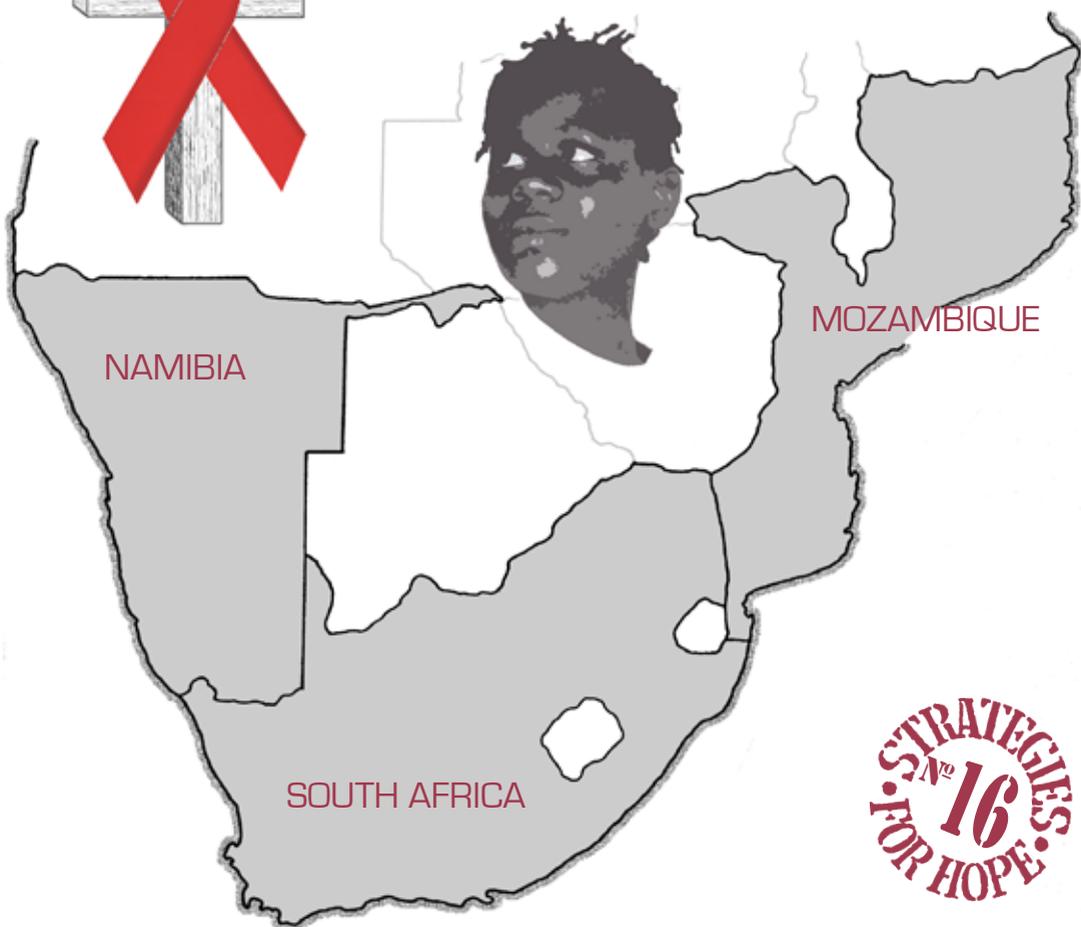


JOURNEYS OF FAITH

Church-based responses to HIV and AIDS in
three southern African countries



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FOR HOPE

by Gideon Byamugisha, Lucy Y. Steinitz, Glen Williams and Phumzile Zondi

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Gideon Byamugisha
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Glen Williams
Phumzile Zondi

1 June 2002

NOTE: In most cases the real names of people quoted or mentioned in this book have been used, with permission from those concerned. In some cases, however, names have been changed to respect people's wishes for confidentiality.

PREFACE

Journeys of Faith describes and analyses innovative HIV/AIDS programmes carried out by churches and other Christian organisations in Mozambique, Namibia and South Africa.

This book is the sixteenth in the Strategies for Hope (SFH) Series, which was established by ActionAid in 1989 and is now a project of Teaching-aids at Low Cost (TALC). The SFH series, while not a faith-based organisation, has always recognised the importance of spirituality and of religious institutions in promoting good health and coping with illness. Nowhere is religious faith of greater relevance than in responding to the daunting challenges of the HIV pandemic.

Journeys of Faith describes how several churches and Christian organisations in three southern African countries have responded to the challenges of HIV/AIDS with imagination, courage and commitment based on their religious faith. We hope that other faith-based organisations will find inspiration and encouragement in these experiences. Strategies for Hope also plans to publish a study guide and resource booklet - entitled *Called to Care* - to help church groups reflect on the HIV/AIDS situation in their communities, and to plan and carry out activities aimed at HIV/AIDS care, support and prevention activities.

The writing of this book has been a collective effort involving four co-authors. Parts of the book describe HIV/AIDS work in which two co-authors - Lucy Steinitz and Phumzile Zondi - are directly involved. We would like to make it clear, however, that neither of these co-authors wrote the sections of the book which describe their work.

The organisations and individuals whose work is described in *Journeys of Faith* were actively involved in checking and revising the relevant chapters of the book. Any factual errors or misinterpretations, however, are entirely the responsibility of the authors.

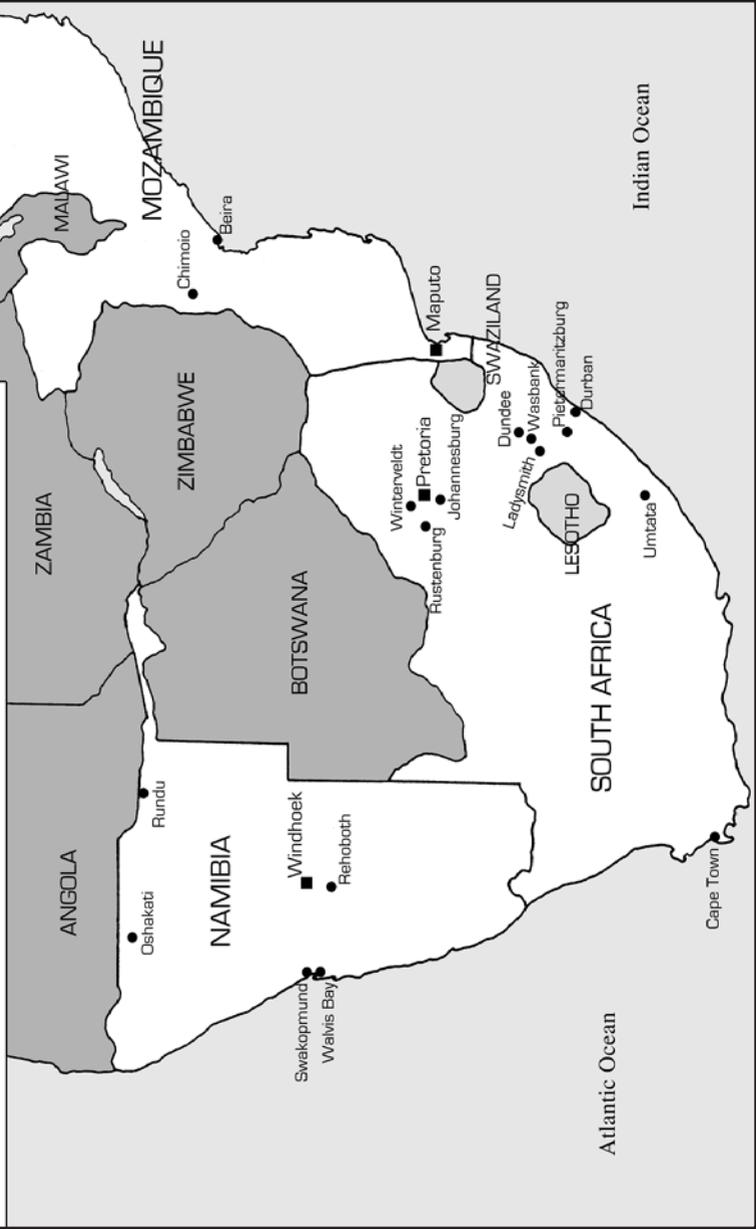
We are deeply grateful to the five church organisations, and the UNAIDS Inter-country Office for East and Southern Africa, who provided the financial assistance needed to make this book a reality. Any views expressed in the book, however, are the responsibility of the authors.

Glen Williams
(Series Editor)
Strategies for Hope)

1 June 2002

MOZAMBIQUE, NAMIBIA, SOUTH AFRICA

Showing locations of places mentioned in this book



Chapter 1:

Introduction

Faith is the mainspring of the soul. Through faith, our aims, desires, plans and purposes are translated into physical, social, economic, political, artistic and spiritual achievements. Over the centuries, positive religious faith has stimulated individual and collective actions for the improvement of people, collectively and individually, in many different spheres of life. History also abounds with instances of religious faith, applied negatively, bringing untold suffering, injustice and evil into the world.

For many centuries, religious faith and spirituality have been major resources in promoting health and well-being, and in helping people to cope with the impact of disease. This is especially the case in Africa, where religious beliefs play a major role in shaping people's personal identities, thought patterns and perceptions of disease, and the decisions they make which affect their health.

Faith communities* in Africa therefore have the potential to play a pivotal role in determining how individuals, families and whole communities respond to the HIV epidemic, which is the greatest health and development challenge facing the continent today. Indeed, in many African countries, churches and other faith-based organisations** have been very much to the fore in developing and spreading

innovative and effective responses to the HIV epidemic. Strategies such as home-based care, counselling, peer education and community-based support for families affected by HIV/AIDS have been pioneered and developed by Christian health programmes and other faith-based organisations in many African countries.

Religious faith can also play an important role in promoting safer sexual behaviour, and in motivating large numbers of volunteers involved in HIV/AIDS care, support and prevention activities. Moreover, the personal testimonies of many people living positively and productively with HIV reveal a deep reliance on inner spiritual resources for strength and willpower.

Yet by and large, the responses of faith-based organisations in general, and of churches in particular, towards the global HIV epidemic have generally lacked sufficient urgency and commitment. This is especially so in the field of HIV prevention, and in combatting the stigma, denial and discrimination that are often attached to HIV/AIDS. The main reason for this failure has been the association, in the collective mind of many members of faith communities, of HIV/AIDS with immoral sexual behaviour.

Many church leaders in Africa – and elsewhere in the world – regard HIV infection simply as the consequence of individual sin.

* We define a 'faith community' as the people who belong to a particular religious faith or who espouse a set of similar spiritual beliefs.

** We define a 'faith-based organisation' as an institution, association or group formed by people of the same religious affiliation. Within the Christian tradition (the focus of this book), faith-based organisations include - but are not limited to - churches and church-affiliated men's and women's organisations, youth groups and Sunday schools, as well as church-based non-governmental organisations, social welfare bodies, schools and health institutions, and both national and international church organisations and networks.

People already infected with HIV are exhorted, therefore, to repent of their sins and to pray for healing through faith. HIV prevention is reduced to a simplistic emphasis on returning to 'traditional' moral values and standards of sexual behaviour. Unfortunately, these judgemental attitudes have had the effect of reinforcing denial and secrecy on the part of people who know they are HIV-positive or believe themselves to be so. This, in turn, undermines efforts to mitigate the impact of HIV/AIDS and to prevent its further spread.

In recent years, however, growing numbers of secular leaders at global and national levels, and among international agencies, have come to appreciate the unique potential which churches and other faith-based organisations have for preventing the spread of HIV and helping communities cope with the impact of the HIV epidemic. Growing numbers of religious leaders and institutions, especially at international level, have realized the urgency of exploring new ways of responding to the huge challenges of HIV/AIDS. Yet most faith-based organisations still lack the information, attitudes and skills, as well as the appropriate policies and strategies, for taking their rightful place in the global fight against the HIV epidemic.

This book documents the journeys which several church groups, organisations and individuals have made – and are still making – in their response to HIV/AIDS in three southern African countries: Mozambique, Namibia and South Africa. It does not claim to be an

exhaustive survey of the responses of churches and other faith-based organisations to HIV/AIDS in these three countries. Christianity is the predominant religion in southern Africa, but it is a relatively recent arrival on the African continent and other faiths also have many adherents. Traditional African religion is widely practised in southern Africa: many people belong to a church but still consult a diviner or other traditional healer in times of personal crisis or ill health. Islam also has many followers in this region, especially in the main urban areas of South Africa and in parts of Mozambique. Traditional healers, Islamic organisations and members of other faith communities have all responded in particular ways to the challenges of the HIV epidemic in southern Africa.

Journeys of Faith describes how church groups, organisations and individuals have mobilised themselves to take collective action in response to the HIV epidemic. In the course of their work they have encountered indifference, scepticism and outright opposition. Yet they have been sustained by their Christian faith and encouraged by the support they have received from many quarters, especially from people infected or affected by HIV/AIDS. Their experiences are a rich source of inspiration and practical guidance for churches and other faith-based organisations looking for a 'road map' to translate their religious convictions into effective action against the HIV epidemic, and in support of people living with HIV and their families.

Chapter 2:

Tumelong Orphan Haven

A place of faith and joy

Every morning, from Monday to Friday, a bus stops near the shack where Joyce Sibasa lives with her two young grandsons, Kgothatso and Katlego. The two boys climb aboard, the bus lurches off and eventually deposits them and 35 other children at Tumelong Orphan Haven, about 10 kilometres away.

“The boys really look forward to the bus every day,” says Joyce. “It’s exciting for them.”

A second bus brings another load of children to the Haven, in the township of Klipgat, north of Pretoria, South Africa. Here they will all stay until mid-afternoon, when they will be bussed home again. Most of the children live with their grandmothers, others with neighbours, a few with older brothers or sisters.

The Orphan Haven consists of a nursery and a pre-school held Monday to Friday, and a club for school-age children held every Saturday and during school holidays. It began in February 2000, with just 16 pre-school children. Two years later, 60 children were attending the pre-school and 10 babies were being cared for in the nursery. Over 100 children aged between 7 and 18 attend the Saturday Club.

Most of the children attending the Haven have lost both parents, and their guardians make no payments for any of the services provided by Tumelong. There are six children, however, whose parents pay a small monthly fee and also make a contribution towards the bus fare. These are not orphans but local children who are very



Pre-school children arrive by bus at Tumelong Orphan Haven.



Joyce Grandmother and volunteer

Joyce Sibasa has two grandsons - five year-old Katlego and seven year-old Kgothatso - attending Tumelong Haven five days a week. The boys have been living with her since their mother died in Tumelong Hospice three years ago.

"My daughter had been sick, on and off, for a long time. The Tumelong people used to visit her. When she went to stay in the Hospice, my grandsons came to stay with me, and when she died they just stayed on. I'm their only relative, so where else were they going to stay?"

"But I couldn't look after them properly. I'm not in good health myself, and I've only got my old-age pension to support us all. I managed to look after the boys for over a year, but really I wasn't coping at all well. Then two other ladies from Tumelong came to see us, and they said the boys could come to this Haven place every day, and without paying! They would even get picked up by bus every morning and brought home in the afternoon.

"I'm very, very happy with the Tumelong Haven, and so are my grandsons. They're well looked after there. They get food and clothing. They're also learning to



read and write, so they won't have problems when they start school.

"What I also like is that they are learning hymns and choruses, and they are even learning to pray. My daughter wasn't a church-goer so they weren't learning those things before. Now they even pray at night, before going to bed.

"I like coming to the Haven to help out in the kitchen now and then. The work's not too hard and I get to meet people and make new friends. For me, it's a good day out.

"What I'm worried about now is how I can support the boys when they start school. Kgothatso should have started already, but I have no money for his uniform, shoes and the school fees. I'm hoping that Tumelong can help there as well."

happy at the Haven, and whose parents are not concerned about their being with orphans who may be HIV-positive.

The mission

The Haven is part of Tumelong Mission, established in 1939 by the Anglican Diocese of Pretoria to provide relief and support to

families in and around the sprawling township of Winterveldt. About 1 million people now live in Winterveldt and seven nearby townships, mostly in make-shift shacks that are bitterly cold in winter and swelteringly hot in summer. The area has an unenviable reputation for crime, violence and extreme poverty.

True to its Tswana name, Tumelong is a

'place of faith', consisting of the Orphan Haven, a health centre, a hospice (see box page 11), a home-based care project, a rape crisis centre, a primary school, a youth centre, a nutrition project, two centres for disabled people and several income-generating activities.

Tumelong is not a traditional mission station, with its activities concentrated on a single site with a large church in the middle. On the contrary, the different parts of the mission are scattered throughout Winterveldt and the neighbouring townships, and the projects it supports blend in with those of local communities. Tumelong staff work closely with several local churches and other community organisations. They have a particularly close working relationship with the health centre run by the Catholic Sisters of Mercy in Winterveldt township.

The land in and around Winterveldt is owned mostly by absentee landlords, and local people

are unable to buy the land on which their houses stand. There are no household amenities such as piped water or electricity. Most of the households are headed by women, many of whom are aged grandmothers looking after their orphaned grandchildren and sometimes other orphans as well.

The Orphan Haven is run by six women staff, including a pre-school teacher and a social worker, and a group of women volunteers. Joyce Sibasa, for example, comes to the Haven two or three times a month to help in the kitchen by peeling and chopping up vegetables, doing the washing up and other odd jobs. Several other grandmothers and guardians also come to the Haven to help with tasks such as washing toys and cleaning the buildings.

A joyful place

The Tumelong Orphan Haven has two main aims. Its first aim is to provide orphans with

The outdoor playground equipment at the Haven is popular with the children.



holistic care – emotional, social, physical, intellectual and spiritual. Its second aim is to provide grandparents, neighbours and other orphan care-givers – most of whom survive on precariously low incomes – with some respite from the daily demands of looking after young children, some of whom still suffer from the emotional or social effects of losing their parents to AIDS.

When the Tumelong executive committee realized the need for a place to bring infants and pre-school children during the day, they made an appeal to the local community for a building. Only one organisation replied positively – the Catholic Church in Klipgat township, where a building previously used as a crèche had been standing, unused, for several years. Tumelong gratefully accepted the offer, but there was still a lot of work to do:

“When we first came here,” recalls Tumelong programme manager, Mary-Ann Carpenter, “the grass in the yard was shoulder-high, and there were rat droppings and cobwebs all through the building. It took us three months to clean it all up, and we added an extension as well.”

The Haven now consists of a huge hall, two large rooms, a kitchen, a pantry, toilets and a bathroom. The local Catholic and the Lutheran churches have contributed furniture, playground equipment and toys for the children. Another donor has provided funds for a tube well, which is ingeniously connected to a roundabout. Whenever children push the roundabout – regardless of the direction in which it moves – water is pumped up into a storage tank, high above ground level. The water is invaluable, not only for the kitchen, the toilets and the bathroom, but also for the large vegetable garden which provides much of the food used in the children’s midday meal.



Creative activities at the Haven: children also acquire simple literacy and numeracy skills so they are not at a disadvantage when they start primary school.

The Haven is a noisy, joyful place. The 60 children attending from Monday to Friday are given two snacks, and a cooked breakfast and lunch, every day. They are encouraged to express themselves through drawings, paintings and making models and pictures with scissors, glue, cardboard, cloth and other materials. They take part in organized play therapy, and use the outdoor playground equipment with great enthusiasm. They also acquire simple literacy and numeracy skills, so that when they start school they are not at a disadvantage compared with children from better-off backgrounds. In addition, they learn Christian hymns and prayers, taught by staff and volunteers from a wide range of Christian denominations.

The children attending the Haven are given regular medical and dental check-ups, and are taken to a nearby clinic for vaccination, but none are tested for HIV. Six babies have died since the Haven began, and HIV was probably the cause of most of these deaths. A two year-old boy who almost certainly is HIV-positive is currently being looked after in the nursery. Since no suitable relatives can be identified to foster the child, a Tumelong staff member is looking after him at home.

Most children come to the Haven because their mother or (less often) father is staying at the Tumelong Hospice. Some begin attending the Haven even before the parent's death. Others are referred to the Haven by Tumelong's two home-based care teams, its own health centre, or by other health centres, hospitals and social welfare institutions.

An average of five to eight new children are referred to the Haven each month, but not all can be accepted because of a lack of transport to bring them. At the end of 2001 there was a list of 50 children waiting to be admitted. Satellite Havens have been started at two other townships, which now receive almost 100 children twice a week. When more care-giver staff have been trained, these centres will operate five days a week.

The Saturday Club

On Saturday mornings, and also during school holidays, a totally different scene takes place at Tumelong Orphan Haven. Over 100 children of school age arrive, most by bus, some on foot. They start with a breakfast of porridge or bread and jam, with tea, then sing a hymn or a chorus, followed by prayers led by a member of staff. The group then splits into two – those aged 16 and over, and those below 16. The older group discusses whatever topic they have chosen for

the day, which might be drugs, sex, pregnancy, careers, food gardens, self-image, and management of stress and anger. Discussions are led by a Tumelong staff member. The younger children meet separately for their own discussions on similar topics, and for activities such as painting and drawing. There is also an opportunity for children to seek help with their homework from staff. A cooked lunch and snacks are served, and outdoor games are played in the afternoon.

Tumelong staff also carry out grief and bereavement counselling, on a one-to-one basis, with children who have recently been orphaned. Social worker Patience Nqoko explains:

“We start by asking whether they understand why they are here. Did they go to the graveyard to bury their parents, and did they understand all that? Usually they've been living with their mother only, and we know her from the Hospice or the home care team, or both. We ask if they've looked at the items in her memory box and read her memory book. Did they understand those things, and would they like to tell us about them?

“Sometimes the child will say ‘oh, I've seen that box but I haven't looked at it’. So we encourage them to go through the box and to read the book, and to treat them as their treasure. Next time they come we'll talk about the contents, which leads them to talk about their parents. We also ask them if they are happy where they are staying now, and whether they are feeling any stigma at school or in the community.

“Very few parents are honest enough to call their children in and say ‘I'm dying of AIDS’. They might say they have TB or pneumonia, but not HIV or AIDS. But they might write about having HIV/AIDS in the memory book, so the first time the child learns for sure that his or



Tebogo

Orphan and would-be doctor

"I come here only once a week and during school holidays," says 16 year-old Tebogo, "but I like it very much and for me it's like a second home. I enjoy going on outings, like to the zoo. I also like the discussions we have here. But I'm also happy to work in the garden, or even to help clean the building. My sister likes it too."

Tebogo and his 9 year-old sister, Tsufelo, have been coming to the Orphan Haven since their mother, Meisie Josephine Khumalo, went into Tumelong Hospice. The two children also moved into the home of a neighbour, Mrs Moima, who was a close friend and had known them since they were born.

While Meisie was a patient at the Hospice the Tumelong social worker, Patience Ngoko, gently raised with her the question of what should happen with the children if she happened to die. Since Meisie had no surviving relatives in the area, she asked Mrs Moima to look after her children, which she and her family readily agreed to do, although they are not well-off.

After Meisie died, Patience began carrying out grief and bereavement counselling with the children, using Meisie's memory box as a starting point. They found that the box contained pictures of themselves, some with their mother, when they were younger. There were also photos of their grandmother and copies of their mother's birth certificate, her identity card and also her will, in which she requested that her death certificate should be added to the box.



Meisie had also written a history of the family, as far as she knew it. She recorded this family history in her memory book, which consists of pieces of paper sewn together with woollen thread and bound between two sheets of cardboard. For both children, their mother's memory box and book are treasured possessions, to which they return again and again.

"I know the cause of our mother's death," says Tebogo, "so I take a lot of interest in everything to do with HIV and AIDS. I read everything I can about things like antiretrovirals. I'd like to become a doctor when I grow up. My sister wants to be a nurse."

Tumelong provides both children with school bursaries and is also helping them in other ways. For example, with assistance from Tumelong, Tebogo recently travelled to Cape Town for the National Children's Forum and spoke to MPs in parliament about what it is like being an orphan:

"I learned a lot from going to Cape Town," he says. "I enjoyed meeting people from other parts of South Africa. Before, I didn't realize that there were so many young people like me all over the country."

her mother died of AIDS is when they read it in the memory book, which can be difficult for them to cope with.”

The home environment

Tumelong’s commitment to orphans extends beyond the Haven, into the communities where orphaned children live. Staff try to establish a relationship with the guardians or relatives of all the children attending the Haven. Says Patience Nqoko:

“There’s no written contract between Tumelong and the guardians, but we expect them to be involved in the child’s growing up, to know what’s happening with the child, for example, whether the child is ill or not. If we want to take the children on an outing, we expect them to know about that and to sign consent forms.”

In addition, a meeting of guardians, relatives and Haven staff is held once every three months. This is an opportunity for staff to report on latest developments, such as donations received, the numbers of children attending the Haven,

and any deaths that might have occurred. The guardians and relatives ask questions about who the Tumelong staff are, why they do certain things, which families are eligible for food parcels and school bursaries, and how long Tumelong will continue to assist orphaned children.

For most orphans, living conditions at home are at best basic, often harsh. In cases of extreme poverty, Tumelong’s home-based care teams provide families with blankets, second-hand clothes and a monthly food parcel. If guardians are unable to meet the costs of keeping children at school, Tumelong can provide small bursaries. In 2001, for example, Tumelong distributed 300 blankets to the children attending all three orphan havens; 15 children received school bursaries and 10 families were given monthly food parcels. Tumelong helps families to start home food gardens rather than providing many families with food parcels, as this mobilizes care-givers in the household and is less likely to create a sense of dependency.

Winterveldt:
a harsh
environment
with few basic
amenities such
as domestic
water supplies.



Providing this kind of family support requires considerable resources, many of which Tumelong is able to mobilize locally through churches, youth movements, local businesses, foreign embassies and the staff of international agencies. Several churches, for example, raise funds for Tumelong through jumble sales and other events. Scout groups and churches collect items such as mealie meal, sugar, tinned fish, powdered milk and beans for family food parcels. Local supermarkets supply fresh fruit and vegetables and any other foodstuffs that happen to be available at particular times. St Albans College for Boys in Pretoria organises a Christmas party and toys for the children, and a school near the Haven donates clothes. Foreign embassies in Pretoria give cash donations. Afribike and staff of the World Bank organised a sponsored bike ride for World AIDS Day, and donated the funds raised to the Haven. Tumelong also receives external funding, through the Southern African Catholic Bishops' Conference, for the Haven, the Hospice and the provision of health services.

