

## CHAPTER 1. EVERY STORY HAS A BEGINNING

### 1. INTRODUCTION

I developed an interest in the study of the impact of HIV and AIDS in 1993 when I worked for the South African Council of Churches (Vaal Branch). As one of the personnel who worked at their Education and Development desk, I had to undergo rigorous preventive education training in HIV and AIDS and related issues. Since the virus was mainly associated with promiscuity, my main focus as a young and vibrant Pentecostal preacher was on the opportunity of using the knowledge gained in ‘preaching’ to people to repent and lead a righteous life. After years of minimum participation in HIV and AIDS-related issues, I was forced to be more involved in the preventive education when my only sister fell ill and the cause was diagnosed to be an HIV and AIDS related illness in 1997. It was from this experience that I decided to work hard to acquire as much knowledge as I could and be able to assist members of my community whenever a need arose.

#### 1.1 Every story has a beginning: Background information on HIV and AIDS

For this research to be concrete, it would be very important to introduce background knowledge and the impact that HIV and AIDS has had in our world. It has been 28 years (1981-2009) since the discovery of the Acquired Immunodeficiency Syndrome (AIDS). It was in the USA in 1981 that a rare form of *pneumonitis* and a rare skin disease appeared simultaneously in several male patients (Van Dyk 2001:5). As all these patients were young homosexual men, this new disease was called ‘homosexual’ illness. It was in 1983 after further research that it was discovered that this disease is caused by a lymphadenopathy-associated virus (LAV). As late as 1986 this virus became known as the human immunodeficiency virus (HIV). A few years after this American discovery, a new disease with the same symptoms as HIV/AIDS was identified in Central Africa among the heterosexuals. According to Fourie (2006:1), South Africa claimed its first HIV and AIDS victims in 1982. As in America, these first victims were white homosexual young men.

## **1.2. Human reactions: Adding more pain to the story**

The human reaction to those infected by the virus was to stigmatise and label them as promiscuous. This was not different in churches, especially among those with a fundamentalist foundation that preached individual salvation and moral purity above social and communal sins. These were the types of churches which would condemn a drunkard or adulterer, but be silent when apartheid destroyed the lives of Blacks in South Africa. The stigmatisation was the best defence mechanism for the church to keep itself 'pure' from those out there 'whom God was punishing for sodomy and promiscuity'.

To some pastors from the above mentioned background, the HIV and AIDS infection motivated them to scare the 'immoral' and to encourage faithfulness among believers. The message of condemning sex before marriage, which I truly believe to be the truth, was now being prioritised and exalted above other immoral behaviour. Added to that, the message of salvation was also narrowed to being sexually pure, regardless of one's shortcomings in other areas of personal struggles. It is this type of environment that created secrecy about one's HIV and AIDS status. As a result, nobody wanted anybody to know because this would result in either being disciplined, ostracised, stigmatised or even excommunicated. Because of these reactions from churches, the infected and affected people chose to suffer in silence rather than exposing themselves to 'torture' by revealing their status.

An interesting fact is that in these 28 years, many churches have softened and some have changed their stance from that of denial, stigmatisation, and labelling HIV and AIDS as a punishment from God, to more openness, acceptance, tolerance and care for those infected and affected. Many are practically involved in ministries and projects for those in need.

In emphasising the seriousness of HIV and AIDS, I would like to admit that there is no national or world calamity that can be likened to the spread of HIV and AIDS. Demonic, evil and terrible as apartheid was, it in nothing compared to the destruction HIV and AIDS has caused in the world. Whether we talk of the holocaust in Germany against the Jews, or the genocide of Burundi, or whatever we can try to liken it to,

nothing comes closer to the destructive nature of this pandemic. In one of the leaflets distributed by the National Youth Commission for the June 16 commemoration in 2000, the NYC had as its theme for the day: “HIV/AIDS: THE NEW ENEMY”. And as its introductory remarks it stated that

*“24 years ago brave young people fought against apartheid and defeated IT! 24 years later, there is an unseen enemy attacking youth- HIV/AIDS! Like the system of apartheid once did, HIV/AIDS threatens the survival of generations to come... We could all see apartheid being enforced at schools, workplaces and wherever we went. We cannot see HIV/AIDS with the naked eye, but unless we join the fight we will all be affected by it in some way”.*

True as the statement is that we cannot see HIV and AIDS, but the fact remains that we can see its destructive effects in our communities, neighbours and ultimately among our family members. We are not only affected as individuals, but many are also infected. Its effects are more dangerous and deadlier than war. The prevalence of HIV and AIDS is unstoppable because it has no medical cure and because of the secrecy surrounding it.

Be that as it may, HIV and AIDS challenges the church to look at itself, its attitude to judgement, morality and respectability, to create its own communities where people can learn to move forward and grow with each other (Woodward 1990:70). I agree with the WCC Study Document (1997:84) that the church is the place where people seek solutions, but the church has, in fact, been shying away from the realities of everyday life. The church is slow in reacting to social issues. Moreover, many priests are poorly informed about HIV and AIDS. Their only source of information is what they read in newspapers or see on television.

Instead of engaging in solutions to the crisis, some church leaders were busy debating the morality or immorality of HIV and AIDS, or whether to allow the sexually active youth to use condoms or not. Woodward (1990:51) is right in saying that sickness is not a theatre in which to rehearse arguments about blame and divine retribution or to score morality points. It is issues like these which retard the role of the church in dealing with the spread of this virus. It is only when people close to us become ill with HIV and AIDS that we first begin to understand the sheer scale of suffering

involved (Nicolson 1996:15). It is only at this stage that we start asking why they did not use all the precautionary measures like condoms. It is only then that we stop theorising because HIV and AIDS is no longer *'out there'* but *'in here'*. This is exactly the situation I faced when my sister was diagnosed as being HIV positive. That was my real wake-up call to action.

### **1.3 A “holocaust” story: the seriousness of HIV and AIDS for our world**

#### 1.3.1 World statistics

According to UNAIDS and WHO (2006:6), there was a total of 39.5 million people who were living with HIV in 2006. This was 2.6 million more than in 2004. This figure includes the estimated 4.3 million adults and children who were newly infected with HIV in 2006, which was 400 000 more than in 2004. In many regions of the world, new HIV and AIDS infections are heavily concentrated among young people between the ages of 15 and 24 years. This age group accounted for 40% of new HIV and AIDS infections in 2006.

#### 1.3.2 Our Continent, Africa

Africa has 70-75% of the people living with HIV and AIDS in the whole world. Between 80-90% of all HIV and AIDS-related deaths occur here, as well as 95% of HIV and AIDS orphans in the world. In this continent, there are more women living with HIV and AIDS than men. I agree with the statement that I read in one pamphlet saying that *'in Africa HIV/AIDS has the face of poor black woman'*. This implies that in this continent, HIV and AIDS infects, affects and kills more women than men.

#### 1.3.3 The Sub-Saharan Africa HIV and AIDS statistics.

This region continues to be the leader in the global pandemic. It prides itself on two thirds (66%) of all adults and children infected with HIV and AIDS, with its epicenter in Southern Africa. The Southern Africa region has one third (33%) of all people with HIV and AIDS globally and 34% of all deaths in 2006. Almost three quarters (72%) of all adult and child deaths due to HIV and AIDS in 2006 occurred in the region: 2.1 million of the global total of 2.9 million. Overall, sub-Saharan Africa is home to an

estimated 24.7 million adults and children infected with HIV and AIDS. And this is 1.1 million more than in 2004.

#### 1.3.4 South African HIV and AIDS statistics

The Actuarial Society of South Africa (ASSA) developed a demographic and HIV and AIDS model that makes use of data from several sources to project the potential course of the epidemic and the demographic impact that it is having. According to ASSA2003 projections, there are about 5.4 million people out of the total of nearly 48 million South Africans who were infected with the virus in the middle of 2006. This gives a total prevalence rate of over 11% of the population. Of those infected, 11% of them are already sick with HIV and AIDS-related illnesses. The projection further states that this number will continue to rise and exceed a total of 6 million by 2015. At that same time, the number of HIV and AIDS-related illnesses will reach nearly 797 000 and it is further estimated that a total of 1.8 million people would already have died by then (Dorrington *et al*: 2006:1, 20-21).

#### 1.3.5 Provincial indicators

The ASSA2003 model reveals that the prevalence of the epidemic is the highest in Kwazulu Natal with an estimation of 40% and lowest in Western Cape with an estimation of 17%. Five other provinces are levelling off at between 30%-35%. My concentration will be on the Free State province, since the community of my research is in this province. The number of people living with HIV and AIDS (PLWHA) in this province in mid 2006 was 388 000. Out of this number, 46 000 of them were already sick with HIV and AIDS-related illnesses. The percentage of death due to HIV and AIDS is 51% of all deaths in the province. Out of the 103 000 orphans under the age of 18, 69 000 of them are the HIV and AIDS orphans who have either lost one or both parents (Dorrington *et al*: 2006:43-44). The life expectancy of the population in this province (Free State) is reduced to 46.9 years. While the males' life expectancy is 45.2 years, the females' is a bit higher and can be expected to reach 48.7 years.

## **2 EVERY STORY HAS A CONTEXT**

### **2.1 Description of specific context**

Marks (2002:15) describes context as that which names the ways in which human life and actions are subjected to the pushes and pulls of an environment. And the term environment means the background, situation or location. The term background includes the following: cosmic, biological and historical conditions of human situations and locations. The situation, on the other hand, is the configuration of the elements of background as they have a bearing on an individual, community or other social entity in a particular time and place. Situations are never separated from a background, but they differ from it in that the events or elements of situations impinge on and specifically shape the everyday life of the individuals or that of a group. Locations are those aspects of a situation that bring about social and psychological identity. Therefore any of these three: background, situation or location, can determine the meaning of context and contextual.

As a theologian and a researcher, I want to remain true to my context by way of location and situation and also by participation in my community of faith in Tumahole. It is this community that influences my life, my identity and situation. It is this community with its perplexities that gave my thinking its theological or pastoral character.

The action and action fields of pastoral care of three Christian women infected and affected by HIV and AIDS as well as my own exposure to individuals, family members and communities living with HIV and AIDS appealed to and impressed itself upon me to such an extent that I would like to interact with this specific action and action field in order to listen to, experience and understand more of how people perceive their own experience of pastoral care in Tumahole in relation to the knowledge, insights, attitudes, perceptions and behaviour of fellow believers, their immediate community and society at large.

The action part includes the problem, but goes beyond that. In the narrative approach the ‘now’ is the action, and therefore dynamic in nature. To take the action seriously and to have it told is to open up a possibility to create a new ‘now’ for tomorrow.

The research project is, however, not only or even in the first place about the action, the action field and the related stories, but about these women involved in these actions, action fields and stories. In this way, the social-constructionist character of our research takes shape from the outset, while conducting free-ranging and in-depth conversational interviews with these individuals that will further enhance the narrative nature of this research.

My personal story within the context would be better described as my insertion. De Beer *et al* (1998:49) describes the term insertion as the first step in doing theology. It has to do with my present experiences and the actions I take in responding to the challenges raised by the context, and at the same time I am relating that response to my faith. It is a response to the present challenges within a specific context. As a Christian, my response will always have its starting point in faith. Theology is the knowledge about God; how one understands God in one’s present situation. The way one understands and experiences God, is how one will respond to and reflect on Him in a given situation. As situations differ, so will the experiences and reflections of people. For the experience and reflection to be relevant, it has to be influenced by the context. Insertion can also be understood in terms of the incarnation of Jesus. I agree with De Beer *et al* (1998: 51) when they say that in incarnation we are challenged to enter the reality of the inner city (context) as Jesus entered our reality, giving ourselves as Jesus did, becoming human for other human beings, showing solidarity with the pains of the city.

The incarnation therefore means to be ‘immersed’ into one’s community in ‘every way’, to be part of it through and through. It also means God’s dwelling with and among us. It is He choosing to identify with us. I fully agree with Carr (1989: 74, 83) when he explains incarnation as God’s statement of His willingness to be used in the confused human dynamics of transference. The doctrine of the incarnation is firmly

located both in common human experience and in the particular experience which pastors themselves acquire while ministering to and with people. This process is called contextualisation of the message to a particular situation. Nolan (1988:27) defines contextualisation as the process of discovering what the Spirit is saying to the churches in our context today and this is done in the light of what the Spirit said to the churches and the prophets and Jesus in the past. Incarnation, therefore, means that God has already entered into our human situation and now we must open our eyes in order to see where God is, what the risen Christ is doing and what the Spirit is calling us to do. This compels us to move out of our comfort zones to where God wants us to be.

My background is that I am an ordained pastor in the Apostolic Faith Mission of South Africa (henceforth AFM). The AFM is a Pentecostal church. I became part of this church since 1983 when I was reborn. A year after completing Matric (Std 10/Grade 12), I was employed as a laboratory assistant at the Randfontein Estate Gold Mine (REGM). It was during that same year that I felt the inner urge of the calling of the Lord in my life. The following year (1985) I went to Central Bible College in Soshanguve to study and be equipped for the ministry. I completed my studies in 1987 and began my ministerial practice in a small place called Refengkgotso near Deneysville along the Vaal Dam. It was in this community that my ministry changed from being an ordinary preacher focusing on the Bible and individual sin. Poverty and people's needs in this community challenged me to focus on helping the poor to uplift themselves. I helped the community in forming the development organisation that focused on helping them to become the best. After eight years of my ministry at this community, I received a call from Tumahole (a township near Parys). I arrived in this community on 8 May 1996 and stayed there for five years until I received and took another call to Naledi (Soweto) in 2001.



## 2.2 The Tumahole Community

The narrative research is contextual. This research paper tells the story of three people and their families living in Tumahole. Tumahole is situated in the magisterial district of Parys in the Free State province. The town is on the banks of the Vaal River at the border of Free State and North West provinces (Greater Parys TLC 1998:8).

