TRAUMATIC STIGMatisAtiOn AND rEJEction OF MiGRANT MiNE LABOURERS DUE TO HIV AND AIDS iN THE WELKOM AREA. A PASTORAL CARE PERSPECTiVE

DEsERTATION iN PARTiAL FuLFiLMEMENT FOR THE DEGREE OF MASTER OF ARTS

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I

Declaration

I declare that this mini-dissertation, submitted in partial fulfillment of the Degree of Master of Arts in Practical Theology, is my original work, that all sources of reference and assistance have been acknowledged, AND that it has not previously been submitted to any other university.

Student: Job Lempye Sempane

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UNIVERSITY OF PRETORIA

PRETORIA

APRIL 2011
This research is dedicated to the migrant mine labourers in the Welkom mines, who have been diagnosed with HIV/AIDS. Some of them died very destitute without anyone looking after them. Their willingness and openness about their HIV status positively contributed to the finality of this work.

My co-researcher, who has been addressed by the pseudonym Zama, who passed away before the submission of this research. (May his soul rest in peace). His openness, commitment and understanding has helped me to understand the plight and trauma that the migrant mine labourers experience whilst away from home, without a shoulder to lean on.

Lastly, this work is dedicated to my brother in Christ, the late Rev Makgalane Jonathan Mohlala (may his soul rest in peace). A committed Methodist Minister and a class mate during our Honours and Masters Programmes, Rev. Mohlala was eager to see his research completed but unfortunately death cut his life’s journey short before he could realise the fulfillment of his academic dream. It was during his funeral service that I was challenged to complete this piece of work.

“Where, o death, is your Victory?
Where, o death, is your sting?”
The sting of death is sin, and the power of sin is the law.
But thanks be to God!
He gives us victory through our Lord Jesus Christ.”
(I Cor 15:55-57)
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Acknowledgements

There are many people who have contributed to the completion of this work and it would be impossible to acknowledge them all. However, I would like to mention few people whose contribution stood above the rest.

- I would like to mention the Rev. Prof MJS Masango who played an important role not only to my academic work BUT as a spiritual mentor and counsellor. “Ngiyabonga, phondo libomvu lika Masango.”
- Pastoral Care class, especially the Masters and Doctoral students. I humbly acknowledge and thank their contribution in shaping this work, especially their criticisms which helped to sharpen my pastoral care arguments.
- I’m deeply indebted to three ladies i.e. Lorraine Mochebelele, Karabo Nhlapo and Lucia Mabunda. These ladies tirelessly typed my notes, sometimes struggling to make sense of my hand-writing. I would like to thank them from the very bottom of my heart for their patience and generosity with their spare time.

Last but not least, I wish to thank my wife Kehumile (‘Mateng) and my two sons, Letlotlo (Tsona) and Tlotliso (Tsimane). I thank them for the space they created for me to concentrate on my studies, their support which enabled me to continue as a husband, father and student at the same time.
Abstract and Summary

This research focuses on the lives of migrant mine labourers in the Free State Gold mines of Welkom. After a lengthy absence from home, away from home, some of the migrant mine labourers contact the deadly disease of HIV/AIDS. As they become weaker to work at the mines, some are relegated work at the surface, some are sent to the local hospice whilst some are left to die alone without anyone caring for them.

The local community of Welkom regarded these miners as the carriers and transporters of this deadly disease due to their perceived slackness in morality by using the services of the local ladies of the night (commercial sex workers).

On the basis of the above painted scenario, the migrant mine labourers were thus subjected to discrimination and stigmatisation by the local community, who regarded them as foreigners even in their country of birth.

The research, therefore, aimed to pastorally journey with the infected mine labourers through their trauma of being infected by HIV/AIDS AND of being discriminated and rejected by the community which is supposed to support them in their hour of need and despair.

Since the spread of HIV/AIDS is largely through sexual contact, the research, therefore, examined both the community and the church’s attitude towards sex, stigma and discrimination. A participatory
observation approach was used and the analysis of the concepts that were at play during the trauma of the infected mine labourers were examined.

In this research, the local community was viewed as the fertile ground of hostility against the infected migrant mine labourers. In this regard, the study powered the infected mining community with the challenges posed by HIV/AIDS and therefore sought ways and means of forming a support base for those infected and affected. This was done by breaking the conspiracy of silence around the issue of HIV/AIDS both at the community and the church level.

Finally, the study concluded with ways of empowering the pastoral care-giver on how to journey with someone who has been diagnosed with HIV in order to close one’s last chapter of life in honour and dignity. New approaches based on relevant literature and affirmation of God’s power and healing were suggested.
Research keywords

**Migrants**
People who come from all over the country and neighbouring countries who come to the cities and mining areas in search of work.

**Compounds**
Migrant mine labourer’s place of residence, normally these are single sex hostels at the mine premises.

**Stigma**
Refers to any meaning or set of values associated with someone perceived as having HIV.

**Trauma**
Trauma is a broad topic that encompasses many forms, taking the form of physical, sexual and/or emotional abuse and torture. In the research, it is referred to an event that disturbs the normal way of living.

**Church**
The local community of believers

**Opportunistic Infections**
The infections that develop to HIV infection.
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**Infected** In the research, the infected is referred to as someone who has been diagnosed with HIV.

**Racism** Refers to negative discrimination on the basis of physical characteristics, religion or culture of an individual or a group.

**Ladies of the night** Sex workers/prostitutes

**Magama mathathu** Three words, referring to HIV. This is a Fanagalo lingua (Fanagalo is the language used in the mines which is a combination of a number of languages in order to enhance communication amongst the miners).
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>HIV</td>
<td>Human immuno-deficiency Virus</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>PLWHA</td>
<td>People living with HIV and AIDS</td>
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<td>NGO</td>
<td>Non Governmental Organisations</td>
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<td>STD</td>
<td>Sexually Transmitted Disease</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>ARV</td>
<td>Anti-retroviral Medication</td>
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<tr>
<td>WCC</td>
<td>World Council of churches</td>
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1.1 BACKGROUND OF THE STUDY

Every ministry has its roots. My personal pilgrimage in the field of HIV/AIDS intensified in Welkom where I laboured amongst the miners as a pastor amongst the miners. Although I had read newspapers and magazine accounts of the growing AIDS pandemic amongst our people, mostly homosexuals, I had never expected to find a person living with HIV/AIDS in my ministry path.

AIDS was simply not my issue of calling. However, the day I met Zama (pseudonym) (person living with HIV/AIDS), was the beginning of the HIV/AIDS ministry for me. I was uninformed about HIV/AIDS, and had unresolved prejudices in my attitude towards the infected. The problem I was facing was my conservative theology, which could not include sinners in ministry.

As a Methodist Pastor, I’m assigned pastoral oversight over the Inner City Mission, basically pastoring to mainly migrant labourers at the mines in Welkom (Welkom is regarded as the Free State Goldfields). The miners came as far as Lesotho, Mozambique, Malawi and some parts of the former Transkei region for employment and my task was to pastor the emigrants during their stay of employment.

With the declining economy, mining is no longer producing gold like it used to and the price of gold has drastically dropped in the international markets. This found many labourers being retrenched at a larger scale. Poverty, unemployment and the HIV/AIDS scourge have devastated the City of Welkom and the city is now reduced to a shadow of its former self.

The once vibrant mine shafts that used to produce the most precious mineral (gold) have been closed. Some of them have been turned
into hospices because of the rampant scourge of HIV/AIDS, while others have been transformed into orphanages in order to cater for orphans left behind by the pandemic.

Against this background, that is where I met Zama at the hospice in St Helena hospital. A wealthy and happily married young man in his heydays, Zama came from the rural Eastern Cape in the former Transkei. He was discharged from working in the mines, when he was diagnosed with full-blown AIDS. He could not carry himself any longer because of the sickness. He was literally a shadow of his former self.

Those who used to hang around with him during “his” days as a Mine boss suddenly deserted him, not wanting to associate with him any longer. Even fellow mine bosses who used to check him on a regular basis, suddenly reduced their visits preferring only to phone the ward matron at the hospice to enquire if he was still alive. The above incident reminded one of an idiom that says “**when days are dark, friends are few**”. As I came to the hospice for a visit, he said in a fading voice: “**Mfundisi, andinamtu**” (Pastor, I don’t have anyone).

In this case, stigmatization and isolation played a crucial role. The author is reminded of the man at the pool of Bethesda. He had no one to help him into the pool when the water was stirred. (John 5: 1-7). As Zama lay on the hospital bed, he kept asking himself many questions that probably made his health to deteriorate even further, questions like:

- How will his family react to his condition?
- How will his family accept him back home and care for him?
• How will his community treat him as he is?
• Will God still regard him as his child after being diagnosed with HIV/AIDS?
1.2 PROBLEM STATEMENT

Migration and AIDS are two of the crucial social issues facing today’s changing world, posing unique difficulties for any discussion of a stigmatized disease – AIDS –, and an often stigmatized group of migrant labourers. In their book, Crossing Borders, Haour-Knispe and Rector state that the patterns of migration are in a state of considerable flux. Throughout the world, escalating civil unrest, wars, ethnic cleansing, ecological changes, economic imbalances, individual search for a better life or just plain restlessness and curiosity, push or pull people to relocate (P.1). However, for the purpose of this study, which forms the problem statement, migrant labourers in the Welkom area are of a particular concern to the local community. Firstly, these migrant labourers are perceived as carriers and spreaders of the deadly HIV pandemic on the local community. Many who work in the mines as migrant labourers often feel the brunt of being finger pointed and always referred to by the local community as “not of us”. All these insults result in their stigmatization and rejection by the local community especially in the case of those diagnosed to be living with the virus.

As migration is a complex phenomenon, migrant labourers relocate permanently or temporarily or vice versa. In either case, migrant labourers leave their families behind in search of economic sustenance, acquire the virus at their place of work and transport it back home, thus spreading the scourge of the pandemic. On the other hand, as their work contract ends, the local community
especially women, are left with the deadly disease and the children who are born fatherless and infected with the HIV/AIDS virus. **Thirdly**, the most complex challenge confronting modern society has raised basic questions about the rights of individuals versus those of the society and the nature of societal response to HIV/AIDS. These questions may be summarized as follows:

- How do we empower or educate the migrant workers about the danger of HIV/AIDS?
- How do we journey with the infected and affected in leading a positive life-style after diagnosis?
- How do we educate or empower the local community of Welkom to accept the mineworkers who have been diagnosed with HIV/AIDS in order to combat stigmatizing and rejecting them in the community?
- And lastly, how do we engage the local church towards a theology of accepting the infected in order to pastorally help them close their last chapter of life in honour and indignity?

These questions helped the author in researching the issues of rejection, which leads to stigma.

1.3 **RESEARCH GAP**

A lot of research has been made on the subject of HIV/AIDS and the focus of these researches have been on the cause of the pandemic, how it is transmitted and largely on the management of the disease. Few researchers have concentrated on the response of the church to the pandemic, setting out a curriculum to help the churches and individuals to deal with it as T.M Maluleke did in his article published
in the WCC publication (2003:5).
No study has been done on the traumatic experience of migrant labourers especially mine workers in the Welkom area due to the stigmatization and rejection by the local community. This study therefore envisages to dwell very much on the trauma experienced by this group of people and the pain of being regarded a foreigner in their own country of origin simply because they have acquired the incurable disease called Aids.

**THE RELEVANCE OF THE RESEARCH**

Firstly, During the first twenty-five years since the advent of HIV/AIDS on the global scene, Christianity has been dominated by an exclusive, judgemental perspective, contradictory to the character or essence of the church – which is to rise to a pastoral model that will heal the infected and empower the pastoral care givers to deal with the issue of HIV/AIDS in the community. This has to be done since the church community regard HIV/AIDS as a curse or punishment from God, thus perpetuating the theology of exclusiveness. Those diagnosed to be infected are regarded as promiscuous and outcasts which is contradicting to the gospel of Christ which states the acceptance of all regardless.

**Secondly**, the objective of the study is to empower the community to break the conspiracy of silence. By doing this, the community of Welkom will be empowered to move away from denial to constructive pastoral engagement. As someone who comes from the Black African traditional background, it is difficult to initiate any topic regarding sex education. One is always confronted with statements like: “don’t talk about sex, we are Africans” or “don’t talk about sex,
we are Christians”. This research will tackle the issue of sex education as taboo to the African people. Jonathan Mann, the first director of the World Health Organisation Global program on Aids, once suggested that every person and society undergoes three stages of reaction to HIV/AIDS i.e.:

1. Denial that there is a problem;
2. Minimisation of the problem’s significance; and
3. Emergence of constructive engagement to solve the challenges (1991).

For the community to become forever in denial about the presence of HIV/AIDS and not becoming constructively engaged, we do not only contribute to the denial and minimization stage but also promote and reinforce the levels of discrimination and stigmatization.

**Thirdly**, the aim of this study is to provide basic information on the relationship between human rights and HIV/AIDS. Human rights are defined as basic standards without which people cannot live life in dignity as human beings and it is clear that HIV/AIDS impacts not only on the physical health of individuals but also their social identity. This makes HIV/AIDS different from other diseases. The stigma and discrimination surrounding HIV/AIDS can be destructive as the disease itself as it often results in human rights abuses. Tackling this issue will be done by empowering the local community to accept the migrant labourers who live with HIV/AIDS. The study will also seek to empower the employer with tools to support the mine workers who have acquired the disease.
This will be done by means of making the working conditions suitable to those who have being diagnosed as such.
1.5 METHODOLOGY

This study was based on the participant observation approach with a view to investigate a phenomenon that is already in existence, and attempting to correct it, thus providing guidance. This model was used within the framework of qualitative strategy of information gathering and interpretation.

Firstly, the study concentrated on the mine workers who contacted HIV infection whilst at work in the Welkom area. The study used the qualitative method in order to examine the question of how migrant labourers in the Welkom area were affected by stigmatisation and discrimination by the local community, which cause their trauma. The area of focus was to look at their thoughts, feelings, attitudes and perceptions. By using a qualitative approach (method), an attempt was made to understand their traumatic experience on a subjective perspective. This was done by interviewing mine workers who have been diagnosed with HIV.

Observation and listening are the easiest ways to gain information about the pandemic, whereby the infected will tell their stories and identify their troubling issues. In order to enter into someone else’s world, one has to have skills and respect their view of that world and the way to enter into such a world is through active listening (Gerkin 1997:188). Essentially, qualitative interview is ideological. Due to the nature of the disease, a semi-structured interview was used, whereby the researcher prepared a number of specific open-ended questions to present uniformity to each of the participants.
This type of interview was especially appropriate when the experience is so deeply habituated or the participant is very insecure. The results of this type of interview tend to be cognitive and informational as distinct from emotional and experiential. The major advantage of this method is the ease of its analysis, its categories are already identified by each question, and the researcher has only to organise the material within each question (see appendix A, for the interview questions).

Secondly, a questionnaire focusing on the community of Welkom was be used randomly for data collection in order to determine their perception regarding migrant labourers in the mines. Twenty (20) community members were selected randomly to ensure that people at different levels of society were represented, and their views/opinions were taken into account regarding stigmatisation and discrimination of mine labourers living with HIV and AIDS in their area. The results of the questionnaire were presented and analysed. This method was selected on the grounds of its suitability to the qualification of results and the anonymous participation of respondents (see appendix B, for the questionnaire).

