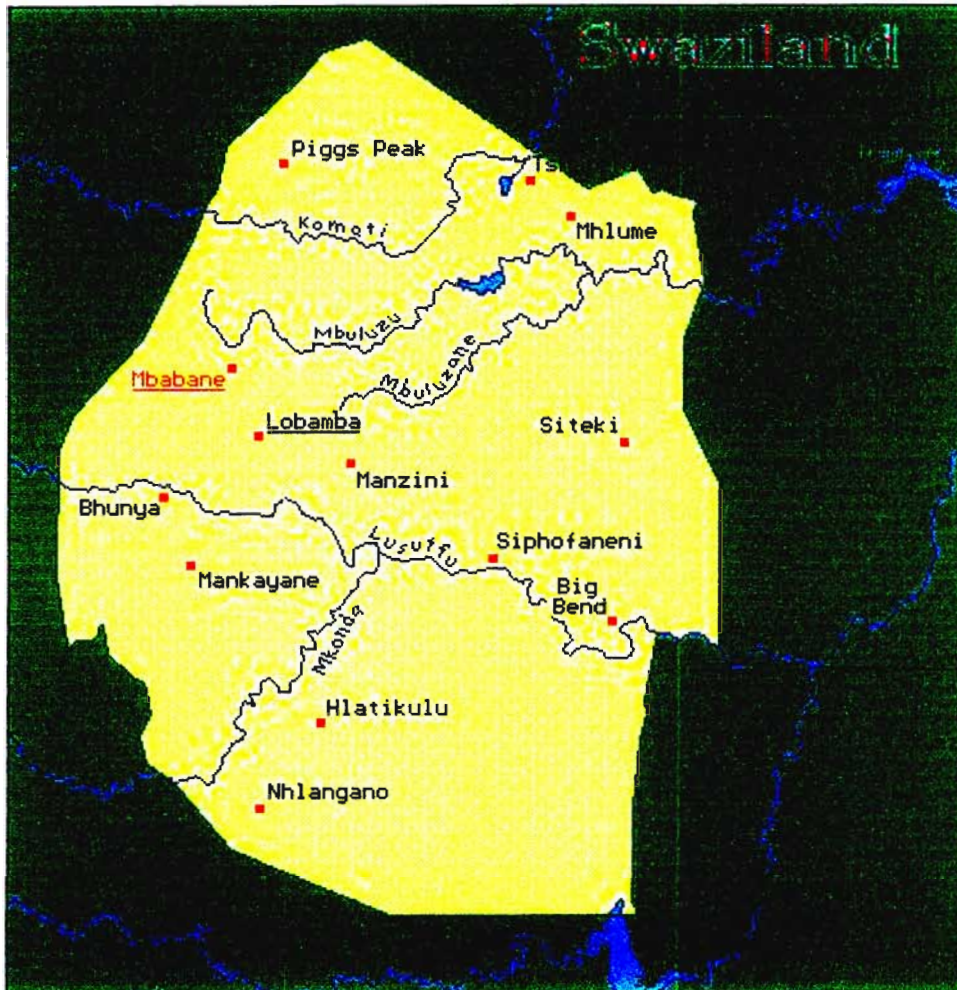
Figure 1.1: Map of Swaziland.

Source: Kuper (1963).

1.12 Outline of the Study

This research study is divided into five chapters. Chapter one provides a general background and overview of the key aspects of this study. The study is introduced by pointing out the incidence and prevalence of the pandemic in Swaziland and its consequent impact on the entire Swazi nation. The focus of this study, the aims, motivation and the rationale for pursuing this study are presented. The key research question, research hypothesis and review of literature, research problem and objectives are presented in detail. A brief outline of the Methodology employed in this study marks the end of this chapter.

In chapter two, focus is put on HIV and AIDS in Swaziland from a historical perspective and its impact on Swazi society as it affects life expectancy, health systems, social life and economic growth. The chapter delves into the factors that contribute to the spread of the disease in the country and looks at the responses of the government towards the HIV an AIDS pandemic.

Chapter three, attempts to look at the notion of *Shalom* and the mission of the Church. It endeavours to show that S*halom,* as a theoretical framework of this study, is important and vital for the mission of the Church faced by the HIV pandemic. Since the Church needs to operate from a firm theological foundation, the chapter provides theological principles as it attempts to theologize the epidemic (HIV and AIDS).

Chapter four is focuses on the HIV and AIDS policy of the MCSA. It attempts to unpack why the document was produced, who led the process, and the identity of the participants. The chapter presents the theological background of the participants and further focuses on the objectives and goals of the policy document in order to show its impact thus far.

In chapter five, the research theologically provides an analysis of the HIV and AIDS policy of the Methodist Church of Swaziland. This analysis engages the theological notion of *Shalom,* peace with justice. The chapter deals with recommendations or suggests a way forward for the MCSA in Swaziland in the light of the theological critique outlined in the previous chapter.

Chapter six focuses on the recommendations and way forward, conclusion and bibliography.

1.13 Conclusion

The chapter has introduced the entire study. It has outlined the key themes to be tackled in the thesis. For instance, the notion of HIV and AIDS in Swaziland, the *Shalom* concept, the HIV and AIDS policy document of MCSA and the theological critical analysis of the HIV and AIDS policy of MCSA in Swaziland. It has also

presented the key question to the study which is; how relevant is the MCSA policy document for the Church's response to the HIV and AIDS epidemic in Swaziland? The findings to this will provide the gist of the research. This chapter has presented also the focus of the study, the aims, methodology, motivation and the rationale of the researcher to pursue the study. Having seen the introduction to the whole study, we now turn to Chapter two, which is about the HIV and AIDS situation in Swaziland.

CHAPTER TWO

HIV AND AIDS IN SWAZILAND

2.1 Introduction

Swaziland is one of the developing countries that have been seriously hit by the HIV and AIDS pandemic world-wide. It has got a high prevalence of 42.6%.[34] This poses a huge and serious challenge to the Swazi government, individuals, and the Churches in the country, which of course doesn't exclude the Methodist Church in Swaziland. Therefore this chapter will look at the profile of Swaziland in the first place. Then it will discuss Swaziland and HIV/AIDS, its prevalence, the factors contributing to the spread of HIV, the impact and the influence of HIV.

2.2 Background and profile of Swaziland

Swaziland is an independent monarchy situated in Southern Africa, bordered by Mozambique and South Africa as shown in figure 1.1 in chapter one. "Swaziland is one of the smallest African states on the African continent with an area of 6,704 square miles or (17,363sq km)."[35] The country offers the challenge of considerable regional variation. According to Hildah Kuper, (1963), in her book entitled "The Swazi: A South African Kingdom",

> In the west are rugged highlands where grass is short and sour, trees grow mainly in deep ravines and the weather is cold and exhilarating. The mountains slope into the undulating plains of the more fertile and more midlands, which in turn gradually give place to bush country with hills rising from 170 to 360m (560 to 1180 ft), where cattle thrive throughout the year on green foliage. Between the lowveld and the eastern seaboard, the wind swept Lebombo range forms the fourth topographical region. One of the best-watered areas in southern Africa, Swaziland's four major rivers are the Komati, Usutu, Mbuluzi and Ngwavuma, flowing west-east to the Indian Ocean.[36]

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[34] NERCHA and Ministry of health and Social welfare. "*Our concern on the increase on HIV and AIDS.*" Times of Swaziland, 19 March, 2006: 10.

[35] Kuper, H. *The Swazi: A South African Kingdom.* San Francisco: Holt, Rinehart and Winston. 1963: 2.

[36] Ibid, 1963: 3.

Swaziland is divided into four administrative regions, namely Manzini, Lubombo, Shiselweni and Hhoho or Mbabane, which is the capital city, and is believed to have a population density of 56.5per sq km. The country has got an estimated population of 1,173,900 (July 2005 estimate), which is distributed into 77% in the rural areas and 23% in the urban and peri-urban areas and showing the Manzini region to have the highest population (30.2%).[37]

The Swazi people are part of the millions of Bantu-speaking peoples of Africa who migrated at different times from places further north and eventually arrived in the south eastern region between the Drakensberg Mountains and the Indian Ocean. From their homelands they brought cattle and seed for cultivation, and hand-made products of iron, wood, skin and clay.[38] Following their historicity, most people in Swaziland live on subsistence farming, likewise many a people in several African Countries.[39]

Swaziland is homogeneous in terms of culture and language. English and siSwati are both the official languages used in the country. As far as religion is concerned, 60 percent of the total population is Christian, with most of the remainder, apart from Islam and Baha'I, faith adhering to traditional beliefs.[40] The indigenous Swazi religion is traditional and it has been handed down from generation to generation. It is rooted in the past and its adherents do not depend on written material to acquire it, but rather on the past generation.[41]

The Swazi society has always had men and women of good memory who serve as the depositaries of traditional knowledge or else information and secrets.[42] Religious beliefs and knowledge are passed on to the succeeding generation by these men and women of good memory through oral tradition and silent tradition, the latter being the handing over of religious beliefs and values by way of example.[43] The Christian population (60%), being the highest in the country, brings us to the conclusion that

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[37] Nexus, *Situation Analysis of Swaziland Churches' response to HIV and AIDS*. 2003: 7.

[38] Kuper H. *The Swazi: A South African kingdom*. 1963: 1.

[39] Signs of hope a midst times of Challenge: *9ᵗʰ Round of National HIV Serosurveillance among women attending antenatal care services at health facilities in Swaziland*. 2004: 14.

[40] www.iata.org/training/travel_tourism. (Accessed on 27, Aug, 2007).

[41] Kasenene, P. *Swazi traditional Religion and Society*. Mbabane: Websters. 1993: 4.

[42] Ibid, 1993: 4.

[43] Ibid, 1993: 4.

Swaziland is a Christian country. Christianity came to Swaziland first through royal revelation and then royal invitation.[44]

King Somhlolo, the grandfather of King Sobhuza I, had a dream in which he saw the white-skinned people carrying a scroll (*umculu*) and a round object which was a coin (*indilinga*). Again in the dream, Somhlolo saw his aunt advising him not to accept the coins but the book and also not to hurt the white-skinned people.[45] Apparently King Sobhuza I acted on this dream when he sent a delegation to Thaba Nchu to ask for the missionaries to come to Swaziland to offer education and the gospel.[46] Consequently the request was granted and therefore, James Allison the missionary, was the first to arrive in Swaziland in 1844.[47] According to Mzizi, "the implication of the dream suggests a marriage of convenience between church and state in which the Swazi church hoped for a permanent religious monopoly in the country, with the state standing to benefit through assured blessings of all its activities and counting upon the support of the church at all times."[48]

The dream of King Somhlolo was the only contributing factor towards the good reception of the missionaries in the country and the easy acceptance of the natives to carry out their mission work without any disturbance. It resulted also in the popular view that Swaziland is a Christian country, with currently 60% of the total population adhering to Christianity. It's probably from this dream that the Methodist Church and other churches in Swaziland draw the idea of their duty to support the state in social matters.

Concerning the aspect of social convention, Swaziland has a social structure which is both traditional and modern. Traditional ways of life are still strong and Swazi culture, in the form of religious music, dance, poetry and craftsmanship, plays an

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[44] Mzizi, J. B. "Is Somhlolo's dream a scandal for Swazi Hegemony? The Christian clause debate reexamined in the context of prospects for religious accommodation", *in Missionalia* Vol. 33, No.3, November 2005:44.

[45] Kumalo, R, S. 2006. "Methodism in South Africa: The Teaching of Five native Mission Agents". *Studia Historiea Ecclesiasticae: Journal of the Church History Society of Southern Africa*. 22 (2): 7-8.

[46] Ibid, 2006: 7.

[47] Ibid, 2006:7.

[48] Mziz, J, B. 2005. Is Somhlolo's Dream a scandal for Swazi Hehemony? The Christian Clause debate re-examined in the context of prospects for religious accommodation, *in Missionalia* Vol. 33, No.3, November 2005: 44

important part in daily life.[49] The traditional structure is much more community and family oriented. The major function of this traditional structure is to offer social protection towards the family and community members. The labour force is mostly found in this structure, but sadly, HIV has incapacitated this structure as a large number of people in this setting contract the virus, get sick and eventually pass away.

The other one is the modern structure which is characterised by modern dictates, that is to say, encompassing modern behaviour, western way of life, family life and values.[50] This can be exemplified by the late King Sobhuza of Swaziland as Kuper puts it.

> He was the head of the most conservative homestead in Swaziland, but he had built for himself two of the most modern houses in the country. He retained the heavy drapes and solid furniture of the original white owners in the front rooms, where he used to serve hard liquor and tea from bone china cups. He had rooms at the back which had acquired a more traditional atmosphere, where one could sit on mats on the floor with Sobhuza's wives and drink beer from the common bowl. His clothing and housing mirrored a conflict of cultures.[51]

Swaziland has a monarchy system of governance. Her customs and traditions remain crucial and have played a key role in the politics of the country. Politically, the country maintains a dual system of government with a modern government led by the Prime Minister on one hand, and the traditional system of governance run by chiefs who report to the king as (*Ingwenyama*) on the other. The monarch is the head of state who appoints the prime minister and ministers. The parliament consists of the senate with 20 appointed by the monarch and 10 elected members and the house of assembly with 10 appointees and 55 elected representatives. Elections are not direct but made by an electoral college which itself is directly elected on a regional basis through traditional local councils or various constituencies known as *Tinkhundla*.(centers) Political parties do not exist in the Swaziland system of governance. They were banned by king Sobhuza II through the 1972 decree which declared him an absolute monarch with absolute control and authority over the state.[52]

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[49] www.iata.org (accessed 27, August, 2007).
[50] Poverty Reduction Task Force. *Ministry of Economic Planning and Development. Social protection of vulnerable children including orphans*. 2003: 3.
[51] Kuper H. *The Swazi: A South African Kingdom*. San Francisco: Holt, Rinehart and Winston. 1963: 4.
[52] Parikh, A, in Whiteside et al. *The Socio-Economic Impact of HIV and AIDS in Swaziland*. Mbabane: NERCHA. 2006: 5.

2.3 HIV and AIDS Situation in Swaziland

Swaziland has been extremely affected by the HIV and AIDS pandemic. The first case of HIV infection in Swaziland was identified in 1986 and the first AIDS case was diagnosed in 1987.[53] Since then, the number of people living with HIV and AIDS in the country has rapidly increased. Data from National HIV sentinel surveys of women attending ante-natal clinics indicate that in 2004, the number of pregnant women who were infected by the virus (HIV) had risen from 3.9% in 1992 to 42.6%. This percentage does not include the number of men who are infected neither does it include those who have not tested for HIV. This trend of course labels Swaziland as having the "world's highest rate of HIV infection."[54]

Unlike in many countries in Sub-Saharan Africa where HIV prevalence is declining or else stabilizing, in Swaziland, it is on the increase. The HIV infection is said to be growing at a rate of approximately 6% a year.[55] This is because some serious measures to combat the disease have not been put in place. For instance, until now, since the virus was detected in the country, there has not been a national policy on HIV and AIDS. The figure 2.1 below shows the trend in the level of HIV infection among ante-natal clients (ANC) in Swaziland since 1992.