In my five years' stay in this community, I became very much involved in community structures. In the first month there, I joined the local ecumenical body called Tumahole Ministers' Fraternal (TUMIFRA). In 1997 I was instrumental in founding another organisation of the Pentecostal and evangelical churches called Tumahole Pentecostal and Evangelical Churches' Alliance (TUPECA). The reason for this body was the fact that most of the churches in the Pentecostal and evangelical traditions either felt intimidated or did not feel comfortable among churches of others traditions like those in TUMIFRA. I was the chairperson of this organisation until I left the community in 2001.

Apart from my involvement in churches or the ministry's related matters, I was also involved in educational and developmental issues. In education, I was the chairperson on the Botjhabatsatsi Primary School's SGB (School Governing Body). When the SGB's of the community decided to come together to solve issues of common interest, I was also elected chairperson of the newly formed Tumahole Local SGB's Association.

In the community developmental involvement, I was able to establish a centre for students who would later register with UNISA to do a Practitioner's Certificate in Adult Basic Education and Training. Some of these students went even further to complete a three year diploma in ABET. It was through this centre that projects such as the Early Childhood Development (ECD) and the Dressmaking School were established.

In short, I would say that I was part of my community in every way. I was fully incarnated into my community. Their concerns became mine. Their pain also became mine. It is from this perspective that I feel that conducting a research in this community will help me and these women to transform their specific community.

### 2.3 Solution: “One step at a time”

According to statistics from clinics and medical centres in Parys and Tumahole, the estimated infected people in this community are between 800 and 1200 (between 8-10% of the population). Almost every week, the community buries between 12 and 20 people of whom the majority (i.e. 60%-75%) are HIV and AIDS related.

The above figures are alarming, shocking and discouraging to those who want to do something. On this score, one is bound to pause and ask whether individual stories, like the ones of my three co-researchers, can make any difference in this ocean of despair. It is here that I am reminded of the story of the starfish that I read in Dube (2003:60). It read thus:

*“There was an old man in a small fishing village who woke early each morning to fulfil a special, self-given task. He made his way to the coastline to save the many starfish that were washed up on shore the night before. With the subsided tide they were guaranteed to lose connection with their life source, the ocean, and die within hours.*

*“Each morning, thousands were washed ashore. And while our friend could not save them all, he did his best to save as many as he could.*

*“One day, a young tourist stopped the man and asked him, ‘Sir, why do you work so hard to save these starfish? There are thousands. Surely you cannot save them all, and chances are that many will be in the same predicament tomorrow. Why do you toil so, when you do not make a difference?’*

*“The older gentleman was saddened by the words of the young man. He reached down, grabbed a starfish, and helped him safely back into the ocean. He looked at the man and said, ‘**It made a difference to that one.**’”*

The moral of this story is that the church should not try to change the whole world because this would result in dismal failure, but she should use whatever influence she possesses to influence individuals who would in turn influence their societies. Although the figures of the infections and prevalence mentioned earlier are scary and shocking, that shouldn't discourage us, but must be used as a basis to start with the intervention. Behind every number in the statistics, there is a human being; husband, wife, father, mother, brother or sister. Every number represents a living person. It is in this regard that the individual stories play a very important role. It is the moral obligation of the church to make a difference to individuals and to society as a whole. Gennrich (2004:72) reminds us to consider that in the church's involvement with individuals infected and affected by HIV and AIDS, we should know that God does not look at the number, but to Him every life is important. Each of the church's small actions count before God. And to the isolated, marginalised and stigmatised individual, the thought that one cares for him/her makes a great difference. The church is the friendly feet and anointed hands of Jesus to those in need, whether she is being appreciated, applauded or just ignored. This is what should motivate the Christian churches in their fight against this pandemic.

#### **2.4 The shock of my life: “*My sister is HIV and AIDS infected!*”**

My most shocking experience with a person living with HIV and AIDS was when my own sister informed me that she was diagnosed positive 4 years before this revelation. She had kept this secret until she was too sick and after the doctor had taken blood samples for testing. Her reason for deciding to inform us was to prepare us so that we should not be surprised with the results. I know the pain she must have been in because I was with her in the last few hours before her death. It caused even more pain to me when I had to inform people about the cause of her death. What we decided to tell people was that she died of pneumonia. This was what was written on the death certificate. Losing a member of the family because of HIV and AIDS brings psychological tension because of the stigma the community has placed on such people.

I can vividly remember a day when she was better and was able to attend a church service during which there was a time for the laying of hands on those who were sick,

as is a tradition in most Pentecostal churches. The elder who was administering the service asked those to be prayed for to tell him what their problems were so that he could pray for their specific illnesses. My sister was in the queue. When he came close to her, I shivered. It was as though the earth could open and swallow me up. I was really disturbed to know that she had told him about her HIV and AIDS status. After the church service when we were at home, I asked her what she has said her problem was. Innocently, she told me that she said it was HIV and AIDS. Her answer made me so angry that I ended up shouting at her. In anger I tried to ‘lecture’ to her about HIV and AIDS. I must reiterate that I loved my sister. The thought of losing her to this pandemic was unbearable. What made me feel more uncomfortable was for people to know her status. That fact was too much for me and I couldn’t handle it.

Some weeks after this incident, she became very weak and even lost her mind. I then took her to my brother who was staying at Sebokeng. This was the last time she was at my home alive.

My training and knowledge about HIV and AIDS failed to help me to handle my sister’s situation. It is sometimes very easy to counsel people who are not blood related to you, but when somebody closer to you is in that situation, reality starts to dawn and one realizes the difference between theory and praxis. It is always easy to talk about HIV and AIDS when it is out there, but a very different and difficult thing to embrace it when it faces you head-on. My sister’s experience has strengthened me and I think that if I were to be in that situation again, I would act differently. Although the experience was traumatic, it has empowered me with real life experiences.

After her death, we discovered that she was not covered in our mother’s funeral scheme because of being over-age. Together with my brother and our cousin we contributed for the funeral. Though the funeral was expensive, we managed to pull through.

It is this experience and that of members of our church who came to inform me of their lives with HIV and AIDS, which revived and initiated me into dedicating this research to pastoral care for people infected and affected by HIV and AIDS.

### **3 THOSE INFECTED AND AFFECTED BY HIV AND AIDS: LISTENING TO UNHEARD STORIES OF CHRISTIAN WOMEN**

The emphasis of my research is on listening to unheard stories of Christian women infected and affected by HIV and AIDS in Tumahole. By unheard I mean stories which might have been told or not told by my co-researchers to some people close to them, but which have not been unpacked and used to heal both the co-researchers, their families and the broader community, as I intend this research to do. I fully agree with White and Denborough (1998:2) when they say that narrative ways of working are based on the idea that people's lives are shaped by the stories which individuals and communities of people develop in order to give meaning to experiences. These narratives of meaning do not simply reflect or represent our lives, but they actually shape and constitute our lives. In this regard, the narratives will play a very important role as a therapy to my co-researchers. I fully agree with Demasure and Muller (2008:4) who say that stories construct the person's identity, they reveal more than concepts and each person's story is unique.

The stories to be heard are those told by three Christian women belonging to the Apostolic Faith Mission. To put it clearly, the story is not that of the church, but is women's stories with regard to their experiences of pastoral care in their church in the Tumahole community. I chose the Christians because it would be easy to relate their lives of faith to the church when they are faced with problems that need the support of that community.

In dealing with their stories, I will use the in-depth interviewing approach. Coupled to this, I will from time to time use what White and Denborough (1998:3) call "externalising conversations". This means the refusal to see problems as internal to people. Problems are problems and people are people. People are not the problems. The externalising conversations are therefore conversations that create space for people to see themselves as separate from problems affecting them. Once this is clear, it is easy for a person to take appropriate steps to bring or participate in activities seen as bringing a solution. For us to come up with an appropriate solution, to those infected and affected by HIV and AIDS, we need to be 'reborn' so that we can see things as they are and as they should be and not as we want to see them. People with

HIV and AIDS are not a problem. Their condition of being infected is the problem affecting and impacting their social life and they need our help so that they may be empowered to deal positively with their situation. Once a problem (HIV and AIDS) is seen as separate from the identity of the person, it becomes easier for these women to be in a position to take new action in dealing with their condition.

### **3.1 Why is telling these stories necessary?**

What makes this research unique is that it is based on my personal experience as a person who has lost a sister to HIV and AIDS and the experiences of my co-researchers caring for their partners who were infected and who (partners) also infected them (co-researchers). It is research that comes from people's experiences with HIV and AIDS.

This research has not been undertaken before. It is therefore based on this small community and its experience of being infected and affected. The approach of postfoundationalist practical theology is also a new concept in practical theology and as such, not much research has been done on using it. The emphasis in this methodology is the locality of the research and its contextuality. Rather than generalising, it begins with what concerns people in their specific context. Based on the outcomes from the specific context, I will then use the knowledge gained to move from the local context to the general South African and the global community. Although much research has been done and recorded about HIV and AIDS, none has been done and recorded about the people in Tumahole and none has also been written using the postfoundationalist practical theological approach.

### **3.2 Focus area**

My research is focused on three Christian women in the AFM church in Tumahole who are infected and affected by HIV and AIDS. Two of these women are infected and the other one is affected by the virus. Two of the three women have already lost their husbands. The co-researchers play a very important role in this research. It is their stories that set the ball rolling. As people with important roles to play, their

stories are attentively listened to and understood. The aim in the stories is for those who will read them to be transformed.

## **4 THICKENING THE STORY**

### **4.1 The overall aim and objectives of the research project**

The research project's overall aim is in line with that of the SANPAD 2002 group which is to reach the holistic understanding of the stories of these Christian women infected and affected by HIV and AIDS about their experiences of pastoral care in Tumahole (Muller *et al* 2003:5). The SANPAD stands for South Africa-Netherlands Programme on Alternative Development. It is the initiative encouraging and funding programmes of research work.

In view of the overall aim, the specific research objectives are firstly to facilitate the telling of the 'unstoried' parts of the narrative of people infected and/or affected by HIV and AIDS concerning their experiences about care. Secondly, to research alternative ways and means of making the unheard stories known in Tumahole and ultimately to South African society and beyond its borders, particularly in churches and other faith-based communities. Thirdly, to be, as a member of narrative researchers, part of a 'story development' process, through which different alternatives, more holistic stories of pastoral care can be explored. And lastly, to disseminate research findings concerning the unheard stories in such a way that developmental policies, if possible, can be influenced to enhance alternative, holistic stories of care in the South African society.

### **4.2 Facilitating the telling of a story and the exploration thereof**

In the book on Social Research, Babbie and Mouton (2001:19-68) mention and describe various paradigms and traditions of research. And as a narrative researcher I place myself within the post-modern, social-constructionist paradigm and will use a narrative-based research approach. I fully agree with Van Niekerk (2004:8) in saying that the narrative approach is a comfortable way to be true to post-modern social-constructionism. I also fully concur with Freedman and Combs (1996:22) who say

that the adoption of a postmodern, narrative, social-constructionist worldview offers useful ideas about how power, knowledge and truth are negotiated in families and societies.

#### 4.2.1 Postmodernism approach

The post-modern approach is linked with a post-structural paradigm. There is a very thin line between the two and both are used interchangeably (Van Niekerk 2004:10). To understand postmodernism or post-structuralism fully, one needs first to understand modernism or the structuralism concept.

Gergen and Kaye (1992:167) state that the rationale of modernity is that knowledge enables society to make accurate predictions about cause and effect relations and this, in a process, allows mastery over the future. In a way, outside and expert knowledge play a vital role in determining a solution to people's problems. In these instances, we find that patriarchal discourses function very strongly in the modern worldview (Pienaar 2003: 33). This is the position that has been adopted by fundamentalist churches like our Pentecostal movements. In these churches, the role of the father in a family is unquestionable. Women are encouraged to do whatever their husbands tell them to, because this is what the Bible says. The problem with this approach is that it encourages spousal abuse and domestic violence. Most African cultures find their refuge in this worldview.

On the other hand, post-modernism culture, although seeming to be opposed to modernism, it is not so. Instead of abolishing the modern worldview, it chooses to be its critical companion and is both a reaction to and a result of modern culture (Rossouw 1993: 895, 903). The difference between the two is that modernism starts from something resolved from foundations and absolutes, while post-modernism is not solidly rooted, but rather afloat and still developing. While modernism claims that there are rules serving as criteria for rational judgement, post-modernism claims that these criteria are invented as we go along or are constituted afterwards (Van Niekerk 2004:15).

The four main ideas of post-modernism's view on reality are:



#### 4.2.1.1 *Realities are socially constructed*

Unlike in modernism where reality is a given fact, post-modernism reality is something that is constructed by people in various communities as they live (Freedman & Combs 1996:25). In my research, this fact would be realised when looking at the role which religion and culture play in the abuse of women. The fact that men are heads of families and therefore have the right to be abusive to their spouses does not work in modern times. What tradition claims to be the universal truth about gender equity is viewed very sceptically and is vehemently challenged. Reality always depends on the social condition in which the situation presents itself. It is on this ground that I align myself with Muller (1996:55) in saying that postmodernists celebrate an inherent distrust in objective truth as providing hope for a particular society. Each context has a way in which to interpret the happenings surrounding it. Gergen (1985:268) says in post-modernism there is a shift from focusing on how an individual person constructs a model of reality from his or her daily experiences to focusing on how people in a particular community interact to construct, modify or maintain what their society holds to be true and meaningful.

#### 4.2.1.2 *Realities are constituted through language*

While the modernists are of the opinion that language is seen as a reliable and accurate link between the objective and the subjective worlds, the post-modernists believe differently (Freedman & Combs 1996:28). According to modernists, we can know the real world through the use of language. The post-modernists, on the other hand, believe that it is in language that societies can construct their views of reality. In this sense, language serves as an interactive process and not as a passive receiving of pre-existing truth. The language dictates how to see the world, not the other way around; it does not mirror nature, but it creates the nature we know (Anderson & Goolishian 1988:378). It is through language that meaning is created, yet it is not in language *per se*, but through the use of that language in a particular society and context that reality is constituted (McLean 1997:14). Kotze and Kotze (1997:31) state that the postmodern emphasis in social construction discourse is not primarily on language, but on the discourse. The various discourses in society have a constitutive or shaping effect on the personal discourses and lives of people (Pienaar 2003:37).