Thirdly, one of the advantages of qualitative research methodology is that it should be sensitive to the human situation, thus involving an empathetic dialogue with the infected and contribute to their emancipation and empowerment. This advantage is demonstrated by Campbell’s model of pastoral care. In his book “Rediscovering pastoral care”, Campbell’s point of departure is informed by the conviction that, firstly, pastoral care is about human relationships and as such, it touches individual experiences and personal values.
He suggested that pastoral care is about shepherding. The imaginary of a “shepherd”, according to Campbell embraces all that is involved in providing care as illustrated in the biblical usage of the term. It is depended upon a caring attitude towards others which comes from our own experiences of pain, fear and loss and our own release from their deadening grip (1986:37).

He then argued that the “wounded healer” gains power by acknowledging weaknesses and by finding God’s healing force at the moment of deepest despair. There is no shortcut to such healing, no hope without fear, no resurrection without tomb’s deep darkness” (1986:41-42). He finally concluded his thoughts by pointing out that it is only by acknowledging our wounds and confronting our own finitude that “we too, in a small way, can be healers of others”. This approach will go a long way in bringing hope and comfort to those discriminated and stigmatised due to the scourge of HIV and AIDS. It will also kick start a process of acceptance by the community to the infected because “healing which comes within a community of sufferers, where weakness is freely acknowledged, is where the love of God enters” (1986:46).

1.6 POTENTIAL LIMITATIONS/PROBLEMS OF THE RESEARCH

There were various limitations to the research that must be considered, and these may have had an impact on the findings of the research. They are briefly tabled as follows:-

- Due to the nature of the disease, there was difficulty in accessing people living with HIV/AIDS, which is naturally
related to the issues of confidentiality and disclosure. For this study, PLHAS were accessed through the local mine hospice who have undergone some training and counselling to deal with issues related to HIV/AIDS. While an attempt was made to access the other group (non-hospice aligned PLHAS) this was not successful.

- Capturing the community’s discriminatory attitudes seemed very difficult. There’s a significant difference between responses when people are asked individually as opposed to in a group. It is clear that most, if not all, people would not openly admit that they discriminated against people living with HIV/AIDS.

- While no conscious effort was made by the researcher to focus only on one racial group, the group participants were all male Africans due to the mine population dynamics and other dynamics in the area rather than for any other reason.

- Finally, due to the small sample size, the research cannot be generalised to all communities of South Africa, where mine workers are found. However, the findings are indicative and provide a very useful insight into HIV/AIDS stigmatisation and isolation in communities throughout South Africa where mines are located.
Chapter 1.7 Summary

Stigma not only makes it more difficult for people trying to come to terms with HIV and manage their illness on a personalised level, but it also interferes with attempts to fight the AIDS epidemic as a whole. Stigma and fear of negative community reaction can hinder efforts to address the AIDS epidemic by perpetuating the wall of silence and shame surrounding the epidemic. Community level stigma and discrimination towards people living with HIV/AIDS is found all over the world. A community’s reaction to somebody living with HIV/AIDS can have a huge effect on that person’s life. If the reaction is hostile, a person may be ostracised and discriminated against and may be forced to leave their home, or change their daily activities such as work and socialising. This research, therefore, envisaged combating such discrimination and rejection which is meted-out to people who have been diagnosed as infected especially migrant mine labourers.

The most important aspect of this research was on maintaining the confidentiality of people living with HIV/AIDS, their names, location and identity were changed in a way that people may not know who is being discussed. In journeying with these people (people living with HIV/AIDS), the pastoral caregiver carefully considered the benefits of their participation for research process AND ensured that careful consideration on all personal circumstances was taken into account.
CHAPTER 2

2.1 TRAUMA: DEFINITION OF THE TERM

Mitchell (1983) describes trauma as any critical situation faced by a person that causes him/her to experience an unusually strong emotional reaction, which has the potential to interfere with his/her ability to function either at the scene or later (1983: 36). According to Reber (1995:814) trauma means “wound” and it is a term used for physical injury caused by some direct external force or for psychological injury caused by some extreme emotional assault. Faud (in Wilson, 1993) referred to the subjective meaning of trauma as a feeling of helplessness (1993: 201). An incidence like to be diagnosed HIV positive is traumatic and because of this external precipitate, people always have certain emotions related to a traumatic incident. It should be noted that stress reactions after this traumatic incidence are not pathological but rather normal. Figley quoted by Wilson (1993:201), defines trauma reaction as an emotional state of discomfort and stress resulting from memories of an extra-ordinary, catastrophic experience, which shatters the survivor’s sense of invulnerability to harm. A traumatic incident like HIV/AIDS can also be described as a critical one. A crisis or traumatic life event like that disturbs the normal way of living, thus it can be described as a sudden interruption in the normal course of events and necessitates re-evaluation of modes of action and thought. The emotions the
said party may experience can include shock, helplessness and confusion.

Trauma is a broad topic that encompasses many forms, intensities and degrees of hurt – taking the form of physical, sexual and/or emotional abuse and torture, human-induced trauma is a special category of trauma. This trauma is best described as an expression of evil. By moving beyond trauma to evil help, we shift our thinking. It encourages us to consider the powerful forces within persons and our culture that set the stage from potential acts of cruelty against others, without losing sight of the tremendous impact that violence and abuse have on particular persons. Such shift also moves us beyond the psychological and physical dimensions of life where the focus on trauma can limit us into the moral, ethical and spiritual dimensions (Means 2000:1).

This type of trauma becomes evil as it is manifested in and through abuse and violence perpetrated by persons against others. In the light of the above argument presented by means, a suggestion is made that in some instances trauma can become evil since trauma leads to numbness, shock and temporary disorientation whereas evil threaten, attack and desecrate the integrity of the relational nature of life. These forces lead to behavioral expressions of abuse and violence toward self and others; and support and exacerbate the already fractured lives of the sufferer.
Internationally and also in South Africa, we are faced with trauma, such as hijacking, armed robbery, rape, murder, suicide, divorce and other acts of violence on a daily basis. It is important that the survivor of a traumatic incident receives psychological help as soon as possible to help them regain balance in their lives. Psychological intervention should focus on immediate help for the survivor as a normal and healthy person in an abnormal situation. During and after the traumatic incident, a person can experience feelings of aggression, frustration, guilt and vulnerability that sometimes manifest as an inability to stop crying, helplessness and concentration problems. The immobilizing influences of these emotions on the living emphasise the importance of trauma debriefing as an intervention to help survivors to deal with the traumatic incident.

2.2 TRAUMA IN HIV/AIDS

Trauma in HIV/AIDS patients can best be described in terms of both wounding and susceptibility of a person to the wound as Hopper (2000:54) puts it. Some of these wounds in a patient leave scars that may never heal completely. The survivor will need to comfort their powerlessness and beginning to learn how to live with the lasting reminder of a loss. The wound and scars in a traumatized person will be associated with the profound emotional and behavioral disturbances of hysteria. In this sense, trauma seems to be regarded as a psychic wound
resulting from an event so horrifying that the individual is unable to assimilate into normal conscious awareness. A common effect of this experience is that it can change a person’s sense of security and trust in the world and other people.

HIV/AIDS is traumatic. Any person who has been diagnosed to be as such is faced with a traumatic situation. Actually, any terminal illness is traumatic because it fades away any hopes of life, death seems to be eminent and hope vanishes as a result. Teseschi & Calhaom in their book, Trauma & Transformation, describe trauma as a shock event that changes our psychological well being. The authors further acknowledge that all these unexpected events leave people affected, powerless and more likely to challenge their human nature.

With regard to why of being diagnosed with HIV is so traumatic can be captured in the following characteristics:

- The diagnosis is traumatic because it happens suddenly. More often than not, HIV affects those in the prime of their lives; those economically active; and- above- all those that society still expected so much from them. In this case, there’s limited or no time to prepare, to devise and rehearse a plan to cope, identify a method of escape and avoiding the effects being diagnosed as much. This sudden situation leaves the person living with HIV/AIDS temporarily or permanently immobilised.

- **Secondly**, the diagnosis is traumatic because of its dangerous nature. It is emotionally dangerous to the infected as it is to those caring for such a person. Fear of death and destruction of
future plans become an organising element of life, which has the potential of leaving a devastating imprint on the memory of all those who experienced the effects of the disease.

- **Thirdly**, the event is emotionally overwhelming. The individual’s attention to the demands of the environment, be it work, family or some other setting, is so continuously aroused that he becomes ineffective in dealing with all the demands of life. This may lead the person living with HIV/AIDS to behave in a way that is inconsistent with his self-concept, which may be wished to belong to the realm of the forgotten.

In my pastoral passage, while working with people living with HIV/AIDS, I find them, generally, to be deeply spiritual. As a stigmatized and outcast group, they often relate to the God of healing and deliverance persuaded by their traumatic situation. The other reason is that: facing the traumatic prospects of an early death, people living with HIV/AIDS often engage in a new and personal search for spiritual values, meaning and purpose.

2.3 **A THEOLOGICAL REFLECTION ON HIV/AIDS**

Although the research was not in the field of systematic theology, it was imperative to look into some of the theological aspects that may empower the Christian community in order to shape their pastoral care approach regarding this epidemic, particularly those who live with it. The AIDS pandemic provides an opportunity to the Christian community to visibly live out our
testimony about who Christ is and about what he can do for the people. The phenomenal growth of Christianity in the first four centuries was partly due to the way in which the early Christians supported and cared for the ill during times of severe epidemics. It is like-wise in our era of HIV/AIDS. It is the researcher's humble submission that this research will assist churches to become involved in projects involving people living with HIV/AIDS and that others will begin to see the love of Christ that constrains the church.

The HIV/AIDS epidemic has underlined that as Christians we see only in part (1 cor 13:9-19) and that the church, as the body of Christ is also infected and affected by the epidemic, as its members suffer in silence and die. The church also needs healing. A number of perspectives highlight the need for the church to repent and re-dedicate herself to the Gospel of Christ. These perspectives can be tabled as follows:-

**Firstly**, the church interpreted HIV/AIDS as a punishment for sin, thus adding and perpetuating stigmatization and isolation to the infected and affected from quality care and support.

There is no mention of HIV/AIDS in the Hebrew bible. One disease mentioned in the Hebrew bible, which offers some parallels with HIV/AIDS because it, too, is widespread and contagious is tsara’at, some kind of skin disease. The word tsara’at is traditionally translated “Leprosy”. Consequently, it is not possible on the basis of the Hebrew bible to regard an illness such as HIV/AIDS as a divine punishment for wrongdoing. Instead, it must be acknowledged that the
situation is considerably more complex and perplexing. Casting aspersions about the moral character of any person infected with HIV/AIDS is, therefore, unjust and unacceptable. According to the Torah, the ill and the vulnerable are to be treated with kindness and compassion (Lev. 19:14). Furthermore, the Hebrew Bible is clear about the fact that the spread of the disease must be contained. HIV/AIDS is different to the condition referred to in the Hebrew Bible as “Leprosy” in that it can be transmitted only through the exchange of bodily fluids. In accordance to the Levitical law (interpreted here analogously), it is the responsibility of all those who know (or suspect) themselves to be HIV positive to prevent the spread of the virus.

Secondly, the tradition of silence and negative perception of human sexuality has led to conflicting messages and unresolved approach in the area of safer sex and HIV/AIDS prevention. Based on the church’s insistence on sexual purity as the sole answer to the scourge of AIDS, the biblical perspective of sacredness of all human life has not received adequate attention. Perhaps the reason why the church finds it difficult to handle sex and sexuality related issues is because we have considered sex as belonging to the domain outside of God. The church seems to be comfortable with the fact that sex education is the responsibility of government, schools and NGO’s, and sex thus, remains taboo for the church. Even our African cultures have perpetuated this present state of affairs.
The tragic separation of sexuality and spirituality can be traced back to the early church theologians, whereby theologians like Augustine in his writing, *The city of God*, viewed human sexuality in a negative way (book 14, chapter 14-16). Augustine even suggested that Paul’s warning, “For this is the will of God, your sanctification, that you abstain from fornication, that you know how to control your own body in holiness and honour, not with lustful passion like the gentiles who do not know God” (1 Thess 4:3-5), should be interpreted as meaning that a man who desires holiness would prefer, if possible, to “beget children without lust of this kind”. To this day through the negative view of the church on sexual matters, Christians feel that this sexuality is nature’s strongest competition for their loyalty to God, the reasoning being that a Christian cannot love both God and sex. The message of abstinence and faithfulness needs to be distinguished. It is a message that needs to be understood against the background of a desire to build human character. When it comes to the African context, Mercy Oduyoye reminds us that spiritual needs are as important for the body as bodily needs are for the soul (1979:111). Such an acknowledgement will help us understand the scourge of HIV/AIDS in a holistic manner. The issue affects and touches on everything in life and any effective tackling of the problem needs to take this into consideration.

**Thirdly**, while HIV/AIDS is more than just an individual issue, but also a social and structural epidemic, the church’s capitalization on the messages of abstinence and faithfulness
have indicated its failure to assume its prophetic role. The church has not adequately and prophetically addressed the social epidemic of poverty, war, gender inequality, and discrimination on the basis of racial/ethnic and sexual orientation, which is the fertile soil of HIV/AIDS.

**Fourthly**, the church has also been riddled by insufficient knowledge, insufficient counselling skills, limited financial resources and managerial skills to combat the issue of HIV/AIDS. The disease, therefore, challenges the church to a new and fresh theology, intense research and rethinking of our lives around the message of Christ’s healing and restoration of our human dignity.

It is becoming inescapably clear to churches that the gospel should call the Christian community to examine what it can do to help. The church has a vitally important role to play at several different levels i.e.

- With the wide network of congregational meetings every week it can play a valuable role in increasing awareness and transmitting basic information about HIV/AIDS.
- Because the church is a body, like Christ, it should have a concern for the poor and the ill, the widow and the orphan and also play a major role to the people in need.
- Because the church is an education community where people are learning the meaning of being human, of being Disciples of Christ himself, it can and should engage in discussions and give advice on the future control of the
The church as the body of Christ is a community of healing and compassion (WCC, 1997:77). By preaching the good news of Jesus Christ, the church espouses the message of social, individual, national and international wholeness. Its close connection with individuals, families and the community, its availability even in the remote areas, has put it in the centre of HIV/AIDS care.

The global AIDS emergency compels us to reclaim the essence of the church. The very being of the church of Jesus Christ requires the inclusion of all God’s people. The church as koinonia, as true fellowship, is violated when some Christian believers are excluded, stigmatized and suffer discrimination because of the church’s teachings and actions. The very message of the church is at stake when people are excluded from God’s mission and ministry. Inclusiveness is not optional for Christians but rather a way of being; which is a basic element of our faith in Jesus Christ and our Christian identity. Inclusiveness is a pre-condition for the church’s distinguishing marks set forth in the Nicene Creed: “one, holy, catholic and apostolic church”. This unity, holiness and universality of the church flow from Christ’s inclusive gospel.

Discrimination and stigmatization of persons who live with HIV and AIDS is immoral and these attitudes are contrary to the teachings of Jesus. Rev Jape Heat, an Anglican priest who lives with HIV/AIDS, echoes this sentiment. The Priest, who
disclosed his status publicly and also to the church, linked stigma and discrimination to what he described as the church’s double standards when it came to the concept of “sin”. He asserts that lying and cheating on tax returns were considered “socially acceptable”, while HIV was equated with being caught in adulting. The church has been exceptionally good at being judgemental, Heat said (IRIN 22 September 2003).