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[53] Ibid, 2006:5
[54] Sentinel Surveillance. 2004
[55] Nexus, *Situation analysis of Swaziland Churches' Response to HIV and AIDS.* 2003: 7.
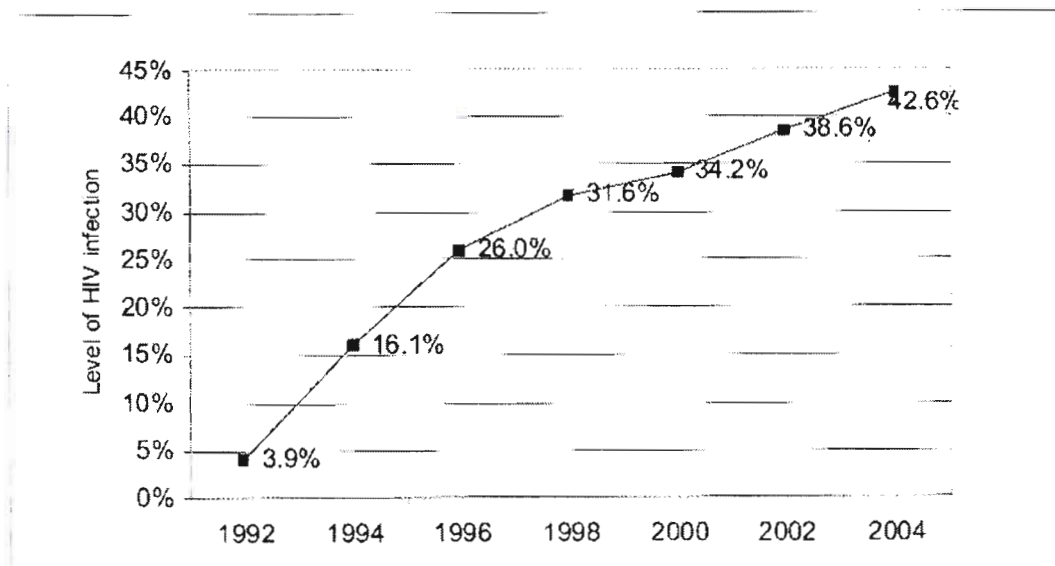
Trend in the level of HIV infection among antenatal clients in Swaziland since 1992

Figure: 2.1

Source: MOHSW

According to figure 2.1, the percentage increase in the level of HIV infection among antenatal clients year by year, indicates that HIV infection is growing at a fast rate and hence the HIV situation in Swaziland is escalating. However, while HIV prevalence has been on the rise in most age groups, it seems to be stabilizing among the 15 to 24 year olds. The latest statistics show a decline of HIV prevalence in the age group of 15-19 year olds between 2002 and 2004 as indicated in figure 2.2
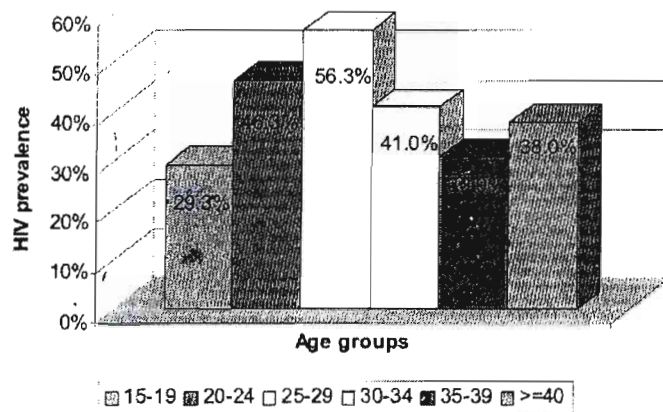
Figure 2.2: HIV prevalence rate by age group
Source: MOHSW

The statistics sourced from HIV and AIDS organisations show that about 42.6% of the population of 1.1 million is living with HIV.[56] In addition, estimates for the AIDS deaths in the year 2000-2015 are between 12000-15000 per year and that in the year 2000 alone, 40,000 orphans were recorded. It is thus estimated that by 2010, Swaziland will have over 120,000 orphaned and vulnerable children (OVC).[57] This poses a big threat to the entire nation and to the capacity of Churches and organisations involved in the provision of care and support activities.

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[56] Dlamini, C. *The Needs of ELCSA Ministers as they cope with burnout in their ministry to people affected by and infected with HIV and AIDS.* Masters thesis at UKZN, 2006: 28.
[57] Nexus, July *2003, Situation Analysis of Swaziland churches' Response to HIV and AIDS,* 2003: 8.

2.4 Factors contributing to the spread of HIV in Swaziland

The factors contributing to the spread of HIV in the country may be situated in the political, socio-cultural and economic context.

2.4.1 Political context

Swaziland is an absolute monarchy and maintains a dual system of government with a modern government led by the prime minister on the one hand and on the other a traditional system of governance run by chiefs who report to the king. The king appoints additional members, including the prime minister and cabinet.[58] Therefore no law or policy can be passed without the endorsement of the king. Obviously the king cannot endorse any law or policy that may happen to be in contradiction of cultural values, even if that policy can help to prevent HIV.

Due to the escalation of the HIV and AIDS situation in Swaziland day by day, despite all the efforts that are currently in place to make an impact on the pandemic, one of the AIDS activists in the country, Mr. Vusi Matsebula concluded that, "both the government and the NGOs have not done enough to educate the people about the pandemic."[59] In affirmation of Matsebula's point, I have also observed that the Government and NGOs have not to any great extent offered strong and focused leadership in developing HIV and AIDS programmes. The Methodist Church together with some other denominations, are trying in this area, but unfortunately they don't have enough capacity in terms of personnel and funds to plan and coordinate the programmes. In addition, the Director of the National Emergency Response Council on HIV and AIDS (NERCHA) Dr. Derek Von Wissel, said that, "it becomes almost impossible to win the battle against the scourge, if the government is not allocating enough resources to deal with it."[60] As an objective of its formation in 2001, the National Emergency Response Committee on HIV and AIDS (NERCHA) was given a mandate by the Swazi government to coordinate and mobilize resources for an expanded, scaled-up and coordinated response and to foster the multi-sectoral

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[58] Parikh A. *The Socio-Economic impact of HIV and AIDS in Swaziland*, 2006: 15.
[59] Times of Swaziland – March 23, 2007: 38.
[60] Ibid, 2007: 38.

involvement of all stakeholders. Sadly, the organization cannot carry out all of her duties effectively because the government does not allocate enough funds to it.

I agree with Vusi Matsebula when he accuses the government and NGOs of not doing enough to make the people aware of the pandemic. The government is slow and does not seem all that serious about its undertakings regarding the disease. For instance, in October 2000, a draft of the National Action Plan for HIV and AIDS (2000-2005) was produced but never implemented.[61] Again it is now almost two decades since the virus was detected in the country, but it is only now that a new National Strategic Plan (2006-2008) is in the process of being finalized as a new National Action Plan and national HIV and AIDS policy.[62] This is a clear indication that the reaction of the government towards the pandemic is slow and not very effective. The major weakness on the part of the government lies in its lack of good governance and this is clearly seen in its lack of proper monitoring and implementation of its actions thus creating a good atmosphere for the virus to flourish.

The optimum freedom of speech is yet to be realized in the country. The press is limited in this area. For instance, as a state-owned medium, the Swazi Observer (*News paper*) has not been able to report freely on the government's failure to effectively deal with the crisis. This is also akin to Swaziland Broadcasting and Information Services (SBIS).[63] Not allowing the press to critique the government is a major weakness on the government's part, because without such criticisms the government cannot improve, neither can it rectify certain conditions. In Swaziland it is believed that everything belongs to the king and is under the king, therefore any Bill of Rights or law has to be passed or endorsed by the king and of course this affects the freedom of speech.

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[61] Anokhi, P, in Whiteside et al. *The Socio-economic Impact of HIV and AIDS in Swaziland*. Mbabane: NERCHA. 2006:16.

[62] Ibid, 2006, 16.

[63] www.globaljournalist.org/Swaziland (accessed 4, Sept, 2007) : 1.

2.4.2 Socio-cultural context

In order to have a thorough understanding of the AIDS epidemic in Swaziland and the factors contributing to the rapid spread of HIV infection, it is worth unpacking the complexities of Swazi society, particularly the cultural beliefs and practices. There are various cultural beliefs and practices that are viewed as contributing to the spread of HIV infection in Swaziland and these are as follows.

2.4.3 Multiple female partners

In Swaziland, there is a practice of having multiple female partners. This is ideally known as *Bunganwa* in siSwati. It does not necessarily mean engaging in sexual activities with them. However, the common practice now is that they are treated as sexual partners, which is dangerous. This situation applies even to married persons, who often have sexual relationships with secret partners. Regarding the young male adults, there is a popular belief that multiple sexual partners provide a wider choice for a good future spouse. This practice of having multiple female partners may be advantageous to this way of thinking but presently with the AIDS scourge it does increase the risk of exposure to HIV.[64] For males *Bunganwa* is seen as heroism and of course it is a part of partriachy. The danger of this kind of relationship is that the female partners will also probably have other partners somewhere. If one is infected no matter if it is a male or female partner, all involved will be infected.

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[64] Parikh, A, in Whiteside et al. *The socio-Economic impact of HIV and AIDS in Swaziland*. Mbabane: NERCHA.2006: 17.

2.4.4 Polygamy

Polygamy is a term that refers to the union of a single husband with several wives.[65] Generally, according to Benn Kisembo (1997): 86

> The institution of polygamy in traditional Africa was certain not merely a means of satisfying male lust. It had a number of well-defined social functions and advantages and it certainly helped to stabilize the institution of marriage and to integrate the family with society. It had nothing to do with "free love" and it was often a remedy for divorce.[66]

In traditional Africa, polygamy had the function of catering for the sexual needs of men and of minimizing the chances of promiscuity and prostitution. More importantly, polygamy helped to satisfy the need and desire of having a large family, while at the same time it kept the fertility rate of the woman at a low level. It also catered for the childless union and offered a kinder solution than of divorce when a wife was barren. It provided care for the widow and children, after the husband had died. It was a form of security and a guarantee of prosperity when a large family community was necessary to exploit the environment and provide for basic needs. Also polygamy helped to stabilize the institutions of marriage and the family through multiple marriage alliances with several families. It helped to tighten the bonds of society and broaden the circle of relatives and associates.[67]

Swaziland is one of the societies in Africa whereby polygamy, to a large extent, is still commonly practiced, basically for the same functions as we have seen above. In siSwati "Polygamy" is referred to as "Sitsembu."[68] The royal family has traditionally been one of the main proponents of this way of life.[69] In Swaziland and almost everywhere polygamy is practiced, it safeguards men from engaging in casual sex with outside partners. For men who always engage in casual sex outside the wedlock, this practice helps to reduce the risk of exposure to HIV. However the argument is that the modern-day polygamists prefer maintaining several homesteads for each of

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[65] Kisembo B et al. *African Christian Marriage.* Nairobi: Pauline's Publications Africa, 1997: 85.
[66] Ibid, 1997: 86.
[67] Ibid, 1997: 86.
[68] Whiteside A. et al *The Socio-Economic Impact of HIV and AIDS in Swaziland,* 2006: 17.
[69] Tumusahbe, J et al. 2006. *What is driving the HIV and AIDS in Swaziland and what can we do about it?* www.sarpn.org.za (accessed 12 September 2007): 26.

the wives geographically dispersed across the country rather than locating all the wives in one homestead as it used to be in the past. This living arrangement may lead to unfaithfulness among the spouses, which may increase the risk of exposure to HIV.[70]

Looking at the aspect of unfaithfulness among the spouses in the sphere of polygamy as a common practice, one would argue that the practice should be discouraged. In a state like Swaziland where the practice is fueled by culture, it may not be all that easy to simply do away with the practice of polygamy. Therefore the coalition of the state and the Church is necessary in this scenario in educating the people about the value of faithfulness and trust among the spouses within this kind of union (polygamy). If faithfulness prevails in a polygamous family and partners are faithful to each other then HIV is not a threat. If one partner is unfaithful then it is much more likely that an infection will spread through the household.

2.4.5 Extramarital Relationship

In Swaziland there is a common practice of having extramarital relationships with lovers who may either be married or not. This practice is referred to as *"Kushenda"*. Dlamini (2005) perceives this practice as a perversion of the traditional practice which allowed a married man to have a young unmarried woman (concubine) who would be known by the wife or wives, usually with the intention to marry her at some stage.[71] The danger with this practice is that this concubine may also be involved in other relationships as she is not certain whether marriage will ever take place. Therefore this practice of *Kushenda* may increase the risk of contracting HIV.

2.4.6 Widow inheritance

The customary practice of widow inheritance or levirate is quite common in Swaziland. This entails that the widow of a deceased brother or next of kin is given another male within the family or next of kin, for the purpose of the sustainability of

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[70] Dlamin A. "Youth at the Margins: *Tradition, Sexuality and Young people's struggle with HIV and AIDS in Swaziland (Draft)" Swaziland National Commission for UNESCO,* 2005: 17.
[71] Ibid, 2005, p.17.

livelihood for herself and her children. This practice is referred to as *"Kungena."* Actually it means that the widow is obliged to have sexual relations with the male to whom she is allocated. Therefore this practice plays a role in the spread of HIV in Swaziland.[72] This kind of practice used to be common among many African tribes. For instance, I have witnessed it among the Ganda tribe in a certain family in Uganda, but nowadays it is very rare. In other countries in Africa, to mention but a few, Tanzania, Zambia, DRC and South Africa with specific reference to Kwazulu-Natal Province, this practice is very common.

2.4.7 Concubine or *Kuhlanta*

In Swazi culture, when a married woman is unable to have children, a young sister (or some other younger female relative) is attached to the husband in order to have children for the infertile wife and this practice is called *"Kuhlanta"*. This is normally the practice when the husband has paid lobola or bride price. Culturally, lobola is used as surety for reproduction of offspring.[73]

2.4.8 Kucetsa or Kujuma

This is the practice that refers to occasional short-term or overnight visits between unmarried lovers. In Swazi culture this is quite common and it is expected and even encouraged that boyfriends and girlfriends visit each other's homesteads and spend one or more nights there. According to Dlamini (2005), "the couple is expected to avoid penetrative sex." In actuality this practice helps in preventing the accumulation of multiple sexual partners and casual sex, but the present practice may involve penetrative sex during the visitations and besides, these visitations may be for more than one day. It may be concluded that this current practice by young people is likely to spread HIV infection as they are likely to engage in unprotected sex.[74]

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[72] Whiteside, A et al. *The socio-Economic Impact of HIV and AIDS in Swaziland.* Mbabane: NERCHA. 2006: 17.
[73] Ibid, 2006: 20.
[74] Dlamin, A. *"Youth* at the margins: Tradition, sexuality and young people's struggle with HIV and AIDS in Swaziland" (Draft): Swaziland National commission for UNESCO. 2005: 18.

2.4.9 Swazi way of Dressing

The Swazi way of dressing, most especially on the part of women when some parts of their bodies remain uncovered, particularly during cultural festivals, may interfere with men's libido which may result in engaging in unpremeditated sex. In 2003, a certain pastor, Oseadeba Ekoh commented that, "part of Swazi culture is the opposite of decency."[75] By this statement, he was referring to the women's traditional attire in Swaziland which is supposed to leave the breasts uncovered. His statement implied that the showing of the breasts does not help in bringing down men's sexual urges.[76]

Personally, I disagree with this statement in the sense that men in Swaziland most especially the Swazi men themselves have to understand the norms and customs of their culture. The way the Swazi women dress traditionally has to be regarded as normal by men. Perhaps the non-Swazi males in the country may be disturbed by women's traditional way of dressing, but they should also understand that cultures differ and hence they have to discipline themselves, especially during cultural festivals when this way of dressing is expected.

2.4.10 Alcohol and Drug Abuse

A number of young adults, especially men who involve themselves in the excessive use of alcohol and drugs, are much more likely to engage in sexual behaviour which, in turn, will make them more vulnerable. It has been noted by researchers that condom use in the country is very low and therefore this adds to the primary factors which contribute to the spread of HIV due to insufficient levels of awareness.[77] In affirmation of this, Vusi Matsebula, an HIV and AIDS activist, attributed the problem of increasing HIV infection in Swaziland partly to alcohol abuse which results in irresponsible behaviour.[78]

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[75] Oseadeba, E. 2003. Swazi Dressing. Times of Swaziland 13th/May/2003: 25
[76] Ibid
[77] Ginindza, A, In Whiteside et al. *The Socio-Economic Impact of HIV and AIDS in Swaziland.* Mbabane: NERCHA. 2006: 1.
[78] Times of Swaziland-Friday, March 23, 2007: 38.