Based on this understanding of the use of language, I fully agree with Gergen (1985:270) in saying that to social-constructionists, knowledge is represented in linguistic propositions. It does not exist in people's heads, but it is what people do together. People exist in language because meaning and understanding come about in language (Pienaar 2003:36). Language creates a community and a sense of belonging. Meaning is not carried in a word by itself, but in that word in relation to its context, and no two contexts will be exactly the same, even if the same words are used (Freedman & Combs 1996:29). Members of different communities understand even the unspoken language in their society. They can even interpret the bodily expressions and be able to tell what the person means or what his or her moods are. The advantage that I have with my co-researchers is that I am part of their community and have known them for a time, so I am able to listen to bodily language and probe my observation.

#### *4.2.1.3 There are no essential truths*

In the post-modern approach I am taking, there are no known truths. The only thing the researcher can do is to interpret co-researchers' stories and their experiences (Freedman & Combs 1996:33). Rather than having one option, the post-modernists celebrate diversity. Different views on the same facts end up raising different meanings. Paterson (2009:13-14) explains this better in saying that theological issues raised by HIV and AIDS prevention are complex ones not open to easy solution and are difficult to be addressed from the standpoint of religious and scriptural certainties. The problem with this complexity is caused by fellow Christians who accuse others who try to take a more nuanced and contextual view for losing the power and the uniqueness of the gospel message by adapting and accommodating too much of the world. What these fellow Christians fail to realize is that when churches make statements or advocate a particular theological and ethical position, they cannot expect to be immune from questioning. In the stories of my three co-researchers, we research the stories of pastoral care as it applies to their lives, but each co-researcher's story brings different view points to be pursued.

#### 4.2.1.4 *Realities are organised and maintained through narratives*

The central role of narratives is to organise, maintain and circulate knowledge of ourselves and our world. Stories move from one generation to the other through the use of language (Freedman & Combs 1996:31). According to Mair (1988:127), stories are there to inform life, either hold us together or keep us apart. Each culture has its great stories. We literally live through stories. The African culture that copied the Judeo-Christian culture of patriarchy and male dominance has been passed through stories from generation to generation. In this regard, we find that some cultures have been used to oppress the other, while some have been imposed on people of marginalised cultures (Freedman & Combs 1996:32).

Muller *et al* (2001:76) describe the narrative researcher as a person with the sole purpose of listening to the stories and being drawn into those stories. As a result, the narrative researcher has the subjective integrity in mind and strives for participatory observation. This differs with the structuralistic researcher who has the objective in mind to be an observer from outside. The narrative researcher gets into the action and plays together with the ‘players’. The research approach adopted in this dissertation is the one that allows my co-researchers to be able to tell their own stories in their own words while I open my ears and mind to listen to them.

The importance of the narrative approach is to help the infected and affected persons to tell the story in their own words. This way of telling the story is therapeutic in nature. Story-telling in itself is a helpful tool in the healing process. As a therapy, the stories will help these women to emerge as the victors and champions of their stories, rather than as victims. In order to emphasise the importance of the story and the storytelling, theologians like Fackre (in Lapoorta 1995:1) propagate what is today known as Narrative Theology. In this kind of theology, he further argues the fact that a story is determinant for the understanding and interpretation of faith and is extricably linked to the expression of reality in all forms of theology. In emphasising the importance of the story in narrative theology, Metz (1980:207-208) says:

*“The story is itself an event and has a quality of a sacred action... It is more than a reflection – the sacred essence to which it witnesses continues to live in it. The wonder that is narrated*

*becomes powerful once more... A rabbi, whose grandfather has been a pupil of Baal Shem Tov, was once asked to tell a story: "A story ought to be told" he said, 'so that it is itself a help' and his story was this; 'my father was paralysed. Once he was asked to tell a story about his teacher and he told how the holy Baal Shem Tov used to jump and dance when he was praying. My grandfather stood up while he was telling the story and the story carried him away so much that he jumped and danced to show how the master had done it. From that moment, he was healed. This is how stories ought to be told".*

The emphasis in the passage is that when the story is told, the storyteller and the listener can't avoid being both emotionally and physically captivated by the story. It is this captivation that brings healing and therapy to the victims.

#### 4.2.2 A good researcher is a good listener

Listening also plays an important role in the story. In emphasising this, Kelsy (1993: 139-140) says for theology to qualify to be called theology, it has to listen to people's stories. He further says that stories can be told and heard in a collaborative setting that includes cultural diversity and this means that stories can overlap enough to be understood across lines of 'otherness' that divide the listeners.

Gerkin (1997:91) mentions listening and observation as the important elements in pastoral care for those involved in the daily affairs of their community. Listening, in this case, involves more than just hearing the words from my co-researchers, but is also attentive to the emotional communication that accompanies the words. This means listening to hidden conflicts, unspoken desires, unspeakable fears and faint hopes. Observation as the second most important element of pastoral care means to look carefully at and make evaluative judgements about social environment that surround those who are subject to pastoral care.

In listening to the stories of these women infected and affected by HIV and AIDS in my community in the way described by Kelsy (1993:141), these women (co-researchers) don't have to be made to feel as though they have been manipulated and used to advance my academic research at their own expense. In so doing, I would like my approach to be recognised as that of the researchers who do not "*pathologise or victimize their narrators*" (Graham 2000:112).

Furthermore, narrative therapy and research go beyond mere storytelling and listening. In fact, a very particular characteristic of the narrative approach is the development of new and alternative stories.

#### 4.2.3 Social-constructionist approach

As mentioned above, to post-modernists, knowledge is socially constructed through the use of language since humans are born into a social world of which they attempt to make sense (Hevern 2003:2, van Niekerk 2004:16). It is therefore through language and interpretation that meaning is given to human beings' lives and their experiences within the social realm. As Pienaar (2003:62) puts it, social-construction discourse not only provides lenses through which to view the reality of her context in her research experience, but also empowered her to constitute realities in relationships and language.

Gergen (1994:241- 245) explains three implications which social-constructionism has in therapy and which, according to Van Niekerk (2004:16), are also applicable to research as follows;

- The focus of the therapist, in this case the researcher, moves from cognitive/internal processes towards social process.
- The shift from superior knowledge and an expert position moves to one of equality and co-construction.
- The shift from diagnosing and healing moves towards religious and cultural responsibility.

These three concepts are applicable in my research since the focus is on the context of my co-researchers and I do not present myself as an expert, but somebody who comes to learn from and with them. In social-constructionism, knowledge is described as a social process between different people. This knowledge is not the objective truth outside the person and is not constructed by one person alone. The voices of the previously disadvantaged and marginalised unheard people can now be taken seriously (Van Niekerk 2004:17). This is the reason my research topic is *'the unheard*

*stories about pastoral care of Christian women infected and affected by HIV and AIDS’.*

#### 4.3 Postfoundationalist practical theology

In his opening remarks in the paper that was presented at a workshop at the International Biennial Conference of International Academy of Practical Theology, Muller (2005:72) states that:

*“The concept of Postfoundational practical theology is in itself a rediscovery of the basic form of practical theology. It is an effort to move beyond the modernistic boundaries of practical theology as a very formal, rationalistic venture. On the other hand it is also an effort to avoid the relativism of anti-foundationalist theories. It is hopefully a **terra incognita**, very necessary for practical theology to explore”.*

One of the characteristics of this approach of postfoundationalist practical theology is that it is postfoundational, meaning that it is neither foundational nor non-foundational. But it means that this concept has moved from the restrictions and comfort zone of theological foundationalism. It is also guided by the moment of praxis; i.e. always local, embodied and situated. In explaining this point further, Muller (2005:73) alludes that Practical Theology, to qualify as practical theology, must happen whenever and wherever there is a reflection on praxis, from the perspective of the experience of the presence of God. It can be part of ministerial activities on the congregational level, or it can be highly academic on university level.

Van Huyssteen (1997:4) states that the focus in postfoundationalist Christian theology is a relentless questioning of our uncritically held crypto-foundationalist assumptions. This allows for a free and critical exploration of the experiential and interpretive roots of all people’s beliefs, with the recognition that we relate to our world through the interpreted experience in matters of faith, religious commitment and theological reflection.

Therefore, for practical theology to qualify as postfoundationalist practical theology, it has to be locally contextual, socially constructed, directed by tradition, exploring interdisciplinary meaning and pointing beyond the local (Muller 2005:78). In postfoundationalist practical theology, context plays a very important role. The answers to a particular problem in a particular situation cannot be solved by importing the solution from another situation which has no relation to a particular context. Each context has its unique way of bringing its problems and solution. Though we might learn from different situations and contexts, the fact remains that each context is different and needs to be treated as such.

According to Muller (2005:74), postfoundationalist practical theology constitutes a rediscovery of the basic forms of practical theology and it should be seen as a way of understanding within the paradigm of the hermeneutical approach. And yet it moves beyond hermeneutics as a metaphor for practical theology.

This approach firstly compels us to listen to the stories of people struggling in real life situations. It does not merely aim to describe a general context, but we are confronted with a specific and concrete situation (Demasure & Muller 2008:9). Using this approach, I would like to reflect on the stories of these three women who were bold enough to discuss their status and that of their partners openly. Muller (2005:73) also states that the concept of postfoundationalist practical theology is in itself a rediscovery of the basic form of practical theology. It is an effort to move beyond the modernistic boundaries of practical theology as a very formal, rationalistic venture. On the other hand, it is also an effort to avoid the relativism of anti-foundationalist theories. It is hopefully a *terra incognita*, very necessary for practical theology to explore.

One of the characteristics of this concept of theology is that it is neither foundational, nor non-foundational. But it is post- foundational. It can neither be described with the metaphor of a foundation, nor with the metaphor of non-foundation or anti-foundation. It has moved beyond the restrictions and “insular comfort” of theological foundationalism, but at the same time it is not to be found within the sphere of

relativism and the arbitrariness of anti-foundationalism (Van Huyssteen 1997:43). It is also guided by the moment of praxis (always local, embodied and situated).

I want to emphasise the words of Muller (2005:79) again that for practical theology to qualify as postfoundationalist practical theology, it has to be locally contextual, socially constructed, directed by tradition, exploring interdisciplinary meaning and pointing beyond the local.

#### 4.3.1 Epistemological understanding with regard to practical theological research

Because we relate to our world epistemically through the interpreted experiences, this means that theology and the various sciences offer alternative interpretations of our experiences (Van Huyssteen 1997:15). This is possible when Christian theologians locate theology within the interdisciplinary context. In postfoundationalist practical theology there is therefore a clear overlap between theological and scientific modes of knowing. Theology needs science to interpret the religious experiences in our world. A postfoundationalist model of rationality includes an interpretation of religious experience that transcends pitfalls like that of dualism that sets up the natural against the supernatural. This concept therefore comes to this conclusion as noted by Van Huyssteen (1997:28) that:

*“The postfoundationalist choice for the relational quality of religious experience thus opens up the possibility of interpreting religiously the way that we believe that God comes to us in and through our manifold experiences of nature, persons, ideas, emotions, places, things and events.”*

##### 4.3.1.1 *What is theology?*

The study of theology is concerned with God. Since God cannot be objectified and made into an object of scientific study, theology can at most be the study of people’s statements about God and about faith in God (Heyns & Pieterse 1990:3). The object



of theological study is therefore human faith in God and human religious statements about Him. Theology is concerned with both God and humanity (Heyns & Pieterse 1990:4). Giulio Girardi in Assmann(1975:3,5) adds that our God is the living god who continues speaking in history because he did not suddenly stop talking after the last book of the bible. His actions and footprints are seen in every human history. Theological discourse concerns a truth that is the way and that is about the word that is located in the midst of history. According to Barth (1969:18), theology is about God as the God of human beings and human beings as people of God. Adding to this definition, Fiet (1975:379-380) in Heyns and Pieterse (1990:3) states that theology does not invent its own questions, but theological questions arise from the religious contemplation of the believers. It is in this 'religious contemplation' that one can ask about the presence of God in the midst of the HIV and AIDS infected and affected world. Theology is therefore a systematic reflection on faith under stringent scientific conditions. I concur with Assmann (1975:6) in saying that embracing the poor person into our lives leads to active solidarity with his/her interests and struggles. This commitment is expressed in an attempt to transform a social order which breeds marginalisation and oppression. Participation in the historical practice of liberation is ultimately the practice of love, the love of Christ in one's neighbour and of encounter with the Lord in the midst of a history ridden with conflicts. Moon Hee-Suk Cyris in Nolan (1988:16) defines this better in saying that history changes from time to time and God's Word is preached throughout this changing history. But what does not change in all these changes is the fact that God acts throughout history. He acts freely in history and his actions are not always repetitions of past actions. Often, His actions are radically new. It is in these definitions that one draws the conclusion that theology is about people of God everywhere in the world, propagating their faith through words and actions in helping fellow human beings to become better persons.

Theology therefore assumes different forms depending on the Christian experience and the preaching of the Gospel to people at a given moment of historical development. Theology is not simply something to be known, but is something lived and experienced by an individual in a particular community (Assmann 1975:5, Anderson 2001:22). This means that my experience of God in my particular situation will, most of the time, differ from another person's experience in a different context

and *vice versa*. My experiences as an HIV and AIDS affected person will always differ from that of an infected persons. My experiences of dealing with a family member who died of HIV and AIDS will differ, most of the time, with a person who has never experienced that and who does research on HIV and AIDS for academic purposes. God does reveal Himself in our hour of need. This is further supported by Anderson (2001:12) when stating that theology occurs as a divine partner who joins us on our walk, stimulating our reflection and inspiring us to recognise the living Word, as happened to the two walking on the road to Emmaus on the first Easter, as recorded in Luke 24:13-35 (NIV).

#### *4.3.1.2 Practical Theology*

Based on the above definition of theology, practical theology will therefore mean ‘how one puts his/her experiences of God in his/her real life situation’. It is further described as the critical theory of religious actions in society, a framework of communicative actions in the service of the gospel (Firet 1987:260 in Heyns *et al* 1990:6). Practical theology therefore concerns itself with an encounter between God and humanity, the interpretation of the interactions between God and His people, and is concerned with the dialogue and encounter between God and human beings (Louw 1998:4).