The issue of residential care

Some of the children attending the Saturday Club have expressed a desire to sleep at the Haven. Tumelong's policy makers and staff, however, are strongly opposed to the idea of residential care for orphans. Says social worker Patience Nqoko:

"A residential home separates children from their communities. Also, when they reach the age of 18 and are supposed to leave, they aren't yet ready to go into the outside world because they haven't learned how to cope for themselves."

Programme manager, Mary-Ann Carpenter, believes that communities themselves have many untapped resources:

"We have many people phoning in to offer support and to ask if they can foster a child."

The Government of South Africa's Department of Social Development has a programme to provide foster parents with a monthly allowance for orphaned children. Unfortunately, the bureaucracy involved in fostering a child is extremely difficult and time-consuming, so very few people are able to claim this allowance, even when they do take foster children into their families.

Staff attitudes and ethos

The Tumelong Orphan Haven has demonstrated both the value – and the viability – of non-residential care, in a Christian context, for orphans and other children made vulnerable by HIV/AIDS. Although few of the staff of the Tumelong Orphan Haven are professionally qualified, all take part in a range of in-service training activities which serve constantly to upgrade their skills and maintain high morale.

Every second Friday, for example, nursing sisters from a Catholic hospital in Pretoria come to provide professional guidance and support, and to do health check-ups of the children. Experts from other professional institutions also visit regularly to provide training in areas such as pre-school education, and identifying and coping with physical and sexual abuse in children. Also important for maintaining a high level of staff morale are monthly outings to recreational centres, which help everyone to 'de-stress' and enjoy one another's company.

Most importantly, all staff at the Haven have a Christian background and their faith helps to strengthen their motivation to carry out their work, for which they receive only modest



Tumelong Hospice

A few kilometres down the road from the Orphan Haven stands Tumelong Hospice, also part of the Anglican mission. The parents of many of the children attending the Haven have spent their final days here.

Most patients are referred to the Hospice, which has 21 beds, by one of Tumelong's two home-based care teams. Other patients are referred by local clinics and hospitals, or have heard about the Hospice by word of mouth. Some suffer from cancer, many from advanced TB, but most have HIV/AIDS.

"Looking after dying people is stressful, yes, but I really love my job," says Vivienne Msiza, in-patient supervisor of the Hospice.

In the two years between January 2000 and December 2001, the staff of Tumelong Hospice nursed a total of 323 patients, of whom 238 died in the Hospice. Yet this is not a morbid, depressing place. On the contrary, it has a reassuring atmosphere of peace and calm, broken occasionally by laughter.

The entire staff of Tumelong Hospice consists of lay people. A team of 18 community health workers (CHWs), all trained in palliative care, looks after patients around the clock. A doctor and a nurse - both volunteers - visit two or three times a week to carry out examinations, write prescriptions, and provide staff with professional guidance and support; they are also constantly on call in emergencies. A team meeting is held once a week to enable staff to discuss problems, give one another mutual support and upgrade staff skills through in-service training sessions.

The Tumelong social worker visits the

Hospice to provide advice and practical assistance with problems such as making a will, planning for children's futures, and funeral arrangements. She also helps the family to understand legal and administrative processes such as inheritance rights and orphan grants from government. Hospice staff encourage patients to keep a memory box of items such as family photos and favourite possessions, and to maintain a memory book about their lives, which their children can treasure and use in the future.

The Hospice provides all its services free of charge, and family members are encouraged to visit their loved ones. If the family cannot afford transportation, the Hospice can provide assistance. If the family of the deceased person has difficulty meeting the costs of the funeral, the Hospice can provide financial support for the coffin, the undertaker's charges and the grave site.

Spiritual support is an important part of the life and activities at the Hospice. An Anglican chaplain visits fortnightly to hold services and to pray with patients. A nun from the Sisters of Mercy visits patients at least twice a week to do spiritual counselling. Individual patients are also visited by priests, pastors or traditional healers, depending on their particular faith backgrounds. The staff are also ready to give spiritual support:

"I offer to pray with the patients, or to read the Bible with them, and most of them are very glad to do that," says Vivienne Msiza. "But we don't force anything on them. If they believe in ancestors," she adds, "I just pray silently for them and hold their hand."

Tumelong staff members: monthly outings help everyone to 'de-stress' and enjoy one another's' company.



material rewards. Social worker Patience Nqoko believes that the Christian faith which the staff share also makes a difference to the quality of the care which they provide to the children attending the Haven:

“I think the fact that this is a place which is faith-based keeps us on our toes. It makes us

want to do things as well as we possibly can. It's not just a matter of 'OK, at the end of the month I'll get my pay', as though we were working only for money. This is an Anglican Church project. It's a service to the community we live in, so we've got to answer to our own consciences for the work we do here.”

Chapter 3

Catholic AIDS Action

“The courage to fight and the strength to care”

“When I arrived in Namibia I realized that AIDS was a time bomb about to explode,” recalls Sister Raphaela Händler. A missionary doctor who previously had worked in Tanzania, Sr Raphaela had come to Namibia in 1996 to manage the Catholic Church’s 16 hospitals and health centres.

“What struck me,” says Sr Raphaela, “was the fact that the churches were doing nothing to address the issue. In fact, the churches were conspirators in the silence about AIDS in Namibia.”

By 1998, with more than one in five adults HIV-positive, Namibia had the third highest HIV prevalence of any country in the world. But Sr Raphaela was working hard, largely behind the scenes, to convince church leaders that a broad-based church response to HIV and AIDS was needed. Her efforts bore fruit in February 1998, when the Namibian Catholic Bishops’ Conference approved the establishment of Catholic AIDS Action, the first national, faith-based response to the HIV epidemic in Namibia.

Two months later Sr Raphaela recruited Lucy Steinitz, an American with over 20 years experience in the management of social welfare organisations in the United States, to manage the new organisation. This was, to say the least, an unusual appointment – not least because Lucy Steinitz is Jewish – but Sr Raphaela had no misgivings:

“Lucy was an excellent choice, really God-

given. She had experience, commitment and enthusiasm, and her religious values were central to her life. That was what I wanted.”

Before planning any activities, Catholic AIDS Action looked carefully at the experiences of HIV/AIDS programmes elsewhere in Africa, especially at the HIV/AIDS home-based care and prevention programme of Ndola Catholic Diocese in Zambia.¹ Valuable lessons were learned through this process of consultation, especially about the role of volunteers in community-based HIV/AIDS programmes.

Core issues and priorities

Catholic AIDS Action was officially launched on 9 August 1998. “AIDS is a disease, not a sin,” declared Archbishop Bonifatius Haushiku, head of the Catholic Church in Namibia, at the launch ceremony. While committed to serving both Catholics and non-Catholics on equal terms, the new organisation defined its mission as follows:

“Acting in the spirit of Christ, Catholic AIDS Action challenges the AIDS pandemic in Namibia with the courage to fight and the strength to care. It builds on Roman Catholic-affiliated groups and institutions to inspire and support programmes of HIV/AIDS prevention, home-based care, spirituality and support of orphans”.



Catholic hospital in Oshikuku, northern Namibia: the Church has an extensive network of health facilities and educational institutions throughout the country.

There could be no doubt that care for the sick and support for orphans should be high priorities for Catholic AIDS Action. These activities have been part of the mission of Christians – and people of other faiths – for centuries. It was much more difficult, however, to find common ground on the issue of HIV prevention. Lucy Steinitz recalls:

“We wanted to distinguish ourselves from the government and most other non-governmental organisations, which were focused mainly on promoting the use of condoms. We felt that this was an insufficient strategy, given the continued escalation of HIV infections. But we knew that we had to address issues of sexual behaviour openly and honestly. To ignore or condemn condoms would be to invite rejection. We also knew that the Sixth Commandment, ‘Thou shalt not murder’, applied to situations where one partner is infected with HIV but the other is not. So even for loyal Catholics, there were some serious moral dilemmas here.”

After much internal debate, Catholic AIDS Action decided to adopt a modified version of a four-point approach to HIV prevention, which originally had been formulated by the World Health Organisation’s representative in Namibia, as follows:

- A** is for Abstinence from sex before marriage.
- B** stands for ‘Be faithful in marriage’. This is the Christian way, and it guarantees life. But if you find that you cannot follow this teaching, then choose
- C** for Condom, or else face...
- D** for Death.

This four-point approach to HIV prevention has enabled Catholic AIDS Action to promote Christian moral standards, while also emphasizing the importance of safeguarding human life through appropriate sexual behaviour.

Organisational strengths

The church-based nature of Catholic AIDS Action gave it certain unique advantages. For a start, many Namibians can be reached through the Catholic Church's 91 parishes and 300 'small Christian communities'. One in four Namibians are Catholics and church attendance is high.

Throughout the country the Catholic Church has an extensive human infrastructure of local congregations led by deacons, elders, catechists and other lay church leaders, under the guidance of parish priests. Many communities also have access to a church school, health clinic or hospital, usually run by religious Sisters and other skilled professional staff.

The Catholic Church in Namibia also enjoys a high level of public and official trust because of its long record of public service, and also for its support for the liberation movement in the years leading up to Namibia's independence in 1990. Finally, the church's links to a network of foreign donor agencies and international organisations are extremely important. These links enabled Catholic AIDS Action to move rapidly from the

planning phase into the implementation of a range of community-based activities.

The launch of Catholic AIDS Action in August 1998 was backed by as much media hype as the young organisation could muster. Posters bearing the organisation's motto – "The Courage to Fight and the Strength to Care" – were mass-mailed to all 13 political regions of the country. Sample sermons and background materials in several local languages were also widely distributed. The launch received extensive – and highly favourable – mass media coverage through radio, television and newspapers. The new initiative was off to a flying start.

Human resources

Catholic AIDS Action quickly established offices in five regional sites, and by early 2002 had ten offices spread out in eight of Namibia's 13 regions. Of 39 staff members, eleven are based at the national office and the remainder in the regional offices. Six staff members are Catholic religious Sisters; 80% of staff are Namibian and the remainder expatriates. As an indicator of the ethnic diversity found in Namibia – and in

Staff at Catholic AIDS Action office, Oshikuku, one of ten offices in different parts of the country.



Catholic AIDS Action in particular – the prayers that are offered at the start of staff meetings in different parts of the country are said in nine different languages.

The real backbone of Catholic AIDS Action at community level, however, is formed by over 1,000 trained home-based care volunteers, assisting over 1,600 sick clients and over 5,600 orphans. The volunteers are the organisation's most precious asset, and they are by no means all Catholics: many in fact belong to Namibia's Lutheran churches and other Protestant denominations.

Ground rules

When they approved the establishment of Catholic AIDS Action, the Namibian bishops had also laid down three ground-rules:

- ❑ The programme had to build on Christian values.
- ❑ The new organisation would have to rely on its own funds.
- ❑ The programme had to be national in scope, i.e. it had to work in all three Catholic dioceses and in all 13 political regions of the country.

Of these three ground-rules, the most difficult to fulfil has been the third. Although Namibia has a population of only 1.8 million, its land area is vast – about the size of France and Italy combined – and sparsely populated. Issues of transport and communication are enormous, given the huge distances which must be covered; some parts of the country are not yet accessible by telephone. In addition, the country's great diversity of ethnic groups and languages often makes communication between people from different areas very difficult. Although English

has been the official national language since independence in 1990, there is still no lingua franca used by all ethnic groups. Added to these constraints are low educational levels, especially in rural areas.

The 'flagship' urban centre

A sign above the gate identifies a cluster of buildings in a neighbourhood of Windhoek as the Bernhard Nordkamp Social Service Centre. In the courtyard, young children play in front of colourful murals depicting scenes from the life of Jesus. The Centre is, in effect, Catholic AIDS Action's 'flagship' project in the national capital. Opened in 1999, it is still the only place in the whole country where people who are infected or affected by HIV can go, six days a week, for information about HIV/AIDS, food, counselling and legal advice,



Children play outside the Bernhard Nordkamp Social Centre, Catholic AIDS Action's 'flagship' project in Windhoek.



Simon Volunteer

Simon is one of the most popular people at the Bernhard Nordkamp AIDS Centre, where he works as a volunteer, and it's easy to see why. With his cheerful, joke-cracking style and his infectious enthusiasm, he has the knack of making other people feel relaxed and happy. Yet less than two years ago 30 year-old Simon was still in jail, living with the knowledge that he was HIV-positive:

"I was imprisoned for four years for a robbery that I didn't do. While I was in jail Master AIDS attacked me. I had diarrhoea and sores on my body, and I was feeling very weak. I had a blood test and afterwards the nurse told me I had AIDS, just like that. When I got that news I felt mad. I thought I was going to die soon, so I decided that I had to make a plan, although I didn't know what."

Simon drew some strength from the visits of evangelical Christians while he was in jail:

"There were these born-again people and they would pray with me. I realized that God was giving me the chance to believe that AIDS was not the end for me. I decided to ask Jesus to come into my life. I was still afraid of Master AIDS but God was giving me a chance to have hope.



"When I got out of prison I went and told my mother about having AIDS. She suggested I should come to this Centre, which I did, and I met the counsellors here. It was here that I learned the difference between HIV and AIDS, and that gave me even more hope.

"I'm now living positively with HIV. I get most of my meals at the Centre. I accept the virus. I'm not afraid of the future now because I'm not alone. There are people here who love and take care of me. OK, I was wrong to take all those girlfriends when I was younger, but that's in the past and there's no point worrying about it now.

"I'm not worried about not having a girlfriend at the moment. With my previous girlfriend, we always used condoms, and I would again in the future, if I had another girlfriend. I've cut down my drinking - maybe one bottle of beer a week."

income-generating activities, orphan-support services, or simply to enjoy one another's company. Over 130 people visit the Centre daily from Monday to Thursday, and almost twice that number attend on Fridays. Many also come for special activities on Saturdays.

By mid-morning on Friday the Centre's

meeting room is full of men, women and toddlers, all waiting for the meeting of their support group to start. There are two such groups, each meeting once a week. A volunteer or a staff member starts the meeting with a prayer, and then reads out a passage from the Bible. The meeting is then open for



Betty

Widow and mother



Betty Strauss was diagnosed HIV-positive in November 1998, after the death of her husband. She soon noticed that people were avoiding her and didn't want her near their children. She also found it impossible to get a job in Rehoboth, where she had lived for many years. Feeling increasingly desperate, she approached her pastor:

"I wanted to tell the congregation that I had HIV but I didn't have AIDS. My pastor listened sympathetically but he wouldn't allow me to speak in church. He never visited me at home either, and neither did any of the church elders. I felt that no-one from the church wanted anything to do with me."

Unable to support her four sons, Betty placed two of the boys with relatives and moved to Windhoek with the other two, both of whom she left in the care of SOS Children's Village. She stayed with friends while seeking work, but without success. Then her fortunes began to change.

On a Saturday afternoon in September 2000, Betty noticed a march through the

centre of Windhoek. People were carrying posters and banners about HIV and AIDS. This was the March of Hope for Namibia's orphans, organised by Catholic AIDS Action. A marcher gave Betty a leaflet, where she read about the Bernhard Nordkamp Centre, which she decided to visit. It was another two weeks before she had enough money for the bus fare, but she finally found the place:

"I found everything I was looking for. The most important thing for me was to get food, because I take medicine for a nervous condition that runs in my family, and if I take it without food I feel weak and dizzy - I can't even walk. My counsellor at the Centre also gave me a place to stay for a while. So my health improved quickly, and I joined the income-generating group at the Centre. I sew bags for the volunteers' kits and I make red ribbons for sale.

"Then I was offered the chance to work at a conference centre, where I clean the bedrooms and wash the dishes, where I'm still working, but I still go to the Centre every Friday. I've told my two eldest boys that I'm HIV-positive and they have taken it very well. I want to tell the younger ones soon."

Betty still sees her counsellor, Agnes Tom, about twice a month at the Bernhard Nordkamp Centre:

"It's very important for my life and my health. We always pray together. It's very important for me to pray because it helps me to look beyond this sickness. It helps me to take each day as it comes and not to worry about the future. I've come to understand the suffering of human beings. I've also suffered in many ways, but I've come to understand that, whatever happens, my life has a purpose."

Queue for soup and bread at the Bernhard Nordkamp Social Centre: some people take home an extra helping for supper or for ailing relatives.



anyone to raise any problems, fears, worries or hopes they might want to express. It is also an opportunity to plan events, such as World AIDS Day, or to discuss how they will celebrate Christmas together.

After the meeting, a meal of thick, hot soup and bread is served and the weekly food parcels are given out. Every day, from Monday to Thursday, the Centre gives out an average of 100 servings of soup, and almost twice that number on Fridays. Some people take an extra serving of soup home for supper or for ailing relatives. All the food used in the soup and food parcels – meat, maize flour, rice, fresh fruit and vegetables, raw garlic, bread and yoghurt – is donated by local businesses and other supporters of Catholic AIDS Action in Windhoek. An additional 200 food parcels are distributed by volunteers to people's homes every week.

The Centre does not have a health clinic, but a volunteer doctor is on hand once a week to give consultations, make referrals and dispense

a limited amount of non-prescription free medication. A local NGO, the Legal Assistance Centre, provides free advice on legal matters at the Centre once a week. The Centre is also the basis for a group of 59 trained home-based care volunteers, who each week visit almost 300 people with HIV/AIDS and other chronic illnesses, in and around Windhoek.

One of the most pressing problems faced by people living with HIV is lack of a regular income. The Centre addresses this issue through income-generating activities, which enable about 40 people to earn money through beadwork, sewing and making toys for sale. A small group has also begun making low-cost coffins from papier maché, for which there is a ready market.

At various times throughout the day, some 15-30 pre-school children come to the Centre to use the playground equipment, and also to have lunch. About 50 orphans and other vulnerable children come to the Centre after school for lunch, and some stay to do their

homework afterwards. These and about 300 other orphans in other parts of Windhoek also receive assistance (school fees, uniforms, writing materials) to enable them to complete primary and secondary school. Local orphans and vulnerable children are also invited to participate in special programmes, such as a special Arts Expression weekend, which resulted in a poster-contest and the printing of 10,000 post-cards (with the children's artwork) which are sold to make money for other special events.

The Ministry of Health and Social Services does not allow Voluntary Counselling and Testing at community-based sites, but trained counsellors are always available to meet with clients at any time. Agnes Tom, programme coordinator of the Centre, is also a counsellor. Like her colleagues, Agnes is a practising Christian (she attends a pentecostal church), and usually ends her counselling sessions with prayer. But she does not abuse her position as a counsellor to promote her own religious beliefs:

“I don't push my Christian beliefs onto people. I would rather deal with the problem at hand, but if I think prayer could be helpful and the other person agrees, then we will pray. But it's not a case of me praying for other people. We pray together. That's why I always say 'Let us pray', not 'Let me pray for you'.”

Apart from these social welfare activities, the Centre also has a small library of HIV/AIDS literature and a large number of videos, as well as video playing equipment. These materials are extensively utilised in training workshops and public outreach activities.

Based on the popularity and success of the Bernhard Nordkamp Centre in Windhoek, Catholic AIDS Action is expanding this aspect of its work. Two small centres opened in urban sites outside Windhoek in 2001, and two larger, multi-purpose centres are planned for 2002 in

Oshakati and Keetmanshoop, in the North and South of the country respectively.

Public advocacy

In Namibia, as elsewhere, denial of the reality and the magnitude of the HIV epidemic helps to spread HIV even further. Catholic AIDS Action has therefore made a major effort to “break the silence” about HIV/AIDS in Namibia through a series of high-profile events, which have received widespread coverage through national radio, television and the press. These have included not only international occasions such as World AIDS Day, but special national and regional events, which have attracted even greater public and mass media attention.

Four large conferences have been organised on the theme “Living Positively with AIDS”. The first, held in Windhoek in September 2000, was addressed by the President of Namibia, Dr Sam Nujoma. The second, attended by over 350 people in the northern region of Oshana, was conducted entirely in the local language, Oshiwambo. Two more conferences on Living Positively, both in Afrikaans, have been held in towns in the South and West of the country. Participants have included people living openly with HIV, volunteers, community and political leaders, church representatives, health professionals and government administrators.

Also in September 2000, Catholic AIDS Action organised the ‘March of Hope’: 1,500 people marched through the streets of Windhoek to call attention to the rising number and increased needs of the country's orphans. This was followed by a public rally addressed by the Prime Minister and by orphans themselves. Many different churches and other community groups joined forces to make this event the largest HIV/AIDS gathering to date in Namibia.

Catholic AIDS Action has continued to campaign for the rights of orphans and other vulnerable children, for example, the rights to schooling, health care and protection from abuse.

Local HIV/AIDS support groups are now taking up the advocacy challenge. On a Saturday afternoon in September 2001, the Catholic Church of St Mary's in the northern town of Rundu was packed with over 1,000 people. The occasion was the official 'coming out' of a group of HIV-positive people from the HIV/AIDS support organisation Lironga Eparu ('Learning to Survive'). The event was organised by Lironga Eparu, with Catholic AIDS Action covering the cost of food, drinks and local transport. In a moving ceremony that generated widespread media coverage, 130 people, all wearing a special 'HIV-positive' T-shirt, filed into the church to demonstrate their commitment to openness about HIV/AIDS and their support for people living with the virus. The great majority of the participants were HIV-positive; others

were volunteers expressing their solidarity with their HIV-positive friends. Each lit a candle as a sign of hope for the future.

Home-based care and orphan support

"It was very hard at first. I was on my own and had to walk everywhere because we had no vehicle," says Sr Charlotte Pandeni, who is head nurse at St Franziskanus, a health centre with 20 beds, attached to Okatana mission in northern Namibia. Sr Charlotte is also Catholic AIDS Action's representative for Oshana Region. Her first task was to recruit volunteers to be trained in home-based care:

"I would go from one community to the next, talking about the need for home-based care and trying to convince people to volunteer. I must have done more than 40 presentations that year. When the applications for training came in we had to process them, but we never refused anybody who wanted to be trained."



In the town of Rundu, 130 people filed into church to demonstrate their commitment to openness about HIV/AIDS and to support people living with HIV.



Katharina

Home-based care volunteer

Before going to bed at night, Katharina makes up a jerrycan of ontaku - a mixture of water and millet flour - which is a staple food in northern Namibia. This is not for her own family, but for Esther, the home care patient she plans to visit next day.

"For home visits, or whenever I go to the hospital, I always put on my T-shirt, so people know who I am," says 31 year-old Katharina, who is a Catholic and lives near Okatana mission, just outside the bustling town of Oshakati, in northern Namibia. She is one of a group of 16 home-based care volunteers trained by Catholic AIDS Action. Usually she visits two or three people at least once a week. Most have HIV/AIDS, but some are physically disabled or are otherwise unable to look after themselves.

When Katharina arrives at Esther's house, Esther is lying in bed and feeling very weak. She struggles to sit up and greet her visitor, who sits on the edge of the bed and gives her the jerrycan of ontaku. Esther's face lights up with pleasure.

Katharina has been visiting Esther for a couple of years, ever since Esther's health began to falter. They discussed whether Esther should be tested for what they call 'the virus', or 'the new disease', which Esther's husband apparently died of. Eventually she decided to go to St Franziskanus health centre, where she was tested for HIV and found to be positive.

Esther had no hesitation in showing Katharina the piece of paper from the



health centre confirming her HIV-positive status. They also shared this information with Esther's relatives. Katharina told them about the difference between HIV and AIDS, and also explained how they can help Esther cope, especially whenever she is sick.

Last year, when Esther developed shingles across her back and under her arms, Katharina helped to have her admitted to St Franziskanus health centre, where she was treated as an in-patient for two weeks. Since she was already registered as HIV-positive, Esther did not have to pay for treatment.

Katharina visits Esther at least once a week, always bringing something to eat or drink. She bathes her and washes her clothes; she also brings her vitamin pills and basic medicines. They pray and read the Bible together. For Katharina, visiting and helping Esther and other sick people in her community is something she feels compelled to do:

"We are from the community so we have a strong relationship with the people here. We provide them with whatever support we can. Sometimes it's from our own resources, and so people end up regarding us as sisters and brothers."

Sr Charlotte was also in charge of training the volunteers, in groups of 12 to 20 people, virtually all of whom were women. The course involved a total of 84 hours of training, divided into three modules of 28 hours each, spread over a six-month period. This is the pattern used by Catholic AIDS Action to train home-based care volunteers throughout Namibia. Between each training module the groups visit every household in their area and record the details of everyone with a chronic illness, and also the names of all orphans* and other vulnerable children**.

After successfully completing the course each volunteer is issued with a certificate, a Catholic AIDS Action T-shirt, and a home-based care kit consisting of basic nursing materials (e.g. latex gloves, soap, vitamins, kidney bowl, disinfectant, aspirin, and various over-the-counter medicines), a notebook, record-keeping forms and a pen. Each group elects its own committee, consisting of a leader, a secretary and a treasurer, as well as persons with specific responsibility for orphan support, counselling and the distribution of vitamins, non-prescription medicines, and other supplies. The programme also provides each group with one or two bicycles, which are used mainly by committee members to carry out their reporting and other administrative duties.

After completing their training, the volunteers are presented to the community in church or at a public meeting, where they explain what they can now do to help families affected by sickness, especially HIV/AIDS and related illnesses. These introductions are very important for

establishing the new role of the volunteer as a person to whom others can turn for assistance with a problem affecting their health or general well-being. By December 2001 the programme had trained over 1,000 volunteers, organised into 75 groups in eight regions throughout the country. Many volunteers are in training and hundreds more are waiting to be trained.

The work carried out by the volunteers falls into four main categories:

□ **Patient care:** Operating in groups of two or three, the volunteers carry out home visits, at least once a week (or more often, if necessary), to people who are chronically ill or disabled. Most of the people they visit are HIV-positive, but they care for people with other serious illnesses as well. They do not visit people who are HIV-positive but in good health. In December 2001, for example, volunteers trained and supervised by Catholic AIDS Action visited a total of 1,625 individuals, and their families, at least once a week.