The African bishops and other church leaders made a declaration at a World Council of Churches consultation held in Nairobi, Kenya in 2001, that HIV/AIDS has exposed fault lines that reach to the heart of our theology, our ethics, our liturgy and our practice to ministry. The declaration further said: our tendency to exclude others, our interpretation of the scriptures and our theology of sin have all been combined to promote stigmatization, 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. Given the extreme urgency of the situation and the conviction that the churches do have a distinctive role to play in the response to the pandemic, what is needed is a rethinking of our mission, and the transformation of our structures and ways of working (WCC, 2001:25-28).

2.4 HIV/AIDS IN AN AFRICAN CONTEXT

How do we understand Aids and what causes Aids? Why do some people become infected and others not? Quotes like these are often informed and answered by our belief systems
Our belief systems are shaped by many factors, including our cultural, religious and ethnic background. Belief systems impact directly on how we understand health and respond to illness. They influence how we make sense of the causes of disease and help us to understand how healing takes place. Every community has well-established ways of maintaining health, preventing disease and treating the sick. Some individuals understand disease to be caused by magical and spiritual forces, others draw from their scientific reasoning and some apply both models.

In explaining, preventing, treating and managing HIV/AIDS in South Africa, different cultures and belief systems are collided, often with serious consequences. The belief in the African setup is that HIV/AIDS is a European disease brought about by the Europeans. A sangoma from Botswana where I once laboured as a pastor, argued that Aids is a new manifestation of an old disease that has re-emerged because people (particularly young women) have rejected or abandoned their culture or traditional practices that may have regulated their sexuality and sexual practices. According to T. Mohlala of the Mail and Guardian as quoted by L. Walker, G. Reid and M. Cornell, he argues that in traditional Setswana medicine, people do not believe in the existence of Aids. There are no Aids and if it is there, it is made by makgowa (whites) because of the many things they recommend to be used (WCC, 2001: 96). Central to Mohlala’s argument is that the notion of Aids has been around for sometime, although in different forms. This is apparent in
the idea that inappropriate sex practice is potentially polluting or contaminating, resulting in a sexually transmitted disease. In a black set-up for example, sexually transmitted diseases are seen and understood to be due to the pollution incurred through breaking sexual taboos (meila). Sexual practices are regulated through a set of taboos that, if ignored or broken, will result in the disease.

HIV/AIDS epidemic in the African set-up is well suited to interpretation through the paradigm of witchcraft because of its elusive, mysterious, difficult to understand and constantly changing in addition to be incurable. It affects the most vulnerable, poor, the youth and the “blameless”. This fuels the suspicions of witchcraft.

The particular witchcraft to which HIV/AIDS is attributed to is “sejeso” (African poison). “Sejeso” is intentionally placed in food intended for the victim, which results in sickness or even death. Witchcraft interpretation of HIV/AIDS can have an extremely negative impact – suspicions are aroused when young, energetic and sometimes-affluent people die. Sometimes such allegations often result in social isolation and violence against older people who may be suspected of witchcraft.

The stigma associated with AIDS is often more likely to be about witchcraft than about sex. With regards to both Aids and witchcraft, silence is the norm (2001: 100). The author here reiterates the fact that the common reaction in many families who have come into contact with the disease is that of denial;
therefore silence becomes part of a recognised strategy to ward off the shame of Aids. Where HIV/AIDS is associated with witchcraft, openness about HIV status would be unlikely if not impossible. This seriously limits efforts to de-stigmatise the disease and encourage families and communities to accept their HIV infected members. It is not surprising that HIV infected individuals are often shunned and rejected. Louw in his book *Illness as crisis and challenge* says that pastoral care in an African context must be seen as a social and community issue (1994:21). He asserts that in the traditional approach of pastoral counselling, the individual stands in the centre of a network of relationships. This means that when one person is sick in the traditional set-up, the whole community becomes affected. In the case of someone being infected with the HIV/AIDS virus, the family as well as the community becomes affected. This is clearly demonstrated by the way African people greet each other, when they enquire, “How are you”. The “you” in this case is in plural form to include everybody at home. Illness and health are thus part of systems thinking, the “whole” is more important than its parts. Components do not function according to their “nature” but according to their position in the network (Friedman 1985:15). In the African context, activities of life, harmony, balance or tranquility must constantly be sought and maintained hence life becomes a liturgy of celebration for the victories and/or sacrifices of others.
As I’m writing this research, my mother is paralysed by stroke. During the early days of her sickness, relatives, church members and neighbours came to be with us and also helped us in the care problem or her suffering from stroke. This did not only affect me as her child but rather the whole family. This in essence signifies that life for the African, is an integral whole of cosmic and social events. For the illness/health continuum, this implies that when one breaks the moral code of society, the cosmic ties between oneself and the community is broken. Recovery and cure thus obtain a new dimension: it is firstly not for the person who must be cured, but the broken ties and relationships brought about by the illness (Louw J.D 1994:22). In the case of HIV/AIDS, it is of utmost importance that the African be viewed as a holistic and social being. When one is infected the whole society becomes affected. This is in contrast to the Western pattern of thinking. In Western psychology, the I – nucleus with its conscious and unconscious process comes into play. “Personally” thus becomes an individual category, which reflects constant factors of typical behaviour and personal characteristics. The human being is autonomous and independent. In an African context, “personally” refers rather to a dynamic power and vital energy, which allows one to come into contact with the ancestors, God and the society (Ibid:22). Illness, therefore, means that the societal order, equilibrium and harmony are disrupted and destabilized thus the interest of the family, clan or society is affected.
For an African, community plays an important role in traditional life. Mbiti explains the importance of the community to the individual in the following way:

“When he suffers, he does not suffer alone but with the corporate group, when he rejoices, he rejoices not alone but with his kinsmen, his neighbour and his relatives whether dead or living. Whatever happens to the individual happens to the whole group, and whatever happens to the whole group happens to the individual. The individual can only say; “ I am because we are, and since we are therefore I am” (1969: 108).

I fully concur with Mbiti because in African philosophy, no man is an island. One doesn’t live for himself but for the community. Whatever affects the individual, affects the community as well. The collective existence and the unity of the person with the community should be kept in mind in the fight against HIV. The community involvement in the fight against this scourge is vital for its success. Educators should be creative in incorporating traditional beliefs and healing methods into AIDS education programmes. In biblical terms, Paul summarises this in this way: “for we are one body in Christ, if one part is aching, the whole body becomes sick (1 Cor 12: 21 – 26).
2.4.1 HIV/AIDS AND THE USE OF TRADITIONAL HEALERS

Although HIV/AIDS is purely a “medical” disease, which requires scientific or medical intervention, for an African, it is treated just like any other disease. It is thought of as witchcraft (boloi). The understanding is that the chain of African or traditional protection has been damaged and this gives risk to the anger of the ancestors and spiritual powers which harm or wreak evil upon the person and the community. It is in this stage that the family invokes the services of a traditional doctor (sangoma). Berinyuu emphasizes that the family will seek the services of a traditional healer/diviner to investigate if the sick person is a victim of aggression or punishment directed specifically against him/her, (1988:49-50).

In the case of mineworkers, although they have heard of HIV/AIDS through the mine educational programmes and on other mediums including radio and television, they remained unsure about all the facts regarding the disease. When interviewed, most of them cited major symptoms of HIV infection as sores over the body and a lean skeletal frame. It is at this stage that the infected seek the help or intervention of a traditional healer. Even though one may seek the intervention of the western medication, the last stop in seeking help will notably be the traditional doctor/healer. It is very surprising taking into cognisance the fact that miners are generally regarded as the less enlightened workforce, that they are able to move between polarities of healing systems i.e. western biomedical and traditional healing without any sense of
contradiction between the two. The reasons for this less contradiction is that, miners took the western biomedical information/treatment given about HIV/AIDS, and interpreted it through a filter of health knowledge and experience of traditional healing. Many mine-workers believed that, as soon as they learned that they are HIV positive, they would simply have to consult the traditional healers within the mining compound. These traditional healers claim to have a cure for AIDS. The traditional healer will administer the African concoctions to cleanse the blood in a bid to flush the virus out of the system. The cleansing of the system is mostly done through inducing vomiting (uku phalaza in isizulu) and administering enema (uku chatha) which will be followed by steaming (uku futha). All these processes have a psychological effect in the traditional treatment of ailments as they believe to be cleansing the reproductive system.

Snidle and Welsh in their book, Meeting Christ in HIV/AIDS, acknowledge that traditional healers and traditional medicine have an important role to play in HIV/AIDS prevention and care because they understand local belief systems and can explain illness and misfortune in ways that people understand (2001:49). According to the authors, most people with HIV approach traditional healers because they usually treat the “whole” person, not just a disease. They take into account a person’s mental, emotional, spiritual as well as physical well being. For the fact that they see their patients together with
other family members, they play a major role in family
counselling by reducing stigma and discrimination that can
possibly be meted out by family members to the person living
with HIV/AIDS. It is further argued by the authors that
traditional healers play an important role in the reduction of the
spread of the virus because they promote sexual abstinence
among the youth and fidelity within marriage among adults.
Such values often agree with traditional beliefs about the
causes of sexually transmitted infections and other illnesses,
and it is recognized that the reduction in the numbers of sexual
partners is a powerful factor in reducing HIV transmission (Ibid:
50). In the light of the above, traditional healers can be
regarded as the vehicles of attitudinal change. Through their
influence, people can change their sexual behaviour and their
treatment of the infected.
No AIDS prevention programmes can be successful in Africa
without the help of traditional healers. Traditional healers are
effective agents of change because they have authority in their
communities. They function as psychologists, marriage and
family counsellors, physicians, priests, tribal historians and legal
and political advisors. They are the guardians of traditional
codes of morality and values, they are legitimate interpreters of
customary rules of conduct, and they have the authority to
change or invent new roles and to influence their people and
have greater credibility in their communities than village health
workers, especially with regard to social and spiritual matters
The above argument pre-supposes the fact that colonialism has done a de-service to African communities by regarding African practices as remote and uncivilised. This had a negative and tragic consequence in that practices like circumcision were conducted in secret thus breaking the community moral values and sexual behaviour. (African circumcision is regulated by traditional healers where young initiates are taught moral values which regulates sexuality model which protects adolescents from engaging in sexual activity outside marriage (a positive step in reducing the scourge of AIDS).

2.5 RACIAL DISCRIMINATION AND HIV/AIDS

The word racism refers to negative discrimination on the basis of the physical characteristics and/or the religion or culture of an individual or a group. Racial prejudice can be defined as discrimination based on these same criteria but without personal or institutional power to back it up. Although the belief that the world is neatly divided up into different races has long been considered simplistic, we are left with the implications of this belief in the concept of racism. People who are directly affected by HIV/AIDS and who are also from ethnic minority groups experience many different levels of racism and stigma, both covert and overt. Although it is difficult to measure racism, it can be even more difficult to disentangle the multiple experiences of stigma and prejudice when these are
compounded by HIV/AIDS.

In the early days when the Government introduced campaigns against HIV/AIDS, scary pictures and billboards were used in S.A. to portray the devastating effects of the pandemic. This did not help much to encourage the spirit of acceptance of the ones living with the virus but rather saw it as a death sentence. This also promoted negative and stigmatizing imaginary for the ones living with it (HIV/AIDS).

Racial discrimination in the combat against this pandemic plays a major role. Crew states that in the early 1990’s the South African government spent R4, 5 million on the campaign aimed at largely heterosexual population, which was ill conceived, and racists. The billboard representing the white population was a fairly clichéd representation and as for the “Black” poster, it showed the mourners gathered around a graveside burying an Aids victim” (Crew 1992:61). From the above presentation by Crew, it shows that a large scale fear of AIDS, mistrust, popular mythology and the legacy of mistrust left by apartheid has created an environment highly unsympathetic to those infected with HIV and living with AIDS. HIV/AIDS was thus seen as a racial rather than a biological issue. Blacks were, therefore, seen as the carriers of the pandemic. This perpetuated the stigma, and rejection of those who were diagnosed as HIV positive.

South Africa was not the only country plagued by racism and HIV/AIDS discrimination. European countries like Britain suffered the same fate as South Africa. O’Brien and Khan as
quoted by Haour-Knipe and Rector (eds) argue that the daily experience of racism and prejudice by white Irish people in Britain differs in substantial ways from that of Black minority ethnic groups. They further acknowledge that a largely white minority group is less a visible target for racist behaviour. But it has been that very invisibility which has made it difficult for the Irish to collectivize their experiences of racism and prejudice, and to unite as a minority ethnic group to challenge discriminating behaviour (1996:104). HIV/AIDS bring these issues into sharp focus; those discriminated against constantly faced with issues of racism and stigma related both to HIV and ethnic identity. A story is told in the mining compound that in the olden days black miners were subjected to thorough medical check-ups before they could be employed. The check-ups were racially discriminating as only blacks were subjected to them. The employers’ understanding or rather perception was that blacks were ‘Aids carriers’. Those with lean skeletal frames were denied employment as they were viewed to be “sick”.

2.6 HIV/AIDS: A Human rights issue
The link between HIV/AIDS and human rights became apparent early on in the HIV/AIDS aids epidemic through the increase of vulnerability of the infected to some group. HIV/AIDS is a human rights issue because groups that are already vulnerable to human rights violations such as woman, children, sex workers and those living in poverty are unable to realize their rights. This makes them more susceptible to HIV/AIDS. The rights of people living with HIV/AIDS are often
violated because of their presumed or known HIV/AIDS status, causing them to suffer both the burden of the disease and the burden of discrimination. Stigmatisation and discrimination may affect the uptake of treatment, and may also affect employment, housing and other rights. Discrimination in turn, contributes to the vulnerability of others to infection, HIV/AIDS related stigma and discrimination discourages individuals infected with and affected by HIV/AIDS from contacting health and social services (Zuberi, 2004:13)

Misinformation accelerates the spread of HIV/AIDS in communities around the country, particularly the minority and poorer people that already suffer more than their share of prejudice and discrimination. What’s worse is that the stigma surrounding HIV/AIDS actually helps to perpetuate the epidemic thus infringing on others’ constitutional rights. Isolation, fear and shame continue to cloud this diagnosis for many. The outcome of this problem is that those most needing information, education and counselling will not benefit, even where such services and available. Prevention and care strategies are hampered in an environment where human rights are not respected. Respecting other people’s human rights will not only curb the spread of economic impact of the pandemic.

The story of Zama, whom we referred to in chapter one, raised a number of human rights and legal issues that this research seeks to address. The fact that he was helpless, laying in the hospital bed, without anyone caring or associating with him, raised the issue of isolation which people who have been diagnosed as such are being subjected to. A right-based approach to HIV/AIDS means locating the needs of those infected and affected by HIV/AIDS in a human rights
context, so that rights can be claimed and asserted. The promotion and protection of human rights will reduce vulnerability to HIV/AIDS infection by addressing the causes, thus lessening the adverse impact of those infected and affected by HIV/AIDS and empowering individuals and communities to respond to the pandemic.

Three common human rights violation associated with HIV/AIDS can include the following as stated by Zuberi:

- Lack of access to health care services or proper treatment, including disclosure of HIV/AIDS status by health care workers without consent, and HIV/AIDS testing without informed consent.