The interaction of theory and praxis plays a prominent part in practical theology. In this way, practical theology is also concerned with meaningful change and purposeful transformation. According to Muller (2005:73), practical theology happens whenever and wherever there is a reflection on praxis from the perspective of the experience of the presence of God. It can be part of ministerial activities on the congregational level, or it can be highly academic on university level. In any case, it is always guided by the moment of praxis (always local, embodied, and situated). Anderson (2001:14) supports this by stating that at the centre of the discussion of the nature of practical theology is the issue of the relation of theory to praxis. If theory precedes and determines practice, then the practice tends to be concerned primarily with methods, techniques and strategies for ministry, lacking theological substance. On the other

hand, if practice precedes theory, ministry tends to be based on pragmatic results rather than on prophetic revelation. The modern approach to practical theology determines that truth and interpretation form the hermeneutical bridge by which reality informs theory and theory determines practice. Exploring this further, Browning's model of practical theology attempted to integrate theory and practice in an ongoing process of action and reflection (Anderson 2001:26-27). To Browning, the concept of practical reasoning places the theological task at the centre of social context, where the theologian stands with and alongside the church, mediating the gospel of Christ from the centre. Like Browning, Fowler (Anderson 2001:32) emphasises the vital reflective and constructive dimension of practical theology, but also makes the important observation that the practice of the church and, by implication, the task of practical theology takes place within the overall context of the church's participation in the ongoing mission of God to the world.

Therefore the practical theology developed out of these women's experiences of HIV and AIDS is, in fact, the particularity of a practical theology that gives it life. The practical theology developed out of HIV and AIDS is about life and hope. It is about destigmatization and giving meaning to every moment in the lives of these women. The approach to practical theology that I want to use for this purpose is postfoundationalism.

#### 4.3.1.3 Pastoral care

Louw (1998:6) describes pastoral care to mean the theological theory known as *cura animarum* (cure of souls). Pastoral care is used to describe the consoling effect which God's empowering and transforming presence has in the world. This, therefore, leads us to salvation which is pastoral care's theological stance and distinctive perspective.

Included in the pastoral care should also be issues like (a) pastoral encounter, (b) pastoral conversation, (c) pastoral counselling and (d) pastoral therapy. In this, I fully agree with Louw (1998:7) that:

*“Pastoral care needs to address the basic problems of human existence: guilt, anxiety, death, sin and meaning. No other discipline is as well-equipped to deal with the issue of forgiveness and the fear of death as pastoral therapy. In fact, the uniqueness of pastoral therapy resides in its ability to offer hope which both transcends the present situation and anticipates the ideal. Even more, it can transform human existence so that victory over sin and death can become a reality which imparts meaning to life”.*

Just as research approaches have moved from modernism to postmodernism, this has also affected how the concept of pastoral care has developed from being the work of the professional clergy (pastor) ‘who knew it all’ to that of the united actions of Christians meeting the needs of fellow believers and their communities through acts of faith. In defining the new concept of pastoral care, Gerkin (1997:23) traces the models of pastoral care from the Bible and looks at how this has developed to our present time. In the history of Israel, God used prophets, priests and kings to take care of his people. Pastoral caring for the people of God in the era of the prophets involved, among others, issues of justice and moral integrity in the life of the people. Included in this care is the model of the shepherd as a leader taking care of the flock just as God is depicted in Psalm 23 as the Good Shepherd of Israel, His people. Jesus also identified Himself in John 10 as the Good Shepherd (Gerkin 1997:25, 27).

In the primitive church, the care of the community of Christians involved the concern for the purity of the congregation in a non-Christian and pagan culture, so that they could qualify for the immanent *parousia* (Gerkin 1997:28). As time continued, pastoral care was imposed as the work of the Christian leaders to care for the morals of the congregants. During the reformation, pastoral care was seen as facilitating the individual’s personal relationship with God. To Martin Luther, the Reformer, pastoral care went further, to mean caring for those who were victims of uncaring practices of their society. Baxter, in his theology, directed pastoral care not as a discipline, but towards the preservation of the faith among the believers in the modern day challenges which they faced. In his fundamental ways, pastoral care meant care for the moral life of people. To him and theologians of his time, pastoral care was not divorced from moral and ethical concern (Gerkin 1997: 42, 46-47).

I fully agree with Gerkin (1997: 50-51), in his presentation of pastoral care towards the end of the 19<sup>th</sup> century, saying that it was at this time that the focus shifted from the pulpit to the pews. The interest was more on the church as a community of believers caring for one another and for their community. In this instance, pastoral care involved caring for the whole community. Through the ages and also in the 20<sup>th</sup> century, pastoral care became the response to people's problems which they faced in their context. It became an answer to the poor, the oppressed and the marginalised. People looked at the church for its response to their daily suffering. This was manifested in new movements such as the Social Gospel Movement, Black, Liberation and African contextual theologies, and the Feminist theology. Pastoral care was later recognised as a specialised ministry to individuals in need of care of all sorts. This care is not done by clergy alone, but involves the whole congregation (Gerkin 1997:92). As pastoral care developed through the centuries, one cannot ignore the fact that the rise of the Third World Theologies responding to social and political problems have forced the church to pay particular attention to issues like poverty, oppression and human rights. Thus the church had to wrestle with the classic polar tension: revelation and experience; text and context; God and human beings (Louw 1998:1). It is therefore this tension that makes pastoral care respond to the question of making the Gospel of Jesus Christ relevant to human experiences and reality and social context, so as to contribute to a life of meaning and quality. Pastoral Care is therefore the reinterpretation of the Gospel and its contextualisation in order to be relevant to the needs of people here and now.

Louw (1998:4) states that there are three key issues in the hermeneutics of pastoral care and practical theology, and these are (a) communication and interpretation, (b) realisation and action, (c) liberation and transformation. This means that practical theology is concerned with communication between God and human beings, the effect salvation has on the development of Christian life and meaningful change and purposeful transformation.

Pastoral care in the post-modern concept means that new ways should be found whereby the traditional language of a Christian community could be asserted and given credence in open and public dialogue with other ways of speaking about human conditions. This means that Christians need to be acquainted with the context their

ministry is in and with the people they are ministering to. As Gerkin (1997:88) puts it, pastoral care at its best is the communication of the inner meaning of the gospels to persons. This, of course, will include all people even those neglected or stigmatised by society.

Having explained the shift from modernism to post modernism, or structuralism (foundationalism) to post-structuralism (postfoundationalism) in practical theology, I would like to use the postfoundationalist practical theology approach in this research.

#### 4.3.2 My epistemological positioning as storyteller

I position myself in terms of a postfoundationalist practical theology paradigm. This paradigm helps me to put my faith and theology into my context and listen to the real stories of real people in their real situation. In so doing, I am able to balance the theory with praxis. In postfoundationalist practical theology, my theology becomes alive in praxis. Muller (2005:74) defines practical theology as the one theological discipline that can never afford to be detached from the basic forms of theological reflection. In this case, the concept of postfoundationalist practical theology has a valuable contribution for the understanding of practical theology and it also constitutes a re-discovery of the basic forms of practical theology.

As a narrative researcher, I place myself within the postfoundational, social-constructionist paradigm and will use a narrative-based research approach. The research method to be used in this thesis is in the field of critical emancipative philosophy.

Narrative metaphor leads one to think about people's lives as stories and to work with them to experience their lives' stories in meaningful and fulfilling ways. The metaphor of social constructionism, on the other hand, leads one to consider ways in which every person's social and interpersonal reality has been constructed through interaction with other human beings and institutions, and focuses on how social

realities influence one. The task of pastoral care is to interpret God in order to give meaning to faith in real life contexts and interpret human beings and their contexts in a way that will give meaning to their faith (Louw 1998:15). Narrative approach brings fusion between the stories about God and His people. The role of the pastor in this approach is to clarify, interpret and guide understanding and build pastoral guidance relationships with persons in all modern situations (Gerkin 1986:101)

In my research, the importance of the narrative approach is to help these infected and affected women to tell their stories in their own words. This way of telling the story is therapeutic in nature and although the focus here is on research, story telling in itself is a helpful tool in the healing process. As such, it is envisaged that the telling and development of the stories will enable these women to emerge as the heroes and champions of their stories, rather than as the victims. In order to emphasise the importance of the story and storytelling, Lapoorta (1997:7) refers to what is today known as the Narrative Theology. He argues the fact that the story is determinant for the understanding and interpretation of faith and is extricably linked to the expression of reality in all forms of theology (Lapoorta 1997:1). Adding to this notion, Van Huyssteen (1997:180) argues that narrative theology takes the basic narrativity of human stories of any kind very seriously in order to think through the nature of specifically religious knowledge. A story told has power to change lives. In emphasising this, Metz (1980:207-208) says:

*“The story is itself an event and has a quality of a sacred action... It is more than a reflection – the sacred essence to which it witnesses continues to live in it. The wonder that is narrated becomes powerful once more... A rabbi, whose grandfather has been a pupil of Baal Shem Tov, was once asked to tell a story: ‘A story ought to be told’ he said, ‘so that it is itself a help’ and his story was this; ‘my father was paralysed. Once he was asked to tell a story about his teacher and he told how the holy Baal Shem Tov used to jump and dance when he was praying. My grandfather stood up while he was telling the story and the story carried him away so much that he jumped and danced to show how the master had done it. From that moment, he was healed. This is how stories ought to be told.’”*

The emphasis in the above passage is that when the story is told, both the storyteller and the listener can't avoid being both emotionally and physically captivated by it. It is this captivation that brings healing and therapy to the victims. According to Freedman and Combs (1996:88), this 'performance' of stories does not happen automatically or every time someone tells a story. But it does happen when a person is 'immersed' in the story and when he/she experiences the story as meaningful. This 'immersion' is what I hope the stories of these women will do to me as a researcher and to them as co-researchers and that, at the end of the day, it will also affect those who read these stories.

Listening to their stories in a way that is mentioned above, their stories would be able to transcend '*any real or imaginery boundary*' that might have been consciously or unconsciously created. The stories would be heard beyond the borders of Tumahole, Free State province and possibly beyond the South African borders. In order to make this concept a reality, these women shouldn't be made to feel as though they have been used to advance my academic excellence at their expense. Instead, I would like to be among researchers who do not pathologise or victimize their narrators (Graham 1992:112).

Furthermore, narrative therapy and research go beyond mere story telling and story listening. In fact, a very particular characteristic of the narrative approach is the development of new and alternative stories. The aspect of theology in which one can apply both narrative and social constructionism without been biased is what is called postfoundationalist practical theology. Practical theology, as enlightened by the postfoundationalist ideas of both Schrag and Van Huyssteen, should be developed out of a very specific and concrete moment of praxis (Muller 2005:76).

In order to explain this approach, I would refer to the specific cases of three Christian women in their particular contexts who are being affected and infected by HIV and AIDS. My positioning in their situation will be that of 'not-knowing' approach. This positioning is seeing research as a process which always moves toward what is not yet known. However, I agree with Freedman and Combs (1996:44) who say that a 'not-



knowing' position does not mean that one does not know anything, but that one's knowledge is part of a process of research, although not the content and meaning of people's lives. To be successful in achieving this 'not knowing' position we concentrate on listening and our talking is guided by and secondary to that listening. As one is listening, one is able to ask whether one really understands the situation my co-researcher is describing. This is the reason why I keep on probing to get some answers to what is not clear in the conversations. The 'not-knowing' position fosters an attitude of curiosity (Freedman & Combs 1996:45). It is this curiosity that makes me probe more for the development of the story.

This approach compels us to listen to the people, real people's stories in their specific situations. In this case to the stories of these women in their specific situations. So it becomes impossible for me to generalize a specific context to represent other contexts of a similar nature. We can only draw particular truths from these women's situations and learn from them. I agree with Muller (2005:75) who says:

*Postfoundationalist Practical Theology should be seen as a way of understanding within the paradigm of the hermeneutical approach. And yet, it moves beyond the hermeneutics as a metaphor for Practical Theology. It even goes one step further and argues for a very specific view of understanding: namely an understanding, which not only includes the local context as one of the hermeneutical circles (cf. Bons Storm 1989:63), but an understanding that can only develop within and from a local context".*

As a researcher, I choose to position myself in this 'not-knowing-position'. This does not mean that I enter into the research field being ignorant, but that I do not allow my prior knowledge to cloud my research and thus influence my analysis and research outcome. This helps me not to think that my acquired knowledge puts me in a position that will make me master of this research. Rather, it is my co-researchers who own this research, it is their story and I do not own it. I am just the facilitator to let my co-researchers tell their stories in their own words. In this case, my position is that of being a facilitator for interpretation, rather than an expert in analysis (Van Niekerk 2004: 10).

#### 4.4 Steps in postfoundationalist practical theology research

##### 4.4.1 In-context experiences are listened to and described

My co-researchers are three Christian women from the Apostolic Faith Mission (AFM) in the community of Tumahole. Two of the three women are infected by the HIV through their husbands, while the third one has been miraculously tested negative, but her husband died of HIV and AIDS related sicknesses. These were the women who were part of my congregation while I was a pastor of the AFM assembly in Tumahole. I happen to know about their situation because they decided to inform me on their individual capacity. The first lady, *Mrs Dise (not her real name, hereinafter referred to as MS)*, informed me when her husband was critically ill and was tested HIV positive. She came to me for prayers because I was her spiritual leader. I was able to understand and relate to her in her situation. This was in 1998 while my own sister was suffering from HIV and AIDS-related illnesses.

The second lady, *Mrs Mose (also not her real name, hereafter referred to as MM)*, came to me in 2001 when her husband was also ill. She too had been tested for the HIV. When her results were negative, she came straight to the manse to inform me about the miracle that the Lord had performed for her. She came so that we could pray and thank the Lord and rejoice with her.