2.5 Gender Factor

Generally the face of HIV and AIDS is a woman's face. Women have greater susceptibility than men to infection due to economic, social, cultural and physiological reasons and are now being infected at a higher rate than men.[79] According to my experience and observation in Swaziland, culture puts men above women and children. Culture empowers men so much so that they look down upon women and children in society as a class they are actually considered to be inferior to men. The attitudes and behaviours of men are critical in prevention efforts. Men hold overwhelming power in decisions on sexual matters. Therefore the social and sexual rights of women are not considered. Weinreich said that, "women are greatly vulnerable to HIV infection because of this gender imbalance."[80] In Swaziland, women's economic dependency on men, their high poverty levels and lack of access to opportunities contribute to their vulnerability to HIV and AIDS. Most cultural expectations and practices in the country are also believed to contribute to women's vulnerability to HIV and AIDS. The Swazi society expects women to be subordinate and submissive. For instance it allows men to have multiple sexual partners which actually, in this scourge of AIDS, exposes women to HIV infection.[81] Some other authors like Musa Dube, and Kanyoro, agree with the view that, "gender inequality is a major driving force behind the AIDS epidemic."[82]

Gender discrimination, poverty and violence lie at the centre of the AIDS epidemic. Physiologically, women are at least twice as likely as men to become infected with HIV during sex. Women and girls are often ill informed about sexual and reproductive matters and are more likely than men to be illiterate. They often lack negotiating power and social support for insisting on safer sex or rejecting sexual advances. Gender- based violence is a major risk factor for contracting HIV. It is not only in Swaziland but also elsewhere, most especially in Sub-Saharan Africa; poverty

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[79] UNIFPA, *State of world population Report*. 2005: 1.
[80] Weinreich et al. *AIDS - Meeting the Challenge: Data, Facts and Background.* Geneva: WCC Publications. 2004:26.
[81] Tumushabe, J et al. 2006. *What is driving the HIV and AIDS epidemic in Swaziland and what can we do about it?* www.sarpn.org.za (accessed 12 September 2007): 27.
[82] Musa Dube. *HIV/AIDS and the curriculum: Methods of Integrating HIV/AIDS in theological programmes*. Geneva: WCC Publications. 2003: 97.

forces a great number of women into subsistence sex work or transactional relationships that preclude negotiating condom use, for example.[83]

Considering the fact that the social and sexual rights of women are violated, places women in a situation where they are vulnerable and this put them at a high risk of contracting HIV. Neither married nor unmarried women can negotiate for safer or protected sex. For instance those who raise the issue of condom use risk charges of being unfaithful or promiscuous by their partners. Therefore violence against women and adolescent girls, and the fear of it, further erode women's negotiating position. It is strange that culture seems to tolerate men's unfaithfulness and this is totally unjustified.[84]

2.6 Economic Context

The politics and socio-cultural reality of Swaziland are set against an economic background of increasing poverty and economic stagnation. Following this, Whiteside (2006) says that, "the epidemic must be seen within this context."[85] Swaziland is classified as a lower middle-income country. In 2004, her per capita GDP was at US$1660. However Swaziland's economy is very much akin to that of a developing country, when taking into account of 70% of her people employed in agriculture and 69% living below the poverty line of US$22 per month.[86]

Two decades ago, Swaziland enjoyed the peak of her economic growth. At the time, unemployment was low and foreign direct investment (FDI) was high. This was so because Swaziland was the most stable country in the region, as at the time apartheid still existed in South Africa, and there was civil war in Mozambique. Therefore South African firms relocated to Swaziland in order to access world markets. This resulted in the growth of both export oriented manufacturing sector and FDI.[87]

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[83] Ibid, 2005: 1.
[84] Ibid, 2003: 97.
[85] Ginindza, A. In Whiteside et al. *The Socio-Economic Impact of HIV and AIDS in Swaziland.* 2006: 19.
[86] Ibid, 2006 p.19
[87] Parikh, A. In whiteside et al. *The Socio-Economic Impact of HIV and AIDS in Swaziland.* 2006: 20.

In the 1990s, South Africa started becoming democratized. This caused Swaziland to lose her regional advantage and thus her economy experienced a down turn. Currently, Swaziland is in an economic slump. In 2005, statistics indicated that her GDP slowed down to 1.5%.[88]

According to Whiteside, Swaziland is one of the African states that are said to experience the *"abnormal normality."*[89] This simply means that Swaziland never experienced normality in terms of the standards of the rest of the world.[90] This kind of economic situation has caused extreme poverty in Swaziland. The finance minister of Swaziland, in his speech of 2005-2006 said that, "High unemployment, food insecurity and HIV caused a 3% increase in poverty in 2005, with 69% of the population below the poverty line.[91]

Due to this and in search for work, people are propelled to migrate to urban areas, leaving their families in rural areas. The people of Swaziland are extremely mobile both within the country and across borders. There is considerable cross border mobility, particularly to South Africa for work in the mines.[92] The most migrant miners are men. These men, of course not all, but the majority of them, can stay up to a whole year without visiting their families. Despite the fact that mobility gives them opportunity, it does increase their likelihood of having non-regular sexual partners which exposes them to HIV infection as they don't know each other and contacts are more anonymous. *Vusi Matsebula* in Swaziland, has this year (2007) listed poverty as another leading contributing factor where women are sexually abused by men in exchange for food and money.[93] Women have to look for money for the upbringing of the family while their husbands are away working in mines, especially in South Africa. Some women are single mothers, yet they need money to look after their offspring. If they are unemployed they end up indulging themselves in the practice of commercial sex. The men who are away from their families working in mines may go to prostitutes for sex, thus exposing themselves to the risk of contracting HIV.

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[88] Ibid, 2006: 20.
[89] Ibid, 2006: 20.
[90] Whiteside, A and Barnett, T. *AIDS in the Twenty-First Century*. 2002: 156.
[91] Whiteside, A and Barnette, T. *AIDS in the Twenty-First Century*. 2002: 65.
[92] Tumushabe, J. et al. 2006. *What is driving the HIV and AIDS epidemic in Swaziland and what can we do about it?* www.sarpn.org.za (accessed 12 September 2007): 33.
[93] Times of Swaziland-Friday, March 23, 2007: 38.

2.6.1 The Impact of HIV on the Economy

The impact of HIV in Swaziland is clearly seen in communities, households, individuals, in the economy (private and public sector), health care, education and income inequality. The HIV impact in Swaziland is associated with a huge unemployment situation and this, on the whole, brings about a problem of food security. According to Ginindza, a researcher on HIV and AIDS in Swaziland, commented that, "Swaziland has still a huge number of people approximately totaling to 225,000 who are vulnerable and food insecure."[94]

Swaziland's economy is stagnating. Her economic gains of the last few decades have been reversed and this is clearly seen in her low growth rates, unfavourable terms of trade and increasingly impoverished population. HIV has played a major role in this economic downturn.[95] HIV is partly a disease associated with poverty.[96] This is so because so many people in the labour force increasingly die of AIDS. Once they get sick, they tend to spend their savings on medical and funeral expenses.[97] In fact "Socio-Economic instability hastens the spread of HIV," says Barnett.[98]

Economic growth is an important driver of economic development. Economic growth entails physical capital accumulation, human capital accumulation and total factor productivity. Physical capital accumulation is driven by savings and investment and is seriously affected by HIV and AIDS both at the level of the individual and firm in Swaziland.[99] Families affected by HIV and AIDS normally deplete their savings and assets so as to cope with the expenditure and income shock. The increased expenditures on, for instance, health care and funerals, and lower income will result in a depletion of savings.[100]

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[94] Ginindza, A. In Whiteside et al. *The Social Impact of HIV and AIDS in Swaziland* … .1.
[95] Whiteside, A et al. *The Socio-Economic Impact of HIV and AIDS in Swaziland.* 2006: 21.
[96] Weinreich, S and Benn C. *AIDS-Meeting the Challenge: Data, Facts and Background.* Geneva: WCC Publications. 2004: 40.
[97] Barnett and Whiteside. *AIDS in the twenty-First Century: Disease and Globalization,* 2002, p.145.
[98] Ibid, 2002: 145.
[99] Ginindza, A.In Whiteside et al. *The Socio- Economic Impact of HIV and AIDS in Swaziland* …. .22.
[100] Ibid, 2006: 22.

Investment has been affected in Swaziland, as investors, especially foreign, choose to invest in some other countries due to lower HIV prevalence than in Swaziland because the HIV prevalence is very high (42.6%). The investors are very much concerned about the costs of training workers who will soon get sick and die of AIDS.[101] In Swaziland, HIV and AIDS, has affected the human capital accumulation and productivity by reducing the labour force. The effect of HIV on labour is massive because the sexually active group, which is hardest hit by HIV, is the same group that is in the labour force. Therefore in this case productivity is affected.

Swaziland's economy is dependent entirely on manufacturing and agriculture.[102] Agriculture is actually the source of livelihood and meets the basic food requirement for the people in the country, especially in rural areas.[103] High morbidity and mortality due to HIV and AIDS have large implications for agriculture, manufacturing and the private sector.

The impact of HIV is felt in the high costs of production and employment. Profits, investment and savings, both at the house hold and firm level.[104] HIV/AIDS is having a huge impact on the manufacturing sector as well as the agriculture sector in Swaziland. According to Fred Muwanga (2004): 7 "the manufacturing industry was the most affected sector in terms of absenteeism, for instance the labour intensive garment and textile sector has been facing challenges meeting production targets and deadlines because of absenteeism."[105] Ginindza adds to this by saying that;

> The textile industry is the most affected in Swaziland due to the high HIV prevalence rates among employees who are predominantly female,which are to a large extent being fuelled by the poor pay and living conditions which are making them vulnerable to HIV and AIDS. absenteeism is an aspect resulting from the impact of HIV and AIDS and it has been reflected in private sector firms and public sector as well. the public sector is the largest employer of people in Swaziland with around 22,000 workers and HIV/AIDS has impacted this sector so much so that the burden it has posed on the budget and the public sector staff that multiplies throughout society is immense."[106]

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[101] Ibid, 2006: 23.
[102] These two sectors are very much affected by HIV. For instance, absenteeism at work due to sickness related to HIV and AIDS.
[103] Social Protection … .1.
[104] Whiteside, A. et al. *The Socio-Economic Impact of HIV and AIDS in Swaziland.* 2006: 27.
[105] Muwanga, F. "A systematic Review of the Economic Impact of HIV/AIDS on Swaziland." Faculty of Health Sciences, Vol. Masters in Public Health. University of Witwatersrand: Johannesburg
[106] Ginindza, A, In Whiteside et al. *The Socio-Economic Impact of HIV and AIDS in Swaziland.* 2006: 37.

Haacker predicts that, "HIV and AIDS in Swaziland will result in a decline in revenue because the increased HIV and AIDS related mortality will consequently bring about a smaller tax base, morbidity and constant decline in personal income and consumption of imports will affect tax revenue and , reduced firm profits will lower corporate tax revenue."[107] Whiteside adds that, "while revenue is expected to decrease due to HIV and AIDS, expenditure is expected to increase in order to deal with increased demand for health and social programmes such as provision of pensions, funding of work place programmes and replacing of lost skills and capacity through training or recruitment."[108]

2.7 Impact on Poverty

Poverty and HIV/AIDS exacerbate each other. Poverty is considered both a driver and result of the epidemic. Whiteside quotes the Swaziland financial minister in the 2005-2006 budget speech that, "high unemployment, food insecurity and HIV/AIDS have together resulted in a 3% increase in poverty in 2005 with 69% of the population below the poverty line.[109]

HIV and AIDS gets people stuck in poverty. People deplete savings and sell their assets so as to cope with the expenditures associated with HIV and AIDS. The depletion of assets makes people, especially the poor, more vulnerable to shocks and deters productive and efficient economic activity.[110]

2.8 Impact on Human Development

HIV and AIDS affect human development by compromising health education and mortality. In Swaziland in the last few decades, HIV and AIDS affected the human

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[107] Haacker, M. The Economic consequences of HIV and AIDS in Southern Africa. IMF. 2002: 34.
[108] Whiteside, A. et al. *The Socio-Economic Impact of HIV and AIDS in Swaziland*. 2006:35.
[109] Ibid, 2006: 38.
[110] Ibid, 2006: 38.

development gains. Whiteside says that "human development index is much lower currently than it was twenty years ago."[111]

2.9 Impact on Income Inequality

If HIV and AIDS raise the real wages of the skilled due to labour shortages as people in the labour force group die, then an increase in income inequality occurs. Therefore HIV and AIDS exacerbate income inequality.[112]

2.10 Impact of HIV and AIDS on Social Services and Welfare

While having a tremendous impact on Swaziland and society, HIV and AIDS has also impacted very much on the individual's ability to access health, education and social welfare services in Swaziland. It has actually impacted the Swazi population's demand for the services just mentioned above and the degree to which such services can be provided publicly. In this section, focus is put on the impact of HIV and AIDS on health care, where consideration is specifically given to the demand and supply of health services as impacted by HIV and AIDS. Consideration will also be given to the supply, quality and demand for education and also the impacts on social welfare.

HIV and AIDS are closely intertwined with other basic welfare issues including poverty, hunger, inequality and family. The epidemic intensifies these and vice versa. Families affected by and infected with HIV are normally faced with the challenge of caring for the sick. In many African states, people tend to leave their villages or rural areas for cities and live there purposely for work and possibly other services that cannot be found in rural areas. Likewise in Swaziland, people go to urban areas and when they get sick they return to the rural areas (their place of birth). The care increases the "expenditure on health care and as the condition of the sick becomes acute, the sick are unable to work."[113] Consequently the usual family income becomes impaired. The funeral expenses leave families financially dried up. Many children are

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[111] Ibid, 2006: 38.
[112] Ibid, 2006: 39.
[113] Sindle and Welsh, R. *Meeting Christ in AIDS: A training Manual in Pastoral Care*. Salt River: Methodist Publishing House. 2001: 51.

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left as orphans. HIV and AIDS generally strike young adults and the demographic impact of this is most manifest in the increasingly large generation of children being orphaned. Ginindza says that,

> The challenge posed to social welfare mechanisms by the orphaning of children due to HIV and AIDS is a unique one, as AIDS is more likely to result in double orphans than other causes of death. Since one parent is infected with HIV and later dies of AIDS, the chances of the other parent to escape this are very slim. Therefore the number of orphans will continue to grow as parents currently living with HIV develop AIDS and eventually die."[114]

According to estimates by UNICEF in 2004, the number of orphans in Swaziland increased from an estimated 20,000 in the year 2002 to 69,000 in 2004.[115] This rate indicates that Swaziland, because of its high HIV prevalence, will disproportionately be faced with an orphan challenge in comparison with other countries in Sub-Saharan Africa, if not world wide. It has been projected that orphans will equal to one in five children in 2010 in countries like Swaziland that are experiencing the highest HIV prevalence.[116] The report by UNAIDS, UNICEF and USAID in 2004 also estimated that by 2015, orphan numbers would reach between 100,000 and 110,000 in Swaziland due to the dramatic increase in the number of orphans year by year as the following figure 2.3 indicates.[117]

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[114] Ginindza A . In Whiteside et al. *The Socio-Economic Impact of HIV and AIDS in Swaziland*, 2006: 55.
[115] UNICEF. "The state of the world's children 2005: Childhood under threat". NewYork, USA: UNICEF. 2004:3.
[116] UNAIDS, UNICEF, USAID. 2004. *Children on the Brink: A joint Report of New orphan estimates and a framework for Action.* NewYork: UNICEF. 2004: 5.
[117] Ibid, 2004, p.5
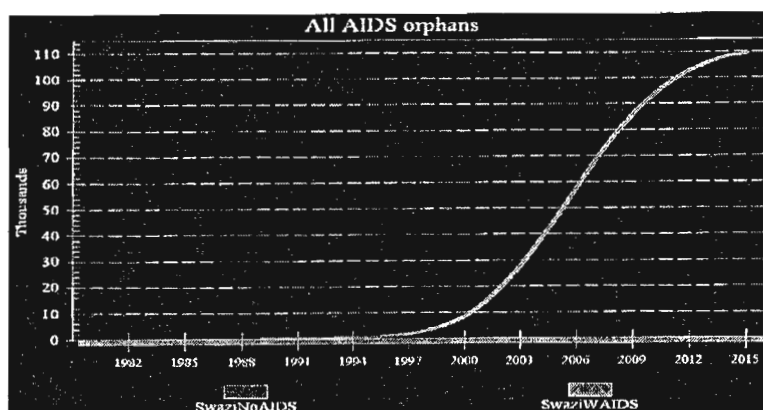
Figure 2.3: Orphans (both Maternal and Paternal) as a result of AIDS.