- Violation of human dignity, often through the actions of family and community and,

- Gender rights violations especially related to the treatment of women by their partners and their in-laws. (2004:14)

Discrimination against people living with HIV/AIDS has been one of the cornerstones of human rights groups. Such people are denied their fundamental rights to security, freedom of association, movement and adequate health plan. The violation of human rights in relation to HIV/AIDS is widespread. The pandemic spotlights many formerly unrecognised inequalities and prejudices in our societies and reinforces long term disparities that people living with HIV/AIDS face isolation and discrimination in virtually all societies and cultures. Their physical symptoms are compounded by the psychological impacts associated with HIV/AIDS. The illness and death resulting from
HIV/AIDS is frequently suffered in loneliness and abandonment, as people living with HIV/AIDS are often isolated and are abused. People living with HIV/AIDS suffer the loss of their own future, whether by losing the opportunity to have a family, or being deprived chances to find meaningful work, or losing other basic human rights. The source of human rights is the recognition of the equally worth dignity of all human beings. In the context of HIV/AIDS, there is a strong public health rational for the respect of human rights. Such rights impose the moral and legal imperative to ensure that everyone’s equal worth and dignity is fully respected, without discrimination.

The most widespread human rights abuses, in the context of the AIDS pandemic are the discrimination and social stigma suffered by people with HIV/AIDS, their families and associated. And people who are considered to be at risk of infection such as gay persons, prostitutes and drug users.

2.7 HIV/AIDS in the workplace

The migrant labour system with its single – sex hostels create an unstable life-style, contribute to the spread of HIV, thus becoming an ideal breeding ground for AIDS. In most cases, migrant labourers are faced with double trauma i.e. rejection and isolation from the local community which does not accept them to be part of their community because they are “foreigners” and are perceived to be the “spreaders / carriers” of the virus to the community. They become ostracised and thus deny them any health-care to alleviate their situation. Secondly, their trauma is exacerbated by not being treated adequately by their
employers who regard them as unproductive and being exposed to hard working conditions.

2.7.1 The impact of the disease in the workplace

The mining sector experiences the impact of HIV/AIDS in a number of ways, such as large numbers of sick people/employees and high death rates. As infected employees become ill, the lucky ones are transferred from working underground to the work “surface”. Surface is above the mine where weak miners are relegated due to their weak status of any ill health. This causes embarrassment to those who have been diagnosed with HIV. The moment any miner is relegated to work on the surface, a signal is sent that the worker is diagnosed with a chronic ailment and thus result in rejection and discrimination.

This practice of relegating sick miners to work on the surface, although it is done in good faith in order to protect their ill health it results in the exacerbation of trauma to the infected miners. They take additional sick leave and this disrupts operational activities. This disruption become worse as more qualified and experienced employees become ill and leave work. The loss of employees means that the right replacements will have to be found by the mining sector. As the HIV/AIDS pandemics advances, increases in absenteeism is experienced as employees attend funerals of family members and colleagues.

Many people are aware of HIV/AIDS but there appears to be a lack of basic knowledge about the disease. The various myths and
misconceptions that people have about HIV/AIDS are further barriers to awareness and effective action on the pandemic. There is a widespread myth/belief circulating in the mining compound that when an HIV positives man sleeps with a virgin, it will cure AIDS. This result in young girls being sexually molested by people who are living with AIDS. This practice further fuels the rejection of the infected mine workers by the local community. This point needs more awareness and campaigns on education/empowerment. In the workplace, the link between fear and misconception is immense. Fear of HIV/AIDS fuels and creates misconception, while misconceptions grow out of the presence of the deep-seated fear. This is very common to the mineworkers. This fear is linked to speaking about HIV/AIDS as a death sentence and a killer. It is therefore the responsibility of the employer and colleagues to create an atmosphere of acceptance to those who have been diagnosed as HIV positive by formulating workplace programmes, which will actively assist in dispelling these misconceptions and fears.

Unfortunately, when it comes to HIV/AIDS in the workplace, there is an atmosphere of secrecy and ignorance shadowing the epidemic. To control this, it is important that worker organizations play a key role in empowering workers to control and prevent further HIV transmission. Workplaces share the social responsibility of breaking the silence and educating employers. The workplace is not isolated from the rest of the society; rather, it is an open system that shows the impact of its external environment. According to an editorial on AIDS analysis, Africa (1995) education in the workplace has proven to be very effective. The workplace programmes should take the form of formal
and informal education to the employers. Employers should be educated on how to deal with the pandemic, and what should be done to reduce the risk of contracting the disease affecting their employees. Education on HIV/AIDS should help reduce ignorance and prejudice against those living with the virus. Its main focus should be on how people can live long, happy, productive and healthy lives inspite the reality the disease. AND they must help reduce the potential fear or disruption of work among employees who have been diagnosed HIV positive and also discourage colleagues against possible discrimination and rejection of the others.

2.8 SUMMARY

If we are truly concerned with people living with HIV/AIDS, then we would have to listen to their stories and the stories of those caring for them in their plight. We need to hear their personal spiritual testimonies and their political cries for social justice. By showing support and responsibility to care for all people regardless of their health or social status, people can act as role models for others in helping to combat stigma, discrimination and isolation of people living with HIV/AIDS. This chapter has successfully interrogated trauma as a result of HIV/AIDS diagnosis. An insight has been given on how the miners reacted on their situation. A theological reflection has been critiqued on how the Christian community excludes those who have been diagnosed as such. The chapter has therefore exposed the mistreatment of the infected by the Christian
community in the name of up-holding the moral values of abstinence.

The following chapter will therefore concentrate on the rejection and stigmatisation of the migrant mine labourers by the community. It will further deal with grief as experienced by the infected and their response to such conditions.
CHAPTER 3

STIGMATISATION AND ISOLATION OF THE MIGRANT LABOURER DUE TO HIV/AIDS

3.1 Migration and HIV/AIDS

According to Mark Lurie in his article, “Population movement and the spread of HIV/AIDS in Southern Africa, by Karim & Karim, migration as population movement has played a critical role in the spread of HIV/AIDS throughout Southern Africa, but relatively few studies have attempted to understand the underlying process in detail or to develop ways to reduce the spread of infection among migrants and their partners (2005: 298). The authors’ argument is that the predominant patterns of the spread of HIV/AIDS have been from returning migrants who, become infected while away from their partners whom they infect when they return home. It is generally assumed that when young men leave their rural homes in search of work, particularly at the mines, they may engage in sex with women who are at high risk and are themselves at high risk of infection. When they return to their rural homes, they may carry the virus with them and infect their rural partners.

The migrant labour system was central to the way in which the political economy of South Africa was ordered in the last century and was intimately bound up with the structure and functioning of the system of apartheid. Migration patterns in South Africa were an integral part of the way in which the government, with the support of industry and in particular the mining industry, structured South
African society from as early as in the 12th century and culminating in the system of apartheid.

Much of the published research on migrant labour in South Africa has focused on the gold mines, which have drawn large numbers of workers from all over the sub-continent. Because these men lived almost exclusively in single-sex hostels, without their wives or families, they are inevitably at high risk of contracting HIV/AIDS. Migration and widespread population displacement have been identified as significant risk factors in the transmission of HIV/AIDS and migration has become an important theme in the discussion of AIDS. The association between migration and HIV/AIDS is more likely to be related to the conditions and the structure of the migration process than to the actual dissemination of the virus along corridors of migration.

While the link between migrant labour and high-risk sexual behaviour has not been explored, frequent and lengthy absences from home are likely to disrupt their familial and stable sexual relationships. It has also been argued that the migrant labour system created a market for commercial sex in the mining towns.

While understanding the context of migration both from the perceptive of sending and receiving areas, it is equally important to study both sides of the migration spectrum at the same time. HOWEVER, for the purpose of this research, the focus will only be on the migrant labourers who contract the virus whilst at the mines rather than concurrently look at migrants at work and their partners at home. This one-sided approach weakens the study on HIV/AIDS, whereas understanding both sides of the spectrum is particularly important if
successful intervention programmes to be implemented. It should also be noted that migration patterns in South Africa put people at the risk of contracting HIV/AIDS infection at both ends of the migratory movement and it is important to know how these combine to determine the direction and the extent of the flow of infection.

According to Haour-Knipe and Rector in their book, Crossing boarders, migration and Aids are two of the crucial social issues facing today’s changing world, posing unique difficulties for any discussion of a stigmatised disease and an often stigmatised group, migrants (1996: 1). The authors argue that there are many factors, apart from economic imbalances, that force people to migrate e.g. escalating civil war, individual search for a better life or just plain restlessness and curiosity.

In the area of HIV/AIDS, many of the political and social problems surrounding migration have become the most evident. Even though the evidence and prevalence of the problem continues to be skewed by geographic region, the receiving areas are now reporting new cases of HIV/AIDS infection where mines are located. The AIDS pandemic has also prompted a more detailed reappraisal of the complex relationship between social and economic conditions on others. It has highlighted the fact that health and social problems are quickly created when people are socially rejected and marginalised. It has also shed light on the harmful health implication of marginalising migrants. In the case of HIV/AIDS, the basis of personal behaviour that has often coincided and exacerbated societal marginalisation of
migrants, and of those whose cultures and sexual preferences are considered “different”.

Gavin argue that everywhere it is the young, often at the peak of their reproductive stage and productive careers, who are most readily displaced through land scarcity, economic deprivation and the call of the city. Whereby they’re up rating and the movement to urban centers involve a dramatic divorce from traditional values and the social control which rural society family structures exercise over sexual behaviour (Garin et al, 1993). Evian (1993) qualifies Garin’s assertions that the migrant labourers’ emotional vulnerability may lead to temporary solutions in serial and potentially high risk relationships which may lead to a wide range of communicable diseases including HIV/AIDS. In some instances (if not all), a cycle of migration has evolved in which young migrant labourers move to the mines at the cities, BUT make short periodic visits to their families and communities. When they do so, they renew old social and sexual relationships or establish new ones with local partners. According to Kane et al, 1993 the sexual link they constitute between their places of work (mines) and their rural areas (homes) may be a significant route of HIV/AIDS transmission which involves families living in otherwise isolated and low-risk communities.
3.1.1 MIGRANT MINEWORKERS AND HIGH HIV INFECTION

Migrant mine workers were selected for this research because of the strong correlation that exists between them and HIV infection in South Africa. The reader should bear in mind that HIV infection is not only a South African problem but also a universal phenomenon. There are several factors contributing to the high rate of HIV infection amongst migrant mine workers BUT for the purpose of this research, only a few will be discussed below:

Firstly, The use of single sex hostels or compounds is one of the contributing factors in spreading the scourge of HIV Infection among mineworkers. As a community of all males without any extra mural activities, the majority of them will complain about high level of boredom and loneliness. Because their families are far away. As a result, the crave for company of the opposite sex becomes high. One miner puts it in this, way: “you cannot call yourself a man if there’s no woman involved” (Campbell 1998:8). The boredom will eventually force them to go out of the mining compounds into the township in search of the female companions in order to ward off boredom.

Secondly, the working and living conditions of mineworkers are both physically unhealthy and psychologically stressing. They work under very strenuous and sometimes stressful and always-dangerous shifts under the belly of the earth; some need some sort of physical reward after work, which in some cases is sex (in some cases unprotected). When asked if they are not afraid of the dangers of the falling rocks under ground. One miner from Lesotho had this to say: “ntate wee,
ha ke a tlela masawana mona, ke tlo sebeletsa bana baka.” This can be loosely translated as: “Man, I’m not here for nonsense, I’m here to work for my children.” The body language suggesting that if there was any other alternative he would happily go for it.

When pursued further about the dangers of engaging in unprotected sex and contracting HIV/Aids, some responded in fanagalo: “Hai khona mina saba magama mathatho” **Translation:** I’m not afraid of three letters (referring to HIV). According to them the falling rocks under the belly of the earth are more dangerous than Aids as they kill you instantly unlike dying slowly due to HIV.

**N.B! Fanagalo** is the informal medium of instruction used at the mines to accommodate all people from sub-saharan countries to communicate in a way they will understand each other.

**The third** and more linked to the second reason is prostitution. The majority of migrant mine workers who reside in compounds use the services provided by commercial sex workers. More often than not, the “ladies of the night” who come from the local community see/regard the mine workers as cash cows. This is not an ideal situation as it increases the infection rate of HIV not only amongst mine workers BUT also to the local community. This practice further escalates the spirit of rejection of mine workers by the local community who regard them as “transporters” of the disease.

**Finally,** In my frequent visit to the mine compounds, I found that mineworkers have a strong belief in traditional healing/medicine. According to them almost all ailments can be cured through traditional medicine. More often, especially when they are off-duty, they will queue to the local Inyanga who is based within the hostel
for African Concoction (Pitsa) either to strengthen their sexual appetite or to cure some sexual ailments. (“Pitsa” is a herbal mixture used to enhance someone’s sexual prowess.). This practice is not always bearing good fruits **BECUSE** even if one is infected with HIV, it takes time to be detected and treated. It only becomes evident/visible during the last stages of the virus when the infected is about to die. From the above-statements, denial plays a major role.

### 3.2 STIGMATISATION OF MINE LABOURES DUE TO AIDS

#### 3.2.1 Stigma: Definition of the term

Goffman (1963) traced stigma back to the classical Greek ever where it was described as “a brand placed on outcast groups”. He defined stigma as “an attribute that significantly discredits in the eyes of society and reduces the person who posses it’. He further argues that a stigmatized individual is seen to be a person who posses “an undesirable difference”.

Based on Goffman’s original definition, Alonzo and Reynolds. define stigma as a powerful discrediting and tainting social label that radically changes the way individuals view themselves and are viewed as persons (1995: 304).

On the other hand Parker and Aggetion (2002) in their book, HIV/AIDS related stigma and discrimination, argue that Goffman’s work has been used a lot in HIV/AIDS research as though stigma
were a static attitude rather than a constantly changing social process and has seriously limited ways in which stigmatisation and discrimination have be understood in relation to HIV/AIDS. They argue instead that stigma and discrimination can be dominant. In their argument, they assert that stigma plays a key role in producing and reproducing relations of power and control in all social systems and cause some groups to be devalued and further fuel the thinking that they are superior to others in some way. It is therefore, linked to social inequality.

In this chapter, HIV/AIDS related stigma refers to any meaning or set of values associated with someone having or being perceived as having HIV/AIDS. Stigmatisation is viewed as a dynamic social process involving the following dimensions: identification, the assignment of negative values to that person and the concurrent devaluation or loss of reputation of that person and discriminatory behavior, including inaction towards the person in question.

The following quotation recounts the person’s experience, which provides an example of stigma: “In the week I received my HIV/AIDS results (which turned to be positive), I informed my colleagues at work. Suddenly my world changed for the worst. They no longer ate my food, and refused to share the office with me. Even the kitchen utensils I touched or used, they didn’t want to use them anymore because I was sick (Zama recounts).

This shows that HIV/AIDS stigma is a social process, which manifests in different ways and also in different contexts. In this section of the
chapter, the researcher aims to provide a new and more understanding behavioural intentions as attitudinal responses to people living with HIV/AIDS based on the psychological functions they perform. This will subsequently lead us to critically analyse the different dimensions of stigma, as they will be dealt with below:

- **Symbolic stigma**: this type of stigma is based on judgmental attitude towards those perceived to have put themselves at the risk of infection through immoral or irresponsible behaviours (Stein, 2003: 8). As it is to be noted in the above-stated quotation from Zama, the attitude of his work colleagues’ judgmental attitude and the perception that the disease/infection is self-inflicted due to his immoral and reckless actions. In this case, the symbolic attitudes by his colleagues are informed by deeply held values based on the metaphorical social meanings attached to AIDS, because the disease is negatively associated with the outcast group. Like other sexually transmitted diseases, HIV/AIDS has served to signal pollution and contamination and consequently people living with it have been associated with dirt and uncleanliness (Goldin 1994). This occurs when individuals distance themselves from the fear of infection of HIV/AIDS by assessing that their own moral behaviour is not conducive to HIV/AIDS transmission, thus HIV/AIDS is perceived as a disease of the “outsiders”, which situates the “in group” as safe from infection.