The third lady, *Mrs Toke (also not her real name, hereafter referred to as MX)*, tested positive before her husband. This was after I left Tumahole for an assembly in Naledi, Soweto. My family and I had attended a wedding in Tumahole. She decided to inform me about her condition and also asked me to inform her husband because she was afraid to do so as her husband was physically abusive.

On listening to their stories, I was able to interact with some of their family members. These women and their families' trust in me brought about the telling of their stories. Being aware of the case of three women who were suing Patricia De Lille, (*the leader*

*of the Independent Democrats*), the journalist, Charlene Smith and the New Africa Publishers for an amount of R600 000.00, alleging that De Lille used their names in her book without their consent (*Sunday Times Newspaper*, 19 October 2003), one is compelled to be very careful about ethical guidelines when it comes to research involving people. De Vos (2000:24) defines ethics as a set of moral principles which are suggested by an individual or group, is subsequently widely accepted, and which offers rules and behavioural expectations about the most correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants and students. Ethical guidelines, therefore, serve as a standard and the basis upon which each researcher ought to evaluate his/her own research. Ethical principles should be internalised in the personality of the researcher to such an extent that ethically guided decision-making becomes part of the total lifestyle.

#### 4.4.2 Ethical guidelines

In order to avoid the embarrassment and abuse either or of myself or these women and not exploit them in any way, I will follow the following acceptable ethical guidelines:

##### *4.4.2.1 Avoid causing harm to my co-researchers.*

It is my intention in this research to avoid anything that might, either directly or indirectly, expose my co-researchers to any emotional harm. This is the reason why I chose to use pseudonyms rather than their actual names. Though the three of them had no problem in using their actual names, we came to an agreement to avoid this for their sake in the church and the community. In communities like Tumahole there is still a stigma attached to persons who have the HIV or are at the AIDS stage. People who suffer most are those related to such people. So to avoid this, I will not use their true names.

#### *4.4.2.2 Informed consent*

It is always difficult for a pastor to do research on his/her congregants. This was a problem that I nearly encountered when conducting these interviews because co-researchers as congregants tend to agree with everything that the pastor says without checking the pros and cons. nevertheless my co-researchers wanted their proper names to be used, I realised that they might not be aware of the consequences to their families, especially to the children. A definite advantage, however was the fact that when I conducted this research I had moved from Tumahole where my co-researchers were situated and was now in Naledi, Soweto. I drew up a consent form and presented it to them. After reading it and making sure that they understood its contents, I made them sign it.

#### *4.4.2.3 Avoid deception of my co-researchers.*

In order not to deceive my co-researchers, I informed them about the purpose of this research which is to gain my PhD qualification. From the beginning I informed them that no financial compensation to be expected. All three of them are aware of this and have also discussed this aspect.

#### *4.4.2.4 Avoid violating the privacy of my co-researchers.*

Privacy, as Sieber (1982:145) puts it, is that which is not intended for others to observe or analyse. The right to privacy is the individual's right to decide when, where, to whom, and to what extent his/her attitude, beliefs and behaviour will be revealed. Privacy applies to elements of personal privacy, while confidentiality indicates the handling of information in a confidential manner.

It is therefore my duty as the researcher not to violate either the privacy or the confidentiality of my co-researchers. Before using the tape recorder, I informed them

of this and requested their permission. I explained that this would help me in transcribing their conversations *verbatim*. We also agreed that I could not divulge the content of the research without their consent and that, wherever I would be disseminating the information about this research, their proper names would not be used.

#### *4.4.2.5 Release or publication of the research findings*

I agree with Strydom (1994:18-19) that until the research is introduced to the community in written form, it will mean very little or not be viewed as research. Therefore the thesis emanating from this research will be as accurate and objective as possible so that it can be understood by those it is intended to reach. It is my responsibility to ensure that, at all the times, the research proceeds correctly and that nobody will be deceived by its outcome. My co-researchers will also be included through the reflection groups that will be established in order to engage a number of people in the final product.

### **4.5 Telling the story:**

#### **4.5.1 Telling the story: Interpretations of experiences are made, described and developed in collaboration with co-researchers.**

The research process is not only about storytelling and listening, but also about story development. Therefore the narrative researcher, patiently look and wait for the research plot to grow. The reason for this is because I do not know beforehand what the solutions will or should be. The research is not only about an action, but more about these women in the action. These women are participants and not objects. They are the co-researchers and should be allowed to be part of the evolving process.

My self-reflection as researcher on the research process and on individual discourse and literature narratives will be shared with the co-researchers, the reflection group and other academic peers. The reflection feedback will then form part of the reconstruction of understanding the meaning of the whole.

For the balanced interpretation of the conversations with my co-researchers, the following steps will be followed;

1. *Listen to the tape recording and read through the notes of interview no 1.*
2. *Listen and read again from top to bottom and identify themes.*
3. *Then read from bottom to top and identify themes.*
4. *No.2 and no. 3 are known as TaF reading of a text (To and Fro) and assist in identifying themes from the different perspectives of the text.*
5. *Organize the themes.*
6. *Interpret the themes in order to come to dimensions of understanding of their meanings.*
7. *Then I will try to grasp the discourses underpinning the themes and meanings.*
8. *I will take what I have done from steps 1 to 7 back to the co-researchers and reflect with them on my themes, my understanding of their meaning, and my insight into the discourses. Then I will integrate the conversational partner's feedback into my own interpretation.*
9. *I will repeat the same process with each of the other two interviews.*
10. *I will arrange a focus group with these women in order for them to reflect with me on the integration of my interpretation and understanding of the meaning of the three conversations.*
11. *I will then share my conclusion with my scientific community eg, my students in a reflection group, Multi-Disciplinary Team members and the PhD group in order to get their critical input.*

12. *From this point I would be ready to allow myself to be led by the ultimate themes and discourses to the relevant literature from various disciplines.*
13. *Lastly, I will bring all the themes, discourses, literature, my own story, with their corresponding features, differences, variants and their reflection of multiple realities into harmony with one another.*

In addition to the above points, interpretation of the stories would be done in constant feedback loops and in collaboration with my co-researchers, the broader scientific community in this case, the PhD discussion group and the discussion group meant specifically to deal with the research feedback. I will also use the multi-angular theoretical sampling where different sources, means, points of time and persons are brought together in order to broaden the focus and to meet the richness of the data from the narratives.

#### 4.5.2 Telling the story: A description of experiences as they are continually informed by traditions of interpretation

Faith communities have specific traditions which inform their perception and behaviour. I, as the researcher, together with my discussion/ reflection group, will have to identify these discourses and try to gain some understanding on how current behaviour is influenced by these discourses. It is also influenced by listening to the co-researchers, literature, the art and culture of a certain context. Furthermore, informative theological traditions will be listened to.

It is through the interpretations of the discourses discovered within the interviews and revealed in the discussion groups that the decision on which “traditions of interpretations” should be employed. The interpretations of the discourses would be done by revisiting the research narratives as described by 13 steps in 4.3.1 above, based on the discourses. I would also be able to use relevant literature, art and other cultural phenomena.

In his lecture, Muller (2005:79) states that the idea of socially constructed interpretations and meaning is clearly part of the postfoundationalist approach. Van Huyssteen (1997:15) adds that:

*“...we relate to their world epistemically only through the meditation of interpreted experience, and in this sense it may be said that our diverse theologies, and also the sciences, offer alternative interpretations of our experiences. Alternative, however, not in the sense of competing or conflicting interpretations, but of complementary interpretations of the manifold dimensions of our experience.”*

Muller (2005:80) postulates that the concept of ‘received interpretation’ puts emphasis on tradition, on culture and on cultural discourses, all of which contribute to the interpretations. Reality is not constructed in an individual and subjective sense, but is socially constructed.

From the above, one comes to the conclusion that the method to be used is listening effectively and with open minds to the stories of my co-researchers and also paying attention to relevant literature and traditions from other pastors and church leaders who are already involved in issues related to HIV and AIDS.

The stories of the marginalised, as Foucault (1979:46) puts it, are cracks or openings through which we see or get a glimpse of the discourses at work. As a researcher, it is my responsibility to peep through all the cracks and interpret whatever I see in there. The interpretation, of course, will be mine as well as that of my co-researchers.

#### 4.5.3 Telling the story: A reflection on the religious and spiritual aspects, especially on God’s presence

*“Postfoundationalist Practical Theology includes the ideas of social constructionism and the narrative approach, but provides us with the apparatus to better position ourselves within a theological world. It also helps us to better position ourselves*



*against the relativistic tendencies in some approaches within the social constructionism and the narrative approach” (Muller 2005:80).*

Listening plays a vital role in postfoundationalist research. In listening, I will be very sensitive to any clue or words that reflect on or point to religion or God’s presence. But our conversations begin with these women as Christians. This step is not a forced effort from my side as a researcher to bring God into the present situation. Instead, I will honestly undertake to listen and understand my co-researchers’ religious and spiritual understanding and experiences of God’s presence. This would be possible by listening to their experiences about God, His love, mercy, grace and providence use of the Bible in times of shock or depression, prayer and visiting other Christians and/or their pastors to discuss their situation. It will not be a problem to these women because they are already Christians and the research is also about pastoral care in their church.

#### 4.5.4 Telling the story: A description of experience, thickened through interdisciplinary investigation

Most of the times, the interdisciplinary work is difficult and complicated because. language, reasoning, strategies, contexts, and ways of accounting for human experiences differ greatly among the various disciplines. The interdisciplinary movement is part of Practical Theology and as such, it includes conversation with other theological disciplines and with other relevant disciplines like sociology, psychology, philosophy, health, education, and science. As a researcher, I will have to be careful about the various stories and make an honest effort to integrate them all into one.

As mentioned earlier, my point of departure is Practical Theology. So, in order to make sure that I use relevant material from other fields, the following methods will be used:

- Literature study

- Interviews with colleagues from relevant fields which can play a role in solving the problem at hand
- Focus or reflection group, as well as the PhD discussion group
- Multi Disciplinary Team (MDT)
- Support group members

As mentioned in 6.1 above, I am going to make use of other non-theological evidences in order to reflect on my conversations positively. To balance this with theology, I shall have to listen carefully to the various stories of understanding and make an honest effort to integrate them all into one. Theology can learn a lot from other disciplines such as psychology, anthropology, philosophy, social and natural sciences, etc.

#### 4.5.5 Telling the story: The development of alternative interpretations that point beyond the local community

The practical theological research is not only about description and interpretation of experiences. Alternative interpretations mean that this way of doing theology is also about deconstruction and emancipation. The bold move should be taken to allow all the different stories of research to develop into a new story of understanding that points beyond the local community. This is rather a case of doing contextual research with such integrity that it will have possibilities of broader application. According to the narrative approach, this will not happen on the basis of structured and rigid methods through which stories are analysed and interpreted. It happens rather on the basis of a holistic understanding and as a social-constructionist process in which the co-researchers are invited and engaged in the creation of new meaning.

My co-researchers would definitely be involved in every step because this is about their stories. They are the ones to help me with my interpretation and understanding of their stories. They will be involved through clarification and interpretation

discussions, seminars held with them and the concentrical dissemination to various communities of faith on different levels.

## 5. CONCLUSION

Having read and listened to different speakers and sources blaming the church for failing to tackle issues related to the HIV and AIDS infection, I am bound to differ with their opinion. Contrary to this view, the church has not failed but it is our theological training and approach that has failed the church and, as such, rendered it irrelevant in dealing with the new challenges the church faces, such as HIV and AIDS-related issues. This research is biased towards the postfoundationalist practical theology approach. My argument is that this approach will help and empower churches to be relevant and use the local context in dealing with people's needs. There might be other approaches to deal with HIV and AIDS challenges in the church, but at the moment this approach can play a vital role in conscientising the church to listen to God and the cry of the people, allowing themselves to become the hands and the feet of Jesus for those in need. In working within one's context, one is bound to recognise available resources and work already done by others before us. The church's program about HIV and AIDS intervention is not aimed at competition, but at complementing one another.

The next chapter will concentrate on my interviews with my three co-researchers, and together, including the MDT will identify the themes drawn from these conversational interviews. It is these themes which will form the heart of this research.

## CHAPTER 2 “*ALL I EVER WANTED...*”

*All I ever wanted was happiness,  
And that is exactly what you gave me.  
All I ever wanted was to be loved,  
And there you were to share your love with me.  
All I ever wanted was to mean something to someone,  
And you told me that I mean the world to you.  
All I ever wanted was to be provided for,  
And oh! Baby, you became my provider.*

*I loved you,  
I sacrificed part of my life for you,  
My education, my freedom.  
I chose to stay with you and stick by you.  
While everyone warned me about you.*

*I became a wife to you.  
A mother to our kids.  
A pillar of strength.  
A giver of satisfaction.  
But I never thought that someday I would become a victim of you.*

*You played with my emotions;  
You abused my trust,  
You took me for a ride,  
A ride of a lifetime.  
You made me share you in every possible way-  
Worse, you dirtied our sheets.*

*All I ever wanted was a man who will;  
Love, care, make me happy and provide for me,  
But I found a man who killed me in every second  
Of our love making.  
**A man who gave me HIV.***

*By: Corporal Dladla (SAAF MDW)*

## 1 THE ART AND POWER OF ASKING QUESTIONS

Medefind and Lokkesmoe (2004:49) clearly state that every revolution begins when someone asks a question. Great communicators understand that well-formed questions can be wielded as a battle horn, soft and low at first, then growing as they echo from mind to heart and back again, serving as a clarion invitation to new possibilities and previously unconsidered truths. A question is like a knife that slices through the stage backdrop and gives us a look at what lies hidden behind it. Revolutionaries are those initiators of transformation in human lives. They are men and women who understand the power of a question. This also applies to narrative research. In trying to understand the plight of my co-researcher, in as far as pastoral care is concerned, I have to ask relevant, yet penetrating questions.

In narrative research, the art of asking questions is very important and how one asks a question determines the answer one will get. Wrong questions will lead to wrong answers which will lead to wrong analysis and ultimately wrong prescription. Asking questions is an art which needs to be taught and mastered. This is the reason that, when asking questions in this research, I made sure that I do not confuse my co-researchers. Instead, every question would be attuned to the uniqueness of each co-researcher's situation (context), probing would be for clarifying purposes and finally it must provide a space for my co-researchers to decide for themselves without me trying to bring a solution to their problems.