Source: MOHSW

Caring for increasingly large numbers of orphaned and vulnerable children is placing a tremendous economic and social burden on extended families and community networks. In communities, the responsibility of overseeing the OVC, or caring for the sick, has apparently shifted to the elderly. Therefore this shows how the impact of HIV and AIDS jeopardise the welfare of the elderly as they begin to use their savings and pensions in the care of the sick or OVC.[118]

The impact of HIV and AIDS is making it difficult for individuals in Swaziland to access good quality health, education and social welfare services. HIV and AIDS is increasing the number of OVC who obviously grow without the support of their parents and family, hence making it difficult for them to access education services and more likely to suffer from abuse which puts them at a risk of contracting HIV.

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[118] Ginindza, A, In Whiteside et al. *The Socio-Economic Impact of HIV and AIDS in Swaziland.* 2006, p.56.

2.10.1 Impact of HIV and AIDS on Health

The infrastructure of the health care system in Swaziland is relatively strong. The system includes public, mission and private facilities. Primary care is also provided through outreach services and rural health motivators in communities.[119] However this health system is experiencing a most difficult situation due to a huge and ever increasing shortage of skilled health workers, especially experienced nurses. It is a total disaster in the health sector as nurses also die of AIDS while fighting AIDS and caring for or treating AIDS patients.

Masitsela Mhlanga, the chairman of AIDS Network of Nurses and Midwives in Swaziland stated that, "nurses in Swaziland are infected with HIV in the same proportions as the general population."[120] Green indicated that due to meager salaries and poor working conditions within the health sector "quite a number of nurses go into the private sector and others leave the country for health care systems in other countries for better working conditions and higher salaries, hence contributing to a depletion of the nursing work force."[121]

The impact of HIV and AIDS on the health care system is therefore clearly seen in the sharp rise in demand for care for AIDS-related conditions and the health care burden has highly increased over the past few years[122]. The increasing number of patients overcrowding in the hospital wards, the longer period of stay in the hospitals and the high mortality rate, together pose a major drawback to the health care system.[123] According to Ginindza (2006), "The impact of HIV is already being felt in the health sector through the dual and simultaneous effects of increasing demand for care and

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[119] JTK. *"The Impact of HIV and AIDS on the central Agencies of government of Swaz*iland." Mbabane, 2002: 17.
[120] Dlamin, C. The needs of ELCSA ministers as they cope with burnout, in their ministry to people affected by and infected with HIV and AIDS, Masters thesis at UKZN, Unpublished. 2006: 31.
[121] WHO and MOHSW. "A *situation Analysis of the Health workforce in Swaziland."* Mbabane. 2004: 1.
[122] Health and development Africa Ltd and JTK associates. *"Study of the health service, Burden and impact of HIV and AIDS on the Health sector in Swaziland."* Mbabane. 2005: 1.
[123] Ibid, 2005, p.1.

reduction of the ability of staff to supply health care services as they too are infected and affected by the epidemic."[124]

The number of people receiving antiretroviral treatment has drastically risen in the past few years due to the free provision of ARVs initiated by the government in December 2003, and the launch of the GFATM programme in 2004 in support of ART.[125] The individuals receiving ART tend to live longer and better lives, only the cost of ART is very high and this is a major problem.

The health sector in Swaziland does not only face a problem of the shortage of nurses as has already been indicated, but also doctors. Swazi doctors normally train elsewhere in Africa and overseas due to the absence of a medical institution within the country and therefore often choose to relocate to work elsewhere, pay and work incentives are greater. There are no incentives or requirements in place to keep Swazi doctors in the country after they are trained abroad and overseas.[126] Therefore the Swazi government relies on employing doctors from other African countries or overseas in the public sector. This is very expensive for the government and thus it lacks finances to employ enough international physicians.

2.10.2 Impact on Education

Despite the fact that education has a primary function of furthering human development and adding value to the human capital necessary to fuel socio-economic development, the education sector has been impacted upon greatly by the epidemic as teachers and learners die of AIDS. In the case of Swaziland, HIV and AIDS has had a multiple and deleterious impact on education, for instance through the supply of education, the quality of education and the demand for education.[127]

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[124] Ginindza, A. in Whiteside, A. *The Socio-Economic Impact of HIV and AIDS in Swaziland*, 2006: 41-43.
[125] Global Fund to fight AIDS, TB and Malaria.
[126] Caltabino, E. "The impact of HIV/AIDS on the Health system of a developing country: The case of Swaziland." Unpublished. 2003: 22.
[127] Carr-hill, R. The Impact of HIV/AIDS on Education and institutionalizing preventive education. Paris: Internal Institute for Educational planning/UNESCO. 2002: 4.

The Swazi formal education comprises seven years of primary education, three years of junior secondary education plus two years of high school education, followed by tertiary level education. The pre-primary education services are offered predominantly through private or community-based establishments.

The Swaziland's education sector has a fee-paying education policy which makes it difficult for children who cannot afford fees to access education.[128] This is one area of weakness in the education sector. Another weakness is that of the high rate of drop-outs, repetitions and average number of years taken per student to complete primary education which points to inefficiency in the system's ability to deliver educational services effectively.[129] The impact of HIV and AIDS is likely to be felt at all levels of the formal education system, that is to say: primary, secondary and tertiary. The supply of education is affected because of the sharp increase in morbidity and mortality due to the epidemic which leads to increased absenteeism and loss of professional educators and system administrators, either because they themselves are sick from AIDS basically or else they are caring for the sick family members or orphans.[130]

There were two projections made by the ministry of education (MOE) in 1999 that, as a result of HIV and AIDS, 13,000 individuals instead of 5093 will require teacher training by the year 2016. Another projection is that, sick and death benefit costs associated with teacher morbidity and mortality are estimated to reach up to one billion Rand by 2016.[131] An article by Maseko, an AIDS activist (2005) in the *Swazi Observer News* noted that in 2005, the Swaziland National Association of Teachers (SNAT) Co-operative Society recorded that the number of its members who died in 2004, totaled 57. This almost doubled to 97 in the following year (2005).[132] Therefore this indicates the extent to which the ministry of education and other associations of teachers in the country are being affected by the epidemic.

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[128] Ginindza, A. In Whiteside et al. *The Socio-Economic Impact of HIV and AIDS in Swaziland*, 2006: 47.
[129] Central Statistics office. *"Education Statistrics". 2003:* 1.
[130] Ginindza, A. In Whiteside et al. *The Socio-Economic Impact of HIV and AIDS in Swaziland*, 2006: 48.
[131] Ibid, 2006: 49.
[132] Maseko, Z. "Teachers withdraw from SNAT Co-operative society." *Swazi Observer*. 29 November 2005: 4.

The quality of educational services in Swaziland is being hampered by HIV and AIDS due to increased teacher absences and shortages.[133] There is also a deterioration of children's learning abilities within the school environment as a result of the psychological and emotional strain associated with losing a family member to AIDS and facing stigma.[134]

The financial strain experienced by an AIDS-affected household often leads to substantial declines in household food consumption that may happen to put children at a risk of being malnourished and this can affect the children's educational performance.[135] The demand for education is negatively impacted upon by HIV and AIDS through the demographic impact of HIV and AIDS which leads to fewer potential school goers, because infected infants rarely survive until school age.[136] Whiteside projects that, "by 2016, there will be a 3% reduction in the size of the primary school population for each grade, for secondary and tertiary."[137] In the context of HIV and AIDS in Swaziland, the education sector is and will continue facing significant challenges. Likewise other sectors will do so too, due to the impact of the pandemic. This therefore calls for an immediate action by the Swazi people and their government, since all sectors and members of the society are affected by the epidemic.

2.11 Impact on Rural livelihoods and Socio-Cultural Norms

This section looks at the impact of HIV and AIDS on the livelihoods of individuals, households, communities and socio-cultural norms. 70% of the population in Swaziland lives in rural areas and is supported by subsistence farming on Swazi

[133] Kelly, M. *HIV/AIDS and Education in eastern and Southern Africa: The Leadership Challenge and the way forward.* Addisababa , Ethiopia: United Nations Economic Commission for Africa, 2000: 17.
[134] Carr-hill, R. *The Impact of HIV/AIDS on Education and Institutionalizing preventive education.* 2006: 16
[135] UNICEF. The state of the world's children: childhood under threat. New York: UNICEF. 2004: 16.
[136] Whiteside, A. HIV/AIDS, Health and Education: *In state of the Art, AIDS and Economics.* Washington DC: Policy project. 2004: 24-29.
[137] Barnett and Whiteside. *AIDS in the twenty-First Century ...* 2002:311.

National Land (SNL).[138] A number of people, such as Whiteside, Ginindza etc who have done research on Swaziland, particularly in the area of HIV and AIDS, have singled out the aspect of *socio-cultural norms* as one of the key drivers of the country's HIV and AIDS epidemic.[139] However the erosion of socio-cultural norms is of a serious concern in Swazi society. A number of natives think and have also said that AIDS is causing a breakdown in traditional values and practices like polygamy, and as people die of AIDS, no one is left to pass on the traditional values. From the point of view of HIV and AIDS transmission, polygamy is unjustified, yet according to the Swazi people who embrace this value, in its true form, it implies faithfulness within the polygamous unit and it is culturally unacceptable to engage with girl-or boyfriends outside of this union.[140]

2.11.1 Impact on Individuals

In general, the impact of HIV and AIDS on the individual is felt first. In the case of Swaziland where people live approximately on one US dollar a day per person, which is total poverty, people cannot afford the necessary treatment. Therefore in the absence of treatment, the infected individuals have got no choice other than to expect to experience periods of illness which increase in frequency, severity and duration. Barnett and Whiteside point out that,

> Individuals who are infected always confront an impacton their health. In most cases they also face an impact on the resources they have at their disposal. The reality for infected individuals is that, the impact of the disease will depend on their circumstance and the resources they can command. [141]

According to my observation this is true and it is happening to a number of infected individuals in Swaziland. The impact on individuals is not felt only by the individual but also the society and community. I have experienced in Swaziland that some key figures die of AIDS, and the systems to which they are directly attached become

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[138] Ibid, 2006: 56.
[139] Whiteside A and Tumushabe, J. *"What is driving the HIV/AIDS epidemic in Swaziland and what More we can do About it?* NERCHA, HEAD. 2006: 1.
[140] Ginindza, A. The Socio-Economic Impact of HIV/AIDS ..... 2006: 65-66.
[141] Barnett A et Whiteside A. AIDS in the twenty-First Century: *Disease and Globalization.* NewYork: Palgrave Macmillan. 2002: 183.

paralysed, yet they are very helpful to the public. Hence the entire nation and community suffers.

2.11.2 Impact on the Household

A household is formed when people come together to reproduce. They have children and bring them up and when the children grow up, they leave home and also start their own households, but the connections remain. According to Barnett,

> an epidemic has got an impact on household reproduction. It impacts the household's ability to sustain itself from day to day and to reproduce itself overtime. For instance, in households where a parent or parents have AIDS, the likelihood is that fewer children will be born and the chances for these to grow and live are very slim. They are much more likely to die in infancy or early child hood.[142]

The implication of this is that, the personnel of the household are not replaced, therefore the values, practices and traditions of that household are not carried forward. HIV and AIDS, have the potential to impact the household budget by reducing sources of income and increasing household expenditures as well. The family income drops due to HIV and AIDS which results in higher adult morbidity and mortality in the household. A decline or loss of income may lead to serious poverty of a household. This is clearly true with HIV and AIDS due to the lengthy period of illness associated with the disease which leads to additional health expenditures.[143]

HIV and AIDS have led to a reduction in the quality of household labour and source of income for the household, through the increased mortality of heads of households and other prominent members of the household.[144] Since the epidemic is associated with a prolonged morbidity in comparison with other non-AIDS illnesses, it may result in a diversion of labour to care for the sick. In Swaziland, members of the household return home in their terminal stages of the illness, and family members,

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[142] Ibid, 2002: 187.
[143] Whiteside, A et al. *The Socio-Economic Impact of HIV and AIDS in Swaziland*, 2006: 59.
[144] Ibid, 2006: 62.

mostly women take leave from working on farms to care for the sick member of the household.[145]

2.11.3 The Impact on the Community

The individual, household and community are inter-related entities in that, individuals make up a household, households make up communities and communities make up nations.[146] The moment one aspect in this sphere is affected the other aspects will be affected too. For instance in Swaziland, the impact of HIV and AIDS on the socio-cultural norms has resulted in cultural change. This has had an impact on the individuals, households and communities too and the way they are structured. Communities are seen as vital for successful prevention and currently the burden of coping with impact is shifting on to communities.

2.12 Conclusion

This chapter has highlighted the HIV and AIDS situation in Swaziland. The country has an HIV prevalence of 42.6% which is believed to be the highest on the globe throughout the history of HIV. The impact of HIV and AIDS in the country has affected the individuals, households, communities and the entire nation. This kind of situation leaves no system unaffected. The economic system in Swaziland has been terribly affected by the epidemic. I would say that the economic trends observed are enough for one to grasp that there is an enormous impact of HIV and AIDS being felt in Swaziland.

The Swaziland's stagnant economy is suffering from increased mortality, increased absenteeism at work, low investment and increased poverty due to the impact of HIV and AIDS. Whiteside looks at the whole situation of HIV and AIDS in Swaziland as a major driver that has reversed the development gains of the 1980s and 90s and of

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[145] Murray, C and Lopez A. 1996. *The Global Burden of Disease and Injury*, Vol.1. WHO: Harvard School of Public Health, World bank. Cambridge, mass: Harvard University.
[146] Barnett and Whiteside. AIDS in the twenty-First Century: *Disease and Globalization*. New York: Palgrave Macmillan. 2002: 183

course makes the country a prey for HIV and AIDS.[147]. On this note, I would rather say that the developmental downturn can be mitigated by a coalition of the state, Church and NGOs in the country, taking a tremendous initiative to spread the HIV awareness and to encourage people living with (PLWHA) to take anti-retroviral treatment (ART) in order to revitalize themselves and become effective producers again. The next chapter will look at the concept of *Shalom* as it shows the need for vitality in the mission of the Church faced by HIV and AIDS.

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[147] Whiteside, A et al. *The Socio-Economic Impact of HIV and AIDS in Swaziland.* 2006: 39.

CHAPTER THREE

THE CONCEPT OF *SHALOM*

3.1 Introduction

Having looked at the HIV and AIDS scenario in Swaziland, we now turn to chapter three whereby we shall attempt to look at the concept of *shalom* and the mission of the Church. As such the chapter endeavors to show how *shalom,* as a theoretical framework of this study, is important and vital for the mission of the Church faced by the HIV and AIDS pandemic. Since the Church needs to operate from a firm theological foundation, this chapter therefore provides some theological principles based on *Shalom* which are essential when theologizing the HIV pandemic. The chapter focuses first on the meaning and understanding of *shalom* from a biblical perspective and then looks at the relevancy of it in our contemporary society which is befogged with HIV and AIDS. The reason why we intend to focus on the notion of *shalom* is because even though the MCSA's policy document for the church's response to the HIV and AIDS epidemic in Swaziland is informed by the notion of *shalom,* in its preventive, treatment, pastoral care, counseling, support in death and dying approach, indeed there is no attempt in the document to lay the background of *shalom* that informs its value system. Therefore this attempts to give a solid and broad theological foundation of *shalom* for the practice that the church recommends.