The volunteers work in collaboration with local hospitals and health centres, to whom they refer people for treatment, and who in turn refer patients to them for home visits. They bring vitamin tablets and non-prescription medicines, and also carry out practical tasks such as washing clothes, fetching drinking water and bathing the sick person. In most cases they also provide patients and their family members with spiritual support through prayer, reading the Bible and singing hymns. They also visit patients who have been admitted to hospital for treatment.

* Catholic AIDS Action defines an 'orphan' as a child under 18 who has lost at least one care-giving parent due to death.

**Catholic AIDS Action defines a 'vulnerable child' as one whose parents are ill but still alive, but who have no income and are unable to provide the child with adequate support. These may include children who have experienced abuse or neglect, or who are at risk with the law due (in part) to troubled family situations.



Home visiting: Katharine (left) visits anyone in her community who is chronically ill or disabled.

□ Family-based HIV/AIDS education:

Regular home visits enable the volunteers to discuss HIV/AIDS and sexual behaviour with family members. Almost invariably, the sick person is willing to disclose his or her status – if not immediately, then later, after counselling – to a circle of family members and friends. Sometimes volunteers call together small community or neighbourhood meetings, or visit schools and shebeens (local bars) to share information on HIV prevention and care, or to answer people's questions.

□ Orphan support: The volunteers have a particular responsibility for monitoring the health and general well-being of orphans and other vulnerable children. Whenever the programme has items such as blankets, school uniforms, and woolly sweaters available for distribution to orphans, the volunteer groups

are responsible for selecting the children in their area who are most in need of assistance. By December 2001, Catholic AIDS Action had registered a total of 9,922 orphans, of whom 5,645 had received material assistance from the programme. Staff and volunteers also provide orphans and other vulnerable children with psychosocial support, especially in crisis situations such as cases of child abuse or neglect. Often this involves collaboration with government ministries, non-governmental organisations and traditional leaders.

□ Outreach activities: Many volunteers give talks about HIV/AIDS, sexual behaviour and other health issues at churches, schools and small-scale community meetings. By December 2001, volunteers trained by Catholic AIDS Action had reached over 10,000 people in public awareness campaigns and special events. The



Benhoff

Church elder and volunteer



"Often the family members need to be educated in how to look after someone with HIV/AIDS," says Benhoff Makina. Aged 33, married, and an elder in his local Catholic Church, Benhoff is a volunteer with Catholic AIDS Action in the Rehoboth area:

"There's a young man I visit - at first I used to bring his medicines, feed him and even bathe him because his family wouldn't help him. It wasn't just that they were afraid of getting HIV from him. They were also angry with him for contracting HIV. They would tell him it was his problem because he had gone looking for it. The poor man felt totally abandoned.

"I spent a lot of time talking with the family about HIV but also about spiritual

matters like love, acceptance and forgiveness. It took two or three months before the other family members fully accepted him, but now they do. The change has been amazing. They now bathe him, feed him, fetch his medicines and spend time talking with him and encouraging him.

"One thing that makes it easier for me to do this work is that I'm a Khoi Khoi speaker, and so many people I visit have told me they are happy to talk in their own language. Another thing they appreciate is the spiritual aspect. Whenever I visit a family, I ask if they want to pray and read the Bible, and they always do. As a church elder I've had a lot of practice in giving people spiritual support.

"But we have a lot of problems with traditional and cultural matters. Alcohol abuse is common and it makes people less responsible for their behaviour. And many young people, especially men, don't even accept that AIDS is real. Some say 'We don't care about AIDS. Ebola is the new killer disease'.

"It's very difficult for these young men to wait until marriage before having sex. Whenever I talk with them about sex they tease me for being holy, but say they can't abstain. My advice to them is, if they can't abstain, then they should use a condom. They can't repent if they're dead. So it's better that they condomize first, so they can stay alive and repent later."

volunteers use these opportunities to encourage communities to be more open about the reality of HIV/AIDS, to combat AIDS-related stigma and to dispel misinformation about how HIV is transmitted. On such occasions they are sometimes asked about condoms. Their

response is to provide factual information about condoms and where they can be obtained. They also encourage people who know themselves to be HIV-positive to abstain from sex or, if that is not possible, to use condoms every time they have sexual intercourse. In keeping with

Catholic teaching, Catholic AIDS Action does not distribute condoms.

Volunteer support and motivation

The volunteers spend anything from five to 20 hours a week carrying out their various duties, which are exhausting and often difficult, and for which they receive no financial reward. Support is given, however, through Christmas and Easter bonuses, a funeral policy, ongoing training, some in-kind supports, and the allocation to each volunteer of N\$10 (slightly less than US\$1) per month as a token reimbursement for whatever the volunteer has spent in order to perform his or her duties. Most groups have decided to pool these payments in order to bulk-purchase washing soap or staple foods, such as maize flour, which are then divided equally amongst the members.

Remarkably, the drop-out rate amongst volunteers is generally very low – less than 10% after an average of two years in most groups. This is probably because the great majority of volunteers feel that their work is worthwhile and are also motivated by their religious faith. In addition, monthly visits by Catholic AIDS Action field staff help to maintain high morale amongst volunteers. Sr Petronella Shetunyenga, Catholic AIDS Action representative in Omusati region, in northern Namibia, says:

“When we visit the volunteers the idea is not just to talk about statistics, and how many clients they have, but also to talk about the problems they are facing and to help them look for solutions. And if they are feeling totally worn out from all the work and the constant funerals, to give them the courage to say they will take a week off to rest.

“We try to say things to strengthen and encourage the volunteers, because the work is

physically and emotionally very tiring. We also pray together, and sing, and socialize with each other. We say they are like the Apostles in the New Testament, travelling from place to place to do God’s work. But we also encourage them to work only half a day at a time.”

Caring for carers

To explore the psychosocial and other needs of volunteer and professional care-givers, Catholic AIDS Action carried out an exploratory five-country study of care-giver sustainability, focusing on grief, the healing arts and support systems for care-givers. This found that spirituality is integral to the development and sustainability of care systems in Africa, since care-givers rely on their relationship with God to interpret and respond to events such as the HIV epidemic. In addition, more training and support programmes – especially involving the arts (music, dance, drama and other visual media) – are needed to support care-givers.

Catholic AIDS Action then published a 90-page manual (in English, Afrikaans and Oshivambo) for use in such programmes. Entitled *Caring for Ourselves in order to Care for Others*², the manual was launched at a four-day conference in Windhoek in June 2001, attended by over 500 volunteer and professional care-givers. The conference addressed topics such as Understanding Loss, Coping and Grieving, Building Support Systems, Finding an Inner Balance, and Moving On. The manual is now being used within Catholic AIDS Action’s own programmes, and also by other organisations involved in HIV/AIDS work in southern Africa.

Training

The need for training is infinite. As far as possible, all training is carried out in the most appropriate



Volunteers such as Ina (centre) spend up to 20 hours a week on home-based care work.

local language. In addition to courses in Home-Based Family Care for volunteers, Catholic AIDS Action runs several short and long-term courses for church workers, youth leaders, health care professionals and other community members. Central to its curriculum is an eight-month course in four modules (25 in-class days, plus field assignments) for “Training of Trainers” in Community Mobilisation, Home-Based Care, and Counselling in HIV/AIDS. This foundation course, which is recognised and partly funded by the Ministry of Health and Social Services, counts government, NGO, and other church workers – in addition to Catholic AIDS Action staff – among its participants.

Training programmes for behaviour change, targeted especially to youth, are an important part of Catholic AIDS Action’s activities. Starting in early 1999, the peer education curriculum *My Future is My Choice* developed by UNICEF was introduced to all Roman Catholic schools and hostels in Namibia, plus many other church

and school-based settings. Facilitators add a Biblical verse to each session, which helps youth to think through for themselves the relevance of religious values to topics such as sexuality, sexual behaviour, sexually transmitted diseases and HIV/AIDS. By early 2002 almost 10,000 young people had passed through this course, which has been transferred to the Ministry of Basic Education, Sport and Culture.

In 2001, Catholic AIDS Action introduced the *Stepping Stones* training package³ to Namibia, for young people aged 12 and above. In 2002 the *Adventure Unlimited* curriculum, for children aged 9 to 12, will be introduced to primary schools, Sunday schools, youth groups, and programmes that serve orphans and vulnerable children.

Community volunteers are trained in the provision of psychosocial support to orphans and other vulnerable children, in order to assist sick parents, guardians and relatives in responding to the needs and problems of these



Father Franz Houben, OMI

Catholic priest



"In the past, it was extremely rare for people around here to commit suicide, but now they do," says Father Franz Houben, who works closely with Catholic AIDS Action in northern Namibia.

What is now driving people to contemplate suicide in northern Namibia is the HIV epidemic, which is taking a heavy toll amongst the young:

"I'm often called to hospital or to people's homes to conduct services and anoint people who are dying," says Fr Houben, who has been based at Okatana Mission since 1974. "In the past it was the older people who were dying, but now it's mostly the young, and I know many of them personally. Just this afternoon there was a young man who was due to be married. The wedding rings had already been bought. But his mother called me out to anoint him because he's very sick and she's afraid he's dying.

"Some of the young men are former freedom fighters who have returned from Angola as heroes of the liberation movement, and for them getting girls to sleep with was easy. They say to me 'Before, we fought for independence, but now we're going to die'. The problem

is that the idea of political freedom has been misinterpreted to mean liberty to do anything you like. It doesn't include taking responsibility for your own actions.

"My own pastoral approach has changed so much. In the past we were supporting the people in the struggle for independence, but now we're fighting against AIDS. One Christmas not long ago, I realized just before Mass that probably one in four of the adults in the congregation were HIV-positive, but very few of them knew it. So I changed what I was going to say in my sermon and talked about AIDS.

"Spiritual support is very important for people with HIV/AIDS, especially if they are at an advanced stage and feel they don't have long to live. It helps them to accept their situation and to prepare for departure from this world. For those who feel they have not been at peace with God for a long time it's a kind of healing.

"I've started a spiritual healing service, not specifically for people with AIDS but I'm sure it's on many people's minds. It started with 150 people and within a few months there were over 600 people there. We have it about four times a year. A few people are embarrassed about attending because of the possible link with AIDS. Some whisper to me afterwards that they've come because of high blood pressure or some other health problem.

"What I find very touching is when a couple who have long been living together come and ask me to marry them, knowing that one or both is HIV-positive. This is especially meaningful for people who are approaching death. Also, if the husband dies first, the wife will at least have the status of his widow, and the children will be recognised as belonging to them both."

children. Courses on Positive Living and Caring for Care-givers are also offered to volunteers, clients and interested community members.-

The training of bishops, priests, religious superiors and deacons in HIV/AIDS awareness is a major part of Catholic AIDS Action's programme. Archbishop Bonifatius – Head of the Roman Catholic Church in Namibia – participated for the whole three days of the first training workshop in January 2002. With disarming frankness, the Archbishop revealed that, until recently, he himself had been afraid of contracting HIV through social contact. He also praised the openness of Catholic AIDS Action on difficult issues, such as the role of condoms in HIV prevention. After the workshop he fixed his certificate of attendance to his office door to show that he is now 'AIDS competent'.

Most recently, as part of the Church Alliance For Orphans (CAFO) – a new, inter-denominational entity which it helped to establish – Catholic AIDS Action has begun training its own staff members, and those of other churches, in the care and support of orphans and other vulnerable children. After being trained, these staff go out into local communities and train volunteers.

Issues, problems and challenges

In order to meet the accountability requirements of donor agencies, Catholic AIDS Action attaches great importance to the monthly reports which the volunteers compile on their activities. A standardised report form, in local languages, has been produced and distributed to all volunteer groups. This provides information about, for example, the numbers of active volunteers in each group, the activities they are carrying out, and the numbers of clients and orphans visited. Because of low

educational levels amongst the volunteers, however, most have difficulty in completing these forms correctly.

A common complaint by volunteers is that many families they visit lack food, so the volunteers feel obliged to share their own food with them. (Some clients complain that the vitamins they receive from Catholic AIDS Action actually make their hunger worse – so they prefer to stop taking the vitamins.) Many volunteers, however, can ill afford to provide additional food because they themselves are living only just above the poverty line.

A particularly poignant problem is the fact that many volunteers are themselves at risk of contracting HIV from their husbands, who spend most of the year working in another part of the country. Sr Charlotte, Catholic AIDS Action Coordinator for Oshana Region in northern Namibia, finds this problem very upsetting:

“Just today a volunteer came to ask me for an HIV test because her husband called her to Walvis Bay, where he works, and told her that he is HIV-positive. The woman feels devastated because she and her husband have had unprotected sex for years. She's getting support from a friend, who is also a volunteer. But she can't sleep, hears voices all the time and feels desperate. And she is not an isolated case. Two other volunteers have already tested positive.”

Since its inception in 1998, Catholic AIDS Action has grown rapidly to become a national programme providing HIV/AIDS-related information, services and support to the general public, irrespective of religion or ethnic group, in most parts of the country. The organisation's rapid expansion has not been without growing pains, and it still faces serious challenges. There is, for example, an enormous need to increase the numbers of trained staff and volunteers, but how can this be done, without a loss of quality,

across vastly different regions at great distance from one another, in several different languages and in collaboration with many different faith communities?

The future

The biggest problem, according to Catholic AIDS Action's Director, Lucy Steinitz, is that there are never enough hours in the day to do everything that is needed. Namibia's demographic projections show that more and more people will become sick from HIV/AIDS, leaving four times the current number of orphans over the next ten years. Thus, the demands upon the organisation to both intensify its services and

expand into new areas will continue to grow. Although Catholic AIDS Action's funding (from over a dozen major sources) seems secure for the next two or three years, the long-term sustainability of these activities remains unknown. Lucy Steinitz adds:

"The key for Namibia is to get everyone involved – more churches, more organisations, more government ministries, and more individuals. We are very heartened by the agreement of cooperation we have signed with the Evangelical Lutheran Church in the Republic of Namibia. Other churches are also expressing interest. To really make a difference, all of us must work together."

Chapter 4

Women inspired by the Bible

The Umtata Women's Theology Group

The town of Umtata sprawls over the rolling hills of the Transkei, in South Africa's Eastern Cape Province. Its main attraction is a museum featuring a large exhibition on the life of Nelson Mandela, who was born in a nearby village. Capital of the former 'independent black homeland' of Transkei during the apartheid era, Umtata now has an unenviable reputation for crime, economic stagnation and social backwardness.

Here, in 1987, a group of women from several churches started meeting to study the Bible in order to understand what God was saying to them. "We started coming together," recalls Welekazi Sokutu, chairperson of the group, "because we felt that the needs of women were often disregarded in our churches."

Meeting in one another's homes, the group studied how women are depicted in the Old Testament, how Jesus treated women, and the position of women in the early years of the Christian Church. In 1988 they published their first Bible Study Booklet, *Women, the Bible and the Contemporary Church: an Introduction to Women's Theology*. This has since been followed by ten other booklets on topics including the theology of sexuality, separation and divorce, ageing, bereavement and death, and HIV/AIDS.

The Umtata Women's Theology Group now consists of 13 women from several Christian churches, and with different racial, social and professional backgrounds. They still meet in one another's houses once a fortnight to pray,



Members of the Umtata Women's Theology Group meet regularly in one another's homes.

discuss and study the Bible. The group has been fortunate in that, ever since its inception, at least two of its members have been trained in theology or Biblical studies at tertiary level.

Exploring HIV/AIDS

The Group began studying the implications of HIV/AIDS for society, and for women in particular, in 1992. As with other topics, group members researched the topic by asking experts for information, but they also interviewed their neighbours and friends on their attitudes and beliefs.

The Group turned to the Bible for guidance, and found that there were parallels between people with leprosy in Biblical times and people with HIV/AIDS during the present, as Welekazi Sokutu explains:

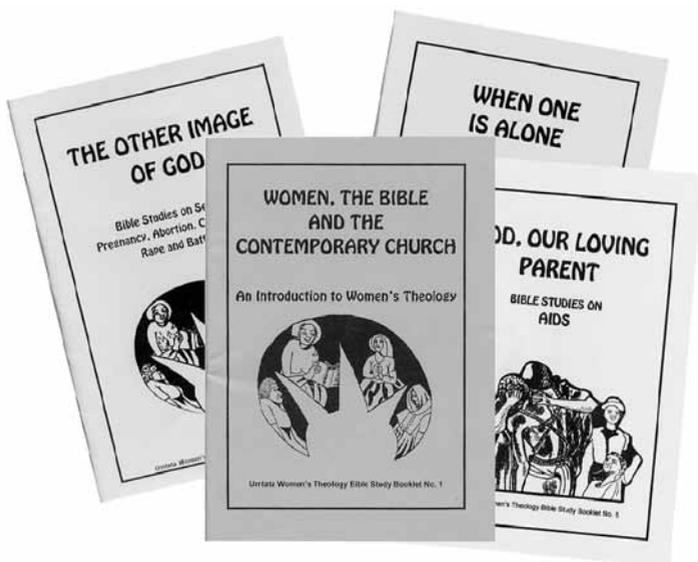
“There was no mention of HIV or AIDS in the Bible, but we saw similarities between the treatment of people with HIV/AIDS and the treatment of people with leprosy, in terms of

the ostracism and isolation that such people experience. So then we asked ourselves how we could make a positive and meaningful contribution to the fight against HIV, from a Christian perspective.

“We came to the conclusion that HIV is not a punishment from God. We also concluded that our role is not to judge people with HIV. Looking at the responses of Jesus to the people who were suffering from similar problems, we felt that we, as Christians, were called to take care of people suffering from HIV/AIDS, and to give them hope. We should help them to live positively with this virus.”

The Group published a study booklet, *God, our Loving Parent: Biblical Studies on AIDS*⁴, which is designed for use – either individually or in groups – by lay people, pastors and priests. It contains factual information about HIV and AIDS, commentary on Biblical passages, and real-life stories from the experiences of people in and around

Several Bible study booklets produced by the Umtata Women's Theology Group deal with gender, sexual behaviour, relationships, values, traditional culture and other issues related to HIV/AIDS.



Umtata. Published initially in collaboration with the Transkei Council of Churches, the booklet has since been extensively revised and expanded. As well as covering theological issues, the booklet also deals with serious social problems such as the sexual exploitation of schoolgirls by teachers: “A girl who does not go to school,” it notes, “has a greater chance of living without becoming infected with HIV than a girl who finishes secondary school.” The booklet is distributed through churches and the local Bethany Bible School.

Practical action

As the effects of HIV/AIDS became increasingly obvious, however, members of the Group began to feel that studying the Bible and publishing study booklets was not a sufficient response to the epidemic: “We had been working on the spiritual aspects of the HIV epidemic, but we felt that we needed to become more involved in the social aspects,” says Welekazi Sokutu.

After looking at what other non-governmental organisations were doing, the Group decided to focus their efforts on support for orphans and for chronically ill people. The work with orphans involves, first, raising community awareness of the problem by speaking to church

groups and women’s organisations about the need for parenting orphans, most of whom have lost their parents through AIDS. The second step is to make the connection between would-be foster parents and the Department of Social Development.

A few members of the Group now make regular visits to a local NGO-run hospice, which provides non-residential care and social support for people living with HIV/AIDS. Other Group members visit a specialist TB hospital, where most patients are HIV-positive. In both places, Group members provide social, emotional and spiritual support to people living with HIV/AIDS, TB or some other chronic disease, and their families. Only a few years ago, however, they would not have seriously considered visiting people living with HIV/AIDS.

The Umtata Women’s Theology Group demonstrates how a small group of Christians can explore the relevance of their faith, and of the Bible, to the HIV/AIDS epidemic which affects the lives of most people in their community. In doing so, they are also translating the ideals of their Christian faith into practical action on behalf of people infected or affected by HIV/AIDS.

Phumzile Zondi, lay church leader



Phumzile Zondi is an elder in the Uniting Presbyterian Church in Southern Africa. In 1999 she received her Bachelor of Theology from the University of Natal in Pietermaritzburg. She has since worked at the university as coordinator of the Women and Gender Programme, running workshops for women at community level on gender issues in relation to Christian theology and the Bible.

A mother of two sons and a daughter, Phumzile has known since May 1999 that she is HIV-positive:

“Life has not been an easy journey since I learned about my HIV-positive status. But I am fortunate in having a strong support system to fall back upon. My mother and a few special friends are always there for me when I need support.”

As an HIV-positive woman, Phumzile is particularly sensitive to the impact of HIV on the lives of other women, especially in rural areas:

“Women are affected most directly by HIV/AIDS because they look after the sick and the

dying. Whenever I ask women’s groups about their main problems, AIDS is always in the top five. They say they don’t know what to do about this disease that’s killing their children. Even discussing AIDS is difficult because of its connections with sex and sin.

“But more and more people are dying of AIDS. It’s obvious from the numbers of funerals every Saturday, and even during the week. AIDS is hardly ever mentioned during funeral services, except in a judgemental way. Sometimes pastors try to use a person’s death as a warning to others. They say things like ‘If you don’t respect the Word of God you’ll end up like this’. In fact most pastors still claim that AIDS is a punishment from God, and that it affects only immoral people who have sinned against God’s law. Some even misinterpret the Bible so as to blame women for the spread of HIV and AIDS.”

Phumzile’s response has been to devise short reflections on Biblical texts (see opposite), interpreting them in ways which are non-judgemental, life-affirming and empowering. She uses these reflections in sermons, with groups of women and with HIV/AIDS support groups:

“My main focus is on empowering people who are infected with HIV, so they won’t let all the negative messages affect them. I try to help them to reinterpret the Bible, so they understand that being HIV-positive doesn’t make you a bad person. God is still with you if you’re living with HIV. That can give people with HIV the strength to stand against the judgemental messages they receive from others. Whenever I have an opportunity to preach I mention these things. I’m very clear about where God stands in relation to HIV/AIDS. God stands with those who are living with the virus.

Luke 10: 30-37:**The Parable of the Good Samaritan
Reflections by Phumzile Zondi**

This text can be interpreted as a symbol of how most people in the church respond to HIV/AIDS - either by ignoring and rejecting the sufferer or by being judgemental. Surprisingly enough, this is often done by people who seem to have all the necessary factual information about HIV/AIDS.

The traveller symbolizes a person with HIV/AIDS (PHA). Life changes dramatically once one finds out about one's HIV-positive status. The reality of a weakening immune system is similar to the beating and robbing of the traveller in the text. HIV robs us physically, emotionally and socially.

The priest in verse 31 symbolises the church or its leadership. Most people in the church are still judgemental towards PHAs. The priest was more intent on observing Jewish law than on caring for someone who needed help. The church still responds like the disciples in John 9, who were more concerned about whose sin had caused the young man's blindness than about making life easier for him. Most churches still preach messages of condemnation and see HIV/AIDS as punishment from God.

The Levite in verse 32 was an assistant in the temple. Purity was important to

him. He probably had the same problem the priest had. Touching a dead person would have been a source of ritual defilement. The Samaritan not only touched the injured man but carried him to safety. He even paid for him to be looked after. Jews and Samaritans were enemies but this did not bother the Samaritan. This is the attitude that Jesus expects from the church. Christians who are involved in caring for the sick are doing what Jesus would have done.

Some PHAs are rejected by their families and friends when their HIV-positive status is known. Christians can rally together and organize support and shelter for those who are rejected. If Christians decide not to care directly for the sick or people with HIV/AIDS, another option is to support organizations that are doing such work.

Texts like the above constantly remind me that, as a PHA and a Christian, I have a responsibility to continue challenging the church on its role in the HIV epidemic. The church has a particular responsibility to interpret the Bible in positive, life-affirming ways, rather than to condemn people. Stifling people's spiritual hope can even cut short their lives.

“When you help people to read the Bible in this liberating way, they will go out and help others to read it with their own eyes, and from their own experience. If you aren't infected or affected by HIV, you don't even think of AIDS when you read the Bible – you think of the issues that affect you more directly. But when

you are infected or affected by HIV, and you read the Bible and encounter God in what you are reading, it can be very empowering.”

The need for openness

Phumzile has been publicly open about living with HIV since 9 August 2001, when

she disclosed her HIV-positive status while preaching during an ecumenical church service in Pietermaritzburg to mark National Women's Day. She has since disclosed her status on several other occasions and has not yet encountered any discrimination. On the contrary, many people simply do not believe her:

"I was facilitating a discussion on gender and HIV/AIDS at an evangelical seminary, and we were discussing how women are affected by HIV. I shared my own HIV-positive status but people couldn't believe it. They had just not expected that. Afterwards some of them came up to me and said they simply didn't believe me.

"But there was another occasion when the young people of one of the more conservative churches asked me to give a talk about HIV/AIDS and our faith, and I disclosed my status there too. Afterwards, four young women came up to me to talk about their own HIV-positive status, which they had never shared with anyone in their church. Because I was prepared to make myself vulnerable by disclosing my own HIV-positive status, people felt they could talk to me. It made me realize how great a challenge we still face in the churches. Here were women with so much potential, yet they felt unable to discuss the reality of their lives in their own churches.

"In fact most churches are still very quiet about AIDS. It's covered in a veil of silence. We know it's there but we aren't prepared to talk

about it, or even ask questions about it. But we should be talking about it everywhere – from the pulpit, in discussion groups, in formal meetings and conferences, in Sunday school and confirmation classes, in youth groups, and in the men's and women's organisations. But there's this fear that, if you want to talk about AIDS or sex in the church, then you have a dirty mind, you're immoral, you're encouraging young people to go out and experiment with sex. Well the young people are experimenting with sex anyway, whether we talk about it in church or not.

"For me, living with HIV is easier if you're open about it. Most people with HIV die of denial, and they die psychologically before they die physically. I think we should encourage people to go for HIV counselling and testing. If they test positive, they should accept their status, be positive, look after their health and establish a positive relationship with God. If people did that, we wouldn't be having as many funerals as we are today.

"For a long time, I struggled with the concept of a male and white God, with whom I found it very difficult to share my problems because such a God could not understand what I was going through. But the God I now relate to is more like a woman – a caring person who listens, who is gentle, who loves me unconditionally and is always with me. So when things are difficult I know that God will always be by my side."

Chapter 5

The Full Gospel Church of God Promoting ‘AIDS competence’

Early on a Wednesday afternoon, about a dozen women have gathered in a small house in Guguletu, one of the townships that sprawl across the Cape Flats, to the east of Cape Town. In the kitchen, two women are washing, peeling and chopping vegetables, and another is cutting meat into small pieces.