- **Instrumental stigma**: it arises from a psychological need to protect oneself but based on the real physical risk posed by
HIV/AIDS. It arises from the perception that interacting with the infected poses a direct threat to one’s own physical well-being. Of-course, this is an incorrect perception because one cannot become infected through casual contact BUT nevertheless people may refrain from hugging and sharing utensils with the infected for fear of the contracting the disease.

- Resource – based stigma: this arises from a unilateral self-interests where people oppose or recent the allocation of resources to with the people living with HIV/AIDS. This is clearly demonstrated when colleagues do not want to share an office with the infected. The infected also get blamed for the financial woes for caring of them.

**3.2.2 HIV/AIDS STIGMA AFFECTS THE FAMILY STRUCTURE**

According to Newmark and Taylor as quoted by Leukerfield and Finbies (eds) in their book *Responding to Aids*, argue that HIV/AIDS like all illnesses, affects the entire family systems. Their contention is that Aids has created the need for redefining the composition of the family, safeguarding the civil liberties of family members and ensuring minimal community services for families in which a member has AIDS (1987:39). Usually in a black set-up, a miner is a black male employee who is a breadwinner and having the whole family depending on him for survival. When HIV/AIDS strikes such a core member of the family, each member has real and imagined problems, such
as isolation, fears of transmissibility, stigma and above all problems resulting in poverty. Each member of the family, like the person with HIV/AIDS, often feels attached by and separated from the other family members as well as from the community at large. All these problems are compounded when family members endeavour limited resources due to the stigma and isolation of the community due to the pandemic faced with at home.

The stigma attached to the family may result to what Bronfenbrenner calls exosystems and becoming a source of conflict. An exosystem is any individual or environment that affects another person without the person’s knowledge of its existence. In this case, the person with HIV/AIDS may establish complete detached family subsystems isolated from other family members that become exosystems in relation to the other subsystems. All these problems may cause boundary disputes and changes in the family’s equilibrium. Individual members may experience a new sense of isolation and detachment as their primary support system shifts and new exosystems are created.

When a family member is diagnosed with HIV/AIDS, the family has to deal with a number of problems of which isolation and stigmatisation are the main ones. It is also important to note that each family member at this stage is also confronted with social isolation from the established family unit, neighbourhood and the larger community due to the stigma attached to the disease. For many families, where a member has been
diagnosed with HIV/AIDS, isolation is being singled out as one of their most difficult social and psychological problems. Isolation within isolation arises when individual family members including the afflicted member, become secretive because they are privy to certain pieces of information that they do not want to share with other family members. This type of behaviour often results in miscommunications that lead to family conflicts. The following is an unusual scenario that always takes place: “Mrs. L. has been married to Mr. V. for almost 20 years. Mr. V. spent most of marital life working at the mines in Welkom, living in single sex hostels for the rest of his working years. He came home very sick from HIV/AIDS related sickness. On arrival at home, Mrs L. wondered in her quietness how her husband had contracted the disease. She wondered if it’s only a matter of time until she too is diagnosed with the illness. Should she prevent her husband from kissing and hugging her?” This woman’s experience reveals the multi-layered nature of stigma within my quote; she reveals being stigmatised but perhaps unknowingly accepting of the stigma against the infected husband. One way of the virus’ transmission is through sexual contact. Therefore, to avoid contracting HIV/AIDS, the spouse or partner will in all fairness refrain from sexual relations with the afflicted husband which will in any case reinforce her feeling of isolation, stigmatisation and ultimately result in rejection of the husband. Because this stigma is so severe, it alienates the person with HIV/AIDS from his family members and ultimately from
community support when the family is so vulnerable. Spouses of persons with HIV/AIDS are unable to talk openly about their husband’s illness for the fear of losing their friends and family support. Even their children cannot even tell their teachers and friends about their father’s illness because they are afraid they will be ousted from school. They feel constrained to discuss the disease with friends, neighbours or colleagues.

The traumatic responses of the partners or spouses of person with HIV/AIDS are similar to those of the family members of other groups of patients. However, because HIV/AIDS is transmitted sexually, these persons have unique concerns as well. Most likely, the partner or spouse has been exposed and possibly infected with HIV through sexual contact with the husband who has AIDS. Therefore, the couple must deal with the impact of Aids on their relationship as well as the uncertainty of the partner or spouse’s future health. The husband may feel guilty for infecting his partner or spouse. Such concerns add new levels of stress to an already stressful and traumatic situation.

3.3.1 PSYCHO-SOCIAL ASPECTS OF THE STIGMATISED PERSON WITH HIV/AIDS

HIV/AIDS stigma affects the psychosocial aspect of the infected. The living conditions of mine workers in the single sex hostels subject them to some psychosocial difficulties especially when diagnosed with HIV/AIDS. Psychosocial studies
regarding the migrant labourers with HIV/AIDS has also underscored the stress experienced by these men. This is intensified by the eminence of death feelings of despair, distress and fear owing to the revitalization of anti-migrant labourers and threats of quarantine and other punitive measures by the local community to isolate them. The response from the migrant labourers who were interviewed revealed that the person with HIV/AIDS responds to their fate as others have responded to life threatening illness. The response is that of anxiety, distress and depression and that they go through the same stages of anticipatory grief (denial, anger, bargaining, depression and acceptance) as noted by Kubler Ross in her book, ‘On death and dying’. Their psychological responses from a fear of the “unknown” and an “anticipation” of what will happen to them. The degradation, the varieties of dehumanizing experiences, the pain and the lack of hope have led many to consider suicide. Their isolation in times of need leads many to mental syndromes, which may mimic functional disorders. All those conditions are exacerbated by negative societal attitudes. Actual or feared rejection of the affected migrant labourers also contributes to high levels of distress. Many labourers also contribute to high levels of distress. Many persons with HIV/AIDS experience rejection by their families, partners, social support systems and employers. Whether real or anticipated, this rejection can profoundly affect their psychological functioning. What often underlines may encouragement the
distressing feeling, is the desire to discover an internal sense of hope and empowerment that can help one focus on living, rather than dying. The maintenance of adaptive coping skills can contribute to a helpful and positive attitude.

People with HIV/AIDS frequently need assistance in adapting psychologically to the many physiological and psychological changes that occur throughout the course of the diseases that results in their sense of a loss of status. Some may be forced to abandon their source of income, social support from their peers in the hostels and above all, their self-esteem due to the gossip that goes around the hostels, where they stay, about their health status. For others, feelings of failure accompany their disappointment at the realisation that their dreams and plans will never be realised due to the scourge of the disease. The drastic alterations in lifestyle necessitated by chronic fatigue, debilitation, the loss of mobility and the loss of bodily functions can result in isolation and depression.

3.3 **Grief as a result of stigmatisation and rejection due to HIV/AIDS diagnosis**

As the research seeks to examine the trauma caused by HIV/AIDS stigmatisation and rejection meted-out to migrant labourers, this section will begin by a lengthy citation/quotation by Neimeyer Keese:

“Grief and trauma are like different sides of the same coin. They are different, yet, they go together and where you find one, you find the other. The felt loss that leads to
bereavement and grief is a form of trauma. The work involved in healing from trauma is similar in ways to the work involved in complicated grief. As in the case of trauma, when loss occurs, we have no control or power to stop it. And as with trauma, while we are helpless to prevent loss and grief, healing from them require us to be active (Neimeyer & Keese, 1998)

Coming to terms with being diagnosed with the disease is very complex and difficult. This section of the chapter aims to give a comprehensive understanding of this process. The grieving process of a migrant labourer in isolation and rejection consists of a number of phases, affects the person in varying and probably unexpected ways. Good communication and trust are important in dealing with grief. A conspiracy of silence is more damaging to the infected as it is to the family caring for the infected. However, it should be noted that grief is an integral part of normal life. The stigma attached to the HIV infection, the fear of being infected and the age of the person infected can however complicate grief. To the family or the partner of the infected, there is a feeling of isolation and depression due to the stigma attached to their loved one. These people will have to cope with discrimination and prejudice.

In the case of the miner who has been diagnosed to have contracted the virus, being unable to carry on with daily chores is traumatic; grief thus moves the infected into a profound complex and unsettling meaning-making process. The severities of a particular trauma also apply when the infected
thinks about the loss that will be experienced due to the disease.
Worden sees the tasks of grieving as recognising the loss, releasing the various emotions, developing new skills and re-investing emotional energy (1991:46).
In the light of the above-stated argument by Worden, the person living with HIV/AIDS has to come to terms with the fact that he is no longer the same person as before i.e. he is now relying on others to accomplish his tasks and the body is no longer about to carry itself any longer. This can arouse very strong emotions. Feelings of anger, sorrow, failure, of guilt, some of which can be deeply buried in their sub-conscious. These feelings may deny reality or bargain for life to continue. Shelp & Sunderland concur with Kubler Ross in arguing that patients frequently use the defence mechanism of denial to exercise control over how and when they face their mortality with dealing with grief (1987:44).
Be that as it may, denial tends to be less effective amongst HIV/AIDS patients as it is hard to be hopeful about the future. This results in diminished self-esteem, which results in depression and ultimately the person tends to have suicidal thoughts. The authors further argue that the skeletal disfigurement due to the progression of the disease, tends to provoke anger, anxiety and for some, resignation to a self-imposed if not externally imposed isolation. Going through this traumatic experience, Kubler Ross will help us on how to
journey with the infected miners. This will be done in going through the five stages as outlined below:

3.3.1 **Kubler Ross’ 5 stages on grief syndrome**

One of the advantages of qualitative research method as stated in chapter one is that it is sensitive to the human situation, thus involving an empathetic dialogue with the infected and contributes to their emancipation and empowerment. In this section of the chapter, the researcher will therefore demonstrate this acumen by referring to Kubler Ross’ model of pastoral care by introducing the 5 stages on grief syndrome i.e. denial and isolation, anger, depression, bargaining and acceptance. The important thing about all these stages is to remember that the care of the terminally ill patient, like the HIV infected, include the following: “we can help them die by trying to help them live, rather than vegetate in inhumane manner” (Kubler Ross 1979:32). Each of the five stages will be used individually to track down how people living with HIV/AIDS and their immediate families respond to each of them as they undergo their traumatic experience of dealing with grief.

3.3.1.1. Denial and isolation

3.3.1.2 Anger

3.3.1.3 Depression

3.3.1.4 Bargaining

3.3.1.4 Acceptance
3.3.1.1 Denial and isolation: denial is usually a temporary defence mechanism and will soon be replaced by partial acceptance (Kubler Ross 1986:35). Most people when diagnosed to be HIV positive react with the statement: “no, not me, it cannot be true” or “no, these tests are not mine, there must be a mix up at the laboratory”. These statements or reactions are the initial reactions of a person who has been outrightly or explicitly been told of his/her condition. Louw calls this stage the impact stage (1990:46). When a person is diagnosed as having HIV/AIDS, the impact is tremendous shock, denial, severe anxiety and helplessness can surface immediately. This person with HIV/AIDS may use this stage as a reaction which may be a temporary stage of shock from which one will gradually recuperate. Since in our unconscious mind we are immortal, it is almost inconceivable for us to acknowledge that we too have to face death. To deny that one is sick and dying may be at first a healthy sign. As a defence mechanism, denial cushions the impact that death may be imminent. The pastoral care- giver’s task during the denial stage is to gently encourage and the HIV/AIDS sufferer in the process of dealing with the new reality.

3.3.1.2 Anger: unless there is a physical healing or remission, I think that denial of the disease (HIV/AIDS) process gradually gives way to anger and rage. Why is it happening to me and not to the other person?. The sufferer demands to know. This
stage is difficult to cope with from the point of view of the family and those nearer to the infected, the reason being that this anger is displaced and projected onto the environment at times almost at random. The family caring for the infected is received with little cheerfulness and anticipation, which makes the encounter a painful event. The problem here, is that very few people place themselves in the infected’s position and wonder when this anger might come from. Maybe I too would be angry if all my life activities were interrupted so prematurely (1986: 45). Kubler Ross further points out that perhaps we do not think of the reasons for a patient’s anger and take it personally when it has originally nothing or little to do with people who become targets of anger (1986: 46).

According to Murphy as quoted by Walt and Mckay, in their article, living with Aids, people living with the Aids experience significantly high levels of anger than people who are seronegative (test negative to the virus). I would concur with Murphy because in most instances the infected person is always blaming him/herself or those closer to him/her who in turn may feel angry because the person they care for is going to die and that the situation is hopeless and renders them helpless. I think one integral problem that excites anger in the HIV/AIDS sufferer is a result of fear on how the illness will progress, social discrimination and stigmatisation, lack of effective means of eliminating the virus and lack of assurance that a medical solution will be available in the future. Those struggling to come to terms with their illness may also be
angered by other’s callous, indifferent or hostile reaction (1986: 48).

3.3.1.3 **Bargaining:** the next stage or attitude in coping with illness is trying to bargain with God. For the HIV/AIDS patient who has been reckless with his/her life will bargain with God. One often hears bargains like: “if you heal me God, I will not have sex again”. For someone whose life’s task are unfinished, would always say: “God give me more time to bid my family farewell or to see my children grow up as adults”. Some promise to become good Christians if they recover from their illness. The pastoral task of the caregiver at this stage is not to exploit the spiritual vulnerability of the sufferer by soliciting a confession and commitment but rather to journey with the sufferer in his/her turning to God. The bargaining stage is fully illustrated in Luke’s gospel: “I will get up and go to my father and say, Father, I have sinned against you and the heavens (Luke 15:8).

3.3.1.4 **Depression:** the patient’s inability to perform some of the daily chores, pay bills on medication, loss of income or job due to the illness may result in depression on the HIV/AIDS sufferer. If it’s the mother who is ill, children usually boarded out, adding to sadness and guilt of the sufferer. All these result in depression. For the simple reason that is associated with stigma that results in isolation, and loneliness increase depression on the
sufferer. Kubler Ross differentiates two kinds of depressions i.e. reactive depression and preparatory depression. The first one is regarded as such because the sufferer reacts to all forms of problems surrounding his/her sickness that result in him/her laid down. In the latter (preparatory), the patient uses this type of depression as a tool to prepare for the impending loss of all the love objects in order to facilitate the state of acceptance, above all the impending death (1986: 76-77).

The second type of depression is usually a silent one in contrast to the first, during which a patient has much to share and require many verbal instructions and often-active interventions on the part of the many disciplines. During the preparatory stage, there’s little need for words. It is much more a feeling that can be mutually expressed and is often done better with a touch of a hand, stroking of the hair or just silently sitting together. It is a time when too much interference from visitor’s who try to cheer up the patient hinders his/her emotional preparation rather than enhancing it (1986: 10).

“Ka Setswana ra re: o ile dikgogeng. O buisana le badimo ba gaabo. O itukisetsa tsela. O tshwere ka lotha”. Which can be loosely translated as: “the patient being in hallucination, talking to the spirits and preparing the way to depart from this earth”.

Holding grief or emotions for long periods of time without
“letting go” can deplete serotonin levels in the brain and increase the patient’s chances for depression and delayed recovery. It is better to feel and communicate our deep emotions without stuffing or repressing them and we gradually focus more on letting go (Aston & Ashton, 1996:93). The pastoral caregiver’s task is to listen to how the patient is dealing with the hard questions, because of depression and loss. Pastoral care in this case not only empowers the patient to make peace with the past but also helps the patient to deal with the present and prepare for the future. Once this stage is perfectly handled, the gift of acceptance is eminent.