Therefore, good questions are a sure means of turning the focus back to where it belongs: the co-researchers. By asking good and relevant questions, we honour their intelligence and, in so doing, they are encouraged to know that we, as researchers, are not interested in preconceived answers, but are attentive to every word uttered. Co-researchers are humans and have the ability to detect and tell whether the researchers are interested in what they are saying or just interested in using them to complete the research work.

## **2 CONVERSATIONAL INTERVIEWS**

Hammersley and Atkinson (1995:151-152) say that all interviews, like any other kind of social interaction, are structured by both the researcher and the co-researchers. This implies that, as a social constructionist researcher, one does not decide beforehand what kind of questions one will be asking the interviewee and the co-researchers are not all being asked the same type of questions. To ensure this, a more flexible approach, allowing the conversation to flow in a way that seems natural and is needed. This can be done by not having a single mode of questioning. On different occasions in the same interview the approach may be non-directive or directive, depending on the function that the questioning is intended to serve. For this research, my approach is non-directive, open-ended questioning.

### **2.1 Unstructured in essence**

For the success of my research, I chose to use unstructured interviews. The benefit of my choice is that it enabled me and the co-researchers to have a deep and informing conversation. In ensuring this, I went to these women, knowing that their lives were either infected or affected by HIV and AIDS. That knowledge was used as the starting point of the conversation and then allowed the interview to get deeper by probing, without leading them to say what I wanted to hear, but allowing them to tell their stories and to explain further what seemed not to be clear in their conversation.

### **2.2 Making use of non-directive questions**

To be successful in this approach of non-directive questioning, as the researcher, I need to be an active listener. This kind of listening requires that I should listen to what is being said in order to assess how to relate to the research focus and how it will reflect on the circumstances of the interview.

A conversational interview is done by making use of non-directive questions which will help to begin the interview. I concur with Freedman and Combs (1996: 45) in saying that one of the advantages of non-directive questions is that even the non-talkative person is able to handle this without being intimidated. Secondly, these

questions help to elaborate and enrich the interview. Thirdly, they help to bring out concrete specifics of the client's world. These questions help to clarify what one has said. Fourthly, they help in identifying and assessing the problem. It is very important for me as the researcher to have these characteristics in mind and to apply them in my interviewing.

### **2.3 The importance of listening**

As mentioned in chapter 1, listening plays a very important role in researching people's narratives. It is therefore imperative for me as a researcher to realize that the stories written about here are not mine, but the co-researchers'. I am just a facilitator to let them talk. It is therefore very important to listen for what I do not know and let their stories unfold without any interference. This forces my position to be one of 'not-knowing'. It does not, however, mean that I do not know anything, but simply implies that my knowledge is of the research process, not of the content and meaning of my co-researchers' life stories. For me to succeed in this positioning, I have to learn to listen. This approach fosters an attitude of curiosity, this is: to be curious about people. I fully agree with Freedman and Combs (1996:45) when they say that just listening and asking facilitating and clarifying questions from a position of curiosity can be very therapeutic.

#### **2.3.1 Deconstructive listening**

Deconstructive listening is required for accepting and understanding people's stories without intensifying the powerless, painful and pathological aspects of co-researchers' stories (Freedman & Combs 1996:46). It helps to open up space for aspects of co-researchers' narratives that haven't yet been told and it allows the silenced voices to speak (Demasure & Muller 2008:8). Hence, the title of the research is the untold or unstoried stories of people infected or affected by HIV and AIDS about pastoral care. Through listening, the researcher discovers different meanings in people's life narratives. It is therefore very important for the researcher to work closely with the co-researchers in deconstructing meaning from their stories. This happens when we interrupt the stories to try to understand the meaning of what has just been said by the co-researcher.

## **2.4 Reporting**

My advantage with these co-researchers is that we all spoke Southern Sotho (*Sesotho*) as a means of communication. Although I did not use the interpreter, which may have resulted in the essence of the message getting lost in the interpretation, in writing this report, I had to translate from Sesotho into English. In translating, I tried my best to ensure that the content of the message of the co-researchers remained as close as possible to what was said. As happens in most translations, some concepts in English would not be able to carry the same weight, power or meaning as intended in the Sotho language and culture.

The main instruments used in the research were the tape recorder, the computer and hand written notes. While I was taping the conversation interviews, I also used the notebook to scribble on. After each interview, I transcribed it in note form and combined this with my written notes. In order to verify the authenticity of these interviews, I went back to the co-researchers with my written notes to confirm, correct or deny. We all came to an agreement, though with minor changes, that this was the true reflection of the interviews.

## **3 CONTEXT OF THIS RESEARCH**

### **3.1 Tumahole: The background of the community**

My co-researchers are all from Tumahole and were members of the AFM. The AFM is the first and the largest Pentecostal denomination in South Africa. I came to know these ladies when I pastored their assembly from 1996 to 2001. The period of knowing them was extended beyond my duties in that community, in the sense that even after I had left the community in 2001, we still called one another. I also continued my pastoral care and counseling to them and their families. As a matter of fact, these interviews were conducted when I was no longer the presiding pastor of their assembly. Another common thing about these women is that, though they were members at our assembly, their husbands were not. As members of my assembly, my responsibilities towards them included, among others, to meet both their spiritual needs, as well as psychological challenges that they were faced with.



### **3.2 Co-researchers and access to them**

My position as a pastor and these women's prior disclosure of their status, as well as that of their partners served as the springboard and opened doors to them as my co-researchers. It was after knowing their status that I decided to interview MM, MX and MS about their experiences as persons infected and affected by HIV and AIDS. (*The names mentioned here are not their true names. We agreed to use pseudonyms in order to protect the women and their family members from any stigmatization*). MM is not infected but she nursed her husband who has since died of HIV and AIDS-related illnesses. Both MX and MS have been infected by their husbands. As the infected, they also had to nurse their husbands.

It was not difficult for me to gain an access to these women since they were persons whom I knew very well. The only foreseen problem with them was the objectivity or lack of it in narrating their stories. I was afraid that they were going to respond to my interviews in ways that would satisfy me as their pastor, but to the detriment of this research. This, however, was proven otherwise, as will be seen from the independence and richness of the information gathered from these interviews.

## **4 STORIES OF HIV and AIDS**

### **4.1 The story of MM**

#### **4.1.1 Background information on MM and her family**

When I came to Tumahole in 1996, MM and her three children had been members of this church for five years. She says that she had been in an abusive relationship since she got married. Whenever Ntate Mose was drunk, he would beat her and her children. One day there was a tent meeting conducted by Evangelist Ananias Ralekholela. The crusade was not far from her house and every day, whenever there was singing and preaching, they would hear what the preacher was talking about. She then decided to visit the tent for a service when her husband was not at home, as he always came home late. MM was very surprised that after the crusade her husband

allowed her and the children to join the AFM. This was the beginning of her faith journey as a member of this ‘new’ church.

I was not too close to *Ntate* MM as he was not open to church people. (*Ntate is a South Sotho word meaning a male person, or a married somebody. In this interview it refers to a husband*). In my earlier talks with him, he made it clear that he was not interested in the church and that we should be happy that he had allowed his family to join us. When he became ill and was bed-ridden, he had softened his position and had more discussions about church and church-related matters. However, he never came or wanted to belong to any church. *Ntate* MM passed away in early 2002. By this time I was already in Soweto, but I managed to go and be with his family in the hour of their mourning.

#### 4.1.2 Interview with MM

The arrangement for this interview was agreed upon in January 2003 at the annual fasting and prayer meeting we hold with some Christians, including MM. We met in my church office in Soweto during the recesses of prayer meetings and had this conversation.

TJ (researcher): Greetings MM and how are you?

MM: *Greetings also to you ntate moruti. I am well through God’s grace.*

TJ: MM, I have come to conduct this interview as agreed before, but you must feel free to stop or continue should you feel uncomfortable about it. Secondly, if we are to continue with this interview, I would like to ask your permission to use my tape recorder so as to capture everything we are going to talk about.

MM: *I am ready to relate my story as previously agreed. I do not have a problem in you using the tape recorder. Feel free to use it.*

TJ: Thank you a lot for this permission. Getting straight to my point, I have come to you, to ask permission from you to make an interview on your story and the effects of

HIV and AIDS in your life and your family. The story would be part of my studies on the response of churches to people infected and affected by HIV and AIDS about pastoral care in churches. If you are willing to narrate your story so that those who happen to read this material would be inspired by your life and that many churches would be informed on what the infected and affected people expect from their churches.

MM: *As I have already mentioned, I do not have any objection to narrate my story. In fact, I have been waiting for an opportunity like this so that people would hear this story. I am going to try to be very honest about my situation and condition.*

TJ: Before starting with your story, would you please tell me about yourself.

MM: *I am a widow whose husband has passed away because of HIV and AIDS related sicknesses in 2002. When he passed away, we had been married for over 30 years. God blessed us with 5 wonderful children; two boys and three girls. My elder son and daughter are both married. The other son would be married in June 2004. My last two daughters are still with me. The other one has completed her Matric while the younger is at high school.*

*Before coming to Tumahole, we were staying at a mine compound. My husband had worked for this mine for more than 30 years. He later volunteered for early pension. We then moved to Tumahole.*

TJ: How would you describe your marital life with him in all these 30 years?

MM: *From the beginning, I never enjoyed my marital life. My husband was very abusive and used physical violence to solve any problem in the house or just to get his way. Unfaithfulness was his way of life. At the beginning, he would give me money which I would put to the bank as an investment. After years of this good practice, and when we wanted to build, I went to the bank to withdraw the money for the material. What surprised me was that instead of finding the amount estimated to more than R50 000.00, I got the receipt that stated that I only had R50.00. This destroyed my self-esteem and I lost meaning for life. It took me many years to recover from this*

*experience. I despised my own stupidity of trusting him in such a way that I couldn't even check how the balance was in my account. I suspected nothing until this horrible day. When I asked him about the money he has been using without my knowledge, he totally ignored me. He would always become violent whenever we were to discuss this issue. At the end, I gave up on getting answers from him for this money.*

*Some of his abusive acts would be when he had gone to drink that when he approach home at early hours of the day that he would switch off the car's engine and come to knock at the door to wake us up and ask me and the children to come and push the car because the engine was 'dead'. Innocently we would hesitantly wake up to push it. In the morning he would start the car and go for his business of welding. This action would surprise us on how would the car start while the engine was 'dead'. This he repeated over and over again. Then I realized that he was doing this to provoke us so that he would physically assault us by using a sjambok. This attempt failed to provoke us. We kept on doing what he asked us to do. But still, he would not be satisfied he would always get something to sjambok me and the children. This abusive life caused me many sicknesses. Despite all these, I endured and persevered.*

*Although he was a member of another church, he never attended and also denied us to attend any church except the one his family belonged to.*

TJ: Then how did it happen that you came to AFM church?

*MM: In 1995, Evangelist Ralekholela conducted a crusade at our community. The reports we got from people who attended the crusade were that miracles were happening and people were being saved and healing were taking place. As I said earlier that my health was deteriorating due to the physical abuse that I suffered, I wanted to go and be healed. I longed for the peace of the soul. My last son, attended and brought the good report of being saved. I then decided to go on the other day with all my three children. I knew that this act would provoke my husband to sjambok us but I was ready to take a risk.*

*I did go to attend the crusade meeting. When I arrived there, I knew that this was for me. The message was so perfect that I just waited for an altar call so that I could go to the forth. When the altar call was made, I was among the first to respond. From*

*that day my life was changed. After the crusade, it was already very late in the evening, we had to go back to our home. The reality of my husband came back to me and children. We started to realise that we were in trouble. The reality of what was going to happen consumed the joy of what had just happened in the church. When we arrived at home, I told children to take out their shoes before entering the house and walk very softly to their rooms. To my surprise, he was still awake when we arrived. Instead of him beating us as usual, this did not happen. He just left us as we were and we slept. This was my second miracle of the day; my salvation and now being not punished when arriving late. In my thoughts I saw this as God's intervention.*

*The following evening, just few minutes after the service had started, (this was possible to detect due to the fact that musical instrumentals were very loud and would be heard from far even though one was in the house), my husband arrived at home and looked surprised to find us at home. He asked me whether I was not going to the service today. This was now my third miracle within the space of 24 hours. I told him I was waiting for his permission, which he gave to me. Freely we went to the service until the last day of the crusade. After the crusade was over and the tent was folded, I was left with no church to attend to. My neighbor, who belonged to the AFM church, invited me to her church. I visited there once and never to look back. This was how I became a member in our church. Few years after this act, my husband became ill and soon (two years) after contracting this sickness, he passed away.*

TJ: Can you elaborate more about your husband's illness.

*MM: From 1998, my husband became sick but at that stage this was not very serious. As months went by, his condition changed for worse. His skin had many black spots which I later came to know as cancer of the skin (Kaposi sarcoma) as he was informed by nurses after attending a clinic for his regular check-ups. For his treatment, he had to attend a hospital once a month for few days at Pelonomi provincial in Kroonstad. He attended the monthly treatment until the last few weeks before his death.*

*His health deteriorated until he could not work at his business. I was advised by some personnel at the clinic to register him for disability grant. This idea seemed very good*

*because the little money I got from hawking could not support the family and his medication.*

*I, then, asked him to get a letter from the hospital that showed that due to his deteriorating health condition, he was unable to continue working. After one of the regular hospitalization, he surely brought the said document proving his medical unfitness. I was very glad to have this document and without looking at its details on what was written therein, I took this document, his and my ID documents to the clinic to fill the necessary form.*

TJ: So, what happened at the clinic?