In one corner of the front room three women are sitting close together, speaking softly:

“Look,” says Maria, holding up a condom in an unopened packet, “as someone with HIV you really should use a condom every time you sleep with your husband. Otherwise you could be re-exposed to HIV, and that would be very bad for your health. If you want to live longer, you have to protect your health.”

Sophia frowns and looks dubious. She responds hesitatingly, her voice reduced to a whisper:

“Well, you see, my husband’s penis is very long and very big, and the condom is so small...”

But Maria has heard this objection before and knows exactly how to respond:

“No, you just try filling up the condom with water. It’ll be as big as this,” she says, stretching her hands out wide, and all three women double up with laughter.

This is the weekly meeting of the House of Care support group for people with HIV/AIDS in Guguletu township. It is organised by the Full Gospel Church of God, an indigenous,



At the weekly meeting in the House of Care, church volunteers prepare lunch for members of the HIV/AIDS support group.

independent, pentecostal church with over 800 member congregations throughout South Africa. It is the first HIV/AIDS support group started by an independent church in the Province of Western Cape, perhaps in the whole of South Africa.

House of Care

The House of Care grew out of a conviction on the part of the Rev. Gideon Nqiwa (see box opposite), pastor of the Full Gospel Church of God in Guguletu, that churches have to respond in a positive, creative way to the HIV/AIDS crisis. He first broached the subject in his own church in the middle of the year 2000. But discussing HIV/AIDS also means talking about sex, and this is not easy in the Pentecostal Church, which is traditionally conservative on social issues:

“When I introduced the idea of this AIDS programme,” recalls Rev. Nqiwa, “a lot of people in the church were unhappy. They felt that AIDS and sex were not subjects to be discussed in

church. What helped to change their minds was when a young HIV-positive man from the Treatment Action Campaign (see page 91) came and spoke during a Sunday service. He explained that he had something inside him that he carried around wherever he went – this HIV virus. When the congregation heard that, many people cried. Some came over and hugged him, and others prayed for him.”

Finally, in April 2001, the Full Gospel Church in Guguletu launched its HIV/AIDS programme, with an all-weekend workshop attended by over 500 people. The walls of the church were decorated for the occasion with colourful posters, pictures, leaflets and even with condoms. Speakers from the Department of Health, the Treatment Action Campaign and the University of Western Cape led discussions about HIV/AIDS and sexual behaviour. Only a year earlier, most members of the congregation would have regarded these topics as taboo



The Full Gospel Church of God in Guguletu: many members were initially unhappy about discussing AIDS and sex in church.



Rev. Gideon Nqiwa

Pastor and broadcaster



At 5.45 every Wednesday morning, Rev. Gideon Nqiwa hitches a trailer to the back of his car and drives to a warehouse in the Cape Town suburb of Wynberg. Here he collects supplies of fresh food, donated by supermarkets to the Lions Club. He is never sure exactly what food he'll be given, but usually he picks up three or four boxes of fresh fruit and vegetables, some meat, plus 30 or 40 loaves of sliced bread and five or six dozen bread rolls.

He then drives home, has breakfast, and travels to the South African Broadcasting Corporation, where he works as a producer and broadcaster on religious affairs. He presents programmes in Xhosa, the language of Eastern Cape Province, and also the main language of the millions of people living in the densely populated townships of the Cape Flats, to the east of Cape Town.

Rev. Nqiwa is also pastor of the Full Gospel Church of God, a pentecostal church in the Cape Flats township of Guguletu. In a small house behind the church, his wife, Thandi, runs the House of Care support group for people living with HIV/AIDS. Here, every Wednesday, Thandi and three lady volunteers prepare a hot lunch for the support group, using the food which Rev. Nqiwa has collected earlier in the day.

It is unusual for a pentecostal pastor in South Africa to be involved in HIV/AIDS work of this kind. Rev. Nqiwa explains how it happened:

"I knew there was such a thing as HIV and AIDS, but I'm from a pentecostal background, where we believe that once you've accepted Jesus Christ as your personal saviour, you cannot sin and so you cannot

have HIV and AIDS. In our church, there is a widespread belief that AIDS is a punishment from God. But I don't think that is so. HIV is a virus that can affect anybody, including babies whose mothers have been infected with HIV by their husbands.

"So I went all over to get more information about HIV and AIDS. We then designed a statement of purpose and commitment as a church, to say we join hands in a common effort to provide information for our people - not only the members of our own church but wherever there happen to be independent, indigenous churches. We are now providing information, education and training to people and church leaders on matters of HIV and AIDS, and about sexual health and human reproduction.

"Men are the key to the prevention of HIV and AIDS. If you can inform and educate men, you can also minimize the spread of HIV and AIDS. The Christian principle is that a man shall have one wife, and a woman shall have one husband. But according to some traditional cultures, a man can have as many wives as he can afford. The more wives you have, the higher your status. Even within the church, we have got men who have more than one sexual partner. Fornication and adultery are present - you cannot say they aren't. This is an issue which we have to address."

within their church. The Rev. Nqiwa preached about the sanctity of human life, and the need for Christians to examine their own attitudes and sexual behaviour. He urged church members to be tested for HIV and to consider using condoms.

Immediately after the workshop three church members, including the pastor's wife, Thandi Nqiwa, received basic training in counselling from FAMSA (Family and Marriage, South Africa). This gave them the self-confidence to think about how they, as members of a church congregation, could go about providing services to local people who were living with HIV. Thandi came up with the idea of starting a support group of HIV-positive people:

"I wanted to reach people in need," she says, "people who felt they had no hope, and to give them some hope in life."

The group began meeting weekly in June 2001, starting with only four people. At first the group met in the church. Thanks to a donation from an external supporter, a small house behind the church was purchased and now serves as the group's meeting place. Over 50 people – mostly women – now attend the meeting every Wednesday afternoon. Another group of about 30 HIV-positive women, all with young children, come to a separate meeting for mothers and children on Thursday afternoons.

Rev. Nqiwa, who also attends the support group meetings, explains the basic approach:

"Here we try to create a conducive environment, where people can share their HIV-positive status. We try to address the needs of the whole person – spiritual, moral, emotional and physical too. Our approach is based on Christian principles, but we don't accuse people with HIV of having sinned. We accept them as individuals



Thandi Nqiwa demonstrates condom use to members of the House of Care support group: practising safer sex is part of living positively with HIV.

whatever their beliefs – Christian or African religion, or whatever."

When enough people have gathered at the House of Care, Thandi Nqiwa speaks for a few minutes about some aspect of health, such as treatment of infections, nutrition and living positively with HIV. Often she talks about the importance of using a condom during sex, and demonstrates how to put a condom onto a wooden model. She also takes a box of condoms from one person to the next, urging them to take as many as they need.

By 4 p.m. about 30 people have come to the House of Care support group, but some have stayed for only an hour or so and then left. About 15 women are still present when the meeting closes with prayer. But this is not a solemn, formal prayer led by a religious leader. On the contrary, everyone stands up and prays out loud, individually and fervently. After several minutes,



Linda

HIV/AIDS campaigner and educator

"When I learned that I was HIV-positive the first thought that came to my mind was, 'if people know I have HIV, how are they going to treat me?' Because they knew me as a person who was always preaching, always singing the gospel."

A born-again Christian, 25 year-old Linda Sambata was diagnosed HIV-positive in 1999. She could hardly believe that the diagnosis applied to her:

"I thought being HIV-positive was for people like gays, or people overseas. I didn't know anyone who was HIV-positive, and I wasn't involved in any HIV/AIDS work."

Linda joined a support group in Kayelitsha township, near Cape Town, where she also lived and attended church. This gave her the courage to disclose her HIV-positive status to her pastor and also to a friend in the congregation. Her pastor agreed that she could hold an HIV/AIDS workshop in church:

"I put up some posters and I talked about HIV/AIDS, sex and condoms, and about having an HIV test. I didn't disclose my own HIV status. But the church elders and older women were angry with me. They said AIDS was a punishment from God, and I shouldn't be talking about such things in church. This upset me so much that I broke down and cried in front of them."

A few weeks later Linda disclosed her HIV-positive status on television:

"That was the first time I had gone public. I was fed up with hiding this HIV thing, and I just felt I had so much strength to go public. Next Sunday in church the same people who objected when I held the workshop treated me as though I was



something disgusting. So I decided to stop going to that church, although I had been in it all my life."

When Linda was invited to speak at the Full Gospel Church in Guguletu township she was given a completely different reception:

"They were saying that Christians should not condemn people who are HIV-positive, who are children of God and are welcome in this church. I felt relieved, because even if I can get medicines and food, my soul still needs the Word of God. So I became a member of this church and they treat me as one of their own children."

Linda now works for the Treatment Action Campaign, or TAC (see page 91), where she carries out campaigning and educational work with local churches. She says:

"I would like the churches to invite TAC to hold workshops on HIV/AIDS, on treatment, on nutrition, on positive living - all those things. But we can't talk about HIV without talking about sex, and that is still very difficult in most of our churches. I would also like the churches to care for people with HIV, to open up a platform for people with HIV to disclose their status, and to give young people a chance to present their ideas about dealing with HIV/AIDS. Most people in South Africa are Christians, and I believe that it's only the churches that can make a real difference in this struggle against HIV."

as if on a signal, the voices become softer and some stop, until finally everyone is silent, their heads bowed.

Some members of the Full Gospel Church were initially critical of the House of Care, and especially about distributing condoms:

“There was one lady,” says Thandi, “who was very sceptical, so I invited her to come to the support group. So she came, and she met the people who come here and talk openly about being HIV-positive. Afterwards she said she was very impressed because she could now understand why we are supporting these people.”

Food, counselling and social support

Most people attending the House of Care support group were referred to it initially by nurses at a government clinic in Guguletu or a neighbouring township. Others have heard about it through friends or neighbours. Nolita, a 30 year-old mother, heard about the group from a clerk

when she went to court to lay charges against her husband for infecting her with HIV:

“I like coming here,” she says, “because we learn a lot from Thandi and the other counsellors, and we also get some good food.”

All the women attending the support group are unemployed, as are most of their partners. Several are single mothers. For many, the hot meal they receive at the House of Care is the only time in the week that they eat meat. They also take home a bag of food, which usually consists of fresh fruit and vegetables, with a loaf of bread or several bread rolls.

Most of the food is provided free of charge by the Lions Club, who collect it from supermarkets in Cape Town and pass it on to charitable organisations. Members of the Full Gospel Church also provide food, such as fruit and vegetables, on an occasional basis. Whenever donated food supplies are insufficient, Thandi Nqiwa buys food using money contributed by the congregation through special collections



Members of the support group share information and experiences with one another.



Maria

Support group member



At the end of the support group meeting everyone prays out loud for several minutes. Maria, tears coursing down her cheeks, prays loudest, longest and most fervently. She has been coming to the support group since it started in June 2001.

Aged only 28, she is on an invalid pension of about US\$60 per month. The heavy labour at the leather factory where she used to work left her with back problems, and the harsh chemicals used in treating the animal hides damaged her lungs. But she is lively, vivacious, and a constant source of advice and encouragement for the other members of the group.

Maria was diagnosed HIV-positive in October 1997 at a government hospital in Cape Town:

"I was tested for HIV when I was pregnant. I got my boyfriend to come with me to the hospital, where the doctor explained the situation. My boyfriend accused me of

infecting him, but that wasn't true because I hadn't been sleeping around. He left me and gave me no help at all with the baby - no money, no clothes, nothing at all.

"I told my parents and my sister, and also two friends, that I had HIV. They felt very sorry for me and gave me a lot of love and care. My mother and sister prepared good food for me, and the doctor got me AZT when it was time to give birth, so my son is not HIV-positive. He's three and a half now.

"I used to attend a local church but I don't any more. The pastor there believes that you can't be a born-again Christian and have HIV. Two of my friends from the church used to keep telling me not to take any medicines, just to trust in Jesus to heal me. I couldn't accept that. I want to have Jesus and to keep taking medicines. So I don't go to church any more, but I pray every morning for my family, for my son, for the doctors and for everyone living with HIV/AIDS.

"I've had a lot of illnesses but I'm still in good spirits. I've had TB twice, and oral thrush - I'm still taking medication for that. I've had a skin rash but that's cleared up since I've been using a cream. Sometimes I sweat very heavily at night and get a dry mouth.

"I have a new boyfriend now. We've been together for 14 months. He's also HIV-positive, and he does home-based care work for the Red Cross. We always use condoms, and we put them on together. I always check the date on the condom, and we've never had one burst yet."

once a month in church. Some members of the church also collect second-hand clothes and shoes for members of the support group and their families.

Equally important is the counselling and sharing of information that takes place through the support group. Typical problems are rejection by family members,



Mabel

Support group volunteer



Mabel is a member of the Full Gospel Church of God in Guguletu. She is employed part-time as a domestic worker at an embassy in Cape Town. Every Wednesday, which is her day off, she and her mother, Nomsa, come to the House of Care and cook a hot meal for about 30 people who come to the support group. They also prepare food parcels (bread, fresh fruit and vegetables) for people to take home.

As far as Mabel is concerned, giving up one day a week to help the support group is simply a small service to the community:

"There are more and more funerals now on Saturdays, and I have lost some of my neighbours to AIDS. I also saw a television programme about AIDS, so felt I should do something about it.

"Then Thandi, the pastor's wife, asked me to help this support group, so I was glad to get involved. I like doing this work because I get to talk with the people who come to the group. I didn't know any of them before, but many of us have become friends. They are just normal people, but they have this disease.

"I also want to learn about AIDS, so that if anyone in my family - my husband, my children or me - gets it, I'll know how to cope.

"I would like to do counselling but I would have to be trained first. So far I haven't had time for that. But when my employer returns to Europe next year I plan to do a counselling course.

"Nobody in the church has criticized me for doing this work. If they have critical thoughts it's because they don't understand how AIDS affects people. They should come and see the support group and meet the people here."

discrimination by neighbours and friends, and fear of disclosure to partners. Group members counsel one another in an informal way, sharing their experiences and offering empathy and emotional support to those experiencing a crisis at a particular time. They also exchange information about effective treatments for infections. The three volunteers who have received basic training in counselling also discuss these problems, on a one-to-one basis, with group members. They mediate between partners, for

example, when a woman feels unable to disclose her HIV-positive status to her partner.

The volunteer counsellors receive support from Regina Dlakulu Mlobeli, a member of the Full Gospel Church who works as a psychologist at the University of Western Cape. Although often unable to attend meetings of the support group, Regina either visits people in their homes or receives them in hers:

"When people are diagnosed HIV-positive but are still in denial, or feel unable to tell

Volunteer counsellors do one-to-one counselling with members of the support group.



anyone else about it, I help them to accept the diagnosis and to share it with others. Sometimes people are not given proper pre-test or post-test counselling, or they are given one but not the other. Often they don't know the difference between HIV and AIDS. They know nothing about positive living – that they can still live a long time with a good diet and treatment for opportunistic infections.”

The support group is also helping to revive traditional forms of social support in times of bereavement. Until recently, when someone was believed to have died of AIDS, their relatives were left to mourn on their own. By breaking down the social stigma attached to AIDS, the support group is helping the community to rediscover simple gestures of community sympathy and support for those in mourning. Dolly, for example, is a member of the group and brings her five year-old son to meetings. Her husband had been ill with HIV/AIDS for some

time but did not attend meetings of the support group. When Dolly's husband died, about 12 group members visited her in her home, where they prayed, read the Bible together and comforted her. They also collected money to help cover the funeral costs, and several group members attended the funeral.

Men's fellowship

Very few men attend the House of Care meetings, a pattern that is repeated in other support groups in Cape Town, and indeed elsewhere in South Africa. This is partly because some men are at work outside the neighbourhood, and partly because men are more reluctant to disclose their HIV-positive status to other members of the community. Many men are also uncomfortable about discussing topics such as sexual behaviour in the company of women. Nevertheless, men are willing to talk frankly about sex and HIV/AIDS amongst themselves.

In June 2000 the Full Gospel Church in Guguletu started a men's fellowship, or *amadodana*, which meets every second Saturday afternoon, and is attended by 20 to 25 men aged between 17 and 35. The group consists of men who are married, men who are single, men who are living with a girlfriend, and men who are married but also have a girlfriend. The *amadodana* group has discussed HIV/AIDS and sexual behaviour, traditional customs and beliefs regarding sex and marriage, gender roles, homosexuality and practical issues such as HIV testing, condom use and treatment for opportunistic infections. They have also discussed how to live a healthy, positive life with HIV. Materials such as the Uganda video, *Born in Africa*, and the booklet *Positive Health*⁵, distributed by the Metropolitan Group, have been valuable sources of information and inspiration.

Attendance at the *amadodana* meetings has fluctuated and meetings have not always been held as frequently as planned, but Rev. Nqiwa believes that this group has helped to bring about important changes within the church community and beyond:

"There's greater acceptance in the community now of the reality of AIDS, that HIV causes AIDS, and that HIV is spread through unprotected sex. There's also more willingness on the part of men and women to use condoms. Some wives have told me that they have suggested condom use to their husbands, and the husbands agreed. There's also a much more accepting and supportive attitude in the church towards people with HIV/AIDS."

Children and youth

It is not only adults in the church who are now talking more openly about HIV/AIDS and sexual behaviour. The Sunday School, which is

attended by children between the ages of seven and twelve, recently asked Thandi Nqiwa to come and talk to them:

"As a trainer, the first thing I did was to ask the children what they would like me to talk about. Their responses were very interesting. Number one was HIV/AIDS, but they also wanted me to talk about teenage pregnancy, STDs, breast cancer, boyfriends, girlfriends and relationships. So now I'm covering one subject every week, on the overall theme of 'sex and sexuality'."

The church organises workshops on HIV/AIDS, sex and sexuality for young people. The message is clear but tempered with a sense of realism:

"What we are saying to our young people," says Rev. Nqiwa, "is 'no sex before marriage'. We do that by saying 'wait for your turn, because your turn will come'. We see no reason why they should rush into sex because they can have it for the rest of their lives after getting married. But these days young people are becoming sexually mature at an earlier age than before. If they feel they must have sex before marriage, then they should use a condom as a preventive measure against HIV/AIDS and pregnancy."

A force for change

Much has changed in the short time since the Rev. Gideon Nqiwa suggested that the Full Gospel Church of God in Guguletu should respond in a positive way to the HIV/AIDS epidemic. People within the church – including children and young people – are now much more 'AIDS competent' than before. They are aware of the reality of HIV and AIDS within their community, and of what they need to do to avoid HIV infection. They are also helping to provide services and support to people living with HIV.

It is surprising, however, that only one

Children's choir at the Full Gospel Church of God, Guguletu: 'sex and sexuality' is part of weekly Sunday School lessons.



member of the church, Linda Sambata, has openly disclosed her HIV-positive status in church. Several more church members have privately disclosed their HIV-positive status to Rev. Nqiwa or his wife, Thandi, but are not yet prepared to 'go public'. This suggests that, even though overt HIV-related stigma and discrimination have declined sharply within the church community, most HIV-positive people still practice 'self-stigma'.

The programme owes a great deal to the vision and commitment of its pastor, Rev. Gideon Nqiwa, and his wife, Thandi. Its future also depends to a large extent on these two people. Thandi plans, for example, to start an income-generating project for the unemployed women who come to the support group. This will probably start with making papier maché toys, leather goods and tailoring. She also hopes that enough volunteers can be found within the

church to start a home-based care project.

Rev. Nqiwa's vision, however, extends far beyond his own church in Guguletu township. He is acutely aware that, amongst South Africa's many independent churches (to which half the Christian population belongs), the level of HIV/AIDS knowledge and awareness is still very low. Nowhere is this more true than amongst the pastors of these churches, most of whom have had little or no formal training in theology or pastoral care, and many of whom are either semi-literate or completely unable to read or write. It is hardly surprising, therefore, that they are poorly informed about issues related to HIV/AIDS and sexual health.

Rev. Nqiwa has therefore committed himself to making independent churches 'AIDS competent' – not just in Cape Town or Western Cape Province, but throughout South Africa. He is a tireless networker

with NGOs, church institutions and political organisations. For example, he works closely with the training organisation, FAMSA (Family and Marriage, South Africa), which is running five-day HIV/AIDS training courses for pastors from independent churches, in which he is responsible for the section on pastoral care. He is also an active member of the board of the Nehemiah Bible Institute, which is producing a training module on HIV/AIDS which pastors can study as external students.

This is all part of Rev. Nqiwa's vision of

how churches should work together in post-apartheid South Africa:

"We want to strengthen what is known as 'post-apartheid solidarity' between the independent, African churches and the mainstream churches. We also want to involve academics, doctors and nurses in working more closely with church leaders to deal with HIV and AIDS. We know that, unless something serious is done soon, we are a dying nation. That something can only be done by the church. If we do nothing, who else will?"

Chapter 6

Kubatsirana

Mobilising churches against AIDS

Otilia Paciencia can't stand to see children suffering. So each day, in addition to caring for her own family, she visits needy orphans who have been assigned to her within her neighbourhood in Chimoio, a town of 200,000 people in north-central Mozambique. Other volunteers do the same. All were trained by Kubatsirana, an ecumenical church-based organisation set up to respond to the HIV/AIDS crisis in this area.

Otilia Paciencia says she has little to give the orphans, but she tries her best:

"We generally do our visits in pairs, two volunteers together. When we visit the children, we check to see if they are hungry, or if they are

sick. If they need food, and if I have just a single coin, I will give it. Or I bring some food from my own family. Should a child need to go to the hospital, then we will organise some neighbours and volunteers together and take her, and we will pay the fees. Sometimes, we will just talk with the children. It gives them a good feeling, and then I feel good, too."

Otilia and her fellow volunteers come from different churches in the same neighbourhood. Until Kubatsirana brought them together, neither these volunteers, nor their respective churches, had ever worked together for a common purpose. Years of civil war, intimidation and colonialism had rendered such



Kubatsirana office in Chimoio, Mozambique.

cooperation impossible. But now, through Kubatsirana, the new war against AIDS has brought them together.

Humble beginnings

The organisation Kubatsirana dates back to 1995, when a small group of Christians in the provincial capital of Chimoio asked the Swedish Alliance Mission and F.A.C.T.- Mutare* to conduct a pastors' awareness training and undertake an assessment of the needs and opportunities presented by the growing HIV/AIDS pandemic. They chose the name *Kubatsirana* for their ecumenical organisation because it means "help each other", as suggested by its logo of two women assisting each other in carrying a pot of water.

Many factors pointed to the need for drastic action at that time. Chimoio had grown rapidly as an area of refuge during Mozambique's 14-year civil war, by absorbing newcomers from all over the country who were without the support of their extended families. The town also serves as a frequent stopover on the transport corridor between the seaport town of Beira, Mozambique, and the inland town of Mutare, in Zimbabwe. Health officials in Manica Province, where Chimoio is located, estimate that 24% of the adult population is infected with HIV.

Owned by the churches

Kubatsirana belongs to 74 local churches, who constitute the organisation's official membership. Most are small evangelical churches, as these make up the majority in the town's 25 *barrios* (compounds or neighbourhoods). Kubatsirana's mission is to work ecumenically through church structures at grass-roots level, by identifying and training



Neighbourhood church in Chimoio: most of Kubatsirana's 74 member organisations are small, local churches.

pastors and other volunteers to provide HIV/AIDS awareness, hands-on programmes and follow-up support. Their goal through this approach is to help reduce the further spread of HIV/AIDS, and to improve the quality of life for those already infected or affected by the disease. Kubatsirana draws its guidelines for both prevention and care from Biblical principles. Training and support is also provided to church groups in outlying areas, in the hope that they will spawn similar networks that will retain contact but otherwise function independently of Kubatsirana.

According to Faustino Manuel Araujo, Kubatsirana's director, prior to 1995 the churches had not been involved in the fight against HIV/AIDS because they considered it immoral to discuss sexual matters. Yet, at the same time, they were experiencing the loss of

* F.A.C.T. = Family AIDS Caring Trust, an NGO based in Mutare, Zimbabwe.

important members of their congregations. They felt stuck, wanting to do something, but fearing that any action they would take might run contrary to their Christian beliefs.

The secret to Kubatsirana's success, according to Faustino Araujo, is that it provides a path by which the church-based community can act constructively with regard to the HIV/AIDS pandemic, without forcing anyone to deny his or her cultural or religious beliefs. Its Christian message has opened the door to church involvement in both prevention and care issues, in contrast to the strong promotion of condoms by government and other organisations, which in the past had caused churches to resist such involvement.

Involving key leadership

In addition to the membership base of 74 local churches, Kubatsirana comprises thirteen staff, a Board of seven Trustees (most of whom are pastors), and 325 trained volunteers. To manage their work, all are grouped according to the

barrios in which they live and the churches with which they affiliate.

Kubatsirana's goal is to build capacity within the churches and the local community to develop and maintain their own programmes, to the extent possible. This is done through an initial community mobilisation and assessment process (to determine local HIV-related needs and opportunities), an almost constant array of training courses, and regular follow-up visits for quality-assurance and support.

Kubatsirana provides training and refresher courses to everyone who is involved with the organisation, including all its affiliated pastors and volunteers. In addition, periodic training is offered to local youth and community leaders, groups of people living with HIV/AIDS, and pastors from nearby communities who want to start similar activities in their own towns – close to a thousand trainees in all. Constant reference is made to Christian values, the importance of volunteerism, the need for inter-church co-operation, and the role of one-to-



Kubatsirana staff and volunteers: aiming to build capacity within churches to develop and maintain HIV/AIDS programmes.



Pastor José Francisco Manuel Madeira

Vice President of Kubatsirana Board of Trustees



"I was born in the north-eastern town of Tete 46 years ago, into a non-religious family. But as long as I can remember, I have always had a spiritual feeling. My mother was a traditional healer. In my teens I attended Roman Catholic schools and wanted to become a priest, but my father said no. Then in 1978 I was recruited into the army to fight RENAMO. During those military years I had many religious visions.