3.3.1.5 Acceptance: acceptance is not necessarily a happy stage, neither is it an unhappy one. It is not a helpless resignation to the inevitable but rather more like a personal victory, a spiritual triumph over the fear of death. If a patient has had enough time to prepare him/herself, having gone through all the stages of grief syndrome, he/she becomes at peace with him/herself. The person is now ready to go and close one’s chapter of life with honour and dignity thus approaches the stage of acceptance. A person who has reached the final stage (acceptance) is portrayed in Luke’s gospel: “now, Lord, you have kept your promise and you may let your servant go in peace” (Luke 2:29). Kubler Ross says acceptance should not be mistaken for a happy stage. It is almost void of feelings. It is as if pain had gone, the struggle is
over and there comes a time for ‘the final rest for the long journey’ (1986: 100). In this stage communication becomes non-verbal than verbal. This is also the time during which the family of the patient needs support than the patient him/herself.

There are, however, few patient’s who fight to the end, those who struggle and keep hope that makes it almost impossible to reach the final stage of acceptance. In other words, the harder they try to deny it, the harder they try to deny the inevitable death, the more it will be difficult for them to reach this final stage of acceptance with peace and dignity.

Regarding this final stage, Ashton and Ashton give an analogy of the shepherd through the valley of death as depicted by the Psalmist: “I walk through the valley of death” (Psalm 23:23) (1996:93). The patient doesn’t have to get stuck down the valley of death yet its best not to run out or get a quick fix or get over with it as many try to do. Although grief doesn’t ever completely leave, one can live with one loss and feel true joy again even on a deathbed.

Helping a person in the situation is often more to do with “being” than “doing”. The infected needs to be able to share his inner feelings to talk in order to grapple with the “why” questions. Listening should be with feelings of acceptance, understanding and empathy, allowing the
griever to find their own words. However, Kubler Ross argue that the final stage of acceptance should not be mistaken for a happy one (1987:100). This is the time when the family caring for the terminally ill needs more support than the infected. On the other hand Shelp and Sunderland contend that Kubler Ross’ presentation of the grief syndrome often appears arbitrary and mechanical as if people’s reaction to grief may be programmed or even manipulated, as if each stage is a pre-requisite for the next. Kubler Ross’s presentation of the cycle of grief doesn’t always apply to all patients as some react differently to grief.

### 3.4 Hope in a hopeless situation

#### 3.4.1 Grief: an opportunity for a healing process

Facing the prospect to death due to HIV/AIDS can be traumatic. Facing a lonely death due to rejection and isolation always compounds the trauma. However, Bruggermann speaks of grief as a means of bridging private hurt to public expression (1987: 87). In illustrating the above, he uses the story of the Israel exodus from the land of bondage in Egypt (Exodus 2: 23-25) as a major catalyst that eventually empowered them to confront their powerful captors and escape. The same applies to someone on his deathbed dying of Aids. The patients waiting on the deathbed should be viewed as a public growing intended to break the long bottled up silence over his sickness and loneliness. It is only through the expression of grief that hope can be re-kindled.
On the other hand, Means regard grief as a turning point towards a healing process (2000: 148). For healing to take place and the sufferer, as in the case of HIV/AIDS, to reach the stage of acceptance, grief has to be allowed to take its course. Means (2000: 149-150) mentions few aspects that need to be considered by the infected, they are tabled as follows:

- Firstly, the patient’s moment of grieving, is an acknowledgment that something drastically has happened in his life, perhaps, that has altered one’s life’s programmes. This acknowledgment presents an opportunity to the sufferer to begin a process of re-engaging in life.

- Secondly, grieving openly can be viewed as a painful exercise and a sign of weakness. Its positive side can be an indication of valuing and respecting oneself. One grieves for something that is important and precious, and in this case life becomes a precious commodity that is being grieved for, especially a healthy life.

- Thirdly, grieving presents an opportunity for the sufferer to take control of his life. In this case, he longer takes the blame, shame and discrimination meted out. Grief, therefore, marks the start of the healing process in order to take control of his life.

- Lastly, the grieving process marks the transition that the sufferer takes from being stuck in the hurt of the past to the hope of the future.
3.5  **Response to stigma and rejection**

3.5.1  **Key findings on interviews with the infected mine workers**

The association of Aids with dying and with death is a more likely source of its stigma and illustrates many aspects of people’s responses to AIDS. In my interviews with the infected, my informants explicitly stated that their fears of undertaking HIV tests stemmed from the possibility of discovering that they had been infected with a fatal and incurable disease. Most migrant mine workers interviewed said knowledge of being HIV positive would hasten rather than delay their deaths. Most of them take solace in denying that they are sick and seek comfort in pretending to be ignorant. One miner had this to say: “I don’t want to suffer. I don’t want to be rude. If you test positive, you’ll lose your memory, thinking all the time about death and dying. People will gossip about you. They will regard you as dead and refer to you as living corpse”.

The concept of negative self-image was discovered when analysing the results of the interview with the infected mine workers. This design has captured the feelings of shame, guilt and self-depreciation related to HIV and AIDS infection. The qualitative data collected supported the position that these are real and common experiences in the lives of the affected.
A commonly expressed feeling was associated with being the ‘other’ or ‘apart from the rest of the community’ as a result of HIV infection. Being alone and socially isolated was also a recurrent theme related to personalised stigma.

3.5.2 Key findings on interviews with the community

Local community’s perceptions of treating the terminally ill migrant mine workers shape and the miners’ responses to HIV and AIDS. By virtue of being terminally ill, miners taking residence in the mining compounds, secluded from the entire community, isolation, discrimination and rejection play a major role. Traditionally, a sick young man will be nursed by his father and a married person by his/her spouse. However, due to the vagaries of labour migrancy, the sick mine workers staying in the mining compounds face death with disgrace as no-one looks after them because the local community rejects and isolates them, regarding them as transmitters of the deadly virus.

HIV stigma is a critical issue that impacts negatively on the quality of life of all persons with HIV. HIV stigma meted out by the local community has been found to have deleterious effects on both the behaviours and self-image of the stigmatised persons. Behaviourally, stigma has been found to have negative impact particularly on the people who are willing to disclose their status. The interviews further found that HIV stigma and
discrimination are associated with issues such as feelings of shame and guilt, fear and anger, mental strain and feelings of self-loathing. It has also been associated with symptoms of depression and has long lasting negative effects. The harmful effects of stigma include social isolation and rejection, which may result in the patient’s further deterioration in emotional and physical health.

3.5.3 Discussion on the findings of the interviews

The purpose of the interviews both with the infected migrant mine labourers and members of the community was to explore the experience of HIV stigma and discrimination and validate trauma as experienced by the infected migrant mine labourers in the Welkom area. The general qualitative findings amongst the infected migrant mine labourers suggests that the issue of disclosure is very critical as it would make or break one’s emotional being, thus exacerbating trauma that is being experienced. As a result, the concept of self-protection from stigma and discrimination is perpetuated through silence. This becomes evident as they visit the local clinic for treatment. Instead of openly declaring their HIV status, they would rather refer to opportunistic infections experienced. This is done as a protective cushion against discrimination and rejection by the nursing staff AND to alleviate the effects of the trauma experienced when visiting the clinic.
It should be noted that during the interviews, both with the infected and members of the community, open – ended interviews were used. Although this type of interview was suitable for this type of research considering the sensitivity of the diagnosis, it ran the risk of not bringing to the fore issues troubling the interviewee. Therefore, three cardinal shortcomings / limitations were diagnosed i.e. Firstly, a small sample drawn from a limited geographical area. This was necessary because it was difficult to locate and also to convince the people living with HIV/Aids to present themselves to be interviewed AND also to locate the locals who harbour some discriminatory attitudes towards the infected mine labourers, who were prepared to come out openly about their attitude.

Secondly, the accounts of the interviewees were taken without questioning either their encounter with stigma / discrimination by the local community. One had to respect their feelings and accept their responses and feelings as they presented them.

Thirdly, because participation to this project was solely voluntary and no inducement was offered, it could have had a negative impact in that the perceived participants were hoping to receive something in return for active participation.

The interviews revealed that most of the respondents who were misinformed about HIV transmission gave stigmatising
responses, suggesting that increasing the understanding about behaviours that are related to HIV transmission may result in lower levels of stigmatising beliefs about infected persons. This type of attitude challenges the researcher that AIDS educational efforts need to communicate more effectively how HIV is transmitted. It has been made evident that HIV stigma is more likely to thrive in an environment of ignorance and half-truths.

The other factor revealed by interviews with the infected migrant mineworkers is what the researcher can term “double discrimination”. The first discrimination concerns their place of residence. More often than not, they are discriminated because they are coming from the mine compounds. This is illustrated by the miner in this way: **when the locals speak to us, they address us as Makomponi (the ones living in mining compounds). When you buy from the local shop, realising that you are from the mines, the shop assistants immediately switches to fanagalo in a derogatory manner. (Fanagalo is a language used down the mines. It is a mixture of a number African languages into one to enable the miners to communicate)**

The second discrimination is experienced at the local clinic, when they receive their monthly medication supply. This discrimination is vividly captured in the following interviews with the infected miners:

**Interviewee:** The nurses made us to queue aside, waiting for the local residents to be served first. We will wait aside until everyone has been served. On an awkward day, we will go back to our
compound unattended, only to try for help the next day. There's no way we can avoid coming here (at the clinic) because it is our only source of help.

**Interviewee:** The moment the nursing staff realise that you coming from the mining compounds, you are immediately regarded a potential danger to their health. They will use protection masks, and gloves, for fear of contamination.

Goldin in his publication, ‘Stigmatisation and AIDS’, concurs with the findings of the research by asserting that HIV/AIDS has served to signal pollution and contamination, consequently PLWHA have been associated with dirt and uncleanness (1994: 1359 – 1366). As a result of the stigma associated with the disease, the community as well as the practitioners have judged PLWHA less favourably than they often do to others.

### 3.6 SUMMARY

HIV related stigma and discrimination severely hamper efforts to effectively fight the HIV and AIDS epidemic. Fear of discrimination often prevents people from seeking treatment for AIDS or from admitting their status publicly. The stigma attached to HIV and AIDS can extend to the next generation, placing an emotional burden on those left behind.

Denial goes hand in hand with discrimination, with people continuing to deny that HIV exists in their communities.

So how can progress be made in overcoming this stigma and discrimination? How can we change people’s attitude to AIDS
and those living with it?

A certain amount of success can be achieved through the legal process. However, no policy or law can alone combat HIV and AIDS related discrimination. Stigma and discrimination will continue to exist as long as communities whole have poor understanding of HIV and AIDS and the pain and suffering caused by negative attitudes and discriminatory practices. The fear and prejudice that lie at the core of the HIV and AIDS discrimination needs to be tackled at the community level with HIV and AIDS education playing a crucial role.
Chapter 4

So far, the first three chapters have painted a bleak picture of the devastating effects of HIV/AIDS on the migrant mine workers’ life in the particular area mentioned in the topic. Chapter two particularly, has depicted the shortcomings within the religious circles and the issues of discrimination and rejection of Christians who have been diagnosed as such. Chapter four will, therefore, specifically deal with those issues i.e. discrimination and rejection experienced by the mineworkers in pursuance of a new model of acceptance of those infected. The chapter will further explore ways of journeying with the infected as they close the last chapter of their lives in honour and dignity.

4.1. HIV/AIDS: A Pastoral Care Challenge towards a theology of acceptance.

In correcting the church’s Pastoral Care Model towards people living with HIV/AIDS, it is important to refer back to our case study's background mentioned in chapter one about Zama:

“Zama was a staunch church member, active in his hey days. When he laid on his death bed, everyone deserted him, he echoes in a fading voice: Mfundisi, andina mtu (Pastor, I don’t have anyone).”

Traditionally, in the Christian Community, the Pastor and the congregation normally care for the sick and those in need
BUT in the case of HIV/AIDS, it is sometimes if not always different due to the condemnation of the infected. Often the disease is regarded as a result of promiscuity, which is against the sanctity of life as prophesied by the teachings of the church. This is clearly demonstrated by the neglect and isolation of Zama by the church in which he worshiped.

Kirkpatrick, in the quest for a paradigm shift towards people living with HIV/AIDS refers to two types of death experienced by the infected i.e. The first death is when the person living with HIV/Aids decides to make public the fact that he is living with the virus and has to cope with the society’s disapproval, rejection and condemnation while suffering shame and guilt. Kirkpatrick’s second death refers to the gradual decay of the person’s physical being when death approaches (1988:3).

The above mentioned attitude meted-out by members of the Christian Community, clearly denies the infected any space whereby they can deal with their unfortunate situation, verbalise their anger and confront feelings of guilt in a space in which forgiveness is possible.

In inculcating a new theological paradigm shift of accepting people living with HIV/AIDS, the narrative of Jesus meeting with a man afflicted by Leprosy contained in the Gospel of Mark seems very appropriate:
“A man with Leprosy came to him and begged him on his knees, if you are willing, you can make me clean…” (Mark 1:40-45)

In the light of this, Markan quotation stated above, and Walter J Smith concur with the injustice Jesus felt at the sense of isolation and rejection (1988: 88). According to the author, Jesus showed the gesture of acceptance, support and solidarity with the afflicted, which ultimately helped to restore the man to his rightful place in the community. A lesson or two can be learnt from Jesus’ action in shaping the Christian community’s Pastoral Care Model in dealing with people living with HIV/AIDS. Firstly, the church has the primary responsibly of caring for the infected, which is the Modern Leprosy that isolates people from the community and the Christian family.

Secondly, the example of this caring ministry is demonstrated by Gerkin in his Shepherding Model of Pastoral care (1997: 27). His caring and tendering of his flock illustrate the analogy of the good Shepherd. The weak and weary ones are compassionately carried on the shoulder to continue with the journey. This is vividly captured in psalm 23:

The Lord is my shepherd I shall not want…
even though I walk through the value of the shadow of death I will fear nothing.

Campbell concurs with Gerkin in his shepherding model of pastoral care. Accordingly, in order to revitalise the imaginary
of shepherding in pastoral care, the church must restore its much neglected quality which is courage. The analogy can be the turning point for the effective Pastoral model of acceptance where the infected are isolated, rejected and discriminated. In this case, the pastoral care-giver as the shepherd is expected to be courageous in defence of discriminated and the rejected due to HIV/AIDS. It is this element of courage based on trust in God which seems obviously neglected in modern accounts of pastoral relationships. But there are other features of the shepherd’s character which are tenderness, skill in leadership, and concern for wholesomeness that make up a rich picture of what it means to care.

On the other hand, in its role as the shepherd of God’s flock, the church must address herself to the pandemic of HIV/AIDS by alleviating suffering in order to care for the mission of the church to be seen in terms of healing, guiding and reconciling the people of God and also the restoration of personal health.

In the correction of the church’s approach to the issue of HIV/AIDS, another author, Musa W Dube suggests methods of integrating HIV/AIDS in biblical studies, which can be tabled as follows:

- Since biblical study is a discipline that centers on the divine creation of life and the search for the divine will for all life and relationships, it cannot ignore HIV/Aids attack on life and how it affects particularly the sociality disadvantaged population and those facing
discrimination on the basis of sexual orientation and ethnicity.

- The impact of HIV/AIDS itself warrants a pedagogical response in biblical studies. It underlines the need for transformative compassion.