*MM: When I arrived at the clinic, the administrator who attended me and who is also a member of our church was keen to assist me. We chatted a little before handing the documents in my possession to her. I then explained my reason to be there. As she took the document and read the medical record as well as the recommendation letter for my husband, her face changed and she threw them down (on the counter). She seemed very shocked. This reaction surprised me and I asked her what the matter was. She asked me whether I had read what was in the medical report. With shock, I took the papers to read and only to discover what I feared and prayed that it should not happen to my family. The paper was written “HIV positive”. That was it. It is true. Fear and anger overshadowed me. I did not know what to say or do. It was like I was in a dream. I knew there and there that I was positive and that I was going to die. My thoughts wondered about my children. Without any word, I took my documents and left the place. Up until this moment, everything seemed like an unending nightmare. From the clinic to my place is a distance of 4 kilometers but on this particular day it seemed like a long distance of many hours or days. My feet were heavy and my thoughts were wondering far and wide. I felt like I was dead already.*

*I wondered why my husband could not tell me about his situation before embarrassing myself like this. My heart was full of anger and revenge. I wanted to vent my anger on him in a way that he never thought I could do.*

*To my surprise, when I was just few meters before entering my yard, I saw him sitting in a veranda. Although he was sick, he looked so innocent. The look in his eyes burned and destroyed all the anger in me. I felt very sorry for him. I tried very hard to suppress this anger in me, but I couldn't. I ended up throwing the letter to him and asked him why he did not tell me all these times about his condition. But he pretended that he knew nothing about this. He denied any knowledge of his status. I left him to go and sleep.*

TJ: What happened after this?

*MM: Late that afternoon when I woke up, my anger had subsided. I was like a person who came from a nightmare. I thought and wished that all the happenings were just a dream. But things did not turn out my way. My 'nightmare' was my reality. I then tried to read the Bible but it made no sense. In the evening, after dinner with my children, I went to sleep early. Throughout my wondering thoughts, I thought of my husband being dead. I felt so sorry for him and decided there and there to forgive him.*

*The next morning was like a complete new day and I felt so relieved. I woke early and did my daily chores as if nothing had happened. After giving my husband the breakfast and without him asking for forgiveness, I told him that I have decided to forgive him. It was after this conversation that he also shown the remorse and expressed how sorry he was. But still, he did not admit that he was HIV positive.*

*I was shocked one evening after eating supper, my body started to swell. The thoughts of being HIV positive dawned in my mind. It is this shock that made me to decide to go and volunteer for HIV testing to know my status.*

TJ: Where did you get the idea of testing?

*MM: Although it did not register in my mind when I first discovered about my husband's status, I vividly remember the administrator saying to me that I can do the testing if I want to know my status. It was after this experience that her words came back to me.*



*I then went for the testing. After pre-test counseling, they took the blood samples and asked me to come back after two weeks.*

TJ: What was your experience during these two weeks of your waiting period?

*MM: This was the toughest period of my life. My testing was both secretive and confidential. I was the only one who knew what was happening. Suffering alone was my worst nightmare. Though I hoped against hope, the reality was that I was afraid. Waiting to be told that you are going to die is not good for anybody. I prayed hard and fasted for a miracle. I believed that God will intervene and that results will be the opposite of what was expected.*

*Like any other waiting, finally, the time was up and the waiting was over. The date for my results had arrived and I had to go and fetch them. A night before this day, my last-born child told me that she dreamt a person coming with a gun where my husband and I were sitting. The man shot my husband and he died and nothing happened to me. I interpreted that dream as the confirmation that God had intervened in my situation. This gave me strength and power to face my own problem.*

TJ: What happened when you arrived at the clinic?

*MM: On my arrival I was told to wait for the nursing sister for the results. Before these could happen, I had to undergo the post-test counseling. While all these were done, my mind was just on the results. I did not concentrate on what the nurse was saying except on one thing that I came there for; to know whether I was positive or not. The nurse then read my results. Against all odds, the results came out negative. I was thrilled with this good news and I in my heart I thanked and praised the Lord.*

*After leaving the clinic I went straight to my pastor to inform him about this great news. We rejoiced with him. I then met some prayer partners to inform them about what had happened. They, too, rejoiced with me. To me this was like a heaven on earth. There was never a day like this before.*



(My reflection (TJ) on the day she came to show me her results. I was in the dining room at the mission house, 608 Mota Street, one afternoon when MM came knocking at the door. I opened for her and she looked very excited to meet me. Without any waist of time, she gave me a paper to read. That was the paper about her results. She then related to me the whole story from the beginning. I was very glad for this news but felt very sorry for her husband. We later prayed before she went home).

TJ: What do you think is the reason for you to test negative?

MM: *Honestly speaking, that is beyond my comprehension. I think it is just by the grace of God. Until the time my husband was seriously sick, we were still involved in sexual intercourse. This stopped when he was too weak to do anything. My condition and status was just by the grace of God.*

TJ: In your involvement in sexual intercourse, did the two you ever use any protection like condoms to avoid any sexually transmittable infections?

MM: *Not at all. Until this time, I knew nothing about condoms especially among the married couples. What surprised me was that when he was weak to work, I volunteered to clean his car. As I was cleaning inside, I found condoms in his car. I was so shocked and asked myself why he did not use these condoms with me. The other thought that came to me was that maybe he wanted to infect me. But I did not ask him about it.*

TJ: After realizing his and your status, did you continue engaging in sexual intercourse?

MM: *When we realized our status, my husband was already weak to engage in any sexual intercourse. This was a good time and reason to abstain, which we did.*

TJ: After getting your results, did you inform your husband about them?

MM: *I went home to inform my husband about my results. To my amazement, he was very happy for me because he knew that after his death his children will have a parent to look after them. As time went on, his situation and physical body deteriorated.*

TJ: Did you or your husband ever inform your children about their father's condition?

MM: *Although I knew what was wrong with him, it was very difficult to inform my children. The other thing that made the situation worse was that he did not want them to know. He felt that it was a very bad thing for children to know that their father was dying from HIV and AIDS related sicknesses. I decided to remain silent for a long time until I could not contain myself anymore.*

*One day when he was at the hospital for his monthly treatments, I decided to inform them. The reason for this was that there were already rumours in the community about his status and my children were beginning to ask questions.*

TJ: How did they react when you revealed this to them?

MM: *They were very shocked and hurt. They felt betrayed and been shamed that such an old man was dying of HIV and AIDS. The eldest daughter even went further to tell me that I should have left him long ago. But after I explained about my situation, they tried to understand. In bitterness against their father, they left and went to sleep. The next day one would be able to read the situation that things were not normal. The tension was very visible. When he arrived from the hospital, they chose not to speak to him. As a mother and a Christian, I had to show them the power of forgiveness from the word of God. I did this thing for several days until the message dawned into their minds on how to react in love to their father. After some weeks, normality came into place. They started talking to him, being happy and giving him the respect he deserved as a father.*

TJ: In taking care of him, were you not afraid of the infection?

MM: *Truly speaking, I was not. But I had to take precautionary measures of using cloves as the health workers taught us on how to take care of the HIV and AIDS patient.*

TJ: As you said he was not working and that you made money by selling things, how did you afford his medication?

MM: *Financially, it was very difficult. I tried all I could to sell so that I could help him and in most cases I was able to raise the money needed for the task. Medically, the clinic and the hospital supplied him with medicines. On rare occasions, I had to take him to the doctor. On some occasions, my children helped me with the finances.*

*The moral support from my children boosted a lot. This made things very simple for all of us. Family support is one of the greatest things people infected and affected need. Once this is in place, it becomes easier to face whatever challenge that may happen.*

*Later on, the situation was simple when social grant was approved for him. He earned this for three months before he died.*

TJ: In all these struggles what was the role of your church?

MM: *I must indicate that the church didn't know the problem with my husband. The pastor was the only person and few of the prayer partners were the only persons who knew. For their part they did everything to show us the support. Other members only knew that he was sick. They used to come to pray for him and with us. It was in one of these visitations that the gospel was presented to him and he responded by surrendering his life to Jesus.*

TJ: Why didn't you inform the leadership of your church or go public to let the assembly know so that they may help you?

MM: *I did not have boldness to inform the leadership. My feeling was that immediately this is known, it would become a public knowledge and as a result my family's dignity would have been compromised. The stigma around HIV and AIDS is very high and I couldn't risk to be ostracized. For the sake of my children I did not think it would be proper to go public. Although my husband was dying of HIV and AIDS, he was still my husband and the father of my children. I loved him and did all I could to protect him. He also kept his status a secret. He never revealed it anyone except to one cousin of his.*

TJ: Is this all about your story?

MM: *No, I want to narrate all until his death and drama that unfolded thereafter. His situation deteriorated so badly that he was hospitalized. This was his last time go to hospital and the last time of him as a member of the family. After two days in the hospital, we were informed that he had passed away. Although I knew that this was going to happen, his death brought a pain to children and me.*

TJ: As a self-employed person, how did you afford the funeral costs?

MM: *In our township culture, funeral is a very expensive thing. His funeral costs were around the range of R8000.00. My children and contribution from individuals in the church, community and family helped. The money from the disability grant also helped us a lot.*

*After the funeral, I made a vow to fully dedicate my life and house for the work of God. I started an interdenominational intercessory prayer in the community. These people meet every Wednesday from 9am to 12pm and Sundays for the employed from 6pm to 7pm. In these meetings we pray for every problem. Families have been reconciled and sicknesses have been healed. We do counseling to those who need it. Some of people with members infected by HIV and AIDS come to me for counseling and advises and I avail myself to their service. One brother who has now gone to be with the Lord chose to come and stay with me because his family was pressuring him to consult a sangoma and take traditional medicines. He chose to suffer and die with a clear conscience. He remained faithful until the last day of his life.*

*At the moment, there are two destitute children who are staying with me. My children regard them as their own sister and brother.*

TJ: In order to meet the needs of those infected and affected, what do you think is the role of the church?

MM: *For a church to be a caring church, it can do the following four things: Support groups; Other organizations outside the churches have their support groups. People come with different results of changed attitude from their meetings. If this would be started in churches, many people who suffer with nobody on their side would be helped.*

*Counseling: Counseling prepares to face our dark side of life with no fear. The ministry in this regard would of a great help to many.*

*Discipleship: When people are faced with difficult situation, few of them come out still confessing the Lordship of Christ. Putting the basic courses for new believers would help them to mature and understand that 'we should not expect only good things from God.' This cause should be followed by the advanced once which are related to people's needs. Courses added here should like the once on sexuality and HIV and AIDS. Teaching on these subjects from the church will help many than where the church is silent while people were dying.*

*Taking care of orphans, widows and aged: HIV and AIDS is killing and will keep on killing many people. Parents would die and leave children alone. It is the church's responsibility to be guardians to such people.*

TJ: What is your last message?

MM: *My concluding remarks would be Christians should take suffering positively knowing that there would be an end to every thing. Nothing remains the same for ever. If we believe in God and prayerfully making our petitions known to him, HIV and AIDS would be a thing of the past. Secondly, Christians should not be afraid to*

*face death because we all know that it is our destination in this world and our way of meeting our Savior.*

#### 4.1.3 Themes evolving from MM's story

- *Her husband*

In MM's story, we found that her husband was a non-churchgoer. He was a violent, domineering and abusive person who physically assaulted both MM and the children. He was also a drunkard who misused his money to buy alcohol. He psychologically and emotionally abused his wife by having extramarital affairs.

- *Herself*

MM is a Christian believer and a member of the AFM. She is also an obedient wife who tried to satisfy her husband under all circumstances. She is self-employed, making ends meet by selling goods to feed her family.

- *HIV and AIDS*

In its initial stage, HIV and AIDS appeared to be a mysterious sickness that attacked her husband. To her husband, the opportunistic sickness was skin cancer (*Kaposi sarcoma*). Later her husband's health deteriorated to an extent that he could receive a grant.

- *Her social and economic condition*

MM and her husband were self-employed people. Their family is very poor and depended on the little money they made when their goods had been sold. Later, for a few months, they received a stable added income from a disability grant, which the husband received after being declared physically disabled, due to the HIV and AIDS-related illness.

- *Support needed*

MM's main need is finances to take care of her family, to consult doctors and to receive medical care at reasonable prices. She also needs moral support from fellow Christians.

- *Stages of HIV and AIDS and reactions from her husband, herself and her children*
  - Shock. When MM first discovered that her husband was HIV and AIDS positive, she was very shocked. She could not believe it. She felt betrayed and fooled by him.
  - Denial. Her second reaction was to deny that it was true that her husband was HIV and AIDS positive. On confronting her husband, he also denied the fact of being positive. He held to this position until a few days before his death. He only informed two or three close relatives about his status.
  - Secrecy: MM's husband kept his status a secret to his own wife, thus exposing her to the danger of infection. Once the two knew his status, they both agreed to keep this secret from their children and close relatives.
  - Gossip: Though they tried to keep this secretive, rumours started to spread about MM's husband's illness. It was these rumours that compelled MM to inform the children about their father's status.
  - Lies: MM's husband, when approached about his status, did not only deny what he was confronted with, but also lied to his wife.
  - Embarrassment: Having a HIV and AIDS positive husband and father was an embarrassment to MM, her husband and to their children.
  - Stigma: Children expressed the shame of being associated with a HIV and AIDS positive father. The stigma also fuelled the fear of disclosing his status. One reason MM's husband refused to disclose his status was the fact of stigmatization associated with HIV and AIDS. He felt that it would be an embarrassment that an old man of more than 60 years should be known to be positive.
  - Acceptance: At a later stage, MM accepted her husband's situation and decided to forgive him. The husband also accepted his status before his wife. It was becoming easy for both of them to communicate about this.

- Pain and suffering: Dying of HIV and AIDS-opportunistic illnesses is the most cruel and painful death one can ever face. On his deathbed, a once strong husband was now a helpless, insignificant person who was dependent on the woman he once abused and treated as nothing but a slave.
  - Sympathy: It was this helplessness that compelled his wife to stand by him through his sickness.
  - Remorse: Towards the end of his days, he was very remorseful about the pain he had caused his family.
- 
- *God talk*

When MM went for testing, and while waiting for her results, she fasted and prayed so that God would intervene in her favour. She had faith in God for healing. She trusted God for intervention in turning her ‘positive status’ into the negative. She read the Bible, meditated on the scriptures and found joy in doing so. And in this whole process, she learnt to forgive her unfaithful husband. In so doing, it was easy for her to care for him until his death.