"Around this time I also met my wife, who said she wouldn't marry me unless I officially joined a church. So I agreed, but in 1984 I was wounded at the front, and had to be demobilized. In starting up my life again, I had to find a new job, and a new church, as my old denomina-

tion wasn't in the town. That's when I joined the Free Evangelical Assembly of Mozambique, which is where I am now. In 1990 I was ordained as a pastor. For the past ten years, I have been a provincial pastor in charge of eighteen churches, with 1,200 adult members.

"I came into contact with Kubatsirana in 1996, soon after they got started. Kubatsirana gave me the chance to do the community work I had always wanted to do, without other pastors suspecting that I was trying to recruit people into my own church. It also took away the stigma about working with HIV/AIDS, because this kind of outreach had become acceptable in a Christian way.

"In working with Kubatsirana, we have had a lot of successes. My church denomination spreads across four barrios, and does home-based care and orphan work in each one. Our commitment to caring pre-dates Kubatsirana, but Kubatsirana gave us a lot of training so now we know what to do. Before Kubatsirana had its own office, many of its meetings were also held in our churches, and then we would also visit other churches, too. That helped a lot to create a feeling of community unity."

one encouragement and spiritual support with regard to both prevention and care activities.

The initial mobilisation occurs in phases. Kubatsirana enters a community by meeting with key church and neighbourhood leaders

whom they have identified as being the most sympathetic and strategically important for Kubatsirana's success. Kubatsirana then invites these people to an Awareness Day, in order to discuss their local situation, including a range



Neighbourhood committee: Kubatsirana enters communities through a meeting with key church and neighbourhood leaders.

of local problems and development issues. In this way, they focus on the root causes and consequences of HIV/AIDS, without breaking with traditional African and Christian values.

The Awareness Days generally lead to a four-day PRA (Participation, Reflection and Action) Workshop for key leaders identified by the community, focusing on HIV/AIDS prevention, home-based care, the care of orphans, youth outreach, micro-economic projects (for self-sufficiency), and support activities by and for people living with HIV/AIDS. Technical support and mentoring visits follow every seminar.

Building support over time

AIDS activism is a process. Kubatsirana started with the notion that churches had to get involved, but the nature of that involvement was left to the

individual church to decide. Baptist church pastor and staff member Inancio Zambo João Xavier explains that in the beginning many of the churches shied away from Kubatsirana:

“In the beginning, we started with the Catholics, because they were the most responsive. Maybe this is because they were centrally organised, or because our first staff person – half-time – was a priest.

“But little by little the doors opened, and soon the Evangelical Protestants began to join as well. Other church leaders asked to get involved when they saw their own members suffering and dying from this disease. They also realized that, with Kubatsirana, they no longer had to deny their Christian values in order to join the fight against HIV/AIDS. Once they signed on, staff gained access to a wide range of very committed, community-based volunteers. This expansion

happened via the training sessions, which were a real eye-opener. Eventually, the independent churches joined in, too. Now we have a waiting list of pastors who want to be trained.”

Deepening the pastoral commitment

Ms. Beatriz Cintura, President of Kubatsirana’s Board of Trustees, explains the organisation’s basic approach:

“Prayer, combined with education, works miracles. For us, this often means giving new skills to the pastors, as well as reinforcing old ones, so that they can be stronger in their work. We don’t rely only on classroom training sessions for this. We also visit regularly with each pastor, to help him develop his church programme in HIV/AIDS prevention or care. Pastors are welcomed as official members of Kubatsirana after they take our four-day Pastors’ Awareness course, and after they demonstrate that they have done something in their church to implement what they have learned.”

Kubatsirana aims to ensure that each barrio has sufficient church leadership to mobilise the whole community. Individual churches are free to emphasize different programme components, depending on their own orientation or preference. Home-based care and orphan support projects are generally the most active. By contrast, support groups for people living with HIV/AIDS remain quite undeveloped. This is probably because, until recently, very few people living with HIV were aware of their HIV-positive status. HIV testing facilities have been available in Chimoio only since November 2001.

Expanding one barrio at a time

Zeca Saire Virgillio, a community leader in the neighbourhood known as Barrio May 1st, describes how Kubatsirana helped his community to become better organised to respond to the problem of HIV/AIDS and, in particular, to the needs of orphans:

“Back in 1998, I met one of the workers from

HIV/AIDS training course for pastors: because of war and poverty, most pastors have little or no formal education.



Kubatsirana, Madam Clara Chinaca, who had come to my house. I asked, ‘What problem do you have for me to solve today?’ She answered, ‘I only have a meeting planned for you.’ So I said I would help with the meeting...

“When the day came for Madam Clara’s meeting, I played my part by ensuring that a good number of residents were present. The discussion was about what we could do to help the needy orphans. We identified someone to take charge of a small needs assessment, and the rest of us agreed to divide up the barrio into small sections, and then visit and assess those homesteads where we knew there were needy children. Often we found orphans being well cared for by a grandmother or a neighbour. But sometimes we found children who had no care at all. It became clear to us, as church-going people, that these needy children would have to become our responsibility.

“Since that initial meeting, I got more and more involved. Some of the pastors in the barrio have been given leadership training on HIV/AIDS, while our church women received training on home-based care and community visiting. I also participated in many courses, on how to start income-generating projects to assist clients and orphans, on home-based care and orphan support, and on how to start a Care Committee for the barrio.”

Another community leader, Pastor Ferão Williamo of the Apostolic Zion Church, adds that Kubatsirana appealed to him because it brings its message through the words of Christ:

“I had the strong desire to work with orphans before the meeting organised by Kubatsirana was held, but I had been discouraged by our tradition that says that, if you go out and do this work alone, people will suspect that you have a self-serving motive. Also, during the years of Civil War, or under the Colonialist and Marxist

regimes, we couldn’t freely associate with one another in large groups. People would be afraid, or try to undermine you. But with the churches involved, this wasn’t a problem any more.”

Training the pastors

Central to the Kubatsirana mission is their training courses for pastors. Trainer João Pedro Atibo explains:

“We adapted our curricula from other sources in Zimbabwe and Kenya, and also locally⁶. Our materials are all in Portuguese now, although sometimes we have to translate them into indigenous languages too. People usually come to the training sessions with a lot of questions such as:

- ‘What can the churches do to make a difference?’ or,
- ‘How can churches teach HIV awareness without acting contrary to our values?’ or,
- ‘If we welcome people with AIDS into our church, won’t some people accuse us of promoting prostitution?’

“Always, we go back to the Bible for support. For example, to Psalm 32, Verse 8, or to the story of Jesus asking the Samaritan lady for a drink at the well (John 4). Or we quote the story of Jesus helping the blind man, without asking about the man’s past. There are also teachings about the way Jesus reached out to people with leprosy, which is the closest we have to AIDS in the Bible.”

In most cases, the pastors come to Kubatsirana with little or no formal education, due to past war, poverty and lack of opportunity. Maria Angelina José Majacunene, Kubatsirana’s coordinator for home-based care, highlights the importance of breaking through the misinformation which trainees often bring to

the sessions. “Our greatest weapon against AIDS is honesty,” she says. This theme is reinforced throughout Kubatsirana’s four-day Pastors’ Awareness curriculum, as follows:

DAY ONE begins with attitudes towards people living with HIV/AIDS, and myths that people have heard about the disease. A case study from Kenya is used to stimulate discussion. It tells of a young woman who learns she is HIV-positive and told to go for counselling. She doesn’t want to go to her pastor, so she keeps her HIV-positive status a secret. But this is very difficult for her, and eventually she realizes that she cannot live a lie any longer. So after six months she goes to another pastor for counselling. The participants are then asked for their feelings and attitudes to both the woman and to her actions. For example, they are asked, “Why didn’t she want to talk with her family?,” “Why wouldn’t she go to her own pastor?,” “What feelings might she have experienced, or how might her family or the church have felt towards her?”

DAY TWO is devoted to facts about AIDS. Much of this information is new to the pastors so, as João Pedro Atibo explains: “We have to be very open and direct.”

DAY THREE is about cultural issues – traditional African culture, modern culture, and Christian culture and beliefs. The participants examine similarities and differences, and then try to come up with ways to reconcile any disparities which might exist.

DAY FOUR is about different things that a church can do. The focus is on the way forward, the options available and the commitments needed for effective action. Issues like counselling, pastoral care for families, home-based care, orphan support

work and youth education are discussed.

After the course, Kubatsirana follows up and supports the participants through visits at community level.

The role of condoms

Kubatsirana’s philosophy differs from that of government, and most other NGOs in Mozambique, in its emphasis on abstinence from sex outside marriage and fidelity within marriage, rather than on the use of condoms. Kubatsirana does not distribute, promote or demonstrate condoms, but staff stop short of condemning their use. When asked about condoms in a training session, Kubatsirana staff generally throw the question back to the audience, by asking the person who raised the question if he or she can think of any circumstances where the utilization of condoms can be justified. This usually results in a lot of “what if?” scenarios which leads the questioner to understand that the situation is quite complicated, especially if there is a discordant couple (where one is HIV-positive and the other isn’t), or if both members of a couple are HIV-positive and want to avoid re-exposure to HIV.

Inherent in this approach is the understanding that churches will differ on this issue. A commonly heard approach is that of Pastor Cristóvão Simao Pedro from Chimoio’s Path of the Truth Church, who puts it this way:

“In the beginning, we religious people were all against condoms. To this day, our church policy strictly prohibits them, because I believe if we embark on a policy of accepting them, we will be seen as promoting promiscuity.

“But I have also learned that sometimes you have to consider a different situation. I, as a human being, cannot prohibit someone else from engaging in sex. I don’t promote condoms, but I can understand if someone has the need



Pastor Blaunde Djadje

Kubatsirana volunteer



"My wife visited the hospital and was offered a condom, which she brought home. She told me she was given this condom for us to use. I asked her, 'Does this mean you think I am sick?' Then I asked, 'If we use the condom, will we breach God's plan for us to multiply? Is there any need for me to do this?'

"During the first week, I was very resistant. It made me angry to think about it. Then my wife went back to the hospital, and she was offered a second condom, which she also brought home. So I said, 'Let us keep them.' I started to think about when it would be acceptable to use a condom. But then my children picked them up and turned them into balloons.

"So I raised this with the Pastors' Group at the Kubatsirana Training Course. I asked, 'Was I wrong to think about this? As a Christian, am I ever authorized to use a condom?' It started many people talking... Not everyone agrees. For myself, I can't imagine ever needing a condom, because I am faithful to my

wife and she is to me. But others may use it, because they are not faithful to one partner. Then it is better to use a condom than die from HIV.

"I won't condemn others. I have to respect their decision, but of course I will still recommend that they should be faithful because that is safest, and it is the Christian way.

"I learned a lot from the Kubatsirana Pastors' Awareness Course. I will tell my wife, and then my family, what I have learned. Then I will tell it in the church. I know we must increase awareness and knowledge. It means we have to depend on ourselves to take responsibility, and to help one other."

to have sex and uses them. I address this when I give people counselling. But I cannot speak out publicly about using condoms, because the danger is that I will be misunderstood, and my words will be taken out of context."

Orphan care

Kubatsirana promotes a community-based care approach for orphans and other vulnerable

children. Orphan Coordinator Clara Chinaca explains:

"Kubatsirana provides direct assistance to 220 of the neediest orphans in Chimoio. All remain in the community, with oversight by one or more of our volunteers. One of our biggest successes this year is that we got 70 children registered for school even though they couldn't pay the school fees. We had to get an exemption

from the welfare office, and we succeeded. There are 40 more in process.”

Although Kubatsirana does not keep statistics on the work of its member churches, or of the work of individuals within those churches, staff estimate that several hundred additional orphans are helped by the churches and their volunteers. This is in keeping with Kubatsirana’s philosophy, whereby the local community should take the initial responsibility for orphan care, with Kubatsirana coming in only as a last resort.

Clara Chinaca describes this process:

“To identify orphans and vulnerable children in a particular neighbourhood, we start with a Community Awareness Day, and after that we go door-to-door with the pastors and community leaders, in order to make a needs assessment. We ask for the help of the political leaders because they know what is going on in their community, and they work well with the pastors and chiefs. We explain that the churches will only be able to help the neediest

of the needy, and that is whom they refer. So they have to choose priorities for whom they can assist, or else the burden on the churches and the volunteers would be too big.

“Once the volunteers get involved with the Kubatsirana children, I have to supervise them. Sometimes the pastors or community leaders give me a report; otherwise I have to check periodically on the children myself. I can’t get to all the children, but I do my best. One problem is that the orphans become an easy prey for burglars or relatives who feel the orphans owe them something from when the children’s parents were still alive. So we try to work with local chiefs and others to ensure that whatever was stolen will be given back. But at other times we feel blessed, when donations of blankets or food come in, that we can use these to help the children.”

In his neighbourhood, Barrio May 1st, community leader Zeca Saire Virgillio, recalls:

“We focused from the beginning on how to care for needy orphans. For example, before



Orphans assisted by Kubatsirana or its member churches live with families in their own communities.



Pinho Ruis, age 12

Orphan with a purpose



"I can't remember my parents. Altogether, we were four children. Since I was little, I lived with my grandmother in Barrio Five. We were always poor, but over time it got worse. I had to leave school at the end of second grade, because my grandmother couldn't pay the fees. She told me I had to go and find food to help everyone else, because she was getting old and weak, and could not feed us any more. So I would walk downtown and beg all day, but I suffered a lot. Whenever I got a coin, I would buy some maize and have it ground, and then go back to feed my grandmother. The next day I would go out begging again. Once I went to my aunt for help, but she beat me.

"For a while I stayed in Barrio Nine with some other children. I would search everywhere for food. Neighbours looked in on us, and sometimes they would hire me for labour. They wouldn't give me any money; just food. But it was never enough. Sometimes people accused me of stealing, and they would beat me. I tried to get some money or extra food to help my grandmother, but I never had enough.

"Finally, when my grandmother fell really sick, I told her that I would have to leave. I was hungry all the time, and couldn't help either of us. She said I should go ahead and do what I can. This happened about the same time I met Madam Clara*, who gave me some beans and rice and cooking oil. She told me that her hands were always open, if I needed more help.

"I was facing real hardship. I had tried to manage, but finally I decided that I could not stand it any more. I am too big to beg successfully on the streets, but I am too small to get a job. So early one morning about two months ago I left, and went to look for Madam Clara. I asked everyone if they knew where she lived. I walked and I walked. Eventually, I came to this barrio and I saw her on the street, outside her house. I said, 'Here I am. I am here because of what you said.' And she answered, 'Okay, you are welcome to stay.'

"I haven't been back to visit my grandmother. I don't want to look back to my old life. My main duties here are to take care of the house, to clean the dishes and sweep the floor. In January next year, I will go back to school.

"I believe I was saved for a reason; that God has a purpose for me. But I do not yet know what that purpose is. Before, I was suffering terribly, and felt hungry and alone. But now I can feel something different inside me.

"I would like to learn how to pray, and study the teachings of Jesus Christ. I have found that prayer is good. Every evening with Madam Clara, we pray before we eat. Now I have hope for the future."

* Clara Chinaca from Kubatsirana.

Kubatsirana, we did not know about the rights of a child to receive counselling, health care, or education. Now, with the knowledge we have, we have helped fourteen children attend school without paying any fees. Others are getting food and clothing, which we share through the participating churches, neighbour to neighbour. We do this because we can't stand to see these children suffer. We always look for people to be volunteers who feel a spiritual responsibility and have some extra love to give, so that they can get involved and visit the orphans."

To this, Clara Chinaca offers her own story as an example:

"I am not married, but in my own home I take care of eight orphans. I think I feel driven to do this kind of work because I was an orphan myself. I never knew my parents, but I grew up with a strong spiritual base. With the help of my pastor, I found good teachers and the power of God."

Civic education for girls

In Barrio Centro Hippico, several volunteers initiated a civic education programme for adolescent orphan girls. Volunteer Luiza Mailaire explains:

"First, we involve them in the church. It doesn't matter which church; maybe the one they attended before their parents died, or else they may choose the church of the volunteer. Then twice a year, we gather all the adolescent girls together, starting when they sprout little breast-buds at about the age eleven or twelve. We teach them how to protect themselves from the dangers they face from older boys and men who want their bodies for pleasure. We encourage them to stay in school and work hard. When the school finishes in the afternoons, we explain that they should partake in domestic

chores to keep busy, because if they remain busy they won't have the time to get into trouble.

"But we teach them other things, too, like what our culture says about good manners and responsibilities. For example, we teach them how to wash their clothes and plant some simple crops. We also teach them that when a visitor comes to the house, they should take out a chair from inside, so the visitor has something to sit on. We stress that they should be serious and think about their future because, as orphans, they will have to take care of themselves.

"The girls come to our educational programmes, and afterwards they say, 'We've heard.' The words don't mean much, but we know that we are making a difference. Because of our programme twelve teenage orphan-girls are still in school in this barrio, whereas they could have dropped out. They are also showing good behaviours. We know this because we do regular follow-up visits, when we talk to each child. We also compile regular reports, which tell us what the girls have absorbed. So far, the majority have stayed out of trouble. But even if they make a mistake and go astray, in the end we are always prepared to take them back into our care."

The power of volunteerism

In order to succeed, Kubatsirana depends on the strong commitment by volunteers. The volunteers, in turn, are motivated by their own faith, and the desire to do God's work, as Christ did before them. Although Kubatsirana gives T-shirts to all their course-graduates, volunteers and pastors do not receive any other form of payment for their work in youth outreach, community mobilisation, home-based care, or orphan support. Yet the volunteers point very quickly to the benefits of training, which gives

Volunteers and pastor: training by Kubatsirana gives volunteers additional knowledge, spiritual strength and respect in the community.



them additional knowledge, spiritual strengths, and a newfound respect in the community.

Volunteer Maria Louisa Laice explains:

“Spiritually, I have grown a lot through Kubatsirana. It feels good that we can do so much more for the sick people. Now I am always prepared to help, because I know what to do, like taking someone to the hospital and speaking up for better treatment; or organising a dignified burial if that is what is needed.”

Her colleague, Luiza Mailaire, adds:

“Since we began volunteering other people look at us differently as well. Often, when we pass someone on a walkway in the barrio, that person will give us a special gesture of dignity because of our work. People talk favourably about us; you can hear it. They say that we are people who can help others. Even in the churches, we can tell the difference. We get more consideration. Everybody recognizes what we are doing. When someone is sick, the community leaders come to us for help. Before

we were nobodies. So now we feel good; we feel honoured.”

Like the Biblical book of Nehemiah

Kubatsirana operates on a shoestring budget. This is a deliberate policy, according to Carina Winberg, Kubatsirana’s consultant from the Swedish Alliance Mission:

“We’re a capacity building organisation, whose sustainability requires that each church learns to take responsibility for its own programmes. At Kubatsirana, we provide lots of training and back-up. Our three cornerstones are capacity building, participation of the volunteers in decision-making, and continuous encouragement to maintain the motivation and the work. But to be successful, the churches have to take the responsibility and work together. Only in this way can all of Chimoio be served. Our long-term dream is that we will be able to help other communities adopt

the same ecumenical, church-based model.”

Faustino Manuel Araujo, the director of Kubatsirana, draws inspiration in the fight against HIV/AIDS from the Old Testament Book of Nehemiah, which describes how the wall around Jerusalem needed to be rebuilt, because its disrepair endangered all the people who lived within the city. According to Faustino Araujo, “it is the same with Kubatsirana, trying to beat back the enemy of AIDS.” He draws out the analogy further:

“Nehemiah faced a huge job – too big for any person or group to do alone. So at first, Nehemiah created an awareness programme in which he explained how everyone was exposed and vulnerable to the enemy. To keep the city

safe, Nehemiah’s idea was to get the key people involved, by each agreeing to construct a part of the wall – just the part surrounding their own house. Nehemiah knew it was not necessary to involve all the people – just those whose property touched the wall. Each household had only to build one section of the wall, but they had to make sure that their part connected to their neighbours’, without any gaps. At first the enemy laughed, saying that this would never work. But with Nehemiah’s encouragement, the people mobilized themselves. Eventually the wall was built, and Jerusalem was saved.

In drawing lessons from this story, Kubatsirana hopes that history will repeat itself. And, judging by Kubatsirana’s progress so far, it just might.

Chapter 7

The Duduza Care Centre

New hope in place of sorrow

Only a few years ago, Maria Ratschitz Mission was still abandoned and derelict, a legacy of the dehumanising policies of South Africa's former apartheid regime. Nestling at the foot of Mt Hlatikhulu in the northwest corner of KwaZulu Natal, the mission had once been the spiritual centre of a large rural community. Every Sunday the Church of Our Lady of Sorrows would be full of worshippers from nearby settlements and farms; pilgrims would come from as far away as Italy and Germany to pray in the beauty of church's ornately decorated interior.

But in the early 1970s, when the national government designated the area around the mission as reserved for white settlement only, the black population was forcibly removed.

With virtually no local congregation to serve, the graceful church with the soaring spire lost its spiritual purpose. The bishop of Dundee Catholic Diocese had no other option than to move the local priest to another area and to lock the church and the other mission buildings.

Following the establishment of democratic government in South Africa in 1994, people have been moving back to the area around Maria Ratschitz Mission. But the legal status of the land is still unresolved and the whole district is in a state of economic depression. Moreover, Ladysmith and Dundee Districts have been hit very hard by HIV/AIDS, as testified by the rapidly rising numbers of funerals at week-

The church of Our Lady of Sorrows, spiritual centre of a church-led HIV/AIDS programme in a rural area of KwaZulu Natal Province, South Africa.



ends. In an ironic twist of fate, however, the HIV epidemic has led to the mission taking on a new lease of life.

Restoration and new purpose

In 1998 the Diocese decided to restore Maria Ratschitz Mission, which had fallen into a state of disrepair, and to use its facilities in the fight against HIV/AIDS. Five Franciscan Nardini nuns, led by a medical doctor, Sr Irmingard Thalmeier, came to manage the restoration of the buildings and to start an HIV/AIDS programme. The restoration project has proceeded at a rapid pace. Old stone buildings have been skilfully repaired and new ones built. With the help of master craftsmen from Germany, the interior of the church has been lovingly restored to its former splendour. There is now a sizeable congregation on Sundays, and pilgrims are also coming in growing numbers.

The HIV/AIDS programme has also made rapid progress. In early 1999 Sr Irmingard was able to open the Duduza Care Centre, housed in an attractive, two-story stone building with a thatched roof. The new building is also the site of an eight-bed hospice. In keeping with the mission of the Franciscan Nardini Sisters "to care for those whom the world has rejected", the hospice provides nursing and medical care, as well as emotional and spiritual support, to people with a terminal illness. Sr Irmingard explains:

"We thought a hospice would be necessary in this area because there would be many people with HIV/AIDS whose families would not be able to look after them properly, or who would reject them."

Recognising, however, that the hospice would not be able to deal with the day-to-day nursing and other practical problems faced by

people living with HIV/AIDS in their homes, the Care Centre has made the training of home-based care volunteers a major part of its activities.

Since many young people are at high risk of contracting HIV, the Care Centre is also implementing two youth projects. The project for out-of-school youth, entitled 'Choose Freedom', is managed by a small group of young people based at the Duduza Care Centre. The project for in-school youth is led by Sr Immaculate Ndlovu (see box opposite), a qualified school teacher. At the invitation of the Department of Education, Sr Immaculate has trained teachers in all 217 primary and secondary schools of Ladysmith District in HIV/AIDS awareness. Her main teaching aid has been a flipchart about sexuality, life skills and HIV/AIDS, which she developed with support from CAFOD and a publishing house in Johannesburg. Multiple copies of the flip chart have since been distributed to every school in the District.

The hospice

The Duduza Care Centre's eight-bed hospice provides palliative treatment and nursing care, and also treats opportunistic infections. Voluntary counselling and testing for HIV are also carried out; since the Centre does not have its own HIV testing facilities, blood samples are sent to a nearby government clinic for analysis. Patients receive a well balanced diet, adjusted to the needs and wishes of the individual. All services are provided free of charge, regardless of the religious affiliation of the patient. A Catholic priest lives at the mission and is on hand to provide spiritual support to patients, but pastors from other denominations are also welcomed.

Contrary to original expectations, many



Sister Immaculate

Religious Sister and HIV/AIDS trainer



Sr Immaculate joined the Franciscan Nardini Sisters at the age of 18. She then trained as a teacher and taught for several years at a convent school. Now aged 35, she is the youngest of the five religious Sisters at Maria Ratschitz Mission.

When Sr Immaculate came to the run-down buildings of Maria Ratschitz Mission in 1998, she was expecting to work at the government primary school near the mission. She discovered, however, that the Education Department was laying off teachers, so there was no job on offer for her.

"There I was, a trained teacher but with no outlet for my skills. Sr Irmingard had started a hospice where there were many people with HIV/AIDS, but I didn't fit in there because I had no training in that field. So I asked myself 'why shouldn't I start some HIV/AIDS education in the schools and the community?'"

First she first had to undertake four months of training in HIV/AIDS counselling, education and home-based care at

government and church training facilities in Ladysmith and Durban. "My worst experience" she recalls, "was when I had to demonstrate how to fit a condom onto a wooden penis. I remember looking at the teacher giving a demonstration and thinking: 'No, I can't do that'. Then my turn came and somehow I was able to do it, but I didn't feel good about it." Since completing her training, Sister Immaculate has dedicated herself entirely to training school teachers, home-based care volunteers and youth leaders in new ways of responding to the challenges of the HIV epidemic.

Sr Immaculate's days are spent mainly in prayer, travelling, teaching and writing. Rising at 4 a.m. every day, she first spends an hour or more in private prayer, before joining the other Sisters for communal prayers in the chapel, followed by Holy Mass at 7 a.m. After (or even before) breakfast she will usually be off to a training workshop somewhere in the district. In the evenings she can usually be found sitting in front of a computer, drafting new teaching materials for workshops, preparing a talk or attending to her correspondence. Her life is so different from what she envisaged when she first came to Maria Ratschitz Mission that she sometimes seems almost unrecognisable to herself:

"People are often shocked by the things I talk about during the workshops. But until I was trained as an AIDS educator I myself would never have used words like 'penis' and 'condom'. I tell people that they should know more about sex and AIDS than I do, because I'm a Catholic nun and I spend most of my time praying. And yet I am the one who has to teach them these things."

patients admitted to the hospice do not die there, but return home in a state of improved physical and mental health. Between June 1999, when the hospice was opened, and December 2001, a total of 63 patients were admitted, of whom only 34 died in the hospice. This is certainly a tribute to the quality of the holistic care which patients receive at the hospice. However, it also reflects the long distances – often well over 100 kilometres – which patients and family members have to travel to reach the hospice. Many people prefer to spend their final days at home, close to their loved ones rather than separated from them.