- HIV/AIDS impacts on all levels of life, socially it affects particular leadership at the community. It’s incurability has raised spiritual questions and its interaction with other social epidemics has exposed culture and many social; structures and institutions as inadequate and in need of a review (2003: 11)

The church by its very nature as the body of Christ has the ability to become a healthy community. Despite the extent and complexity of the problems raised by the HIV/AIDS pandemic, the church can make an effective healing witness towards those affected. The experience of love, acceptance and support within a community where God’s love is made manifest, can be a powerful healing force.

Mwaura in his essay edited by Waruta and Kinoti, acknowledge that it is at crisis point in life that human beings acknowledge their own limitations and learn to depend on God. Without advocating that sickness is necessary for this realisation, we cannot rule that it is in such moments of helplessness that a person starts to ponder about
the meaning of his or her existence and to take stock of him or herself (Waruta and Kinoti 2005: 90). Pastoral Care provided to the sick should therefore inspire hope and courage to the sick and thus not limiting its scope only to events of crises BUT enabling the individual to have control of his or her affairs to the degree the illness might allow.

4.2. Integrating HIV/AIDS in the daily activities of the church

The general theological responses have been made in the previous sub-sections regarding HIV/AIDS. In this section an attempt will be made to be more practical on what sorts of things to be done by the church in arresting the scourge of the pandemic.

More often than not churches, Christian groupings and Christians avoid getting involved in HIV/AIDS ministry because they feel that what they can offer is too little for a major disaster like HIV/Aids. In an emergency situation like the one of HIV/AIDS no effort is too big or small for the community to shy away from. The first step for the church to be effective in the fight against HIV/AIDS, its discrimination and isolation is to recognise that the disease is not only confined to those outside the faith BUT rather people within the church are the sufferers. If this is not recognised, those living with the virus will begin to feel marginalised and isolated due to the lack of programmes in addressing their plight AND above – all, the lack of trust in a church where social or community challenges are not addressed. The researcher’s observation is that in a church where troubling issues
affecting members are openly and genuinely discussed, the response becomes huge and such a church is likely to attract more membership as everyone will have a sense of belonging. The following can help in integrating HIV/AIDS in the life of the church:

4.2.1 Order of Service (liturgy) and a prophetic ministry: Most churches spent vast amounts of time in the order of service that often do not address the issues that the members are grappling with on a daily basis. e.g. In the Methodist church where I’m a pastor, we still pray for the Queen of England whom the ordinary members do not even know or will never meet. Issues like poverty, unemployment and HIV/AIDS are hardly mentioned or prayed for. Members come and leave the church without their troubling issues being touched or prayed for. The HIV/AIDS pandemic therefore challenges the church to re-visit the reconstruction of such liturgies to address the stigma and rejection that members are faced with on daily basis.

The church has a prophetic duty to preach against stigma and discrimination of those infected and affected by HIV/AIDS. The church has the obligation to preach about the scourge of the pandemic. The clergy have a captive audience every Sunday and can use the pulpit and other church platforms to enhance and banish stigma and rejection of people living with the virus. Another area, which the church can be more vocal, is in the area of poverty and unemployment, which are the fertile breeding ground for HIV/AIDS. Churches can initiate self-employed projects to alleviate poverty and unemployment. This will have positive spin-offs as people will be
self-reliant and be able to fend for themselves rather than begging or young girls turning to prostitution in search of survival. Finally, the church from her pulpit should advocate moral values that will tackle cultural practices that make women and children vulnerable to HIV/AIDS and empower them to take control of their own bodies and sexuality.

4.2.2 HIV/AIDS Education and Awareness: An old English proverb says: “where there’s no vision, people parish.” By nature of her huge following, the church can be a perfect launching pad for HIV/AIDS education. As far as I know and as a pastor, the pulpit is the only platform from which people receive information without questioning its merits or demerits. The platform/ pulpit can be used for breaking the silence and discomfort that surrounds HIV/AIDS. The church can be a healing community only if it is truly a sanctuary, a safe place of healing. For healing to take place a conducive atmosphere should be created where people are comfortable to share their pain. People living with HIV/AIDS can be encouraged to share their stories and talk about their own status. This will educate others that AIDS is not a death sentence but rather a challenge to live positively with the virus. The practice will also have positive spin-offs by creating an atmosphere of accepting the ones living with the virus as opposed to rejecting and discriminating them.

A special Sunday service can be dedicated for those living with
the virus and members encouraged to put on their red ribbons as a symbol of being in solidarity with the infected.

4.2.3 Funerals: apart from the emotional and spiritual support that the church can offer, the greatest challenge remains the high death rate due to AIDS. The church is challenged to give more direction about what the Christian response is to funerals and needs to help promote alternatives as opposed to the high expenses involved in organizing such funerals. More often the families of the deceased are being plunged into poverty and debt because they feel it is their duty to provide a proper sent off for their loved one. The church should take the lead in educating and advising members that dignity and respect are more important than the show of material wealth at funerals and thus doing away with some unnecessary costly trimmings.

4.2.4 Raising awareness amongst men: Very few churches have ministries specifically for men. The HIV/AIDS pandemic, therefore, challenges churches to establish men’s forum where issues troubling or empowering men can be discussed. Historically, the church has accorded men enormous power in electing them in leading roles in the church and affirming their leadership at home. In the same vain, their leadership role can be profitably used to lead the campaign against the spread of HIV/AIDS, discrimination and rejection against those who have been diagnosed as such in the church as well as in the community.
4.2.5 Empowering women

Women have little control or autonomy over their sexual lives. They are often forced to submit to the erotic wishes of their husbands. This is supported by the teaching that women should submit to their husbands as the husband is the head of the family:

“Wives, submit to your husbands as to the Lord, For the husband is the head of the wife as Christ is the head of the church, his body, of which he is the saviour. Now as the church submits to Christ, so also wives should submit to their husbands is everything “
(Ephesians 5:22 – 24).

To help women and girls, the church must reject patriarchal structures of the church and society. Too often the church has openly or covertly supported patriarchal tendencies in which women have been treated as objects rather than subjects. Attitudes like those have contributed to the spread of HIV/AIDS because women have no power and control over their well-being. The church is, therefore, called to champion human rights, particularly of women, in order to eradicate sexism and gender inequality in the society. There are some cultural practices that disregard the human rights of women, i.e. some communities still practice widow cleansing and widow inheritance.

The practice of widow inheritance and cleansing prescribe that a widow should be “cleansed” by having sexual intercourse with a stranger after the death of her husband so that she can be inherited
by one of the late husband’s relatives or the younger brother of the deceased husband. This practice is humiliating to the grieving widow and very traumatic to her.

The church has both the moral and pastoral responsibility to protect these vulnerable women AND above-all, the ethical responsibility to curb the spread of HIV/AIDS amongst her members through such practices.

4.3. Journeying with the Rejected and Discriminated Mine labourer towards closure

Sunderland and Shelp in their book, ‘A manual for pastoral care’, liken the response of the infected with that of grief, which in dealing with requires a climate of openness to be created (1987: 34). The authors suggest one cardinal point, which the counselor should take into cognisance if a conducive climate is to prevail in the journey of counseling the person living with HIV/AIDS. These can be summarized as follows:

Because HIV/AIDS patients usually experience rejection and discrimination they are always searching for acceptance and understanding (1987:35)

In the case of the migrant mine worker dying with HIV/AIDS, blame and discrimination can be meted out by the surrounding community members and/or their peers at the mining compounds regarding them
as have been promiscuous or reckless with their being and life-style.

As they are a people facing the threat of imminent death, they are constantly looking for some way of finding meaning both in their lives and in approaching death. In this last lap of their journey Keith – Lucas suggests three critical factors to be considered:

- **Reality** which is an acknowledgement of the situation BUT not discounting the infected with dilemmas and problems.
- **Empathy** which is the carer’s or the counselor’s response to what the patient is experiencing.
- **Support** which will be offered at different levels like physical, mental or emotional (1984: 77ff)

As alluded to in the research methodology that one of the acumen of qualitative methodology is to be sensitive to the human situation thus involving an empathetic dialogue with the infected, in this case, it is clearly demonstrated whereby the person living with HIV/AIDS needs both sympathy and empathy. Through empathy the counselor will try to put him or herself in the patient’s feelings and by means of sensitive listening the counselors enters the unique world of that person. Through sympathy, a process of reciprocal understanding and Pastoral nearness is established thus confirming to the sufferer that he will be cared for, listened to instead of being discriminated. The sufferer will be receptive and accommodative thus opening up for further help to flow through.
In a normal setting, when one is sick, the family will gather around the sick person to form a chain of hope in a hopeless situation. The situation becomes worse in the case of someone at the brink of dying alone in the mining compound without anyone to care for. In journeying with the person living with HIV/AIDS, embracing and touching can play a significant role to the sufferer because it demonstrates the acceptance of them (Amos 1988: 74). Given the extensive stigmatization, isolation and the fear of others, which will ultimately force them to be withdrawn from the society and eventually losing contact with the others, touching and embracing can bridge the gap created by those actions.

Amongst the Batswana people of Botswana where I was the pastor, as with other African Cultural groups, visitors are to be treated with utmost courtesy. When visitors announce their departure, hosts are always expected to persuade them to stay. When visitors finally leave, hosts are expected to see them out of the homestead, perhaps up to the kraal, more importantly; they are expected to travel with them for the good part of the journey. This gesture is called “Go felegetsa” (to accompany). This gesture signifies to identity with the person undertaking the journey. In effect it symbolizes “you are not alone in this journey, I am with you, your journey is mine as well.

In the light of the above – attribute, the Pastoral care giver is called upon to travel with the infected in search for answers moreover in the hour of need. The pastoral care- giver is thus called upon to live out
the positive attitude towards the travelers in the journey of HIV/AIDS. The accompaniment must express solidarity and be sensitive to their (the infected) rights and needs. It must be a journey that will break down barriers between “us” and “them”, which are the cornerstones of discrimination and rejection of the infected. This journey challenges the pastoral care-giver to be compassionate, committed and dedicated.

The notion of accompanying is akin to the African traditional values of Ubuntu. Doing whatever is necessary to care for a sick person because their sicknesses affect everyone in the family, and working hard to ensure that life flows on as normal.

In biblical terms, the notion of Ubuntu and being compassionate to others is captured in 1 John 3:16:

“This is how we know what love is: Jesus Christ laid down his life for us.
And we ought to lay down our lives for our brothers”

This passage reminds us that we are our brother/sisters’ keeper thus we cannot hold back from getting involved in the crisis of HIV/AIDS. Through our ministry, interaction with the people in our communities and in defense of those suffering stigma and discrimination.

This brings us to the call of the church i.e. to care, to uphold the health of the infected and affected community and to offer the community the support it needs to care for the others. It is at this
stage where home based care for the sick seems relevant to the community. As the church identifies with the community’s suffering in the face of HIV/AIDS, like wise, the community of the body of Christ is called to enter into suffering of others, to stand with them against rejection and discrimination.

4.4 Closing one’s chapter of life in honour and dignity

Death from HIV/AIDS can be a horrendous experience. More often it is characterized by isolation whereby the patient’s room is dark and deserted. It may come at a time when the carer’s patience has been stretched to the limit. This is as a result of physical and emotional exhaustion.

Smith asserts that when we talk about the person dying of HIV/AIDS in honour and dignity, it means that every effort should be made to ensure that the patient’s right are safeguarded. AND as long as a dying person is conscious, he needs to take control over decisions affecting care (1988: 133). The author further states that the space created for the patient to prepare his departure, respect for his condition and the commitment to support the person through the transition from life to death can contribute to the dying person’s feelings of dignity.

As alluded to in the five stages presented by Kubler Ross on death and dying, this final stage should not be mistaken for a happy nor an unhappy one (1986: 100). The last lap of one’s journey should also not be interpreted as a helpless resignation to the inevitable but
rather more like a personal victory, spiritual triumph over the fear of death.

The process of closing one’s last chapter of life in honour and dignity is described by Nighswanger (1971: 105-108) as a drama of life and he divides the process into the following dramatic moments:

- A drama of shock = catharsis versus depression
- A drama of negotiation = bargaining versus surrender
- A drama of assessment = realistic hope versus despair
- A drama of commitment = acceptance versus resignation
- A drama of completion = fulfillment versus forlornnes

This can assist in the analysis of the dying process (cited in Louw, 1994: 171).

In the light of the above, words no longer matter. In the absence of consoling words and expression, compassion takes over. There, compassion takes place in the form of being present with the person in distress and entering into his experience.

The journey of helping an AIDS sufferer to chose his/her chapter of life in honour and dignity is characterised by three main “sign posts’ i.e. Compassion shown to the sufferer, love to overcome the fear of the unknown and the attitude towards the infected.

To paint a clearer picture about the situation experienced by the sufferer, these “sign posts” in this journey will be individually discussed:
Compassion: persons dying with HIV/AIDS are to be viewed as humans who contracted a disease caused by a deadly virus, and they therefore in need of compassion and sympathy, how one has contracted the virus is no longer important as this stage as the enquiry will only serve to exacerbate their situation. At this stage, what is important is to focus on the persons in need of compassion and to be treated in the most human manner in order to close their last chapter of life in honour and dignity. It would be insensitive of the pastoral care-giver to be judgemental in the care of the patient concerning the source of the disease they are suffering from. It should be the aim of the care-giver to share the patient’s burden. In offering care to the infected, the pastoral care-giver, will be following the example set-out by the compassion shown by Jesus Christ towards the sick. Compassion was one of Jesus’ attributes in his healing ministry e.g. the man healed of leprosy “Filled with compassion, Jesus reached out his hand and touched the man” (Mark 1:41)

**Love:** The second “sign post” in this journey is love which is demonstrated by the care-giver in order to enable the patient to overcome the fear of the unknown. Fear has been established to be the main barrier in effective ministry to the dying. The loving compassion becomes the basis of the starting point in the process of this journey. John confirms that there’s no fear in love:

> "There is no fear in love. But perfect love drives out fear, Because fear has to do with punishment The one who fear is not made perfect in love

(I John 4:18)
On the basis of the above argument, the Christian pastoral care-givers can be willing to sacrifice themselves to alleviate the pain of the sufferer by dispelling this fear of the unknown in order to help the sufferer to face death in a dignified and brave manner.

**Attitude towards the sufferer:** Attitude is particularly important in the suffering of those infected with HIV/AIDS. Persons dying of AIDS need care-givers who are willing to carry the burden of sickness that they are carrying.

In summarising these three important “sign posts” to the care of the infected in their hour of need, the care-giver who would be truly helpful to help the sufferer to close his chapter of life in honour and dignity, must offer a compassionate response to the sufferer, regardless of his/her personal stance on the morality issue. Through love, the pastoral care-giver must help them deal with their unknown fear.

Their attitude in cultivating this type of caring will therefore foster a meaningful ministry to the HIV/AIDS sufferer.

### 4.4.1 Living and dying in Hope

As we accompany those living and dying of HIV/AIDS, the most critical question is how we proclaim hope in the midst of this devastation. How does the church preach the gospel of hope as many of her members are dying destitute and sometimes lonely deaths away from the caring family members as in the case of migrant labourers.
Such questions are informed by the devastation and despair brought about by the scourge of AIDS. With so much death around, HIV epidemic has led to hopelessness among many young people who die in the prime of their affluent lives.