3.2 The concept of Shalom

Shalom (שָׁלוֹם) is a Hebrew word that is usually translated into English as "peace." However the word *shalom* has a rather broader idea and according to Nicholas Wolterstorff the word *shalom* has an idea of a human being dwelling at peace in all his or her relationships with God, with self, with fellow human beings and with nature.[148] In this respect we note that the word *shalom* is derived from a root denoting wholeness or completeness, and its frame of reference throughout Jewish

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[148] Yoder, Perry. *Shalom*. London: Hodder and Stoughton. 1989: 5.

literature is bound up with the notion of *shelemut,* perfection.[149] Its significance is thus not limited to the political domain - to the absence of war and enmity, or to the social - to the absence of quarrel and strife. It ranges over several spheres and can refer in different contexts to bounteous physical conditions, to a moral value, and, ultimately, to a cosmic principle and divine attribute. According to Perry Yoder there are three "shades of meaning" which he suggests as relevant to the word shalom. This includes, *shalom* as material well-being and prosperity; *shalom* as justice; and *shalom* as straightforwardness in which Yoder argues that it means integrity. This is in line with the English word peace, as we have seen above, which refers to *shalom* as to either peace between two entities (like between two countries), or to inner peace, calmness or safety of one individual. It is also used as a greeting to either say hello or farewell, and is found in many other expressions and names. Its equivalent cognate in Arabic is *salaam* which is also expressed in Kiswahili as *salama.[150]* In this case we note that the word *shalom* expresses love, life, well-being, wholeness, perfection of God's creation, prosperity, and relationship to God and humanity. Perry Yoder observes that,

> *Shalom,* Biblical peace is squarely against injustice and oppression. *Shalom* acts against oppressors for the sake of victims.[151] It demands a transformation of unjust social and economic orders. In the Bible, *Shalom* is a vision of what ought to be and call to transform society.[152]

As such we will discuss first the experience of *shalom* using Perry Yoder's three shades of meaning above as a guide.

3.3 *Shalom* as material well-being and prosperity

According to Yoder the word *shalom* has the notion of material well-being and prosperity.[153] He traces the word *shalom* from Genesis in which he notes that it appears in the Hebrew several times in the story of Joseph. This Genesis narrative starts with Jacob telling Joseph to "Go now, see if it is well with your brothers and with the flock; and bring word back to me." (Gen 37:14). Here the bold text indicates the English word used to translate *shalom*. As the narrative unfolds we see Joseph's

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[149] Ibid
[150] Most of the people in East Africa greet one another with this Kiswahili word as *salama.*
[151] Yoder, Perry, *Shalom,* London: Hodder and Stoughton, 1989: 5.
[152] Ibid, 1989: 5.
[153] Ibid, 1989: 20

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brothers coming to him in Egypt to buy provisions and he enquires about their welfare, and say, "Is your father well, the old man of whom you spoke? Is he still alive?" They said, "Your servant our father is well; he is still alive."' (Gen 43:27, 28). Yoder argues that the above two passages focus on the enquiry of someone's physical well-being: their physical, emotional, psychological and/or material state of affairs which is in line with the understanding and meaning of *shalom*.[154] Similarly this is echoed by Jethro when he traveled to meet Moses in the wilderness. As they met, "each asked the welfare of another, and they went into the tent" (Ex 18:7). Likewise, in 2 Samuel 11:7, David asks Uriah "how Joab and the people fared, and how the war was going." In the latter passage, a complex English phrase is constructed to convey the trust sense of the original Hebrew where both people (Joab and the people fighting against the Ammonites) and events (the battle itself) have a state of *shalom*.

In each of the above passages the word *shalom* is related to a physical state of existence. In this sense, it is comparable to our English phrase "Is everything all right?' or even, 'Is everything okay?" Further it is also in contrast with the English meaning of peace, which is primarily used as a description of relationships between people or nations, or of an inner state of mind: "*shalom* is marked by the presence of physical well-being and by the absence of physical threats like war, disease, and famine."[155] However in Psalm 73:3 the word *shalom* conveys the sense of abundance, where the word is usually translated "prosperity." (See also Jer 33:9; Zec 8:12, where 'a sowing of peace' and the subsequent agrarian language seem to convey an abundant harvest). Therefore, living with HIV and AIDS needs physical, spiritual, economical and social well-being so as to be in state of *shalom*. And this would require the provision of material well-being and prosperity.

In addition to the above we also see a picture of *shalom* as that of all families having their allotment of land and resources, and the ability to enjoy them in peace. The prophet Micah also foresaw a time "in the last days" when "every person will sit under his or her own vine and under his or her own fig tree and no one will make them afraid", (Micah 4:4). This vision was also shared by Zechariah (Zec3:10), which was a return for the ancient Israelites. Thus *shalom* implies a situation where

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[154] Ibid, 1989: 20.
[155] Ibid, 1989: 25

material and security needs are met, and a sustainable state of dwelling giving the opportunity for economic, societal and cultural advances.

3.4 Shalom as Justice

Yoder further observes that the word *shalom* also includes justice. This parallels the English word for peace and the bible understanding of *shalom* as the absence of war between nations. However *shalom* is also used to describe social relationships in which injustice is seen as the absence of *shalom* in society. On many occasions in the Old Testament the word *shalom* is interweaved with justice and righteousness. For instance, in many places the Psalmist cries to God for vindication and liberation from his foes or oppressors. Yoder notes that Psalm 35 focused on *shalom*. An illustration:

> Vindicate me, O LORD, my God, according to your righteousness, and do not let [my oppressors] rejoice over me ... Let all those who rejoice at my calamity be put to shame and confusion; let those who exalt themselves against me be clothed with shame and dishonor. Let those who desire my vindication shout for joy and be glad, and say evermore ...Great is the LORD, who delights in the welfare of his servant.[156]

Looking at the above we note that the Psalmist does not only petition his God for deliverance from oppression for himself, but also appeals for his oppressors to be made accountable for their actions and be subject to the verdict of the righteous judge. This is doing justice. Indeed the anticipated result is that *shalom* is established, justice is brought to bear, the oppressed are not only liberated but also brought to an experience of well-being and prosperity, and oppressors are restrained from, condemned by and held to account for their repressive acts. For Yoder the divine justice, regulated by *shalom*, is about making right a wrong situation, rather than the modern judicial connotations of retribution and punishment.[157] This is described with grace in Psalm 85:10 in which the steadfast love and faithfulness will meet, righteousness and peace will kiss each other when Israel's God saves them from their oppression and restores their fortunes.

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[156] Psalm 35:24,26-27
[157] Ibid, 1989: 30.

Accordingly, Perry Yoder contends that God's justice is a justice that, "sets things right" and is liberating.[158]   In other words, he sees God as a judge of all nations and that the "universal justice" of God is the liberation of the deprived who gains redemption.[159]   This is because justice is a dimension of God's saving action and to participate in the struggle for justice is to participate in God's mission. [160]   In this respect we note that the synergy and synthesis of justice and *shalom* is a theme that is sustained by the biblical prophets and becomes all the more relevant as they reflect on the predicament of Israel's exile and prophecy of a hope for deliverance and restoration to Yahweh's peaceable kingdom. "Then justice will dwell in the wilderness, and righteousness abides in the fruitful field. The effect of righteousness will be peace and the result of righteousness, quietness and trust forever. My people will abide in a peaceful habitation, in secure dwellings, and in quiet resting places". (Is 32:16-18).

By looking at the above we note that *shalom* at it highest is enjoyment in one's relationships. In this case justice is seen as the enjoyment of one's rights, which according to the above *shalom* concepts seems to be indispensable to the notion of shalom. Therefore the issues of HIV and AIDS in the context of *shalom* are the issue of working for justice. When the church or any organization engage in the work of HIV and AIDS ministry we can say they are doing the work of justice.   This is because saving lives is the work of justice as embedded in *shalom*. It can also be argued that the *shalom*-makers are doers of justice. For if the people living with AIDS are not granted what is due to them, like ARVS treatment, and if they are not acknowledged as fellow human beings and are subjected to humiliation and stigmatization then shalom is wounded and this is injustice.[161]

3.5 Shalom as Straightforwardness

Thirdly Yoder sees *shalom* as straightforwardness. This third aspect of *shalom* deals with the moral and ethical dimension, and "integrity" which is very important in the

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[158] Ibid, 1989:33.
[159] Ibid, 1989:33.
[160] Abraham and Joseph 2000: 359
[161] Nicholas Wolterstoff. *Until Justice and Peace Embrace* (Grand Rapid, Michigan:William B Eerdmans 1983:67-70.

context of HIV and AIDS. One element of *shalom* being used ethically is illustrated in 2 Kings 5. Naaman, the Syrian general, having been cured of his leprosy, vows to worship only Yahweh. However, he faces a dilemma: when Naaman accompanies his master as he goes to worship his god, he will be required to bow before the God also, and asks of Elisha that Yahweh might pardon him. As such Elisha responds "Go in peace" (2 Kgs 5:19). Therefore *shalom* in this context has to do with moral blamelessness and innocence this is because Naaman does not incur guilt by supporting his master's arm as he worships his God.[162]

A second element in the moral aspect of *shalom* is illustrated in Psalm 34:13,14 where the people are exhorted to "Keep your tongue from evil, and your lips from speaking deceit. Depart from evil, and do good; seek peace, and pursue it." In this verse the word *shalom* is marked as the opposite of deception, and could be read as equivalent to honesty. Equally, in Zechariah 8:16 Israel is told to pronounce "judgments" which are true and that will enable them to work for peace.[163]

Looking at the above, the experience of *shalom* can only be described as life-changing or characterized by great disruption when contrasted with experiences where *shalom* is absent. A trader making a business dealing in Psalm 34:13 could expect a fundamental change for the better in his transactions should that person depart from evil and trade with *shalom*-integrity and -honesty. This understanding indicates that *shalom* is against dehumanisation and deprivation and as such the church is called to be in solidarity with those who are struggling to achieve their liberation and this includes those with HIV and AIDS. Walterstorff observes that the political dimension of *shalom* is well demonstrated in the Exodus events when God worked in partnership with the Israelites to free them from the bondage of slavery.[164] In the same way he notes that the social aspect of *shalom* implies the harmonious relationships which should be maintained in society.[165] Therefore as a society, the Israelites were to observe honesty, integrity, righteousness and justice which is the moral and ethical demission of *shalom*.[166] Thus, when the church sides with the poor, and the

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[162] Yoder, Perry, *Shalom*, London: Hodder and Stoughton, 1989: 31.
[163] Ibid, 1989: 32.
[164] Waterstorff, N, *Until Justice and Peace Embrace*. Grand Rapids: Eerdmann. 1983:70.
[165] Ibid, 1983, p. 70
[166] Yoder, Perry, *Shalom*, London: Hodder and Stoughton, 1989, p.15-16

oppressed and enhances their integrity, honesty, justice, accountability, she is working for *shalom*- peace with justice. In the same way we can argue that when the church engages in the HIV and AIDS ministry and start helping those who are living with HIV and AIDS she is facilitating *shalom* and this humanises them thereby empowering them to take charge of their development as subjects rather than as objects.

It therefore means that *shalom* is dwelling at peace in all our relationships: with God, with creation, with other people and with ourselves. This is what the people living with HIV and AIDS need from the society. Jesus proclaimed the gospel of peace or *shalom* as central to his mission on earth (Luke 4:18-19). God is involved in the well-being of the world God has created. The story of humanity, however, shows that the word *shalom* envisioned by God for humanity and established at creation was marred in the fall. [167] As a result of sin, not only was the relationship between God and humanity broken, but there was also increasing division among peoples.

In the early chapters of Genesis, we see brother divided against brother, families divided against each other, and nations divided against one another. The devastating effects of this division of and enmity within the human family can be seen in the biblical story. The existence of slavery, ethnic prejudice, and economic oppression are just a few examples. The marring of the original vision of *shalom* is exemplified today in many similar kinds of injustice and division.

Jesus goes to the lost and the outcast, the marginalized and the excluded (like people living with HIV and AIDS). His death and resurrection is a profound proclamation of *shalom*. God has a particular concern for those who suffer. So it is the responsibility of the Church as his representative on earth to continue with this message of *shalom* so that the hindrances towards an effective ministry to PLWHA will be broken. This is well articulated by Walter Brueggermann who affirms that,

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[167] Gen 3

> Shalom at its most critical can function as a theology of hope, a large-scale promissory vision of what will one day surely be. As a vision of an assured future, the substance of shalom is crucial, for it can be a resource against both despair and an overly eager settlement for an unfinished system.[168]

This indicates that the issue of HIV and AIDS is also the issue of poverty. This means that poverty and HIV and AIDS, is not only a condition of scarcity, but it includes the question of unjust power, control and distribution. Justice is one of the most outstanding attributes of God (Isaiah 28:6; 51:4-5). This basic orientation is in agreement with the Christian categories of human dignity, justice, liberation, prosperity, love and redemption. Thus, when the church involves herself in HIV and AIDS ministry, she is reversing the indignity, injustice and enslavement which augment poverty in the society. We now turn ton *shalom* in the New Testament.

3.6 Shalom in the New Testament

In the New Testament the Greek word that is usually translated peace is *"eirene."* The New Testament writers clearly chose it carefully, as it conveys much the same depth as we have seen in *shalom* in the above session. The innovation, and indeed subversion , of the New Testament writers is how they take an essentially sociological term and give it a fundamental theological interweave: *eirene* conveys all that shalom conveys but it becomes the *"shalom* of God" The phrases "the God of peace," "the peace of God" and "the peace of Christ" appear liberally through the New Testament. Of particular note is Ephesians 2:14-17, where *eirene* occurs four times. For Paul it is the issue of the reconciliation of Jews and Gentiles as a result of the "blood of Christ" (Eph 2:13). In the first century, Jews considered non-Jews to be something less than truly human but, Paul argues, Christ Jesus who is,

> our peace ... has broken down the dividing wall, that is, the hostility between us ... that he might create in himself one new humanity in place of the two, thus making peace ... putting to death that hostility through [the cross].[169]

In this case the two entirely opposing groups and that were openly hostile were reconciled and made one through the actions of the "God of peace"- shalom. The

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[168] Brueggemann . W. *Peace.* St Louis, MO: Chalice press. 2001: 5.
[169] Eph 214ff

trauma of the encounter with *shalom-eirene* is especially clear given the modern experience of people who are living with HIV and AIDS. Furthermore this concept of *shalom* can help the church fight stigma, marginalization of people living with HIV and AIDS. This is because *shalom* depended on the relations among people within a society. Oppression meant no *shalom*, but rather judgment, while justice led to *shalom*.[170] In addition to this, in the realm of morality, *shalom* refers to the "absence of fault, guilt, or blame."[171]

Similarly in the New Testament, Jesus is the Prince of *shalom*, the one who fulfills God's promise to establish *shalom* (peace) with justice and righteousness. Further, Jesus, the Prince of *Shalom,* is "both the witness to the coming of God's reign and the one in whom that reign is taking place." If *shalom* is the presence of God's saving grace allowing us to practice righteousness (right relating), then we might consider the "kingdom," "reign," or "household" of God as the space in time where that *shalom* appears. Jesus is revealed in the Gospels as the mediator of the household of God, the one who proclaims, initiates, and embodies the *Shalom* of God. Sobrino argues that,

> The Kingdom of God, formally speaking, is nothing other than the accomplishment of God's will for this world, which we call mediation...According to faith...the definitive, ultimate and eschatological mediator of the Kingdom of God has already appeared: Jesus...God's will for creation is not simply...that a definitive mediator should appear, but that human beings, God's creatures, should live in a particular manner, that history and human society should come to be truly after God's heart: in solidarity, peace, justice, reconciliation, openness to the Father...This reality is the content of the Kingdom of God.[172]

Therefore, God's saving work is much more than individual soul-saving; it is also more than social justice programs. The *Shalom* of God is mediated through Jesus Christ to every part of creation, every relationship, every soul. The vision of the household of God is one of a creation and people transformed and living in mutuality, justice, peace, and love all initiated, grown, and sustained by openness to relationship with God through Jesus in the power of the Holy Spirit. The goal is a future in which the world and the household of God are one and the same.