Mobilising volunteers

The Franciscan Nardini Sisters were clear from the outset that the hospice, on its own, would not be able to meet the needs of the large numbers of chronically ill people, especially those living with HIV, in the area.

There would be an urgent need to train local volunteers to assist sick people living at home, and to educate family members in how to look after their loved ones. As soon as Sr Immaculate had completed her training in home-based care, the Duduza Care Centre started a programme to train home-based care volunteers throughout the whole of Dundee Diocese. Her first task was to recruit people willing to be trained as home-based care volunteers. Initially she did this by visiting Catholic churches on Sundays:

“I would speak to congregations after Mass, explaining the need for home care because our hospice is so small. I mentioned HIV/AIDS but without emphasizing it too much, which would have put people off. I always stressed that it was voluntary work, because I had no money to pay them. They would just have to do the work as good Samaritans.”

People interested in being trained as home-



Sister Immaculate Ndlovu spends her days in prayer, travel, writing and HIV/AIDS training.



Volunteers are trained in home-based care and HIV/AIDS prevention.

based care volunteers would then approach Sr Immaculate after Mass and offer their services. If there were enough volunteers they would then agree on a date for the five-day training course. She always aimed to get a group of 20 people together to be trained. She used no selection criteria – anyone willing to be trained as a volunteer would be accepted for training. Sometimes only a few people came forward after Mass to offer their services, so trainees from two or three congregations came together to make up the numbers.

The first training courses were held at the Duduza Care Centre, where trainees could visit the hospice and meet patients. This proved to be too expensive, however, so courses were then held in local churches, and this is still the pattern. Sr Immaculate either commutes

every day to the training site, or stays in a nearby convent or at the parish priest's house. On a couple of occasions Sr Immaculate has driven to an agreed place to start a course, only to find no trainees at all had turned up:

“I felt very bad,” she recalls, “and I didn’t go back to either place. They haven’t contacted me since then either.”

By the end of 2001, Sr Immaculate had trained a total of 106 volunteers recruited through the Catholic Church. The church’s presence in every local community has been an invaluable asset in identifying and training home-based care volunteers. Surprisingly few volunteers, however, have been recruited from Catholic women’s organisations. Some 90% of volunteers are women, but most are ordinary church members rather than those who are



Sizakele

Home-based care volunteer

When Sizakele Madonsela learned about a case of incest in a family she was visiting, she first went home and prayed about it. She knew the family well. For several months she had been visiting them regularly because the mother was chronically ill. She was in no doubt that the father was sexually abusing his eldest daughter. Finally Sizakele decided she had no choice:

"I went and reported it to the police, and they came and investigated it. The man was charged and the case was taken to court. But the family and all the relatives and neighbours were very upset with me because of that. They didn't confront me about it, but I knew that people were making remarks behind my back. Only a few members of the community supported me."

Sizakele lives in a settlement near Dundee, in an upland area of KwaZulu Natal Province. Now aged 35, married and with three children, she was asked by the nurse at the government health centre if she would be willing to be trained as a home-based care volunteer, to which she agreed:

"I could see that there was a lot of sickness and many deaths in our community, so I thought I should do something to help."

The training was conducted by Sister Immaculate from the Duduza Care Centre. A certificate displayed on the wall of her home testifies to the fact that Sizakele completed the care-givers course. At first she found the work difficult:

"I lacked confidence at first. I didn't know how to approach people, but it's much better now."

Sizakele spends about ten hours a week on home-care work, walking from her house



to the people she visits. In the course of a month she visits about 15 people. She receives no payment or other material reward for this work. On the contrary, she often shares her own family's food and clothes with the people she visits. This has caused some tension within her own family:

"My husband is happy about me doing this work, but he wants to know when I'm going to be paid for it."

A member of the Faith Mission Church, Sizakele reads the Bible a lot and prays every day for herself, her family and other people. She receives no support, however, from her church for her home-based care work.

She often talks about HIV/AIDS and sexual behaviour when she visits families. She encourages condom use, especially when the person concerned has symptoms related to HIV/AIDS. However, she still feels frustrated by the lack of individual openness about HIV and AIDS:

"I encourage people to go for HIV testing, but if they test positive they won't talk about it. There is still a lot of stigma and denial about AIDS around here. No-one is being publicly open about being HIV-positive."

already active in church organisations.

The provincial government's Department of Health heard about Sr Immaculate's training skills, and invited her to train home-based care volunteers recruited through the government's primary health care system. With her customary enthusiasm and energy, Sr Immaculate threw herself into this work as well, and by the end of 2001 she had trained 301 volunteers selected by government nurses.

The training process

From the outset, the training course has lasted eight hours a day for five days. All training is held in the vernacular language, Zulu. The course covers the basic facts about HIV and AIDS, common health problems of people with HIV/AIDS, nutrition, home nursing skills, communication, pastoral care, practical assistance (e.g. fetching firewood and drinking water) and HIV prevention.

Particular attention is given also to dealing with death and bereavement. On these occasions the volunteer has to deal sensitively not only with the grieving members of the deceased person's immediate family, but also with other family members who may come and stay for several days. In this situation the volunteer may feel a sense of rejection, but this can be avoided if she is aware of this possibility and is able to adjust to the changed situation.

Where HIV prevention is concerned, the training course discusses the advantages and disadvantages of the 'A (Abstinence), B (Be faithful), C (Condomize)' recommendations of official government campaigns. The course also provides factual information about condoms,

but takes an integrated, five-pronged approach to HIV/AIDS prevention and care:

- A** = Abstinence from sex before or outside marriage
- B** = Be faithful to one partner
- C** = Change your lifestyle*
- D** = Do not discriminate against people with HIV/AIDS
- E** = Encourage people with HIV/AIDS and give them hope.

This approach to HIV prevention aims to help create a social environment in which people with HIV/AIDS will not feel afraid of revealing their status, at least to a small circle of family members and friends.

The lack of training materials for semi-literate learners has been a problem. In the course of her work, Sr Immaculate has developed her own teaching materials for semi-literate learners. These are about to be published so they can be used in other training programmes.

Ongoing support

Most of the home-based care volunteers trained by Sr Immaculate are supposed to be supervised and supported either by government health workers, or by Catholic priests and religious Sisters. Because of staff limitations, the Duduza Care Centre is able to supervise only 20 volunteers, all of whom are located in and around Matiwane, some 30 kilometres from Maria Ratschitz Mission. At least twice a week, Sr Irmgard makes routine visits to volunteers and patients in Matiwane. In

* Participants are invited to identify what changes in their social and sexual behaviours will reduce their risk of HIV infection, to consider what changes are possible in their circumstances and what support they need to sustain these.



Volunteers display their certificates at the end of a training course.

cases of emergency, the volunteers can also telephone the Care Centre to ask for transport to the hospice or to call Sr Irmingard for medical assistance.

The Matiwane volunteers spend 10-20 hours a week visiting and assisting chronically ill people and their families. They have reactivated the local health and social welfare committees in Matiwane, which previously had been moribund for several years. The volunteers receive no remuneration for this work, but from time to time some ask whether they might be paid in future. The Care Centre has no money available for this purpose yet, but is seeking funds from donor agencies in Europe.

Some local clergy give the volunteers encouragement and moral support. In the Madadeni area, for example, the local Catholic priest meets with the local volunteers and health workers once a month. He is also active in an

interdenominational group of pastors who meet regularly to exchange information and ideas about HIV/AIDS. This degree of involvement by local clergy in HIV/AIDS issues is, however, not yet the norm in Dundee Diocese. Sr Irmingard estimates that, of 29 Catholic priests in Dundee Diocese, only three are actively involved in activities in HIV/AIDS-related activities:

“Most don’t seem to want to touch the topic of HIV/AIDS in meetings or in their sermons. They seem to have a feeling of fear or even of helplessness in the face of this issue.”

The Care Centre is planning to organize an HIV/AIDS workshop for all Catholic clergy and religious Sisters in the Diocese.

The issue of stigma

Based on her regular visits to the volunteers in Matiwane, Sr Irmingard feels that the greatest problem the volunteers still face is that of



Nokuthula

Single mother



Nokuthula Dlamini has known she is HIV-positive for the past 12 months but has not disclosed her status to anyone in her family or her community. Aged 23, single and unemployed, she lives with her four year-old son and her grandmother, whose old-age pension is their main source of income. She is learning to sew, in the hope of earning some money by making and selling clothes.

"My health is not good," she says, "and life is hard because of my family's poor financial status. We can't afford to buy good food and have decent meals. This makes it difficult for me to be positive

about life. Unemployment is a big problem around here, so my hopes of ever getting a job are minimal. Sometimes, with all the difficulties I have, I feel like taking my own life."

Nokuthula used to be visited at home by a home-based care volunteer trained by Sister Immaculate. For the past several months, however, the volunteer herself has been chronically ill and unable to make home visits. Recently the volunteer was admitted to the Duduza Care Centre hospice at Maria Ratschitz Mission, but was discharged after her health improved.

Nokuthula has also spent some time in the hospice, where she was glad to have people she could talk with about her health. Even in the hospice, however, she did not disclose her HIV-positive status to other patients.

Although she jealously guards the secret of her HIV-positive status, Nokuthula believes that other people in her community know about it and therefore despise and reject her:

"People don't say anything bad to me directly, but I'm sure they say nasty things about me behind my back. I left my church because I didn't feel welcome any more. But I still believe in God and pray for a patient, persevering heart."

AIDS-related stigma within the community. Lack of openness about sex is also a constraint:

"There's still too much stigma attached to HIV/AIDS and not enough openness about sex. This makes it difficult for the volunteers to do HIV/AIDS education with family members. They

discuss the general principles of avoiding HIV infection, but they avoid discussing whether a particular family member has HIV or AIDS. It's as though there's a silent acceptance of HIV/AIDS but people don't want to talk about it openly yet. People around here are very

poor, and the volunteers feel that bringing a positive HIV diagnosis could take away their last little bit of hope.”

Because of the stigma attached to HIV/AIDS, the Duduza Care Centre vehicle does not carry a sticker indicating which programme it is part of. Having worked for many years in an STD clinic, Sr Irmingard is struck by the contrast between people’s attitude to STDs and to AIDS:

“I used to see many people with STDs of various kinds, but they never carried

the same stigma as AIDS – perhaps because people still associate AIDS with certain death.”

Yet she believes it is only a matter of time before people become more open about HIV and AIDS as well:

“People welcome the volunteers very warmly. They discuss many other sorts of family matters with them, so it’s only a matter of time before they start discussing AIDS as well. We just have to be patient and practice unconditional love until people feel able to be more open.”

Chapter 8

The Hillcrest AIDS Centre

Programming for ‘unconditional love’

Every morning, from Monday to Friday, Helen Broadway does her bread-run. After taking her daughter to school, she drives to all the supermarkets and bakeries near her home on the outskirts of Durban, asking for whatever bread they can spare. She then takes the loaves and bread rolls she has collected and stores them in the deep freeze at the Hillcrest AIDS Centre.

At first glance, Hillcrest does not look like the sort of place where one would expect to find an AIDS project, especially one serving largely low-income, black communities in a rural area. Nestling in the wooded hills overlooking the city of Durban, its population of about 8,000 is predominantly white and middle class. The

same is true of Hillcrest Methodist Church, a congregation of about 300 people who share a church building and offices with the local Anglican community.

In 1991, Hillcrest Methodist Church started one of the the first faith-based NGOs dedicated to HIV/AIDS work in South Africa. The new organisation was called, unremarkably, the Hillcrest AIDS Centre. Today, the Centre occupies a small corner of the property owned jointly by the Methodist and Anglican churches in the village of Hillcrest. Its buildings are simple and unpretentious: two containers joined together to form a small office and counselling room, and a separate container used as a storeroom.



Staff at the Hillcrest AIDS Centre, one of the first faith-based NGOs dedicated to HIV/AIDS work in South Africa.

The Centre also rents an office in Molweni, a semi-rural settlement about 15 minutes drive from Hillcrest. The whole organisation now has a staff of seven people, supported by about 75 volunteers, most of whom live in rural communities in the Valley of a Thousand Hills, to the north of Hillcrest. During the past decade this small organisation, despite numerous set-backs and threats to its survival, has had a positive impact which its founding members would scarcely have believed possible.

Origins

The Hillcrest AIDS Centre has its origins in an AIDS workshop organised by the Diakonia Council of Churches, based in Durban, in a village near Hillcrest in 1990. At the time, AIDS was little known in South Africa and was widely regarded as a disease affecting gay men abroad rather than heterosexual Africans. During the workshop Dr Daryl Hackland, Director of Medical Services in KwaZulu at the time, made a startling prediction. He warned that an HIV epidemic of huge proportions was already spreading rapidly through the mainly heterosexual population of South Africa, and that KwaZulu was one of the most severely affected areas. A small group from Hillcrest Methodist Church left the workshop convinced that they had to do something about the impending epidemic. The Rev. Neil Oosthuizen, who was pastor of the church at the time, remembers:

“We came away from the workshop feeling that AIDS was going to be a huge problem and that we, as a church, had to be ready for it. We had a strong feeling that God was calling us to do something about this issue.”

But the group did not know what to do next. No-one in the church knew much about AIDS, let alone what sorts of activities they could organize at community level. Nobody in the church had

even met anyone with HIV or AIDS. Yet the group felt committed to doing something and, as Rev. Oosthuizen puts it, “to do the job properly, not as a bunch of do-gooders who know nothing.”

Their first major decision, therefore, was to acquire some practical knowledge and skills that would help them to plan and carry out an AIDS ministry of some kind. Fortunately, the government-funded AIDS Training, Information and Counselling Centre (ATICC) had recently opened in Durban. A group of 16 volunteers, including Rev. Oosthuizen, enrolled for a one-week course in AIDS awareness at ATICC, and eight of this group were later trained in AIDS education and AIDS counselling.

A stumbling start

The Hillcrest AIDS Centre was officially launched on World AIDS Day in 1991. Its initial emphasis was on educating the general public about HIV and AIDS and how the impending epidemic would affect everyone in society. Hillcrest Methodist Church provided office space and some funds to cover running costs, but the work was done by volunteers and Rev. Oosthuizen.

The Centre publicized itself through a mass media campaign, including radio interviews, newspaper stories and advertisements. It was expected that the trained volunteers would take it in turns to answer the phone in the church office, but calls were few and far between. The volunteers therefore phoned up other churches, schools and businesses to offer their services, free of charge, as speakers about AIDS. But the public response was still slow. To give the Centre less of a ‘churchy’ image, the Methodist Church agreed to pay for its relocation to office premises in a Hillcrest shopping centre. The volunteers redoubled their efforts to arouse public interest in HIV and AIDS, but with only

limited success. Moira Cook, a retired school-teacher who speaks fluent Zulu, remembers contacting municipal leaders and chiefs in rural areas:

“They smiled or laughed at the idea of someone – especially a white woman – coming to speak about AIDS and sex, but some of them invited me to come. At first I found the atmosphere a bit threatening, but I was always given a good hearing, although I don’t think many people took what I was saying very seriously. They just didn’t believe that AIDS was going to affect them.”

After 12 months, with little change in client numbers, the experiment of renting office space was deemed to be too expensive and the Centre moved back to the joint Anglican-Methodist premises, but with one important difference: the office was not located in the church buildings, but in a small pre-fab hut in one corner of the garden.

“It was when we made that move,” recalls Rev. Oosthuizen, “that things took off, and I think there were two reasons for that. When we moved into the big office in the shopping centre we were almost denying our heritage as a church-based organisation. When we moved back to the church premises, we were going back to our real ethos. And second, a lot of the people we were trying to reach were from rural communities. They didn’t like going to fancy offices, but they were quite comfortable about visiting our little pre-fab hut.”

Increasing numbers of businesses, schools and rural communities were now inviting the Hillcrest AIDS Centre volunteers to come and give talks or run workshops, using educational materials which the Centre had developed. By the mid-1990s, Hillcrest AIDS Centre volunteers were travelling all over KwaZulu Natal Province to run workshops and give talks. Yet



Moira Cook, who encountered difficulties in her church because of her involvement in the work of the Hillcrest AIDS Centre.

it was by no means plain sailing, as Moira Cook recalls:

“We faced a lot of resistance and even opposition. Our message about sticking to one sexual partner wasn’t popular, especially with the men. At the same time we were doing condom demonstrations and also distributing condoms, which people in our church objected to – some very strenuously. They told me outright that they objected to church premises being used for condom distribution. I gave up doing tea duty after church because so many people were avoiding me.”

In fact very few churches were asking for volunteers from the Hillcrest AIDS Centre to speak at workshops and conferences. Most churches seemed to believe that the Centre supported activities which were, at best, morally dubious. The distribution of condoms from the AIDS Centre office was the greatest bone of

contention, but there were others. At a gay and lesbian film festival in Durban in 1995, for example, Hillcrest AIDS Centre volunteers had a display stand inside the building, while outside other Christians demonstrated vociferously against same-sex relationships. Yet for Linda Knox, manager of the Hillcrest AIDS Centre until 1999, these actions flowed directly from the non-judgmental ethos of the organisation:

“From the start, our whole ethos was unconditional love. Jesus said ‘Love one another as I have loved you’, not with any provisos or conditions. So that’s what we did, even though we got into a lot of trouble for it.”

Counselling, care and support

After the Hillcrest AIDS Centre moved back onto church premises at the end of 1992, people started coming forward in greater numbers for HIV/AIDS counselling. Yet there was a geographical imbalance in the AIDS

Centre’s work. Its location in Hillcrest meant that most people seeking its services had to travel long distances from their homes in rural areas, mainly in the Valley of a Thousand Hills. Two strategies were devised to address this issue.

First, with funding from the KwaZulu Natal Provincial Government, a new office was opened in Molweni, a low-income settlement on the southern edge of the Valley of a Thousand Hills. Here, based in premises rented from the local Methodist Church, two community health workers (CHWs – see box opposite) began to carry out a wide range of HIV/AIDS-related activities, including counselling, education, youth awareness, home visits and income-generating work.

The second strategy was to place the two Molweni-based CHWs, both of whom were trained in HIV/AIDS counselling, for part of their working week in three nearby clinics operated by the Department of Health. This has had the effect of greatly improving the nature

The Methodist Church in Molweni, where the Hillcrest AIDS Centre maintains an office for supporting community outreach activities.





Musa

Community Health Worker

"I've buried so many of my friends and relatives," says Musa. "First we had a decade of political killings. Then the AIDS deaths started and are still continuing. So many members of my family are affected. One uncle and a cousin of mine have already died, and two cousins are dying. I could easily have been dead too. It's only by God's grace that I'm still alive today."

Musa is a 38 year-old community health worker (CHW), based at the Molweni AIDS Centre. It would probably be more accurate to describe him as a multi-purpose HIV/AIDS worker. In the course of his working week he does HIV/AIDS counselling, health education, home-based care supervision, community development, youth work and training.

In Molweni, where he lives with his wife and children, Musa helps the Woza Moya women's group, who make bead badges and grow vegetables for sale. On one or two mornings of the week, he does HIV/AIDS counselling at three different government clinics near Hillcrest. In the afternoons he might help to train counsellors, home-based carers or youth leaders, or visit families affected by HIV/AIDS. Whenever a school, a church or a business phones the Hillcrest AIDS Centre to request a speaker or a workshop facilitator, Musa is likely to be called upon. And when there are special events to organize - sponsored football matches, bicycle rides or choir contests - Musa is always there, in the thick of the action.



"The hardest part of all my work," he says, "is telling a person that they are HIV-positive. People find it difficult to accept a positive HIV diagnosis because of all the stigma and denial that HIV/AIDS still carries.

"When a family's loved one dies of AIDS, they deny the cause of death. They just say he or she died of TB, or diarrhoea or something. In fact they do know the symptoms of AIDS but they don't want to talk about it. Around here there are about six burials every Saturday. People know what's going on but they are still in denial about it. Things are changing but only slowly, because the old customs and culture are still strong in this area."

Despite the disappointments and setbacks which working in the HIV/AIDS field inevitably involves, Musa still enjoys the challenges of his job:

"I especially like going to different kinds of training workshops. It gives me a lot of satisfaction to go out for a week to a course and then come back and implement what I've learned. It uplifts my spirit."

and the quality of the HIV/AIDS counselling provided to people at these clinics, while allowing the nurses to concentrate on clinical care and other issues. In addition, the Hillcrest AIDS Centre's trained counsellor (who is himself HIV-positive) facilitates a support group at one of the government clinics.

The CHWs also began visiting people in their homes. In addition, two registered nurses, based in Hillcrest, were hired to support the CHWs and to provide specialized home-based care when required. But as the HIV epidemic took hold, the demand for home-based care, particularly in rural areas, quickly outgrew the capacity of the project nurses and CHWs to provide.

The Hillcrest AIDS Centre therefore embarked on a programme to train and support home-based care volunteers. The first group to be trained were 16 women from Molweni, all of whom were members of an income-generating group started with the support of the AIDS Centre (see box, Mama Bester, opposite). Groups of 20 women have since been trained in two other rural communities in the Valley of a Thousand Hills. The home-based care volunteers receive no money for their services. After six months of satisfactory service, however, they are given a monthly supply of basic foods, including mealie meal, beans, rice, sugar and tea.

As HIV/AIDS takes an increasingly heavy toll on the lives of breadwinners, more and more families are affected by shortages of food and other necessities. Since the mid-1990s the Hillcrest AIDS Centre has been collecting food from individual families, as well as churches, schools and businesses, to give to extremely needy families, especially those headed by grandmothers or orphaned teenagers. More recently, volunteers have also been collecting



The Hillcrest AIDS Centre supports 300 people a week with food donated by local businesses, churches, schools and individual supporters.

surplus food from local supermarkets, bakeries and food manufacturers.

By the year 2002, the Hillcrest AIDS Centre was supporting 40 families with food parcels every week, feeding about 300 people. Sometimes the food collected is more than required for the families on the AIDS Centre's list of recipients. The Centre therefore gives food to other projects involved in HIV/AIDS work, such as the nearby Thembisa orphan support programme, which supports 90 grandmothers who are caring for orphaned children. Another frequent recipient is the Ark, a large hostel for homeless people (including many with HIV) in Durban.

Modified objectives

As the needs of communities affected by the HIV epidemic have changed, so the objectives of the Hillcrest AIDS Centre have also evolved. By the mid-1990s they were defined as follows:



Mama Bester

Home-based care volunteer

"At first I was afraid of visiting people with HIV," says Mrs Bester Simelane, one of 20 home care volunteers trained by the Hillcrest AIDS Centre in the semi-rural settlement of Molweni. "I didn't know what kind of situation I'd find them in, and I was worried that people would say nasty things about me, you know, calling me 'the one who visits people with AIDS'. My family wasn't happy about me doing the work either, and I was worried that they would be afraid of getting AIDS from me."

Bester is married, and has five children and four grandchildren. It was through the Methodist Church in Molweni, which she attends, that she first became involved in the Woza Moya beadwork and sewing project at Molweni AIDS Centre. This led to her volunteering to be trained as a home-based care-giver. She has found the work demanding but satisfying:

"I visit sick people in their homes every day, and it's no problem. I give them love and hope. We pray and read the Bible together. Now I even do AIDS education with other family members. We talk openly about sex. I encourage the young people not to have sex at all before marriage. But many of them do so anyway, so I advise them to protect themselves if they have sex because otherwise they run the risk of getting AIDS."

The houses and homesteads in Molweni are very far-flung and remote from one another. Bester travels everywhere on foot, sometimes spending a full day to visit only two people. She bathes them, washes their hair, makes their bed and cooks them food. She also encourages other family



members to look after the sick person:

"Sometimes the families want me to do all the work of looking after the sick person. I explain that my job is to show them what to do, but they need to do these things themselves every day."

For the first six months after being trained, Bester received no material support at all from the Hillcrest AIDS Centre, but now she receives mealie meal, rice, beans, sugar and tea every month. As her husband has been unemployed for the past two years, Bester appreciates this assistance:

"It helps a lot when you have nothing else to eat in the house. But when I started, I didn't expect any reward. In fact we were told that we wouldn't be given anything. The work is tiring but I like doing it. It gives me a lot of new knowledge, and also I might be in need of help myself one day. Besides, I feel this is a calling from God. I think God wants me to do this work."

"My family have learned to accept what I do, and the community respect me. They come here and ask me to visit someone, or if they see me in the street they tell me about a relative or a neighbour they'd like me to visit, so I go there. I've never refused to visit anyone. People trust me. They call me 'Mama umbhasophi [carer].'"

- To raise awareness among the people of Hillcrest, Molweni and the Valley of a Thousand Hills that HIV/AIDS is affecting these communities and can be beaten through education, and through caring for people both infected and affected by HIV/AIDS;
- To curb the spread of HIV by targeting innovative HIV/AIDS awareness and education programmes on vulnerable groups, especially youth;
- To break down the barriers that promote the spread of HIV/AIDS, including stigma, prejudice and fear; and
- To provide holistic and unconditional care to those infected and affected by HIV/AIDS in these areas.

Public education and awareness

It is still necessary for the Hillcrest AIDS Centre to devote considerable staff time and resources to informing, motivating and challenging sections of the public about the reality of HIV and AIDS, and of the urgent need for practical action from all sections of society and of government. This is done in several ways:

□ **Workshops:** Staff and volunteers from the AIDS Centre facilitate workshops and give talks at an ever-growing number of schools, businesses, churches, colleges and universities. In the year 2001, for example, representatives of the AIDS Centre facilitated a total of 280 education and awareness workshops involving over 20,000 people in the Greater Durban area. The workshops cover not only the basic facts about HIV/

AIDS care, support and prevention, but also living positively with HIV and what practical steps can be taken by particular sections of society (e.g. churches, schools, workplaces) to respond to the challenges of the epidemic.