On the other-hand, the church has not been spared the wrath of the devastating effects of the pandemic. My fellow Methodist minister, whom I once met at the local grave-yard in Welkom, frustratingly said: “I have invested more time in the grave yard, burying AIDS “victims” than conducting ordinary church services. I feel exhausted and have run out of funeral sermons.”

The critical challenge is how to locate HOPE in the midst of despair, BUT above all, how does the pastoral care-giver resuscitate hope to the infected and to those on the verge of dying, to help them to face death peacefully.

Pastoral care to the dying is about transmitting a hope and life which should exceed the barriers of human potential. How one has lived, determines one’s outlook on life. And who one is, is decisive for the quality of one’s dying process. Thus, people die as they have lived. ‘That is how pastoral care is important to help such people to live life to the fullest before they could die. The quality of care will most importantly determine how they part with their loved ones.

Hope is the distinctive resource that the church brings to the overall response to HIV/AIDS. The church is uniquely placed to bring hope to desperate communities. The church is compelled by her religious conviction to bring forth hope, even during the hopeless situation of
the devastation of HIV/AIDS. This hope is proclaimed by Paul to the Roman Christian community in the midst of their suffering:

“I consider that our present sufferings are not worth comparing with the glory that will be revealed in us” (Romans 8:18).

In the context of suffering and death, the church should proclaim hope as the last resort in order to ward-off the devastation caused by the pandemic. It should not only bring about vision for a better life after the effects of HIV BUT sustain that vision.

4.4.2 Living in Hope: Stories of mineworkers diagnosed with HIV

The stories in this section, as related by my co-researchers, illustrate how hopeful the infected mine workers can be when the Christian community pastorally journey with them to find hope in their despair. It is through loving and caring that the infected are able to regain hope in the midst of suffering.

Story 1: When I was first diagnosed with HIV. I was able to do my work as normal.

No-one ever realised the emotional battle I was engaged in.

The situation changed when I was in and out of hospital. I was becoming weaker by the day. At work I was relegated to work at the surface because I could no longer cope with the harshness and strenuous work underground. As my health deteriorating, I ended up at the mine hospice, not even a single co-worker
cared to visit me, except for the local pastor and some members of his congregation. Their visit reignited my hope and a purpose for living in the midst of my emotional and physical struggle of rejection due to HIV infection. I believe that, if I had not God and encouragement from the Christian community, I would not have coped this far.

**Story 2:** After I was diagnosed, my friends deserted me. My family moved away from me and I was left alone. I have learnt to love myself and not let people dictate the course of my life. No matter how people may try to put me down, I will never fail, as long as the people of God (referring to the church), are there to support me.

The above stated stories signify that HIV/AIDS is not only a tragedy to humanity, BUT, rather God’s opportunity to reveal Himself through his servants. It is an opportunity to draw nearer to God in the midst of suffering AND above-all, a challenge as we strive to be faithful to God’s calling. Spiritual hope in the midst of suffering is echoed by Gennrich (ed) “The gospel of Jesus Christ offers to the world life in all its fullness. The vision of the kingdom of God brings near the hope and reality of a society built on the foundation of all embracing love and compassion and grace. Jesus doesn’t despise those whom society rejects but he shows compassion and love for them. The true proclamation of this gospel therefore requires that we openly
embrace those infected and directly affected by HIV/AIDS, and all that it entails (2004:113)

4.5 Summary

It is the researcher’s contention that no words can appropriately summarise this chapter than the quotation from the Kairos Document to illustrate the urgency to contain the scourge of this pandemic, stigma and rejection associated / linked to it.

“The time has come, the moment of truth has been plunged into crisis that is shaking the foundations and there is every indication that the crisis has only just begun that the crisis has only just begun and it will deepen and become even more threatening in the months to come…”

(Kairos document, 1985: 61 – 81)

It is the researcher’s submission that the words or declaration once echoed by the theologians in the fight against Apartheid during the 1980’s can be echoed even today. The difference is, would be they would be said not against apartheid but against HIV/AIDS, its discrimination and rejection. They spell the urgency to equip people with all amours needed in the fight against the scourge of the pandemic for it has ushered the crises of shaking personal, societal religious and communal foundations.

The signatories of the kairos document explained the kairos in terms of the crisis, the moment of truth, the moment of grace and opportunity. Likewise, the scourge of HIV/AIDS presents the
moment of crisis, whereby people are dying on daily basis, children orphaned and the economy weakened due to the disease. The pandemic also presents an opportunity to show love and care to the infected and the challenge to find new ways of dealing with the pandemic.
Chapter 5

The HIV/AIDS epidemic is the grant challenge facing humanity. The epidemic challenge appalling human suffering to the infected and affected, individuals and their families, communities and nations alike. It leaves nothing untouched and it continues to baffle the world. In the journey to arrest the scourge of this epidemic and to control its effects, many useful strategies have been yielded as well as mistakes committed. Some useful strategies included mobilisation of communities and advocating safer sex practices, which to some extent helped a great deal in breaking the conspiracy of silence associated with the disease. Some of the mistakes committed include among others: the long period of disbelief and the delayed response to the warning signs posed by the epidemic, the self-righteous attitude that associated HIV/AIDS with promiscuity which perpetuated stigmatization and rejection of the infected AND thus associating HIV/AIDS infection with death, resulting in the fear of not revealing one’s positive status.

5.1 Achievements of the study

It is the researcher’s submission that the study achieved what it sought to achieve in dealing with the issue of HIV/AIDS. The following points will justify the opinion as set out:

The study sought to combat the discrimination and rejection of the migrant mine labourers by the local community of Welkom who suffered trauma as a result of HIV/AIDS infection. The study found
without any shadow of doubt that the community isolated the migrant labourers. The miners were thus regarded/referred to as “foreigners” in their country of birth. Those diagnosed as such were regarded as outcasts, promiscious and labeled as transporters of the deadly virus. Webb contests this by suggesting that the influence of the migrant labour system has been exaggerated. They may not be at higher risk than other groups per se. (1997: 90). The study also revealed that those who have contacted the deadly virus, more often that not, suffered in isolation without anybody taking care of them. The study also revealed the plight of migrant workers especially mining workers who reside in mining compounds, away from family members who could otherwise look after them in times of need.

The study showed that the church still lacks behind in the struggle against HIV/AIDS and the issue of safer sex education. The church has relegated the subject of sex to the NGO’s, health sector and government entities. The sex subject is still treated as taboo within the religious circles and how it relates with people who have been diagnosed with HIV/AIDS. To correct this scenario, the study has come up with the following measures in re-shaping the churches response to the pandemic:

Inculcating the theology of inclusiveness. The HIV/AIDS pandemic provides as opportunity for the church to visibly live out the testimony of Christ. The church as the body of Christ is also infected and affected by the epidemic for its members suffer and die.

The study has made evident the delicate, interwoven relationships of human beings and their connectness to all of life. HIV/AIDS requires the analysis of a cluster of inter-related factors i.e. Theological,
ethical, human rights, sexuality and family perspectives that inform, or arise from our understanding of the pandemic of these factors. Human sexuality has received the least attention within ecumenical community and further study is essential in this area for a deeper understanding of those challenges posed by HIV/AIDS. Our exploration of these themes in the study has brought us face to face with issues, understanding and attitudes, which have major consequences for the churches in responding to the pandemic. Lastly, the practical steps to be undertaken by the Christian community in combating stigmatisation and rejection meted-out to the infected, have been addressed by the study. These will create an environment of acceptance and a conducive atmosphere in accommodating those infected and their families.

The participant observation approach model used to analyse the dilemma faced by the discriminated and rejected migrant mine workers in their moment of grief, has successfully opened-up a road map in their journey in closing their last chapter of life in honour and dignity. This has changed or challenged the infected not to view HIV/AIDS diagnosis as a death sentence but rather a challenge to live life positively to the fullest.

5.2 Validation of the problem statement

It is the researcher’s submission that the problem statement has been validated – the discrimination and rejection of migrant mine labourers by the local community of Welkom. This has been proved by the misguided understanding and perception that the HIV/AIDS
virus is being brought about by the migrant labourers thus regarding them as transporters of the virus. Whilst this may be true that their slackness in morality values contributed to the spread of the virus by using the services of commercial sex services, they are not absolutely to be blamed.

A further verification of the problem statement is found in the admission of community members interviewed during the course of the research for this study. In their response to the question as to why does the community discriminate against people living with HIV/AIDS (especially migrant labourers), they readily admitted that they are the ones bringing about misery and pain to their community. Others went further to justify their discriminatory attitude by claiming that they impregnate their daughters and sisters who give birth to “fatherless” children born of AIDS.

The church has been riddled by insufficient knowledge and skills in combating the scourge of HIV/AIDS. The epidemic has challenged the church to a new theology of acceptance.

In view of the phenomenon that has unfolded during the cause of this research:

- A pastoral care model should be adapted to care for the infected and their families not to lose faith in the face of the pandemic.
- The Christian community should take a lead in empowering Christians about the do’s and dont’s in the midst of HIV/AIDS infection.
- The church should minister to the society in a special way by
offering a unique forum for education. The people of God have an important task in providing positive sex education for both church members and the wider society.

- The AIDS epidemic offers a unique occasion to begin a new to live as servants. It offers us an opportunity to respond with compassion to the needs of the unfortunate sufferers. This crisis gives the Christian community an opportunity to emulate God’s love through caring for the infected.

- It should also continue to play a prophetic role of exposing the ills of the society by going a step further to rehabilitate the community’s selfishness and greed. The healing ministry of the church should be seen not only in healing diseases like HIV/AIDS BUT healing other sufferings with an economic, social or political cause.

- The church should empower the communities about the dangers of HIV/AIDS and how to combat discrimination and rejection of those living with the virus. Such a model of acceptance should take into cognisance the cultural and religious background of the community.

- Empower the migrant mining community about the dangers of engaging in multiple unprotected sexual activities and the dangers of HIV/AIDS. As they are community in isolation, they should be empowered on how to emotionally support each other in the event of HIV/AIDS diagnosis, to avoid dying in isolation away from the caring family and friends.
5.3 Hindrances encountered

Accessing PLHA’S has been a major hindrance in accomplishing this study. This obstacle is due to the nature of the disease. Although HIV/AIDS is a chronic ailment, it is surrounded by secrecy as it reveals more about us; in this case conspiracy of silence becomes a norm. Secondly, people are reluctant to reveal their status for fear of judgmental attitudes and discrimination. Therefore, the researcher could not access PLHA’S other than those at the hospice. Regarding the issue of confidentiality and privacy, Sunderland & Shelp have this to say:

“Many patients attempt to restrict the truth about their physical condition to individuals who have a need to know their fears of disrupted relationships, lost employment, cancelled insurance, or loss of housing, based upon their knowledge of reactions to people suspected of having AIDS or actually diagnosed with the disease, are often well grounded. The potential or actual loss of these opportunities can have a negative effect upon a person’s self-esteem, self-actualisation, quality of life and immunological function” (1987: 45).

In the light of the above, people living with HIV/AIDS were not at liberty to reveal their status even to a research that could have otherwise alleviated their plight and that of the others.
5.4 Research contributions to the field of the study

The research has contributed to the field of the study by exposing the plight of the mine workers who have been diagnosed with HIV/AIDS which could be tabled as follows:

- It has helped to expose the discrimination and rejection meted-out to the mine workers. In this way, a spirit of caring for each other has been enforced so that the infected should not be treated as foreigners and outsiders in their country of birth. The spirit of ubuntu (caring for each other) in times of crisis has been enforced. This has been done by bringing to light the traditional short-comings in dealing with the issue of AIDS and breaking the conspiracy of silence which has for a long time over-shadowed the discussions relating to the pandemic.

- Theologically, the study has empowered the Christian community to develop a theology of acceptance by integrating HIV/AIDS into the daily activities of the church in a way of combating stigmatization and rejection of people who has been diagnosed as such.

- Lastly, the research has empowered the pastoral care-giver with some skills on how to journey with the infected and affected, especially those who face their last lap of their lives due to HIV/AIDS, in order to die in honour and dignity. It should be a journey characterised by compassion, love and the right attitude which is undergided by trust to enable the infected to open-up to the invitation of the journey.
APPENDIX A: INTERVIEW WITH PEOPLE LIVING WITH HIV/AIDS

1. How has the community treated you, after disclosing your sickness?
   
   
   
   

2. Who stands by you/supports you emotionally in your situation?
   
   
   
   

3. Where do you find meaning and purpose to your life?
   
   
   
   

4. What special qualities and skills do you have that HIV/AIDS cannot undermine?
   
   
   
   

5. What examples do you know of people whose lives have held meaning even with HIV/AIDS?
   
   
   
   

6. Regarding your health status, how are you treated at work?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

7. Is your status a hindrance in you getting promoted at work?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

8. What are the hindrances/obstacles in socializing with family and friends?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
APPENDIX B: QUESTIONNAIRE FOR THE LOCAL COMMUNITY

1. Do you know what HIV/AIDS is and how it is transmitted?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

2. What do you think is the cause of HIV/AIDS?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

3. What are the physical manifestations of HIV/AIDS? E.g. weight loss, loss of hair

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

4. Does HIV/AIDS cause trauma to the infected?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

5. Why does the community discriminate people living with HIV/AIDS? (Especially the migrant labourers)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
6. Does HIV/AIDS have connection with witchcraft?

7. Why do you think migrant labourers are spreading HIV/AIDS?

8. Why do people living with HIV/AIDS are treated differently than those with diabetes, cancer etc.?

9. What do you think are the consequences of stigma in HIV/AIDS?

10. How do you think the church should treat people with HIV/AIDS?
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Topic: Traumatic Stigmatisation and Rejection of Migrant mine Labourers due to HIV/AIDS in the Welkom area. A Pastoral care perspective.

I am a student at the university of Pretoria in the Masters Programme. As a requirement to the fulfilment of the degree, one has to do a research project. My research aims to empower migrant mine labourers in the Welkom area who find themselves stigmatised and discriminated due to their HIV status.

A set of questions has been designed which I will request to ask you in a one on one interview. In asking these questions, I will request your personal experience of being discriminated and rejected as a result of your status by the local community. The interview will take not more than an hour of your time.

As far as the interview is concerned, there’s no harm in your participation in the study, rather, it is intended to develop a methodology that will enhance a theology of acceptance of the migrant labourers by the local Community and the church towards those who have been diagnosed with HIV/AIDS.
It should be stated up-front that all records resulting from this interview will be kept confidential and will be destroyed at the end of the project. The results from this exercise will be available at the university. Only the programme supervisor and I will have access to the information. And the participant's identity will be kept confidential to the public.

It should be noted that participation in this project is voluntary and no financial gain would be derived. Should you feel to withdraw at anytime for personal or any other reasons, you may do so without any fear of being victimised or penalised. For any questions, clarity or any other enquiry, please feel free to contact either myself (as the researcher) or the programme supervisor at the above-stated contact details.

Thanking you in advance.
Declaration

I, Nokuthula Sokufudumala, a male aged 46 years, agree to be interviewed by the Rev. Job Sempane of the Methodist Church of Southern Africa, where I am a member.

It is my understanding that information given to him about my HIV status will be treated confidentially and only for the purpose of the research undertaken.

It is also my consent that my name will not be used in this study as this may jeopardize my standing in the community and ultimately put my family under severe pressure and emotional strain.

It is our agreement with the researcher that for the purpose of this research and confidentiality, I will be addressed by the pseudonym “Zama” to conceal my identity.

I hope and trust that this will be respected for me to help in this research.

Signed at Welkom:

Participant’s signature ___________________________ on the ________________

Researcher ___________________________

Contact: 083 359 4000
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