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[170] Ibid, 1989:15.

[171] Ibid, 1989:16.

[172] Jon Sobrino, *Jesus the Liberator: A Historical-Theological View, 108.* New York: Orbis Books. 1993: 89-220.

3.7 *Shalom* as redemption

At the heart of shalom is life which God brought into being and the desire to ensure that it is respected and enjoyed[173] However poor people or nations "effort to improve their lives are haunted by various issues including the threat to ill health like HIV and AIDs. De Gruchy affirms that "health is a vital guide to measure development" [174]

It is therefore important to claim this vital issue in life. As such, redemption plays a central role in regaining health. Indeed this is very important in biblical theology where three words *padah, gaal* and *koper* are translated to mean "redeem" or "ransom" which emphasise God's concern in redeeming humanity. Patrick Sherry argues that "redemption embodies the metaphor of getting or buying back". It implies that human beings captured and held captive by power of forces would require intervention from a third party so as to gain their freedom. This is well evidenced in the New Testament when Jesus' life is exhibited as the price of redemption (Matt 20:28 Mk 10:45).

With his blood Jesus bought us back thus we can be released from "the empty ways of life" and receive redemption. God's redemptive solution to what sin had marred is revealed in Genesis 12. God calls Abraham into a covenant relationship that is meant to bless him and his descendents. God makes it clear, however, that Israel is to be a blessing to all nations. In fact, God's larger plan is to bless all nations. God's plan for restoring universal *shalom* is to be accomplished through His particular choice of Israel. This universal reach of God explains the many threads in Israel's life together that speak of the inclusion of the foreigner, the outsider. Laws that show concern for foreigners living with the people of Israel abound.[175] Many parts of Israel's story

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[173] De Gruchy, Steve, "Integrating Mission and Development: Ten Theological Thesis" in *International Congregation Journal.* 2005, 5.1 p.31.
[174] De Gruchy, Steve "Sick world" in *Council for World Mission: inside out*, London: CWM, 2004 August/Sept p.22
[175] Exod. 22:21; 23:9; Deut. 4:5-8.

involve the enfolding of the outsider into the blessings or covenant of Israel while not eliminating his or her ethnic identity.[176]

The early church progressively came to realize the inclusive nature of the Christian community. We see this worked out in the book of Acts as language boundaries and then major ethnic barriers are broken down by the gospel so that the witness of Jesus might reach the ends of the earth. The divine vision for the covenant community now centered in Jesus is the actualization of the truth that in Christ "there is no longer Jew or Greek, there is no longer slave or free, there is no longer male and female." The church is to be a spiritually unified community in which God's spirit dwells in anticipation of that eternal vision of "a great multitude that no one could count, from every nation, from all tribes and peoples and languages, standing before the throne and before the Lamb."

Redemption therefore can be seen as release from "all wickedness" (Tit 2:14). The New Testament applied this understanding to the issue of personal salvation which also reveals a helpless humanity and affirms a God whose love drives God-self to play the role of near-kinsman-redeemer. John Meyendorff reminds us that, "the positive connotation of redemption is that redemption is not only a negative remission of sins but also and primarily new freedom for the children of God in the communion of the new Adam" This means restoration to wholeness which mean *shalom*.

Therefore in the context of HIV and AIDS the church needs to embrace this understanding and offer redemption which in this case means healing, restoring, freeing and reclaiming. This is because redemption, includes all this and also the notion of deliverance, freedom, liberation, salvation, healing and health. In fact this is wholeness and well-being of humanity. This is in line with Paul Tillich who asserts that, "health is a meaningful term only in confrontation with its opposite-disease, and disease contains a partial negation of the essential nature of humanity"[177]

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[176] cf. Josh. 6:22-25 with Matt. 1:5; Ruth 1-4 with Matt. 1:5; 2 Kings 4:8f; 5:1f.

[177] Tillich Paul, The meaning of health" in Stephen E. Lammers and Allen Verhey (ed), *on maral medicine: Theological perspective in medical Ethics*, Grand Rapids, Michgan: William B.Eermans Pub 1987: 161.

Both redemption and health speak of life. Respect for life is important in all our endeavors. Karl Barth affirms that "the first and last word of all ethics is that life must be respected and to preserve and assist life is good and to destroy and harm it is evil."[178] Redemption therefore means that we should care for health in terms of mission because health is part of life. It is God's means of restoring life, as health is part of this life. As such we note that in redemption health is restored. The church which believes in redemption should therefore practice the healing ministry because by so doing she will be redeeming those who are languishing in sickness and yearning for healing.

Sobrino and Russell point to an understanding of God's saving work that is both personal and communal, that promises wholeness for individual lives, for communities, and even for the whole of creation. [179] Further, Russell highlights the concept of *shalom* as a rich and multi-layered biblical term for the goal of God's saving work.[180] The fulfillment of these promises of God necessarily involves relationship both with God and with other people. A vital aspect of God's saving activity is that God offers the grace to enter "right relationship" righteousness with God. The gift of "right relating" is also the place from which to understand all the other promises of God. For example, peace is not gained from isolation and building better defenses; rather peace comes through relationships of trust with God, self, and others. Wholeness is not achieved through caring only for self and amassing wealth; rather wholeness is experienced in relationship to the God who provides all that is needed for human flourishing and for human relationships of mutuality, self-giving, humility, and love. *Shalom* is one way to describe what life looks like when the righteousness of God is made manifest really present in history.

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[178] Barth Karl, " Respect for life" in Stephen E. Lammers and Allen Verhey (ed), *on maral medicine: Theological perspective in medical Ethics,* Grand Rapids, Michgan: William B.Eermans Pub 1987:109.
[179] Jon Sobrino, *Jesus the Liberator: A Historical-Theological View, 108.* New York: Orbis Books. 1993: 89-220.
[180] Ibid

3.8 *Shalom* as a framework for MCSA policy document
Of HIV and AIDS

Looking at the above and looking at the MCSA policy document we note that this document is informed by the *shalom* concepts in its approach to pastoral care, counseling, prevention, treatment care and support, death and dying approach, however, as we have noted earlier, this document lacks the above background on *shalom*. The Methodist Church of Swaziland is motivated to engage in this noble ministry because of her understanding of the value for human life as *imago Dei*. The understanding of *shalom* concept in a wider concept, as we have seen above, is very important if the church is going to continue with this policy document. As we will see in the next chapter, the document has talked of enhancing human dignity, as an authentic part of humanity, but it fails to acknowledge the same. As a matter of fact this policy document seems to provide some preventive measures that will help in reducing the spread of the virus and this is in line with the concept of shalom. However, the document lacks comprehensiveness of the understanding of *shalom* which in my considered opinion is very vital for the faith community. For lack of this understanding can render the response of the church inadequate.

However there is no doubt that the MCSA policy document has articulated the way of response to the epidemic as a Church and the document is providing a framework on how the church can provide prevention strategies, pastoral care, care and support. Therefore medical assistance can be seen as part of the church's work of *shalom*. This is precipitated by the love and obedience to Christ's command to love one another and, as we have seen above, this is working for *shalom*. Therefore the Church's response to HIV and AIDS ministry is   doing the work of *shalom*. The presence of sickness is an encroachment on the life that God created.

The understanding of *shalom* as the framework of the MCSA policy document will enable the Methodist Church to empower the masses so as to be active in fighting the HIV and AIDS pandemic.   The Church should use its available resources to empower people in all dimensions of life so as to have a holistic transformation as indicated in the idea of *shalom*. This is in line with Julius Oladipo who argues that "true development improves the total person in a holistic manner. In fact this is what

the meaning is of *shalom*."[181] For sure the church should understand that *shalom* is the goal of life and is in line with God's vision for humanity. In this case, a comprehensive HIV and AIDS prevention requires a strong leadership that will lead to the achieving of *shalom* in our society, especially for the people living with HIV and AIDS. Therefore the *Shalom* concept becomes a relevant framework for the MCSA policy document on HIV and AIDS and also for our study.

3.9 Conclusion

In this chapter we have attempted to look at the notion of *shalom*. We have noted that there is a need for the MCSA policy document to give a broader understanding of the word *shalom* because it is in line with its approach of pastoral care, counselling, prevention, treatment care and support, death and dying. The chapter has revealed that *shalom* is dwelling at peace in all our relationships: with God, with creation, with other people and with ourselves. This is what the people living with HIV and AIDS need from society, for Jesus proclaimed the gospel of peace or *shalom* as central to his mission on earth (Luke 4:18-19) and God is involved in the well-being of the world God has created. As such the church is called to be involved in the work of shalom-making in the context of HIV and AIDS and therefore the MCSA policy document should reflect this broad understanding of the idea of the *shalom*. This brings us to chapter four which is about the MCSA HIV/ AIDS policy.

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[181] Oladipo, Julius, "*The role of the Church in poverty alleviation in Africa*". Oxford: Regnum. 2001: 223.

CHAPTER FOUR

THE MCSA HIV/AIDS POLICY

4.1 Introduction

Methodism arrived in South Africa with the British soldiers in 1806 but the mission was launched by Barnabas Shaw who reached the Cape in 1816 and William Shaw (unrelated) who accompanied the British settlers of 1820.[182] Barnabas Shaw established a mission among the Khoi at Leliefontein in Namaqualand while his colleague, William Shaw, established Methodism throughout the British settlement in Albany and rapidly planted a chain of mission stations between the Cape Colony and Natal.[183] Methodism extended to Swaziland from Natal following the royal revelation by King Sobhuza I in a dream as already highlighted in chapter one.

In 1882, there were three branches of South African Methodism, namely; The Wesleyan Methodist church of South Africa, the Transvaal and Swaziland district of the Wesleyan Methodist Church of Great Britain and the primitive Methodist missions in the Union of South Africa.[184] As from the 1st of January 1931, the three branches of Methodism in South Africa, including Swaziland district, were united and came to be known as the Methodist Church of Southern Africa (MCSA).[185]

The Methodist Response to HIV/AIDS in Southern Africa: Strategy and Implementation Plan is a document that is currently being used by the MCSA in Swaziland as the key tool and guideline in responding to HIV and AIDS. It was published in 2002 by the Mission Unit of the MCSA in conjunction with the Connexional Task Force on HIV/AIDS. The author of the document is solely a

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[182] The Methodist Church of Southern Africa. www.methodistchurch.org.za (Accessed 18 Nov 2007):1.
[183] Ibid
[184] Hewson, L. A. *Introduction to South African Methodism:* Cape Town, Methodist Publishing House, 1950: 88.
[185] Sibeko, M. African spirituality and Methodism: A survey of Black members of Thaba-Nchu Methodist Church, Masters Thesis, UKZN, Pietermaritzburg, Unpublished. 1997: 24.

Methodist minister by the name of Sol Jacob. This chapter simply presents the HIV and AIDS policy document which is the exact document written by Sol Jacob. The chapter is concerned with the presentation of the issues raised in this booklet by way of summary. It shall simply report on the content, attitudes, and challenges posed in this booklet. It shall also present the process that led to the acquisition of this document. The chapter concludes with the reception of the document and its usage in Swaziland. Therefore, the chapter contains *the formulation process*, *the summary*, and *the application* of the MCSA HIV and AIDS policy.

4.2 The MCSA AIDS Policy – The Formulation process

The MCSA has had no policy on HIV and AIDS up until 2002. It was not until July 2000 that the Connexional Task Force on HIV/AIDS approached Sol Jacob to write an HIV/AIDS policy. This project was supported by the Reverend Ivan Abrahams, the director of the MCSA Mission Unit force at the time, but currently the presiding bishop who offered to publish the document. Sol Jacob was competent for this task for the obvious reason that, besides being involved in AIDS activism as a Methodist Priest in Pietermaritzburg, he had just completed a Doctorate research on HIV and AIDS.[186]

Sol Jacob consulted with several specialists in the writing of this policy. A group of a few individuals who were themselves People Living with AIDS (PLWAs) were consulted on a personal level. The presiding Bishop of the MCSA at the time, Reverend Mvume H. Dandala, was also at least aware of the project and in support of it. There is no record or report which shows that the bishop actually gave content input to the document. Doctor Raymond Ruthvin and Sister Jaye Crane were consulted on 'prescribed medicines for opportunistic infections associated with HIV/AIDS'.[187] The C. J. Development Research was consulted for *pro deo* information and advice on research method and development. By and large, the document is a product of Jacob's personal research on the matter. It was not a product

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[186] Sol Jacob, interview by author, digital recording, Pietermaritzburg City, September 23, 2007

[187] Jacob, *The Methodist Response to HIV/AIDS*, cover page.

of a consortium or a symposium of any nature. I think it is a bad process to draw a Church document when there is poor consultation.

It is a MCSA Church owned position for various reasons. First and foremost, even though the MCSA did not come up with ideas, neither was it represented in the formulation of the policy, it was endorsed by the Church as a position of the church. The document was endorsed by both the MCSA Connexional Task Force on HIV/AIDS as well as the Presiding Bishop Mvume Dandala.[188] Second, the project was funded by the Connexional Task Force on HIV/AIDS. This means that the project was owned and mandated by the MCSA. Third, the MCSA recognizes the document as its blue print response to AIDS for the entire region. There has not been any other document recommended by the church on the same terms. It is therefore the chief point of reference as far as HIV and AIDS in the MCSA is concerned.

It is therefore important, for the purpose of our discussions, to emphasize the fact that the document is a product of Jacob's research, theological articulations, and insightful strategies which were simply adopted and endorsed by the MCSA. The process leading to the acquisition and ownership of any document is as vital as its contents and final implementations. The former can ultimately determine the latter either positively or negatively.

A revision of the MCSA HIV and AIDS policy document was done in June 2006. This led to the reprinting under the title: *The Methodist Response to HIV/AIDS: Revised Strategy and Implementation plan.* Thanks to the financial sponsorship of the British Methodist Church Mike King and Roy Crowder of the World Church office in London helped in the revision and the reprinting of the booklet. Consequently, the Methodist Conference 2006 resolved to adopt the manual as a resource book.

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[188] Ibid.

4.3 The MCSA AIDS Policy – The Summary

The MCSA document in response to HIV and AIDS contains several subheadings. These include the strategy and implementation plan, the MCSA theological position, HIV and AIDS programmes within the MCSA, the fund raising, the charter of rights on HIV and AIDS, the care for people living with HIV/AIDS, and an HIV/AIDS glossary. These are summarized in their subtitles as such.

4.4 Strategy and Implementation Plan

The MCSA plan in responding to HIV and AIDS comprises eight key elements, namely: mobilization, training, education and prevention, health care, counseling, welfare and support, project development, and funding. These are simply listed in the document and not discussed further. The policy lists four overriding objectives which are pursued in the above elements, namely: (1) preventing the spread of AIDS, (2) care for those infected and affected by HIV/AIDS, (3) reducing the personal and social impact of HIV and AIDS, and (4) mobilizing national, international and local resources.

The document further outlines the AIDS crisis in Southern Africa by presenting the epidemiological figures and projection of the six countries that represent the MCSA. These are South Africa, Botswana, Mozambique, Namibia, Lesotho, and Swaziland.

The document figures are very brief and are not discussed either. These are simply presented in graphs which outline the deaths in adults, men, women and children during the year 2001. These figures were collected from the United Nations reports. The figures do not show the previous years records. They also do not show the infection rate nor do they show the prevalence rates. In other words, the figures are too brief to describe the extent of the crisis in any of these countries. They are also too general given the great geographical representation they cover.