At every workshop, the AIDS Centre speaker appeals for support for the work of the Centre. The responses to these appeals are very encouraging. One school, for example, organized a 'knit-a-thon' which produced 56 knitted blankets for families being supported by the Centre. Another school donated the proceeds of their school play, and several others donated food and clothing. A university group donated R2,500, raised from the sale of beaded AIDS ribbon badges which were made by the Woza Moya group in Molweni.

From the outset, the Hillcrest AIDS Centre has made a point of involving people living with HIV/AIDS in giving talks and facilitating workshops. The person who currently does most of this work is Anne Leon, a 'born-again' Christian who has been living with HIV for several years. Anne believes that most AIDS education in South Africa is ineffective, especially with young people:

"Young people are tired of hearing the same old messages about AIDS causing death. They want to talk about sex. But religious leaders are uncomfortable discussing sexual matters with young people, and so are parents."

In all her workshops and talks, Anne addresses various aspects of sexuality and sexual behaviour in an open and honest way:

"I always stress that the best way of avoiding HIV is abstinence before marriage and faithfulness to one's partner. But if people aren't going to abstain it's no use



The annual 'Kick AIDS' soccer tournament in Molweni is a popular event where the Hillcrest AIDS Centre carries out HIV/AIDS awareness-raising.

stopping there. That's why I always talk about condoms. I give people the full facts, and I often demonstrate how to put them on, using a wooden model. In the end, people have to make their own decisions about their sexual behaviour, and they have to accept responsibility for their decisions."

❑ **Special events:** Sporting and cultural activities are organized to reach and involve young people. An annual soccer tournament, 'Kick AIDS', is aimed mainly at young men. Another popular event is the annual Gospel Choir competition, held in Molweni, which involves over 600 young people. Activities are also organized to celebrate special occasions such as World AIDS Day, Women's Day, Youth Day, Condom Week and St Valentine's Day. Some events serve a dual purpose of

fund-raising and raising public awareness: musical and dance evenings, for example, are held to raise funds to provide coffins for families who cannot afford to buy them.

❑ **Mass media:** Extensive use is made of radio, newspapers and magazines to publicize the work of the Centre and to generate more public support. The Centre has also developed HIV/AIDS advertisements which have been painted on public buses – highly visible reminders of the epidemic, which have generated numerous telephone calls from people seeking information and counselling.

❑ **Materials:** Some excellent information and training materials about HIV/AIDS have been developed in South Africa, but these are generally not well distributed. The Hillcrest

AIDS Centre receives many requests for such materials, and therefore distributes posters, pamphlets and training manuals, especially to schools, colleges and universities.

□ **Income-generating activities:** To mitigate the impact of HIV on families that are already poor, the Hillcrest AIDS Centre has initiated several income-generating activities, especially for grandmothers looking after orphans and for widows with young children. About 80 women and a few men – many from the Woza Moya self-help group in Molweni – have been trained in beadwork, fabric painting, sewing and vegetable gardening. Sales of beadwork badges have resulted in substantial pay-outs to these members. A group of 16 people (12 women and four men) earn a living by selling second-hand clothes provided by the AIDS Centre. These income-generating activities have a double benefit. First, the people involved are able to buy food and other daily necessities for

their families; and second, they still have time to look after sick members in their families and communities – either informally or as trained home-based care volunteers.

Resources

With only seven salaried staff (three of whom work only part-time), the Hillcrest AIDS Centre is heavily dependent on the dedication of its volunteers. In Hillcrest itself, 12 volunteers donate anything from a few hours to three or four mornings a week of their time to ensure that the office functions smoothly. The home-based care programme in rural areas depends on 60 volunteer care-givers, who receive monthly supplies of basic food after six months of satisfactory service.

From the outset, Hillcrest Methodist Church has provided the AIDS Centre with financial support, but additional resources have always been needed. The Centre has received financial and material support from several local and



Beadwork is one of several income-generating activities which the Hillcrest AIDS Centre supports in order to help low-income families affected by HIV/AIDS.



Nester*

Mother and volunteer

Nester Mbatha's small house is perched on a steep hillside on the southern edge of the Valley of a Thousand Hills. On one side of the house are four graves - simple mounds of earth covered with thorny branches as protection against scavenging dogs.

"This one," she says, "is my youngest son - he was only 14 months old when he died. This one is my fourth child. This one is my husband, and this one," she adds, after a pause, "is the child my husband had with another woman."

All three children, and Nester's husband, died of AIDS. Nester, who is in her mid-thirties, has known she is HIV-positive since January 1997. She left her husband as soon as she received the HIV-positive diagnosis from the clinic:

"I went to stay with my sister, and I took my children with me. I left my husband because he brought AIDS into our family. Often he would stay out late, spending his money on alcohol and girlfriends."

After her husband died Nester and two of her sons moved back into the family home. She is now at an advanced stage of HIV infection. A nurse from the Hillcrest AIDS Centre visits her regularly. The Centre also provides her with a weekly parcel of food, medicines to boost her immune system, and treatment for opportunistic infections. The local government health centre, however, refuses to give her medical treatment:

"They say they can't afford to treat people like me, who are at an advanced stage of HIV/AIDS. They only give treatment to patients in the early or intermediate stages of the disease."



Nester earns some money by making badges out of coloured beads, which the Hillcrest AIDS Centre buys from her. The Centre is also helping Nester to obtain a government disability grant, and to claim benefits from an employer who dismissed her because of her HIV-positive status. Despite her poverty and fragile health, she feels a responsibility to help other people:

"I've announced my own HIV-positive status in church, and afterwards people came up and hugged me. They were happy because I was open. But the churches aren't doing much to help people with HIV."

Nester also chairs the Ekukhanyeni (There is Light) support group - about 30 people, mostly HIV-positive, who meet weekly in a nearby village to exchange information and give one another mutual support. She is also a volunteer in a home-based HIV/AIDS care project. She is currently visiting three HIV-positive women to give them emotional and social support:

"I encourage them not to drink alcohol, not to smoke, and to avoid sex. Why should a woman with HIV want a man in her life? I certainly don't want one. He would only order me around, and he would ruin my children's future."

* Nester died on 19 January 2002. The Hillcrest AIDS Centre still supports her children with food and other practical assistance.

international sources, but its finances have often been in a precarious state. Linda Knox, the first manager of the Centre, remembers one occasion when its bank account was down to zero:

“It was the day before Christmas and I had to pay the salaries, but we had no money at all. People asked me if I was panicking and I just said ‘no, the Lord will provide’. That same afternoon the Methodist Relief Fund phoned up and said they were putting R16,000 into our bank account! I’m not an extrovert kind of Christian. I’m just a quiet believer, but believing is the bottom line.”

The Centre’s finances are now in the hands of John Lund, a retired bank manager who is the Centre’s Financial Manager as well as a member of the management board. He says:

“I don’t quite know how the organisation survived those financial crises in the past, but it did. We have more funds now, but of course we’re also under an obligation to use them properly.”

Networking and sharing experiences

Churches in KwaZulu Natal have generally been slow to respond to the challenges of HIV/AIDS. In 1996, five years after its foundation, the Hillcrest AIDS Centre was one of only a handful of church-based organisations carrying out HIV/AIDS education, awareness-raising and counselling in the Province, which has the highest prevalence of HIV in South Africa. More and more churches, however, were becoming aware of the serious implications of the HIV epidemic. Increasingly, people from churches, businesses, tertiary institutions and the mass media started visiting the Hillcrest AIDS Centre to learn from its experiences. By 2001, nearly 40-50 visitors were coming to the AIDS Centre every month.

As people in the churches have become more aware of the nature and scope of the HIV epidemic, the open, non-judgemental approach taken by the Hillcrest AIDS Centre has gained greater acceptance. From the mid-1990s onwards, the Centre steadily acquired the reputation of being a model of a holistic approach to HIV/AIDS, based on unconditional love rather than on pre-determined value judgements. Even on issues such as the use of condoms in HIV prevention, the stance taken by the Hillcrest AIDS Centre has become less controversial.

The work of the Centre has become more widely accepted in other ways as well. In 1996 the Diakonia Council of Churches in Durban, with funding from the Department of Health of KwaZulu Natal Province, published the *Basic AIDS Workshop for Churches*⁷ manual and 13 posters which the Hillcrest AIDS Centre had developed. These materials, in English and Zulu, have since been widely distributed in KwaZulu Natal and elsewhere in South Africa.

The Leadership Exposure Programme of the Diakonia Council of Churches takes groups of church leaders to the Hillcrest AIDS Centre and other church-based HIV/AIDS initiatives. The groups view the projects, discuss with the staff and volunteers how they work, and then reflect on their possible relevance to the HIV/AIDS situation in their own communities. The Rev. Andrew Warmback, Organiser of the Leadership Exposure Programme, says:

“The Hillcrest AIDS Centre has been a very good example of a church-based AIDS programme. It’s a challenge to the wider church to take action.”

That challenge is now being taken up by growing numbers of visitors to the Hillcrest AIDS Centre. For example, in early 2001, Diakonia Council of Churches organized a visit to the



Brett

Sales consultant

"I know I contracted HIV from the last guy I was in a relationship with," says 38 year-old Brett Boughardt, who sells concrete slabs and other building products in a shop near Hillcrest.

"We lived together for several years. One day I noticed that he had oral thrush, and I asked him if he had ever been tested for HIV. He told me he had known he was HIV-positive for a few years already. I asked him why he hadn't told me and he said he didn't want to lose me. Then he asked me if I was going to run away and I said no, I would stay with him.

"He went downhill quickly because he wouldn't go for treatment. He knew he was dying but he wouldn't accept help. After he died his parents blamed me for infecting him with HIV, but I know I was 100% clean before I started living with him. But I don't bear him any grudges. I've destroyed the photos of him when he was sick because I just want to preserve the good memories."

After the death of his lover, Brett came to live near Hillcrest. In 1997 he fell ill and was diagnosed HIV-positive:

"The hospital doctor told me that, unless I could pay R6,000 a month for antiretroviral treatment, I should just go home and prepare to die. But he also referred me to a hospital in Durban, where I could get the drugs. At first I wasn't sure whether I wanted to live, but I told my employer that I was HIV-positive, and he was incredibly supportive. He's a member of the Hillcrest Christian Fellowship, and he told me that the people there were praying for me. In fact, through a



computer network, 45,000 people were praying for me. I'm not a church-goer but I am a Christian and those prayers meant a lot to me.

"I also met Anne Leon and Julie Hornby from the Hillcrest AIDS Centre, and they gave me fantastic support with counselling, phoning me up, and bringing me food and medicines. So I started the antiretroviral treatment at the hospital in Durban, and I recovered. I'm in good health again. I'm off the antiretrovirals at the moment but the doctor says I should start taking them again soon. I take Bactrim to prevent chest infections, and two natural remedies to boost my immune system, which I get through the Hillcrest AIDS Centre.

"The counselling I received from the Hillcrest AIDS Centre has helped me a lot. I don't believe I should do to other people what my friend did to me. Whenever I meet a guy and a relationship seems to be on the cards, I tell him that I'm HIV-positive. They all say that's cool, but then they disappear! I'm still looking for another soul-mate. In fact I might have found one - an old school friend whom I met by chance recently. He also happens to be HIV-positive."



The Home of Life hospice, a community initiative supported by the Hillcrest AIDS Centre.

Centre and two other church-based HIV/AIDS programmes by a group of 16 people from four churches in Durban North. The Rev. Roy Govender from Greenwood Park Methodist Church recalls:

“Afterwards we decided to do something along the lines of the Hillcrest AIDS Centre, starting with pre-test and post-test counselling. I offered space in a corner of our church hall, with a telephone, and the Hillcrest AIDS Centre arranged for 20 volunteers from churches in Durban North to be trained as counsellors.”

The Durban North project was launched on World AIDS Day 2000, and during its first year about 175 people were counselled before and after being tested for HIV at a nearby clinic of King Edward Hospital. The project has also started some home-based care work in a neighbouring township. Moreover, two other churches have visited this project, and have decided to start similar activities in their own areas.

The Hillcrest AIDS Centre is also assisting several small-scale HIV/AIDS projects started by committed individuals from small churches in the Valley of a Thousand Hills and other rural areas near Hillcrest. These projects demonstrate extraordinary commitment by the people who initiate them, but they suffer from an extreme lack of material and technical resources.

In the rural community of KwaNyuswa, for example, a group of volunteers have started a home-based care project, Home of Life (*Ikbaya-Lobomi*). With assistance from the Hillcrest AIDS Centre and three local hospitals, 21 young people from Home of Life have been trained in home-based care, and they visit sick people in their neighbourhoods. The group has started a small hospice in a former shebeen, but they have virtually no drugs, no medical equipment and no funds to pay for running costs such as electricity and rent for the building. The only person in the project with any professional qualifications is Patience Mavata, a young staff nurse who



Pearl

Grandmother



At the age of 41, Pearl was diagnosed HIV-positive at a government hospital in Durban. She received no counselling before or after the test:

"I felt as though I'd just been given a death sentence. Fortunately I was with my mother and sister, but they were probably even more shocked than I was. We went home and had a few drinks, and I threw some things around the house."

Pearl's health deteriorated - she developed thrush, ear infections and night sweats. Worse still, neighbours in the block of council flats where she lives put up posters on the walls outside: 'Don't touch Pearl. She's got AIDS'. Her teenage son suffered enormously:

"My son used to take the posters down on the way to school, but he was affected a lot. He started smoking dope and neglecting his school work. My daughter rejected me completely."

Pearl's mother then picked up a leaflet about the Hillcrest AIDS Centre in a hospital waiting room, and phoned to ask for assistance. A registered nurse, Julie Hornby, started visiting Pearl regularly, bringing food parcels every week and

medicines whenever necessary. She was accompanied by a volunteer, Cheryl Goble, who previously had never known anyone with HIV/AIDS.

After a couple of months Cheryl started visiting Pearl on her own. She often chatted with Pearl's son, whom she encouraged not to lose heart but to persevere with his studies. Two years later, he passed his Matriculation examination. Cheryl has also met with Pearl's four siblings, as well as her mother, and helped them all to understand Pearl's situation and problems.

With help from the Hillcrest AIDS Centre, Pearl has also been able to access antiretroviral treatment, free of charge, at King Edward Hospital in Durban:

"I've been on the course for 30 weeks now and it's made a huge difference to my health. I've gained weight, my viral load is down to only 30 and my CD4 count is way up. And because it's a drug trial I don't have to pay. But if it weren't for the Hillcrest AIDS Centre, I wouldn't be here today. If the virus hadn't killed me, I'd have died of starvation."

Pearl is not a church-goer but she believes that the fact that the Hillcrest AIDS Centre is a Christian organisation is important:

"You expect a Christian organisation to treat you like a human being, and they certainly do that. I'm not a very religious person myself. Cheryl and I never pray together, but I do pray for her. And I believe in miracles. I mean, the fact that I've lived to become a grandmother is a miracle, when think of how sick I was a few years ago. And I can even have a glass of wine now and then."

also works at a hospital in Durban. She and her husband, Zimele, support the hospice with their own money and food.

Many other local initiatives have been inspired and assisted by the Hillcrest AIDS Centre. However, the Centre does not yet have the human and financial resources to provide such projects with ongoing support and follow-up, which they need to be both effective and sustainable in the longer term. Moreover, by no means all churches have yet accepted the need to respond to the challenges of the HIV epidemic. The Rev. Nick Kerr, rector of Hillcrest Anglican Church and Vice Chair of the Hillcrest AIDS Centre's board, believes the Centre should work more closely with Zulu-speaking churches in the Valley of a Thousand Hills, where HIV prevalence is high but services are woefully lacking:

“I would like to see the Hillcrest AIDS Centre more involved in church life, especially in the Valley, but I have the feeling that some churches are still keeping the Centre at arm's length.”

Future priorities

In the past decade, the Hillcrest AIDS Centre has made a long and highly eventful journey. It began as a small, obscure church initiative struggling to make its voice heard. It gradually

won the support of businesses, schools, community organisations, the mass media and parts of government, but it was still viewed with suspicion by many churches. In recent years the AIDS Centre has won widespread recognition, especially with mainline churches, for having pioneered a unique and valuable form of AIDS ministry from which other faith-based organisations can draw inspiration and practical guidance.

During the first decade of the twenty-first century, as more and more people develop the clinical symptoms of AIDS, the Hillcrest AIDS Centre will have to decide how to respond to the ever-increasing need for nursing and medical care, and for support for children orphaned by AIDS. New strategies will have to be developed, new programmes planned and new activities implemented in response to the changing needs of local communities. What will remain unchanged is the ethos of the Hillcrest AIDS Centre, which the Chief Executive Officer, Julie Hornby, has aptly expressed as:

“Our priority is to care as Jesus did, through unconditional love. We do this because we're Christians, not to make converts to Christianity.”

Chapter 9

Leading from the front

Two church leaders talk about AIDS

“God’s activist”

A profile of Archbishop Njongonkulu Ndungane



St George’s Anglican Cathedral has long been known as ‘the people’s cathedral’. During the apartheid era this beautiful stone building in central Cape Town was the scene of many inter-faith services in support of South Africa’s oppressed black majority. St George’s is still the venue for inter-faith services focusing on social justice and human rights issues. These days the services are led by Archbishop Njongonkulu Ndungane, who in 1996 succeeded Desmond Tutu as Archbishop of Cape Town.

For Archbishop Ndungane, providing leadership within the church on the AIDS issue was an inescapable consequence of the concerns and values that have long motivated him:

“I’ve always had a deep commitment to social justice and poverty eradication, and that was how I became an AIDS activist. I’ve tried to put a human face on AIDS. All the statistics about the epidemic tend to dazzle us like a rabbit in a car’s headlights. They make us feel helpless. But when we encounter people, especially those who are suffering, we are moved and can act. For me, people matter.

“Because of my concern for people and the impact of stigma on their lives, I decided to have myself tested for HIV and to invite all the members of the House of Bishops in the Anglican Church of the Province of Southern Africa to be tested as well. I believe that everyone should know their HIV status. I also felt that, by embracing the risk of being publicly tested for HIV, we could help to reduce the stigma attached to AIDS.

“AIDS is much more than just a health problem. It’s a problem that challenges everything in people’s lives. Jesus said ‘I came that you might have life and have it abundantly’, but AIDS raises great challenges to that promise. That’s why the church must be concerned about young children and their HIV-positive mothers, child-headed households and orphans. This disease is denying them their future. We need to create environments where children can



Preparing for an inter-faith service at St George's Cathedral, Cape Town: 'the people's cathedral' is the venue for services focusing on social justice and human rights issues.

grow up normally. My vision is of a future that is free of AIDS.

"As a young man, I had a vision of all South Africans sharing equitably the resources which God has given to our nation. In reality, black people were suffering enormous oppression under the apartheid system, so I became involved in movements to change society. As a result, I ended up doing time as a political prisoner on Robben Island*, where I experienced an incredible level of sadism at the hands of our white wardens. But I'll also never forget the white warden who said 'We have tried to break this people's spirit and we have failed. Maybe God is trying to say something to us!' Today, we are in a new South Africa with the most unique and humane Constitution in the world.

So you see, things can change.

"I see a parallel between the AIDS pandemic and the depravity I experienced on Robben Island. There's a sense in which the AIDS pandemic is a darkness over the continent of Africa. Yet there is a miraculous resilience of the human spirit that gives us hope to keep going. We have managed to overcome huge tribulations in the past, and I believe we can overcome this one as well. But it will require stiffened spines, willing hands and strong backs to achieve a generation without AIDS."

Under no illusions

Archbishop Ndungane's approach has always been to lead from the front, even on controversial issues such as the provision of

* A small island near Cape Town where Nelson Mandela and other political prisoners were kept during the period of apartheid rule in South Africa.

South Africa's Treatment Action Campaign

Founded in December 1998, the Treatment Action Campaign (TAC) educates communities about HIV/AIDS, and campaigns for easy public access to HIV/AIDS information, treatments and preventive services at government clinics, hospitals and maternity units.

TAC has a close relationship with St George's Cathedral in Cape Town. In October 2001, for example, TAC organised an inter-faith service in St George's Cathedral to support its campaign to reduce mother-to-child HIV transmission. Zackie Achmat, chairperson of TAC, was one of the speakers at an inter-faith service held at St George's Cathedral, Cape Town, to mark World AIDS Day on 1 December 2001. On the same day, inter-faith services involving TAC were also held in Catholic and Anglican cathedrals in Johannesburg and Durban.

There is growing collaboration between TAC and local churches at community level as well. Through its Project Ulwazi (knowledge), TAC is carrying out HIV/AIDS education and awareness-raising in churches as well as schools, universities, NGOs, trade unions and community groups. It is now increasingly common in Cape Town for a TAC volunteer (several of whom are HIV-positive) to speak at churches on Sundays. Mandla Majola, who coordinates TAC's activities in Western Cape Province, would like the churches to become even more involved:

"Most of the churches are still saying that it's God's will for a person to be HIV-positive, but I beg to differ with that. As much as I respect the power of the Lord, we also have to do something practical on the ground, with the religious sector leading the fight against AIDS."

antiretrovirals and other treatments for people living with HIV/AIDS at government medical facilities. He has led the Anglican Church into alliances with other campaigning organisations, such as the Treatment Action Campaign (TAC – see box above), the Congress of South African Trade Unions (COSATU), the Southern African Catholic Bishops' Conference (SACBC), the South African Council of Churches (SACC), opposition political leaders, and several church and inter-faith organisations. He has, for example, led marches sponsored by TAC to protest against government policies on HIV

treatment issues. This has not endeared him to some in the South African government:

"I have been accused by some in government of political grandstanding. But I am not a politician. I stand for justice out of a deep sense of commitment to people. Like my Lord Jesus, I'm an activist for people. I am God's activist. I'm involved in the AIDS issue because I have a vision of society ordered by God, informed by the Gospel imperatives to love God and to love one another."

Archbishop Ndungane is under no illusions about the magnitude of the tasks facing church

leaders in trying to address the HIV epidemic in Africa:

“The Church is often slow and reluctant to move on AIDS, because it is slow on many human concerns. Like a mighty tortoise moves the Church of God! But the Church has always been conservative. It often retreats to its Seven Last Words: ‘We’ve never done it that way before’. That makes it difficult to get things done as quickly as we would like.

“Some of the difficulty the Church has had is around the issue of sex. There is resistance because sex is about the intimate part of our lives. Sex has been treated as taboo, not suitable for public conversation. But we must continue in our efforts to educate. We must talk with our children. We must teach our youth to take personal responsibility for their lives and

behaviour, and empower them to make life-affirming, life-giving choices.

“The Anglican Church’s commitment to HIV prevention recognizes that all of life is sacred, and that sexual expression of love is a gift from God. We have always affirmed the position of abstinence from sexual expression outside of marriage and of faithfulness within marriage. Nevertheless, AIDS is an avoidable, behavioural, killer disease, and we must teach life-preserving skills to our children and their parents. In the light of our human imperfection, the correct use of condoms is an important strategy for helping to prevent the spread of HIV/AIDS. But the distribution of condoms should always be accompanied by age-specific and culturally sensitive education about all effective ways of preventing the spread of HIV.



Volunteers from the Treatment Action Campaign (TAC): the Anglican Church, led by Archbishop Ndungane, is a key ally in TAC's campaigns for access to HIV/AIDS information, treatment and preventive services in South Africa.

“Without information and education we are ignorant and helpless. Silence about AIDS is equivalent to death. Ignorance can lead to fears that are ludicrous but real. I remember my own first encounter with the idea of AIDS many years ago, at a meeting of the World Council of Churches in the United States. Someone suggested that you could get AIDS from toilet seats, and no-one contradicted that person. I’m very embarrassed whenever I recall how my own fears nearly overcame me, especially when I faced a very long flight back to South Africa, knowing that I would need to use the toilet some time!”

A ministry of caring and hope

In March 2001 the Anglican bishops worldwide, meeting in the United States, asked Archbishop Ndungane to spearhead a campaign to address the HIV epidemic in Africa. Within three months, the Anglican Church of South Africa had organised an historic conference in Johannesburg, attended by archbishops and bishops from 34 African countries, representing 30 million members of the Anglican church in Africa. The conference produced a planning framework for addressing six key areas of concern: prevention, pastoral care, counselling, care, death and dying, and leadership. Archbishop Ndungane is excited about the

prospects for broad-based church activities in his own country, South Africa:

“Change is definitely happening, and it’s a thrill to be part of it. We are launching home-based care with our Mothers Union and the Anglican Women’s Fellowship. We are in the midst of a training plan to empower 90,000 members of these organisations to make a difference in people’s lives. We are also targeting young people. When you consider the fact that, according to a recent survey by loveLife*, 80% of youth in South Africa trust the Church, then you realize what an opportunity we have to make a difference.

“Above all, our AIDS ministry is one of caring. It is based on hope that begins with relationship and is sustained by relationship. No-one should suffer alone, no-one should die alone, and no-one should care alone. Sometimes, all the loss, sorrow and death caused by AIDS seems unbearable. But then, in those dark moments, I realize that I am not alone. We have a ground of hope, who is Jesus. He identified with the poor. He was despised and died on a cross, but even there he ministered to those around him. And death did not overcome him. He was raised triumphantly and he shares his victory with us all.

“Even though we are suffering now, we will not be overcome or vanquished by this pandemic. Our victory will be a generation without AIDS. I will not rest until we reach that day.”

* A consortium of five non-governmental organisations, funded by the Kaiser Foundation, the South African Government and UNICEF, to improve reproductive health and address HIV/AIDS, especially amongst youth.

“The Church has AIDS”

An interview with Bishop Kevin Dowling



Kevin Dowling is Bishop of the Catholic Diocese of Rustenburg, in South Africa's North West Province. As Liaison Bishop for the AIDS Office of the Southern African Catholic Bishops' Conference, he has an influential role in the AIDS ministry of the Catholic Church in southern Africa. Bishop Dowling is also at the centre of a vigorous debate within the Catholic Church in southern Africa about the use of condoms in HIV/AIDS prevention. Strategies for Hope editor, Glen Williams, interviewed Bishop Dowling:

How has the Catholic Church been affected by the HIV epidemic?

“We as a church community have AIDS. It's not as though the church is ‘out there’, doing something for people with AIDS, while we ourselves are unaffected. No – we as a community are deeply affected by this epidemic. You can see how affected we are by all the funerals that take place every weekend now. We can't pretend to be blind to it. We need to view ourselves as the body of Christ with

AIDS. The church has AIDS. Our people are living, suffering and dying because of this disease.”