4.5 Theological Presuppositions

The theology upon which the policy is formulated is summarized in two paragraphs that stretch from page four to five. In this theological presupposition, the gospel of Jesus Christ is seen as the source of hope and fullness. As manifested in the kingdom of God, it pictures 'a society built on the foundation of an all embracing love, alternative lifestyles, compassion and decency'.[189] Because Jesus did not despise those whom society rejected but on the contrary showed them compassion, we should do the same as his followers. The document cites stories such as the publicans and the prostitutes (Mark 2: 13-7; Mathew 11: 19; 21: 31-2; Luke 15: 1), the simple (Mathew 11: 25), the little ones (Mark 9: 2), the least (Mathew 25: 40-5), and the women with a dubious sexual history (Luke 7: 36-50; John 4). The proclamation of the 'good news' requires that Christians openly embrace those infected by HIV and AIDS in self-sacrificing love and care for those who are suffering. The document calls upon both the church and Christians to be the instruments of the incarnated presence of Christ by expressing the love of Jesus for those who are infected by HIV and AIDS and to treat them with compassion and care. On the basis of Mathew: 1-5, it discourages the engagement of self-righteous judgment.

On the basis of this theological presupposition therefore, the document is categorical in stating the position of the MCSA as far as the PLWA are concerned. It states that:

The Methodist Church of Southern Africa does not exclude from its membership those who are HIV positive or those who have AIDS. It calls on all Methodists to act with love and compassion towards the victims in the present HIV/AIDS crisis in our country.[190]

By and large, the MCSA theological position on HIV and AIDS is based on Jesus Christ's acceptance of the rejected in the community. It promotes inclusive and unconditional acceptance of those infected without probing judgmental questions.

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[189] Jacob, S. *The Methodist Response to HIV/AIDS*. 2006: 4.

[190] Jacob, S. *The Methodist Response to HIV/AIDS*. 2006: 5.

The document considers AIDS to be a disease caused by the HI virus which is transferred from one person to another through sexual intercourse, blood transfusion, and mother to baby relations. It maintains that 'HIV/AIDS is not the judgment of God on the infected. It is an opportunity for the Methodists to love and care for those affected'.[191] Besides listing the particular actions that the Methodists in Southern Africa can do, the document goes ahead to suggest a pragmatic response to the AIDS pandemic. A key principle emphasized by the document is 'that people with HIV and AIDS will be consulted in regard to all prevention intervention and care strategies'. The Methodists are encouraged to:

- Promote open frank discussions of sex and sexuality in church and society

- Encourage, empower and train parents to talk openly to their children about sex, HIV/AIDS epidemic and other sexually transmitted diseases

- Impart to young people the vision of a lifestyle governed by informed choices, shared responsibility and healthy sexuality and the ideal of Christian marriage

- Consult the affected

- Promote healthier and safer sexual behavior through education and social integration

- Prioritize preventive programmes for men, women and young people

- Explore models of support and care for AIDS orphans

- Embark on poverty relief programmes for affected households

- Provide information and support systems for private and public health structures

- Advocate delivery of basic programmes and health care

- Provide resources to care for the sick and dying

- Establish HIV and AIDS community-based homes and places for HIV victims especially AIDS orphans

- Promote anti-retroviral drugs to prevent mother-to-child transmission

- Reduce stigma and discrimination

- Work with ecumenical and inter-religious partners and government and societal structures at all levels

- Explore every possibility.

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[191] Ibid.

4.6 HIV and AIDS Programmes

The programmatic response of the MCSA is simply, an integrated approach in that it aims, as a principle, to consult with the people with HIV and AIDS in regard to prevention, intervention, and care strategies. The document states four objectives of the programmes, namely: (1) to prevent the transmission of HIV, (2) to provide a forum for Methodists in Southern Africa to become involved in efforts to combat the spread of HIV/AIDS, (3) to mobilize national, international and local resources to be deployed in the fight against HIV/AIDS, and (4) to protect the legal rights of people infected with AIDS and reject all forms of discrimination.

The document outlines four programmes which are at the forefront of the MCSA's response to AIDS and HIV. These are AIDS awareness education, target prevention for all at risk, preservation of confidentiality, and respect for culture, tradition and practice. The document argues that previous awareness has been using scare tactics which have failed to yield a behaviour change. It advocates for information and behaviour change programmes. The programmes should also target those persons with high risk of contracting HIV. The efforts should therefore include the reduction of risk, access to voluntary testing and counseling, home-based care as well as prevention of pre-natal transmission. The document upholds human rights framework as an embodiment of the entire MCSA response. Disclosure of the HIV/AIDS condition has serious personal and social consequences for the patient. Therefore, the document urges that in every case, the person's right to disclose should be respected. Equally respected by the document is the culture, traditions, customs and religious practices of the infected. "Our approach must encourage those aspects of culture that promote healing and wholeness".[192] As a principle, the MCSA would challenge harmful rituals and practices where culturally supported behavior makes people more vulnerable to HIV.

The document is categorical in highlighting the priorities that are to be maintained in the MCSA response to AIDS. Caring for people living with AIDS is a chief priority. Medical care of the sick is another obvious priority in the document. The 'love box', a

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[192] Jacob, S. *The Methodist Response*, 2006: 11.

medicinal supply scheme in the MCSA, is highly recommended. The MCSA Church promotes the use of herbal medicine. This comprises the use of traditional African medicine especially in deprived communities. The document upholds African traditional medicine because "they have been used for the full spectrum of diseases from self-limited to life-threatening illnesses". [193] Although the document does not cite its authority in this assertion, it argues in defense of African traditional medicine by stating that it has power among the African people to treat opportunistic infections associated with AIDS. The document recommends *ibohlololo lasolwandle* (sour fig) as a safe natural medicine. The juice of the leaves is used to treat thrush, throat and mouth infections, sores, and ulcers.

The document also prioritizes home based care and proper nutrition. It recommends the book *Positive Health* by Niel Orr in association with David Patient (a person living with HIV for over 20 years). The information in this book is seen to be a nutritionally helpful tool. Other key elements of priority in this MCSA document include emphasis on child care, support and poverty alleviation, and the enhancement of HIV/AIDS projects. The document supports home-based care as opposed to the orphanages and children homes. It states:

"Placing children in institutions and homes established outside their community of birth represents a loss of an important cultural value. In impoverished communities people living with HIV/AIDS and their families can cope with material, pastoral, voluntary, and social support with help from the Church, the community and the state". [194]

The document adopts a border-line in the poverty versus AIDS debate. It argues that there is a connection between the two and recommends that help of the poor be attended to. This will include provision of blankets to the people living with HIV and AIDS as well as providing foods and physical needs after proper assessment by the MCSA. Whereas the document prefers the use of replacements for feeding a baby in cases of HIV positive mothers as opposed to breastfeeding, it cautions that certain

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[193] Ibid, 2006: 12.

[194] Ibid, 2006: 13.

cultural factors need to be considered. In communities where breast-feeding is the norm, women who do not breast feed may be stigmatized and therefore social and emotional support must be given to such mothers.

It is clear that the programs target the Methodists that are living with AIDS and HIV and not the entire population outside the church. This shall be revisited in chapter five on evaluation.

4.7 Fund Raising

"The MCSA Mission unit will seek funding for projects established by Methodist Churches that fulfill a certain criteria" declares the document. These criteria consist of six elements, namely:
- Evidence that the project was initiated in consultation with people living with AIDS and those affected by it.
- That the project is based on an accurate needs assessment
- That the cultural context and the location of the affected are taken into consideration
- Evidence of the church's own contribution, (financial, staffing, administration, others)
- That administration and staff costs do not exceed 8 percent of the total budget
- Regular reporting and financial accountability
- Regular monitoring, inspection and evaluation by the MCSA maximum funding limited to R30,000 per project
Any project of the MCSA must meet the above strict criteria. The criteria is, however, too brief as it either assumes or implies certain values. For instance, it is not specified whether the funding limitation is per year or per month. Administration costs limited to 8 percent of the entire budget simply means voluntary leadership. This is simply not stated.

The document explains that the MCSA will seek funding from the South African government for the implementation of the plan and the Methodist response to HIV/AIDS. It will also seek funding from other international donors and business communities. What is amazing here is that it will seek funds only from the South

African government and not other governments where MCSA is represented. This is indicative of the document being drawn with South Africa in mind and not having the entire region in perspective at all. This shall be discussed more deeply during evaluation in chapter five.

4.8 Caring for People Living with HIV/AIDS

The document also consists of a section on caring for people living with AIDS and HIV. This section was added to the document after the revision of 2006. It simply comprises terminologies that ought to be avoided when addressing people living with AIDS and HIV. This section is more on stigmatization than on care-giving. Such words as 'AIDS carrier', 'AIDS test', 'AIDS virus', ' Catch AIDS', 'AIDS sufferers', 'AIDS victims', 'innocent victim', and 'high risk groups' are discouraged on the basis of the social meaning attached to them.. Together with this an AIDS glossary is included. This is a list of words and their definitions as they relate to HIV and AIDS.

4.9 Charter of Rights on HIV and AIDS

The document adopts the Charter of Rights on AIDS and HIV, drafted in 1991 and developed in 1992 through a process of international consultation yet championed by the United Nations. The bill was launched in November 1992 at a conference that consisted of more than 300 delegates from political, medical and religious, backgrounds, as well as researchers, artists, and other stakeholders. The document recommends this bill so as to ensure that there is no discrimination of people living with AIDS or HIV in South Africa. It is interesting that again the document talks of South Africa as opposed to Southern Africa.

The bill consists of such issues as liberty, autonomy, security of the HIV/AIDS person and freedom of movement, confidentiality and privacy, testing ethics, education on AIDS and HIV, employment, health support services, media, insurance, gender and sexual partners, prisoners, equal protection of law and access to public benefits, and duties of persons with HIV or AIDS. These are well summarized in the document.

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4.10 The MCSA AIDS Policy – The Application and Usage

The MCSA expects that *The Methodist Response to HIV and AIDS: Revised Strategy and Implementation Plan* be present on every parish priest's desk. It is expected that this will inform the entire parish on the AIDS ministry in the entire Southern Africa region. Such organizations within the church, like the Women Manyanos and the Young Men's guild are expected to use this guideline in responding to the AIDS pandemic.

Sol Jacob however regrets that there is no follow up committee to see if that is happening at the grass-root level. He is assured and has evidence that nothing much is happening at the grass-root level on AIDS ministry. Indeed, he says:

"This booklet is lying on the desks of many pastors yet their congregations have no idea about it. Even the lay leaders I have spoken to in various regions have never seen it. People have no idea what is the stand of the MCSA on HIV and AIDS simply because the pastor's are not doing their duty well. Besides, this document is not sufficient. It was only a beginning and was supposed to be followed by a whole theological reflection on the AIDS epidemic". [195]

Whereas these books are published and distributed to the pastors freely there is no way of accounting their effectiveness on the ground. At least there is no evaluation research that has been done to ascertain that. By and large, this project seems to be an initiative of Jacob and not so much the MCSA in Southern Africa. Nevertheless, the document is a major step in the church's response to HIV and AIDS, at least in documentation.

Concerning the limitations and disadvantages of the document, it does not postulate at all whether condoms are advocated by the MCSA in prevention strategy. Likewise, the document does not say anything about the age and the content of sex education to be appropriate in teaching young children. We have also underlined that the document

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[195] Jacob, S. Interview by author, Pietermaritzburg, 12th August 2006.

is simply a South African focus as opposed to other countries that it poses to reach. These and other issues will be discussed in the chapter on evaluation

4.11 Conclusion

In this chapter, we have unpacked the MCSA policy document on HIV and AIDS. We have attempted to outline its acquisition process, its contents, as well as its usage. We have ascertained that the document is a guideline as well as a positional statement in various AIDS related debates. These include treatment debate and prevention debate. It is however astonishing that this document is silent on the condom debate and the sex education debate. This chapter simply outlined the policy document. We now turn, on chapter five, to the critical evaluation of the MCSA HIV/AIDS policy document.

CHAPTER FIVE

A CRITICAL THEOLOGICAL ANALYSIS OF THE MCSA HIV/AIDS POLICY

5.1 Introduction

This chapter will endeavour to analyse the MCSA HIV/AIDS policy as documented in *The Methodist Response to HIV/AIDS in Southern Africa: Strategy and Implementation Plan*. It proposes to critically investigate the MCSA policy as outlined in chapter four above. This will be done in the light of the Swaziland context depicted in chapter two and in dialogue with the theoretical framework discussed in chapter three as the *shalom* concept. The chapter is subdivided into three major blocks of critical interrogation: the process of the policy formulation, the context of application and implementation, and the theological framework presupposing the policy.

5.2 A Process Critique

The MCSA HIV and AIDS policy came into being as a result of a process that commenced with formulation and culminated in an adoption. This process reveals the particular strengths as well as the weaknesses of the policy itself.

5.2.1 Strengths of the Process

The document was written by a specialist in HIV and AIDS. Sol Jacob had just finished his doctorate studies on the subject of HIV and AIDS when he started writing the document in 2000. Arguably, he was the most suitable Methodist in South Africa for the writing in terms of background studies. It is therefore no coincidence that the Connexional Task Force on HIV/AIDS approached him to write the policy. The same confidence in the author was expressed by the director of MCSA Mission Unit Force. This confirms that the author of the document was well able to take on the task.

The fact that Sol Jacob consulted, as he confesses in the document, with HIV positive persons is itself an aspect of strength. Unfortunately, he does not go far in describing the nature and the extent of his consultation with the persons. It is assumed that the document has the voice of People Living with HIV and AIDS (PLWHA). It would be unfortunate if other people ended up speaking for them. The policy would be highly lacking in representation.

Another area of strength is the fact that the church was finally consulted, and adopted the policy after the author had completed the write up of the initial draft. The document was signed by the Presiding Bishop Mvume Dandala on behalf of the MCSA. Indeed, he wrote the foreword and committed his support for the document. It was also endorsed by the MCSA Connexional Task Force on HIV/AIDS. In other words, the document was fully adopted by the MCSA hierarchy as the church's policy.

It should be observed as a point of strength of the document process of formulation that there has been a visible effort to revise the document. The revision however did not add much or even change the content in any major way. Nevertheless, the document was revised by the same author in 2006. The fact that the 2006 Methodist Conference resolved to adopt the policy indicates that the document adoption was not just an individual decision. As much as this comes much later in the process, it is a commendable part of the process.

5.2.2 Weaknesses of the Process

Unfortunately, weaknesses of the process of formulation emanate from the flipside of the strengths themselves. First, the document was written by a single individual with very minimum consultation. There was no research conducted. In fact, there was not any methodology of data collection indicated in the booklet. The reader cannot ascertain how the author arrived at particular information and data. It would be right to say that the booklet stands on one man's experiences and understanding of the disease.

The book would have more representation if, for instance, a panel of church workers, theologians, medics, counsellors, and administrators could have had their input. The book alludes to the fact that it consulted people living with HIV and AIDS yet does not mention how those people were consulted. It does not indicate the contribution of these people in any way.

Another weakness of the book is that of its geographical representation. The book undertakes to formulate a policy applicable to the entire MCSA which comprises various countries like Swaziland, Lesotho, Mozambique, Namibia and South Africa.[196] Unfortunately, there was no representation of those other countries in the compiling and writing process. A policy need not involve its representatives in the implementation stage only. For better results it will engage the stakeholders in the formulation process, the writing process, as well as the implementation policy. In this case, if there was any representation at all it was at the 2006 conference which was used as a stamping mark of acceptance.

The same could be said about the adoption of the document by the MCSA. There was no workshop on the document whatsoever. The document was simply accepted by the connexional conference without a critical evaluation of its content. This could lead to enormous flaws in the implementation of the document.

The document represents a South African mindset in its compilation and only takes for granted acceptance by the other countries involved. In its plan for fundraising, it plans to consult the South African government. It says nothing about consulting other governments involved such as Bostwana, Lesotho, Mozambique, and Swaziland. This indicates that the document does not take the contribution of the other local governments seriously.

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[196] The Methodist Church of Southern Africa. www.methodistchurch.org.za. (Accessed 18 Nov 2007)

5.3 A Contextual Critique

The MCSA policy document is almost entirely silent on matters of context. The document does not in any way show an effort to come to terms with African realities let alone Southern African issues or even, more particularly, the Swaziland context. In the area of prevention of the spread of HIV, for instance, there are many cultural situations which cannot be ignored in any fruitful prevention effort. In chapter two I demonstrated how such cultural factors in Swaziland contribute to the spread of HIV. These included extramarital sexual relations (*kushenda*), widow inheritance (*kungena*), concubine keeping (*Kuhlanta*), and overnight visits between unmarried lovers (*kujma*). The document does not say anything about gender inequalities, which is a key factor in the spread of HIV in the region. A Church policy on HIV and AIDS in a country like Swaziland will have to address gender imbalances as a matter of priority in prevention.

The document does not state the Church's policy in handling cultural issues that fuel the spread of HIV and AIDS. One would expect to hear the voice of the church in confronting cultural practices that are obvious catalysts in the spread of HIV. The fact that these issues never arise in the document confirms that the document is hardly representative of the regions that it poses to cover.

The MCSA is almost totally silent on statistics. The reader of the document is left without a background of the impact of the disease in various regions. The importance of statistics in formulating and informing a Church's policy on HIV and AIDS cannot be overemphasized. The document only gives brief figures on death rates in 2005.[197] These figures have long changed. Besides, they do not in anyway show the intensity of the problem in the given regions. The Southern Africa region has different rates in mortality, infection, prevalence and awareness. A relevant policy on HIV and AIDS must take into account the rate of spread and mortality in each particular region. Swaziland, for instance has been termed as a "country facing imminent extinction" given the high prevalence rate. South Africa on the other hand has the largest HIV

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[197] Sol Jacobs, *The Methodist Church of Southern Africa: Revised HIV and AIDS Strategy and Implementation Plan* (Pretoria: MCSA, 2006), 17.

population in the world. These two countries have different contextual needs as it relates to the spread of the virus itself.

The same contextual variations between the countries could be said of the hegemony in the societies. These countries differ in racial representation, economic lifestyles, political and social amenities ratio. Because of the diversity in the region the document only speaks at a very general level on many issues. A good case in point is when the policy aims at using the Charter of Rights on HIV and AIDS drafted in 1991 and developed in 1992 through a process of wide consultation. The HIV/AIDS charter is the Bill of Rights of people living with HIV or AIDS. These may work in a democratic country like South Africa. However, they are bound to fail in a country like Swaziland, which is a monarchy. There is no respect of other human rights in the country. The country is governed autocratically. Therefore, such a statement is simply pie in the sky for the church in the Swaziland political context.

The factors contributing to the spread of HIV in Swaziland are of two kinds: structural and behavioural factors. The rise of HIV prevalence in Swaziland which passes beyond all other countries in the region, cannot be pinned to one cause and neither can a prevention methodology nor programmes be directed only on one cause of the spread. All the programmes that the policy endeavours to use in responding to HIV and AIDS are care and treatment oriented. These include: medical care, positive health care, traditional herbal medication, support and poverty alleviation, children and positive health. Apart from the poverty eradication in the programmes, there seems not to be programmes that directly focus on structural factors that cause the spread of HIV. In Swaziland, as demonstrated in chapter two, the spread of HIV and AIDS is mainly caused by cultural factors that are embedded and strengthened by the political milieu. The monarchy exploits the people economically and drains their physical strengths whilst adding to their flitching poverty. The king would at certain seasons demand that all women and children of the country go and harvest his plantations. Cultural factors such as wife inheritance, are pertinent issues in the spread of HIV in Swaziland.[198] The policy does not have any programme that for example educates the people about their human rights. It does not have a policy on church and

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[198] Whiteside, A et al. The Socio-Economic Impact of HIV and AIDS in Swaziland. Mbabane: NERCHA. 2006: 17.

governance, Christianity and culture, gender education or nutrition values. The fact that it lacks these important ingredients disqualifies it from relevance in the Swaziland context.

A reader of the MCSA HIV/AIDS policy is struck by the silence on prevention. Indeed, there is no programme on prevention whatsoever. The policy has majored on care giving at the expense of prevention. There is a stunning silence on condom use. There is no explicit policy on the use of condoms. The policy advocates the cultivation of behavioural change by way of sex ethical education. This is not a relevant solution, on its own, in the Swaziland context for two main reasons. First, the assumption that creation of ethical awareness around sexuality and HIV/AIDS does not automatically lead to change in behaviour. Secondly, and more relevant to the Swaziland situation, individuals do not always have power over their morality. In other words, there are structural reasons which precipitate people to behave in a certain manner. For instance, a structural factor like poverty may lead girls to prostitution, not because they have willingly chosen that but most probably because they need it to survive economically. The fact that the policy does not address this issue renders it irrelevant in a volatile context such as Swaziland. Indeed, prevention ought to be a key priority in any HIV/AIDS policy. Even though the MCSA policy mentions prevention as a key objective, it does not reflect on it or even stage a programme towards this agenda.

5.3.1 A Theological Critique

This policy is highly lacking in theological reflection on HIV and AIDS. The importance of a theological reflection to a Church's response cannot be over-emphasized. The Church is informed by a particular theology in all its praxis. Its ethos and actions are based on a theology. Failure to have an adequate theological framework on HIV and AIDS can therefore lead to an inadequate response to HIV and AIDS. Worse still, the church can lack action on the pretext of lack of theology.[199]

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[199] Ronald Nicolson, AIDS: *A Christian Response to AIDS* (London: SCM Press, 1994), 2 and 7.

The two paragraphs in the policy entitled 'our theology' are simply disjointed scriptural passages which could be used to construct a theological framework. These do not form a formidable theology by themselves. They speak of the example of Jesus in the Gospels in accepting the rejected members of the society. This could be taken to counter HIV and AIDS related stigma which has been vibrant in the Swaziland Methodist churches.

A more comprehensive theology on HIV and AIDS is necessary. More importantly, a more relevant theology that takes into consideration the plight of the people of Swaziland in the context of HIV and AIDS is needed as a matter of urgency. In chapter three, I explored the concept of *Shalom* as a valuable tool in doing a theology on HIV and AIDS. I would think that given the context of Swaziland and the high rate of AIDS mortality, the *Shalom* concept is most applicable to a relevant HIV/AIDS policy. There are several issues that such a theology will need to address. These are discussed below.

5.3.2 Healing

Swaziland is a sick country. Almost everybody has been affected by the scourge of AIDS in the country. The concept of *Shalom* as used in the scriptures and as demonstrated in chapter three refers to a total well-being. It is the well-being of the soul and mind. It implies a state of mind as well as a physical well being. It expresses love, life, wholeness, perfection of God's creation, prosperity, and amicable relationships. This is what the people of Swaziland need to hear. They don't need a judgemental attitude to their already worsened condition. They seek mercy and reconciliation.

God, in the *Shalom* concept, promises that well-being starts in the mind and transcends to the physical body and relationship. Positive living is vital in overcoming both self imposed stigma and experienced stigma. The promise of peace by God in the Bible sets a foot in such a society like Swaziland where individuals are under enormous pressure to the extent of blaming themselves. They need to be assured of God's promise for peace with themselves and others.

This peace concept and total well-being is totally absent in the MCSA HIV/AIDS policy document. It is not mentioned in the theological statement contained therein. As such, the document leaves out a vital theological component in relation to the Swaziland context.

5.3.3 Justice

In Swaziland, justice is 'pie in the sky'. The political system and the leadership structure of the society are set against justice. Women are abused at an alarming rate. The king sets an example to all other men in championing masculinity which is interpreted as domination against the female. In fact, women have no rights apart from obeying their husbands relentlessly. Sex belongs to the King and the men. Polygamy is not the exception but the norm. All efforts by NGOs to raise the issue of justice and rights awareness have been severely punished. Various cultural systems in Swaziland propagate social evils and injustice against the poor. The churches have always thought of blessing the authorities that are. People living with HIV and AIDS do not have access to ARVs. A day's meal, let alone a balanced nutrition, is hard to come by. It is hard to talk about justice in such a context.

The *shalom* concept, as demonstrated in chapter three is comprised of justice. There is no *shalom*, the vindication of the righteous judge in Swaziland. *Shalom* in Swaziland can only be established and cultivated when the voice of the poor, the oppressed and the sick is amplified and adhered to. The concept of *Shalom* mandates the society, including the religious sector, not to sit and dine with the rich and the perpetuator of injustice but rather to expose the injustice and corrupt deals of the oppressor. It mandates the church to stand in solidarity with the poor and the oppressed.

This aspect is totally lacking in the theological statement of the MCSA HIV/AIDS policy. The absence of justice is the absence of life and tranquility. Our theology of HIV and AIDS should not forget this important component especially in the Swaziland context. Otherwise, both our theology and our HIV/AIDS policy are irrelevant to the realities facing the people of Swaziland.

5.3.4 Lament

The rate of deaths in Swaziland and the rate of suffering as a result of HIV and AIDS call for lamentation. Lament is an emotional wailing as depicted in the book of Lamentation in the Old Testament. However, it is more that a desperate wail. It is an invocation to God's help. It is an expression of weakness and of strength at the same time.

It will be very unfortunate if as a Church we do not weep with the people of Swaziland at this time of need. The MCSA will have lost a *Kairos*[200] opportunity if it failed to show solidarity with the poor by just crying with them and 'feeling their pain and loss. The country is undergoing a lengthy grief, therefore this face and reality must be seen as a genuine portrait of the MCSA. Giving material support is not good enough without being there to provide 'a shoulder to lean on'. This is exactly what *shalom* is all about, showing love and compassion.

5.3.5 Redemption and Hope

Coupled with grief and lament is a necessary component of redemption and hope. The church's presence signifies the very presence of Christ in their suffering. But it does not end with Christ's presence; it moves on into Christ alleviating the problem and redeeming his people from suffering. The theology of HIV/AIDS need not show hopelessness but rather a spreading of the aroma of hope (2Cor. 2: 16). Christ overcame all suffering; he persevered with all pain; he conquered death; and he promises everlasting joy and a painless life both here and in the life to come.

Redemption and hope need not be overly spiritual and eschatological at the expense of political and socio-economic realities in Swaziland. Swaziland needs a redemption that delivers the poor from the oppression of a small minority rule. Democratization of the country would be a starting point for the redemption. A revision of the

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[200] Kairos is used here to refer to a momentous opportunity of solidarity and support during time of a need.

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country's economic structures would bring good tidings to the poor, the sick, and the prisoners (Matt. 4). Good news to the people living with HIV and AIDS, which in essence is redemption to them, must entail the availability of ARVs, eradication of stigma, better health and social amenities, as well as the availability of information and food.

The MCSA HIV/AIDS policy document does not address these issues in its theological statement. It is totally silent on holistic deliverance, hope and lament in its reflection. I think by so doing, it becomes far removed from the contextual theology necessary for the people of Swaziland in a time of AIDS crisis.

5.3.6 Inclusiveness

A reader of the MCSA HIV/AIDS policy document is intrigued by the exclusiveness in the document. The policy is directed exclusively to people within the Church context. It targets those people within the MCSA community specifically. In page four it speaks of its membership as including those HIV Positive and those living with AIDS. Its policy is imperatively directed to Methodists living with HIV and AIDS. It shows commitment to solidarity with members of the church who are living with the disease and remains silent all through about those of other faiths or even non religious people infected by the virus. The church is committed to support only those projects that are Methodist in origin and orientation.[201]

The church of Christ has a responsibility to society at large. This is inclusive of believers and non believers, church members as well as non-members. Therefore, the church policy and theology must have in perspective those within its membership as a church organization as well as those without its membership sphere. The conscience of the church as well as its mission misses a lot if it ignores the community it intends to reach with the love of Christ.

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[201] See MCSA HIV/AIDS policy document, 2006: 16.

5.4 Conclusion

The MCSA HIV/AIDS policy is a major step in combating the epidemic that has threatened life in the Southern Africa region. The church is to be commended for its commitment in responding to the epidemic. In this chapter, I have evaluated the HIV/AIDS policy of the MCSA in relation to our previous discussion. This chapter looked critically at the policy in relation to the Swaziland context enumerated in chapter 2, and in the light of a theology on HIV and AIDS discussed in chapter 3 as the *Shalom* concept. By and large, I have demonstrated that the policy has various outstanding strengths within itself. However, I have also demonstrated that the policy is irrelevant and inapplicable in the Swaziland context because of various pit falls. These relate to the process of its formulation, the context of Swaziland, and the Theological framework on which it is based.

In the next chapter, I shall bring the study into a conclusion by way of summarising the deliberations and making certain recommendations.

CHAPTER SIX

6.1 Recommendation and way forward

In Swaziland's case, the decrease in the economic trends, indicate an enormous impact of HIV and AIDS in the country. The spread of HIV in the country is due to a number of factors but the major ones are socio-cultural and economic factors. The former, for instance, includes having multiple female partners, polygamy, extramarital relationship, widow inheritance and concubine keeping. None of these are in favour of women. Daniela Gennrich points out that, "such cultural practices and beliefs which insist that women should obey their husbands and belief that men naturally need more than one sexual partner make it extremely difficult for wives to insist on their husbands' faithfulness or else to reject unsafe sex, even within marriage".[202] These cultural practices present aspects of gender inequality but sadly the MCSA HIV and AIDS policy document does not say anything about gender inequalities yet this aspect is a key factor in the spread of HIV in the country. I, therefore, say that a Church policy on HIV and AIDS in a country like Swaziland should address gender imbalances as a matter of priority for prevention. My recommendation is, therefore, that the document has to be revisited and have some adjustments made especially in the area of socio-cultural aspects particularly in the Swaziland case.

For the document to be relevant in the Swaziland context, I suggest that it should have programmes that educate the people about their human rights, as they seem to be victims of bad structural and behavioural systems. Looking at the situation of HIV in Swaziland currently, there is a great need to focus on prevention strategies more than anything else. The MCSA HIV and AIDS policy has got no programme on prevention. The policy simply majors on care-giving which is good but I also recommend that it should equally also regard prevention programmes.

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[202] Gennrich, D (ed.), *The Church in an HIV+ world: A practical handbook*. Pietermaritzburg: Cluster Publications. 2004: 13.

Considering the widely accepted view that HIV and AIDS have caused a great number of children in Swaziland to be left orphans. They experience an emotional trauma of losing parents to the pandemic and thus there is a dire need for bereavement counselling of affected children. I suggest that the policy document should put emphasis on the aspect of "bereavement counselling of affected children or OVC" when focusing on care-giving programmes.

The fact is that the ethos and actions of the Church are based on a theology and therefore any failure to have an adequate theological framework on HIV and AIDS renders the response to HIV and AIDS ineffective. The policy, as a matter of fact, is lacking a theology on HIV and AIDS, and therefore I recommend that a more comprehensive theology on HIV and AIDS be included. A more relevant theology that takes into consideration the plight of the people of Swaziland in the context of HIV and AIDS is needed as a matter of urgency. In addition, the *Shalom* concept as a valuable tool in doing a theology on HIV and AIDS should be considered when a reconstruction of the document is undertaken.

The way forward of the policy document would be that, if it is to make a recommendable impact in Swaziland, it needs to be strengthened in these areas; a more theological foundation needs to be cultivated, much more emphasis on prevention, needs to be embraced, and dialogue should take place with the state regarding certain structures such as economic and cultural.

6.2 Conclusion

In conclusion, this thesis critically analysed the theology of HIV and AIDS policy of the Methodist Church in Swaziland. In chapter one, we discussed the background to the whole study as an introduction. Chapter two discussed the HIV and AIDS situation in Swaziland, first by looking at the profile of the country and the factors contributing to the spread of HIV. Furthermore the chapter discussed the impact of HIV. This chapter indicated that the HIV and AIDS pandemic have a huge and negative impact on the country's economy, health systems, education, households and communities. This phenomenon has resulted into a tremendous poverty which is

hampering the people's well-being. Chapter three discussed the concept of *Shalom*. It threw more light on how *Shalom,* as a theoretical framework of the study, is important and vital for the mission of the Church faced by HIV and AIDS pandemic. Chapter four focussed on the summary of the MCSA HIV and AIDS policy. Chapter five discussed the critical theological analysis of the MCSA HIV and AIDS policy. It focussed on the process of the policy formulation, the context of application and implementation, and the theological framework that presupposes the policy.

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