And how has the Catholic Church responded?

“We've always been at the coalface of the compassionate response to health and social problems. When there's a need on the ground and people are suffering, then you'll have the religious Sisters, in particular, and many people making a caring, compassionate response. We do that in a whole variety of creative ways – such as home care, orphan care and ministering to the dying. We've always been good at that, as have other church communities, and our AIDS Office is supporting many responses of that kind.

“Where we are still struggling, I believe, is in the areas of morality and theology surrounding HIV prevention. How do we theologise and proclaim a message about morality in a way which is meaningful, a way that reaches people where they are? It's tempting to take what appears to be the pharisaical approach of merely saying ‘if you want to avoid AIDS, keep God's law’. It's easy to have simplistic attitudes, and I've experienced that in the church.

“But that kind of approach is blind to the realities of life for millions of poor people. It's blind to the situation of so many women, for example, who have lost their partners or been ditched by their partners after testing HIV-positive, trying to survive and keep their children alive by taking the opportunity of an overnight liaison with a man. Unless one meets people living in poverty, really listens to

them and tries to understand their situation, one is going to have a skewed theology and a skewed morality as well. We must theologise in what is a very complex situation.

“In a way it’s easier to just get moving and do something practical about relieving people’s suffering. But to actually look at the moral and theological questions that arise out of this horrific epidemic is very challenging.”

What implications does the HIV epidemic have for the teachings of the Catholic Church in relation to, say, the sacredness of human life?

“The way we care for people, especially for people who are dying in desperate conditions, is terribly important. Their lives, even though they are ebbing away, are utterly sacred. We need to care for them in such a way that they have the certainty that, no matter what has happened in their lives, the God who is waiting for them is not a judgemental God, but a God who loves and treasures them.

“The whole debate in which I became involved in recent months touches on some of these issues. What I was trying to articulate was that the protection of human life in the AIDS pandemic also demands a response in the way we communicate our theology and our moral perspective. We have to start grappling with the issue of people who don’t accept – or feel unable to live up to – some of our ideals, like abstinence before marriage and faithfulness within marriage. If people cannot or won’t live up to those moral imperatives as the only sure way of preventing HIV transmission, how do we deal with that?

“We can just say they are wrong and should change their behaviour. But we live in a world where many people choose not to live according to the values espoused by the church. And

especially in our southern African region, there are so many poor people, women and girl children whose socio-economic and cultural situation takes away their options and choices. In those situations, I believe that people living with HIV must be invited and challenged to use a condom in order to prevent the transmission of potential death to another person, or to protect themselves from infection, especially in abusive and destructive relationships.

“If we simply proclaim a message that condoms cannot be used under any circumstances, then I believe people will find it difficult to believe that we, as a church, are committed to a compassionate and caring response to those who are suffering, often in appalling living conditions. For me, the condom issue is not simply a matter of chastity but of justice. In this terrible pandemic, should we focus all our efforts on proclaiming an ethic of sexuality, or should we not also focus on an ethic of preserving and saving life? In my view, we should not compound one failure, in terms of chastity, with another failure, in terms of justice, by not taking the means to prevent the transmission of death.

“So, as I stated at the beginning of this debate, we have to give people full, accurate information about the means of HIV prevention that are available, within the context of the values and ideals that we proclaim. And we have to try to inform people’s consciences so they can make decisions about their sexual behaviour that will truly protect the sacredness of life.”

Is there much misinformation going around about condoms?

“Yes, there are some red herrings around. Obviously condoms are not 100% effective. Nobody would pretend that. But then to say that, because they are not 100% effective, they

Bishop Kevin Dowling with church workers: “For me, God is manifested in people.”



should not be used at all is a leap in the wrong direction. Scientific studies show that, given the enormity of the AIDS pandemic, especially in sub-Saharan Africa, proper and consistent use of condoms is a significant means of reducing HIV transmission.

“For us in the Catholic Church, the moral issue we have to grapple with is that condoms are seen primarily as a means of contraception. But this is not an insuperable obstacle. In *Humanae Vitae**, paragraph 15, it is made clear that contraceptives such as the pill can be prescribed for irregular menstrual cycles or painful periods. In my view, the condom should be viewed in the same way, as something that is incidentally a contraceptive but whose primary purpose in this dreadful pandemic is to prevent the transmission of death.

“Apart from proclaiming the ideals of abstinence before marriage and faithfulness

within marriage – which we do proclaim – the condom is the only way in which HIV transmission can be significantly reduced. If life is sacred, then surely God is challenging us in the church to proclaim a message whereby we can save at least some lives. So I think we really have to keep debating this in terms of the moral and social teachings of the Catholic Church, and the debate is on.”

How is God manifested in the era of HIV and AIDS?

“For me, God is manifested in people. God is incarnate, God dwells among the people. God is in every situation – in the chaos, the struggle and the mess of life. God is never, ever separated from us. Jesus came and was called Emmanuel – ‘God among us’. So for me, God is a suffering God, one who’s feeling pain because God is to be seen and experienced in people. This is the

* Papal encyclical issued by Pope Paul VI in 1968.

God who articulates God's presence through the hope, the cry and the pain of God's people in the AIDS pandemic. We don't have to look anywhere beyond the reality of the situation to find God, as well as the tremendous opportunities it provides for revealing a God of compassion."

Is there much common ground between Christians, Moslems, other faiths and practitioners of traditional African religion with regard to HIV/AIDS?

"I think we could find a lot of common ground. The theological starting points of the different religious faiths would obviously be different, but we would share fundamental values like respect for life, the sacredness of the human being and the importance of the community. Traditional African healers also have an enormous role to play in a community response to the AIDS pandemic, through their healing methods and the use of herbs, but also because of what they can contribute to enhancing traditional *ubuntu* values, which emphasise the importance of relationships with other people."

What are the greatest challenges that you face in your own AIDS ministry?

"I could identify several. There's the culture of silence and stigma surrounding the pandemic at all levels. There's trying to support home care volunteers who are grappling with these problems at community level, reaching out to people who are excluded and rejected, especially single women. How can we best support these volunteers, themselves poor, who feel called to voluntary service to others? There's the issue of access to treatments, especially of medical treatment to prevent mother-to-child transmission of HIV. One of our greatest challenges is the orphan issue. We face the

prospect of a young, uneducated population entering the next 20 years. We have to turn around the mentality of whole communities so that they can cope with the millions of orphans that we're going to have during the next 10 or 20 years. That will require a massive effort."

What has given you most cause for feeling optimistic?

"The fact that there are many thousands of people, from different faith communities, who have a real sense of calling to respond to the challenges of the AIDS pandemic. Externally it might seem that they have a very simple faith, but when you go into it you find it's very integrated and it's something which is very empowering. I don't see Christian belief in an isolationist mode of a person all alone, purely believing and depending on their faith. For me, Christian belief is always in the context of a believing community, and that is where the hope comes from.

"I remember taking someone to visit the home care volunteers in some squatter camps in our diocese. At the end of the day she asked them 'How can you keep doing this – living and working with people who are dying in such horrendous conditions?' The response was so utterly simple: 'God is with us here. God is in us. We sense that God wants us to do this. We pray together and get strength from the support we get from one another, and from God.' It's a very simple faith but the community dimension in that faith is very strong."

Has the epidemic ever caused you to doubt your own faith?

"It's impacted very strongly upon me in the sense of having to question whether my own faith is relevant to the situation. What do I say to our

overworked Sisters and other health personnel, who are at risk of pricking themselves when taking a drip out of an HIV-positive patient? How can I avoid just mouthing platitudes when I talk with our home care volunteers, who look to me for leadership and support? What presence do I give which provides them with some meaningful support? There's also the lack of financial resources – how can the volunteers continue without some kind of material support to help them and their families survive? How do we replace these people? How do we maintain the spirit of it all?

“The issues are so great that sometimes one is tempted to think that it's all too much.

But then the faith dimension kicks in. When I meet the home care volunteers, or the nursing Sisters, or my colleagues at the AIDS Office, I come away feeling enriched. I believe that, if more people with a sense of calling come forward for this work, or ministry, we can turn the situation around. As a church leader, I see my own role as being a supportive, caring person for those who are doing the critical work on the ground. If I can be a friend, a colleague, a person who really shares their journey, then that's what life and the church are all about. So yes, the AIDS pandemic has profoundly challenged me in all kinds of ways, but it's never overcome me.”

Chapter 10

Empowering faith communities

We are not powerless in the face of the HIV epidemic. It is possible to move the mountains of fear, stigma, indifference, ignorance and inaction that surround HIV/AIDS and threaten the survival and well-being of millions of people throughout southern Africa. The churches, Christian organisations and individuals whose work is described in this book are demonstrating how this can be achieved.

Many HIV/AIDS activities can be carried out by secular organisations as well as those with a church or other faith background. All the initiatives described in this book, however, have one thing in common: their reliance on the resources of Christian faith and spirituality as a source of motivation to reach out to people in need. This is a uniquely valuable resource for addressing the spiritual, emotional

and social needs of people infected and affected by disease.

It is not only the scale of the HIV epidemic which presents a fundamental challenge to the countries of sub-Saharan Africa, but also its long-term duration. The impact of HIV/AIDS on the health, living standards, morale and general well-being of many millions of people in sub-Saharan Africa will be deep and long-lasting. Moreover, most of the damage caused by HIV/AIDS is amongst populations living in economically impoverished conditions.

The people of faith whose work is described in this book have demonstrated enormous personal commitment, resilience and an infectious enthusiasm which inspires those around them. These qualities are based, not on a desire for material rewards, but on Christian

Pastors and church volunteers in Chimoio, Mozambique: committed to responding to the challenges of the HIV/AIDS epidemic.



faith and moral convictions which sustain their involvement, despite the disappointments and set-backs which they encounter in the course of their work. They have committed themselves to the task of responding to the challenges of the HIV epidemic, especially amongst the poor and disadvantaged, in the full knowledge that this is a demanding commitment for the long term.

The role of people living with HIV/AIDS

The stories of HIV-positive people of faith such as Betty Strauss (page 18), Linda Sambata (page 41) and Nester Mbatha (page 83) are powerful reminders of the importance of involving people living with HIV/AIDS in efforts to combat the HIV epidemic at all levels. Their openness has helped to break the silence and reduce the stigma which is generally associated with HIV and AIDS. Indeed, many people are dying of preventable or manageable health problems simply because they do not dare to come out and access the information, skills and services which they need to live positively with HIV.

The destigmatisation of HIV/AIDS and the acceptance of people living HIV are essential preconditions for preventing the further spread of the epidemic. HIV-related stigma and the rejection of people with HIV, however, are rooted in the judgemental attitudes and inhibitions about sexuality which are prevalent in many churches and other faith-based organisations. Such organisations therefore have a particular responsibility to combat stigma and to promote the acceptance of people living with HIV.

Phumzile Zondi's statement (page 34) challenges the attitude among many church leaders of automatically assuming that people living with HIV/AIDS must have loose morals. She also appeals for greater openness by HIV-

positive church leaders about their own HIV status. Although potentially more vulnerable because of their openness, HIV-positive church leaders can actually be highly effective as HIV/AIDS educators, campaigners, counsellors and providers of spiritual support to those affected by the HIV epidemic.

Fresh Biblical interpretations

Each generation in the church has to ask itself whether the ways in which it is proclaiming its theology are meaningful, relevant and life-affirming. In the past, church leaders – mostly men – have largely overlooked women's needs and problems and undervalued their potential contribution to the life of faith communities and society at large. Some church leaders interpret parts of the Bible (for example, the Genesis story of 'the Fall of Man') in ways that blame women in particular for sin, and even for sexual immorality. It is refreshing, therefore, to discover the ground-breaking work being done by women in South Africa (see page 31) who are meeting to study the Bible and to understand what God is saying to them. Since many people still regard HIV/AIDS as a punishment for loose sexual behaviour, the journeys of faith on which these women have embarked are particularly significant.

Societal constraints

Churches and other faith-based organisations are carrying out courageous and inspirational work in response to the HIV epidemic in Mozambique, Namibia and South Africa. And yet, as this book has demonstrated, these efforts are still hampered by deep-rooted societal constraints. Faith communities are by no means immune to attitudes, beliefs, values and practices within society at large. On the

The Umtata Women's Theology Group: meeting to study the Bible and understand what God is saying to them in the era of HIV/AIDS.



contrary, the ways in which they respond to HIV/AIDS are influenced by 'external' factors such as:

❑ **Stigma and rejection:** The massive stigma still attached to HIV often results in people with HIV being rejected by families, neighbours, workmates and friends. Fear of rejection therefore prevents many people from being open about their HIV-positive status. In many situations there are genuine grounds for this fear; in others, however, it may be the result of 'self-stigma'. There is an urgent need for churches and other faith-based organisations to help create a safe and caring environment, in which people feel encouraged to know their HIV status, and if they are HIV-positive to talk about it and seek the support they need to live positively and productively.

❑ **Discrimination:** As Nester's story (page 83) demonstrates, people with HIV are still being discriminated against at some hospitals. Discrimination also exists in many workplaces. Churches and other faith-based organisations should be at the forefront of movements to

protect the human rights of people with HIV/AIDS in all walks of life.

❑ **Denial:** The reality of rejection and discrimination fuels denial, especially by youth and young adults, of both the possibility of HIV infection and the magnitude of the impact of the epidemic. This is hugely counter-productive for both HIV prevention and the care of people living with HIV/AIDS.

❑ **Traditional culture:** Traditional culture, in which men are allowed considerable sexual freedom, is often invoked as a justification for men having unprotected sex with numerous partners. As a result, many women who have only one sexual partner are at high risk of contracting HIV from their husbands. Home-based care programmes, which depend largely on women volunteers recruited through the churches, are losing some of their most able and dedicated personnel in this way.

❑ **Fatalism:** In communities with high levels of HIV prevalence, many people have come to regard HIV as something from which they cannot

escape. They notice that the funerals they attend are often of people they know – including their friends and age-mates – so death through AIDS seems almost inevitable. Fatalism undermines their desire for self-preservation. The churches have a particular responsibility for overcoming this attitude by proclaiming their messages of hope, faith, perseverance, courage and willpower. Even in communities with high levels of HIV prevalence, most people will not be HIV-positive. Churches therefore can combat fatalism by encouraging their members to know their HIV status through voluntary counselling and testing.

Weaknesses within faith communities

Within churches and other faith communities there are several factors – including particular beliefs, traditions and taboos – which undermine efforts to respond to all aspects of the HIV epidemic in the most effective ways. These include, for example:

□ **Uneasiness about sex:** The uneasiness still felt by church leaders and groups regarding the issues of sex, sexuality and sexual health makes it difficult for such issues to be discussed within the church context. Because of their social background and professional training, many church leaders are not adequately prepared for the delicate task of talking about sex in public. Church leaders who attended the Global Consultation on the Ecumenical Response to the Challenge of HIV/AIDS in Africa in Nairobi in November 2001 frankly admitted the extent of this problem:

“Today, churches are being obliged to acknowledge that we have – however unwittingly – contributed both actively and passively to the spread of the virus. Our difficulty in addressing issues of sex and sexuality has often made it



Overcoming stigma and rejection: in Rundu, Namibia, the Lironga Eparu support group organised an ecumenical church service to express support for people living with HIV.

painful for us to engage, in any honest and realistic way, with issues of sex education and prevention”.⁸

It is high time for church groups and other faith-based organisations to re-think their strategies for helping people to understand sexual issues. The case studies documented in this book show that this can be done in sensitive, culturally appropriate ways.

□ **Judgementalism:** Many church-going people automatically assume that people living with HIV are sexually promiscuous and therefore to blame for their condition, as well as being guilty of spreading the virus to others. As church leaders at the Global Consultation in Nairobi stated:

“Our tendency to exclude others, our interpretation of the scriptures and our theology of sin have all combined to promote the stigmatisation, exclusion and suffering of people with HIV or AIDS. This has undermined the

effectiveness of care, education and prevention efforts and inflicted additional suffering on those already affected by HIV.”⁹

Judgementalism of this kind, rather than unconditional love, is the order of the day in many churches. This attitude, which is often based on a narrow interpretation of Biblical verses, drives people who know themselves to be HIV-positive to conceal their status because they fear rejection and discrimination. It also discourages those who do not know their HIV status from being tested. Part of being ‘AIDS competent’ is the ability to understand that there is no automatic link between HIV infection and sexual ‘immorality’.

❑ **The condom issue:** The tensions and hesitations which surround the issue of condom education, promotion and usage as a means of HIV prevention still sap much of the collective energy that should be fuelling the church’s response to the HIV epidemic. As Bishop Kevin Dowling says (pages 95-96), debates on this topic are often beset by misinformation. Some religious leaders justify their opposition to condoms on the basis of inaccurate information about their supposed ineffectiveness in preventing HIV transmission. Many also argue that promoting condom use will encourage sexual promiscuity, although there is no empirical evidence that this is the case. Growing numbers of church leaders, however, see no contradiction between proclaiming the Christian ideal of the sanctity of sex within the commitment of marriage, and advocating condom use in the context of HIV prevention. The debate on the condom issue continues within church circles.

❑ **Low knowledge levels among clergy:** Amongst many church leaders, low levels of

knowledge about HIV/AIDS are a serious constraint on HIV/AIDS programmes. In fact many church leaders in southern Africa have had little or no formal training in theology or pastoral care, and some are not able even to read and write. They are therefore not easily reachable through training activities, such as workshops and distance learning programmes, which require literacy skills. For such church leaders, functional literacy classes may be essential to increased knowledge and awareness of HIV/AIDS and related issues.

❑ **Lack of learning materials:** There is an acute shortage of learning and educational materials to support programmes to train members of churches and other faith-based organisations in HIV/AIDS awareness and skills. Sometimes materials have been produced but do not use language sensitive to religious values, or are not available in the languages spoken by the people being trained. Even when good



Training workshop for church leaders in Cape Town: there is a lack of appropriate HIV/AIDS learning materials, especially in local languages, for church leaders.

quality materials are available, their distribution usually leaves much to be desired. Church leaders and organisations need to encourage the production, adaptation and distribution of HIV/AIDS learning and educational materials, especially in local languages.

❑ The ‘not my problem’ attitude:

There is a deep-seated unwillingness amongst many church-going people to accept that the HIV epidemic affects them, either directly or indirectly. AIDS is viewed as something affecting ‘other people’ – especially those of other races or of a different sexual orientation. This is a common attitude in the early stages of the HIV epidemic in particular communities. However, as HIV/AIDS claims more and more lives – including those of church-going people and their children – the short-sightedness of this attitude becomes increasingly clear.

❑ Confusion and lack of confidence:

Many church-going people lack the self-confidence to take some action in response to the HIV epidemic, or are uncertain about what they can do to make a difference. This is understandable, given the sheer magnitude of the epidemic and the complexity of the problems it creates. It is important, therefore, to document and share whatever information is available about how local churches and communities can make a difference to the lives of people affected or infected by HIV/AIDS.

Orphans and other vulnerable children

Care and support for orphans and other vulnerable children feature prominently in the work of several church-based organisations whose work is described in this book. The immensity of the task of responding to the



Orphans in Chimoio, Mozambique: churches and other faith-based organisations are well placed to support orphans and other vulnerable children.

problems and needs of children affected by the HIV epidemic cannot be over-stated. It is surely one of the greatest challenges faced by governments, communities, international agencies and faith-based organisations at the start of the twenty-first century.

It is often said that facing up to adversity can make people strong, but it is difficult to imagine how this could apply to children orphaned by AIDS. The emotional stress of seeing one’s parents die of a debilitating disease, of growing up without parental love and guidance, of being deprived of education or vocational training, of lacking food and other basic necessities of life, and in many cases being exposed to violence and sexual abuse – all these consequences of the HIV epidemic leave deep wounds in a child’s psyche which even the passage of time may not be able to erase.

Christians have a particular responsibility

for children: “Suffer the little children and let them come unto me,” said Jesus. Churches must ask themselves whether they are doing all in their power to protect orphans and other children whose lives are being blighted by the suffering and premature death of their parents due to AIDS. All is not yet lost. Children have an amazing resilience to cope even in the most trying circumstances, as demonstrated in this book, for example, by the work of the Tumelong Orphan Haven (page 3), Catholic AIDS Action (page 13) and Kubatsirana (page 49).

Churches and other faith-based organisations are particularly well placed to support orphans and other vulnerable children. As the case studies of these book demonstrate, many other sections of society are willing to help such organisations in a wide variety of ways, for example, by donating food, money, buildings, equipment, time and expert advice. Still lacking, however, is a clear commitment on the part of many churches and other faith-based organisations to respond to the needs of the many orphans and other children affected by the HIV epidemic. The small centres of excellence that have been developed in some places must be promoted and multiplied on a national and international scale.

Church leadership and HIV/AIDS

The interviews with Archbishop Ndungane (page 89) and Bishop Dowling (page 94) demonstrate the importance of leadership by example, especially in the willingness of these two religious leaders to explore previously untrodden paths in the search for truth and effective strategies for responding to the new challenges of the HIV epidemic. These church leaders also emphasize the need to go beyond individual morality to address social, economic

and political issues that are directly related to HIV/AIDS. These issues include, in particular, unequal access to treatment for HIV-related conditions, global trade injustices, crippling debt burdens and the vast gaps between the ‘haves’ and the ‘have-nots’ throughout the world.

Aid for faith-based HIV/AIDS programmes

Some international agencies, NGOs and government aid agencies refuse to fund faith-based HIV/AIDS programmes on the grounds that they are sectarian, in other words, that they benefit only the members of one faith community. The statement by faith-based organisations to the UN General Assembly Special Session on HIV/AIDS in June 2001 highlighted this problem:

“In many cases, religious organisations and people of faith have been among the first to respond to the basic needs of people affected by the disease [HIV/AIDS], and indeed have pioneered much of the community-based work. And yet these FBOs are often overlooked. More often than not, the capacity of FBOs has not been maximised because we have not received adequate levels of training or resources to address the impact of the disease.”¹⁰

In reality, the overwhelming majority of faith-based programmes are not selective: they benefit the members of different faith communities, and also people with no religious affiliation. All the organisations whose work is described in this book provide services to everyone, regardless of what religious faith they happen to profess.

Building on success

Journeys of Faith has shown that efforts by church-based organisations to respond to the challenges of the HIV epidemic can be



Public rally after the March of Hope for Namibia's orphans, organised in Windhoek by Catholic AIDS Action, with the participation of many different churches and community groups. More alliances and partnerships of this kind need to be built.

successful, provided there is openness, dialogue, vision and commitment. Leadership by example is a powerful motivating force. This was demonstrated dramatically by Archbishop Ndungane, Head of the Anglican Church in southern Africa, who had himself and his bishops tested for HIV.

Initiatives can also start at community level, as shown by the Hillcrest AIDS Centre near Durban, the Full Gospel Church of God in Guguletu (Cape Town), and Kubatsirana in Chimoio, Mozambique. Women from churches in South Africa have demonstrated how Bible study can inspire people of faith to become involved in HIV/AIDS work.

Some churches have strong institutional structures that can be used to develop programmes quickly over a wide area. In Namibia, for example, Catholic AIDS Action has been

able to achieve national coverage, within a short period of time, by building on the church's existing infrastructure of parishes, dioceses, schools, health facilities and other institutions.

These initiatives are increasingly regarded as models from which other church groups can learn, but the learning process urgently needs to be accelerated. If any significant impact is to be made against the tide of the HIV epidemic in southern Africa, the successful HIV/AIDS initiatives undertaken by churches and other faith-based organisations need to be expanded and multiplied so they reach every community and individual. It would be a tragedy if these models were to remain 'islands of excellence' surrounded by a sea of denial, apathy, fatalism and confusion.

Alliance-building across denominational and faith barriers will be a key strategy for expanding

the response of churches and other faith-based organisations to the challenges of the HIV epidemic. This book has clearly demonstrated what can be achieved. The Orphan Haven of Tumelong Mission in South Africa shows how Anglicans, Catholics and other Christian denominations can work harmoniously within the same organisation. The Duduza Care Centre in KwaZulu Natal, South Africa, has trained hundreds of home care volunteers for local government health centres. Catholic AIDS Action in Namibia employs more non-Catholic than Catholic staff, and has trained almost as many Protestant as Catholic volunteer home-based care givers. The Hillcrest AIDS Centre, although sponsored by the Methodist Church, works closely with several other Christian denominations. In Chimoio, Mozambique, Kubatsirana has brought together 74 different churches in a joint HIV/AIDS programme.

Churches and other faith-based organisations in sub-Saharan Africa have greater potential than any other section of society to reach people in all walks of life with information, skills and services for coping with the multi-faceted impact of the HIV epidemic, and to prevent its further spread. To transform this potential into effective

activities on the huge scale required demands urgent action at two levels:

First, many churches and other faith-based organisations will have to address the denial, judgementalism, misconceptions and inhibitions about sexual issues which still inhibit their capacity to take effective action in response to the challenges of HIV/AIDS.

Second, those who control the flow of financial and technical resources into HIV/AIDS programmes at national and global level should take full advantage of all the opportunities offered by well informed churches and other faith-based organisations to strengthen community responses to the HIV epidemic.

Is this too much to hope for? When the initiatives documented in this book started, their originators often faced obstacles that were daunting in the extreme. Yet they embarked on journeys of faith that have been blessed in more ways than they ever imagined. They still face problems and constraints of many kinds, but they are travelling in hope towards their shared goal of a world where AIDS no longer blights the lives of millions. We can all join this journey of faith. Every journey, no matter how long or short, starts with just one small step.

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Series Editor: Glen Williams

THE AUTHORS

Canon Gideon Byamugisha is a priest in the Church of Uganda and the author of several books about HIV/AIDS and the church.

Lucy Y. Steinitz, PhD, has over 20 years of experience in social services, and has been National Coordinator of Catholic AIDS Action in Namibia since its founding in 1998.

Glen Williams is a writer about international health and development, and is editor of the Strategies for Hope Series, based in Oxford, U.K.

Phumzile Zondi is Coordinator of the Women & Gender Programme at the Institute for the Study of the Bible, University of Natal, Pietermaritzburg, South Africa.

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