- *Voluntary counseling and testing*

MM did not volunteer to test for HIV and AIDS status, but was advised to do so after she discovered that her husband was HIV positive. She tested to see if she too was positive. At the clinic, both the pre-test and the post-test counseling were conducted by nursing staff.

- *Protection and prevention*

As a traditional African woman, MM never used condoms. They indulged in an unprotected sex. The first time she saw a condom was when she was cleaning her husband’s car. To avoid being infected, she attended a course conducted by nursing staff on how to use gloves in bathing the wounds of an infected person.



- *High cost funeral*

The other theme emerging from the interview was the high cost of the funeral.

- *Church's support*

There was no help from the church as an institution, but individual members of the church were there to share the Word with her, and to pray with her. They were also there to comfort her during her husband's final stage of illness and consequently passing away. The church's non-involvement was due to the fact that her husband's illness was kept a family secret.

- *Pastoral Care*

In her understanding, pastoral care will include, among others, a caring community in the form of support groups or small groups. These are the groups where people infected and affected by HIV and AIDS would encourage one another, read the Bible together and pray together. Counseling and discipleship would play a very important role in this regard. A true caring community of believers would also care for orphans and vulnerable children, widows and grandparent-headed families.

## **4.2 The story of MS**

### **4.2.1 Background information on MS and her family**

I got acquainted with this family in September 1996 when they invited me to their 10<sup>th</sup> wedding anniversary. Actually, it was the elder of the church who invited me after agreeing with MS to invite me and use this as an opportunity to expose her husband to the gospel. The occasion was very good and it ended in him giving his life to the Lord, though for that day only, since after that, he returned to his old lifestyle.

In 1998 I was invited by MS to pray for her ailing husband. Without her husband knowing, she informed me that he was diagnosed HIV positive. We (myself and other members of the church) visited this family and prayed with them. By October 1998,

Mr MS was admitted to Johannesburg General Hospital for 6 months because of TB. When his wife visited him, she brought good news that he was recovering well. She also reported that he had asked for the Bible, which she took to him during her next visit and he read it. Every time she went to the hospital, she brought good news and testimonies of a repented man who did not stop speaking about the goodness of the Lord. In February 1999, he was discharged from hospital. He really looked ‘well and healed.’

The first thing that he did was to visit our church and give his testimony of how the Lord had healed him and how he had decided to commit the rest of his life to Him. The members of the assembly were very happy to hear this testimony.

Two weeks after his release from hospital and after this great testimony that he gave in the church, I was disappointed not to see him at the church service as he had promised. I then took it upon myself to inquire from his wife where he was on the Sunday in question. She informed me that he had visited his relatives in Mafikeng to tell them about his miraculous healing. The day after this visit to Mafikeng, MS visited me to inform me that she had discovered that her husband was not in Mafikeng as he had told her, but had visited a girlfriend in Sebokeng. This was a real shock for both of us. This man was scarcely out of the grips of death and he could not play with his life like that. I then decided to approach him with this information. We met in town and I asked him about his whereabouts, especially after his return from hospital. He first told me the lies of visiting Mafikeng as the reason he failed to attend the church service. Knowing that he lied, I then told him what I knew about his ‘visit to Mafikeng’. He became angry that I was so direct with him. He told me that his private life was none of my business and that our church was not the one that was praying for him, but many other churches were. He even told me that he would never attend the services and that he did not want to see me at his house. That was it. The man had gone back to his old life again.

In 2001 he once more became ill. This time he was put on early pension due to medical unfitness. Surprisingly, it was at this time that he asked his wife to borrow my preaching video cassettes. I lent them to him. After returning them, he asked for more and I realized that he was trying very hard to be spiritually revived.

After I left Tumahole towards the end of 2001, I kept on visiting him. He was very positive and receptive to my messages, more than any time before. On one occasion, as we were discussing the situation, I asked him about his will/ testament. He informed me that he had drawn it up with the help of a police commissioner and it was at the police station. I was impressed by this act of boldness.

MS' husband passed away in 2002. Although he had asked for me to bury him, the leadership of the church decided against this and he was buried by an elder. Their reason was that I was no longer the presiding pastor at their assembly. It was after his death that I asked MS to be part of this interview, which she wholeheartedly accepted.

#### 4.2.2 Visit to MS

This interview took place at MS' home. My appointment with her was scheduled for 10 a.m. on 14<sup>th</sup> April 2004. This was an election day, so it was easy for me to travel to Tumahole because I had registered to vote there. Immediately after I had voted, I went to MX to inform her that I would meet her at 12 p.m. at MS' home. I then proceeded to my interview venue. On my arrival, I found children cleaning and they welcomed me into the sitting room. When I asked about the mother, they informed me that she was still asleep because she was not well. From where I was, I could hear strong coughing. This continued without stopping for a long time (about 20 minutes at most). When her children informed her of my arrival, I heard the sound of the water from a tap. I assumed that she was freshening up and after a while, she came to see me. After greeting, she told me that she was feeling very weak, that was why she was a bit late. She was still coughing while she spoke. This coughing was unusual.

On sitting down, she requested the child to leave the sitting room where he was watching TV, to give us privacy for our conversation. After closing the door, we then started with the interview. Just as I did with the former interview, I explained the purpose of my visit and the research. She agreed about the interview and the use of the tape recorder.

#### 4.2.3 Interview with MS

TJ: Before starting with issues related to HIV and AIDS infection and affection, would you please tell me about yourself and your family.

MS: *I am a widow and a mother of four children (two boys and two girls). The two boys were born before I married my husband. When I met him and got married, they did not come to stay with us. This was our premarital agreement. But we also agreed that that there won't be a problem if they occasionally visit. The girls were born in 1988 and 1990 respectively.*

*We got married in 1985 and were able to buy a bond house in later years (1986 to be precise). When we got married, we used to rent the backrooms in the Ramailane Street. Our early years of marriage were the sweetest and the most romantic ones. He loved me and took care of me like I was a queen. But things changed immediately after being born-again and after taking membership of the AFM church. He was not happy that I left the 'family church' although he never attended. He started to arrive late at home, drunk and sometimes been physically abusive.*

*He started not giving me money, not buying grocery for the family and not caring for the children as he used to do. He later started to bring girlfriends into our house. I discovered this promiscuous life after visiting my home in Eastern Cape. I came back sooner than he expected. To my amazement, I found a woman's underwears and clothes in our bedroom. In anger I burned those clothes. Instead of him been apologetic, he was very furious. Later when I inquired about these clothes, he did not have any explanation. Some of his girlfriends were brave to call and insult me. One even came to insult me in my own house. When I reported this to him he said nothing.*

*As years went by, it became very difficult to pay his bond. Because of his debts, he sometimes threatened to commit suicide. Together with some of his family members and the friends we tried to ask him about what was wrong with his life that he threatened suicide, he refused to tell us the reason. In 1997, ten years in the house, he decided to sell it. His debts were so much that he literally did nothing with the money from the house except paying some of those debts. From here we went to stay with his*

*parents for some few months, then moved to a shack for a month and then to a rented house. All these happened in a space of a year and a half. It was at this time he was beginning to be sick.*

TJ: When did he begin to be sick?

*MS: I think I can trace this from the time we were still in our house. He used to complain about chest problems. He would sometimes close himself in the room alone and told us not to make noise for him. In 1998, while at his home, he became very sick that he could not go to work for about a month.*

*He became my responsibility and I had to take him to the doctors. I kept on asking him what was wrong but he never revealed to me the cause of his sickness. One day after taking him to a general practitioner, I asked the doctor what was wrong with him. The doctor informed me that he was surprised that he did not tell me about his situation. Then the doctor, in his presence told me that my husband was diagnosed HIV positive for some years now. I then figured out that this might have been one of the reasons of suicide threats and closing himself in the house.*

TJ; How did you react to these sad and unexpected news?

*MS: In the first place I did not know what HIV and AIDS was. The only thing I knew about it was that it kills people. Hearing the news that my husband has got this disease was very painful. What hurt me the most was that he knew all along what was wrong with him but he never had guts to tell me. The doctor then told me that if he is positive it implies that I too must be positive. He then suggested taking the blood to confirm his suspicions. I did not refuse and the blood samples were taken.*

*Returning from the surgery, I tried to ask him why he did not tell me but I got no answer. We walked like strangers to our rented house. My heart was burdened. I could only smell death all around me.*

*When I arrived at home, I cried like a baby until I slept. On waking up, I took the Bible and read. I always use the small papers on daily Bible quotes. The quote for this day was on 2 Timothy 2:11-13 which read thus:*

*<sup>11</sup> It is a faithful saying: For if we be dead with him , we shall also live with him: <sup>12</sup> If we suffer, we shall also reign with him : if we deny him , he also will deny us: <sup>13</sup> If we believe not, yet he abideth faithful: he cannot deny himself (NIV).*

*The second scripture I read was on James 5:9*

*<sup>9</sup> Grudge not one against another, brethren, lest ye be condemned: behold, the judge standeth before the door. <sup>10</sup> Take, my brethren, the prophets, who have spoken in the name of the Lord, for an example of suffering affliction, and of patience. <sup>11</sup> Behold, we count them happy which endure. Ye have heard of the patience of Job, and have seen the end of the Lord; that the Lord is very pitiful, and of tender mercy (NIV).*

*These two scriptures were the source of my inspiration. I tried to apply the truths of these scriptures to my life and the only conclusion was that I needed to forgive him. I then took a decision to forgive him for he did not know what he was doing. I woke up relieved and ready to face the world. The Bible plays a prominent role to those in trouble especially after receiving the bad news. Until this day, it is still the source of my inspiration.*

TJ: Before the doctor revealed your husband's status to you, did he do the counseling?

MS: *No. There was no counseling done. He just informed me just like that.*

TJ: How about when you fetched your own results, was there any counseling done?

MS: *When the time came for me to fetch my own results, still there was no counseling done. I just got in the consulting room and was told that I was HIV positive. Just like that. When I heard this, I was not shocked, I had already prepared myself and had passed the stage of shock. I knew that there was no way that he could be positive and I be negative. Although I wished for a miracle, I had prepared my mind for the sad news.*

TJ: Did you inform your husband about your results?

MS: *Yes, I did.*

TJ: What was his response when you informed him?

MS: *After I informed him he looked very sorry for me. Although he had said nothing at that time, one could easily read his sad facial expression. Actually, since the doctor revealed his status to me he was somehow withdrawn.*

TJ: Did you ever go for second test to confirm the results?

MS: *Yes, I did. This was done at the local clinic.*

TJ: Was there any counseling done at the clinic?

MS: *Before the test was done and before I was told about my results two weeks thereafter, I was counseled. These results confirmed the earlier one.*

TJ: Can you tell me more about your husband's condition at this time?

MS: *By this time, he was very sick and also very weak. His one friend used to visit him daily. He would always be there for him. Others were nowhere to be found. One day our pastor paid us the pastoral visit to pray for us. I had informed him about our status. (My husband did not know that I had informed him. I thought that my husband will also inform him). After an hour after being in the room with my husband, I was called when the pastor was to leave and he informed me about my husband and friend's decision to accept Jesus as the Saviour and Lord. After prayer the pastor left. I later found that my husband had not informed the pastor about his status*

*From that moment, my husband's life was changed. He started to pray daily. He became a different person and we started sharing about God's word. As he became weaker, he was hospitalized at Johannesburg General Hospital. I visited him monthly for the period of 4 months that he was being hospitalized. Every time I was with him*



*he shared about the verse he read from the bible and we enjoyed the fellowship. He even promised me that when he comes back his life would be so different that his other friend will notice the difference.*

*After the 4 months he was discharged from hospital. He came back 'healed' and happy. He arrived on Friday and on Sunday he was at the church and he even testified about how God has healed him. The second Sunday he was at the church again.*

*On the third week of being at home, he asked me that he want to visit his uncle in Mafikeng. I allowed him to go. After a week he came back a different person. The Saturday of his return he did not sleep at home. He came back the following day drunk. When I asked him he became aggressive. I later learned from his friend that he did not go to Mafikeng as he promised but went to stay with one of his girlfriend in Sebokeng. I realized that he had forgotten his promises. A month after returning from the hospital, he was called back to his work. He told me that he was now healed. He started drinking and sleeping out again. I vividly remember one day as I was passing a house in another section of the community that I saw him topless coming from another woman's room. I was so shocked but avoided to make him recognize me. I learned later that this was his girlfriend for a long time and had bought a bed for her which I later had to pay because he could not afford to pay and that his name was about to be handed to credit collectors and this would affect us.*

TJ: After both were diagnosed positive, did you use protection when you had sex?

MS: *We used a condom. But one day he refused to use it and I also refused to have sex with him. He beat me but I made sure that I wouldn't have an unprotective sex. He gave up and from that day he never repeated this again. He always used a condom.*

*After a year of being 'healthy' he slowly became sick again. Because of perpetual absenteeism from work, he was retrenched on account of medical unfitness. Slowly but for surely his health deteriorated. He became worse. His attitude was now better. He began to read the Bible again.*



*At this time he received his retrenchment package. With this money, he bought us a house in which we are living in and he also bought us clothes and furniture. Although he had vowed never to see my pastor or go to church, he contributed an amount of R1000.00 to the church. He asked me to borrow some video tapes from the pastor so that he may watch. He enjoyed these tapes.*

*In his conversation he would tell me that he does not believe that God would forgive him his sins after the miracle of healing he received. He saw his sickness as a punishment from God about his sinful life. I kept on encouraging him until he accepted that God will forgive him again. When he saw that after all his unfaithfulness and abuse that I could forgive him, he realized that with God all things were possible.*

TJ: Did you reveal his status to his parents?

*MS: Initially, they did not know until I told them. His father was very sad to hear these news because he had lost a girl some few weeks before on account of HIV and AIDS related sicknesses. Although his parents understood what was happening, the problem was with his sisters who started to say that they were going to take a house once both of us were dead.*

TJ: After hearing the news from your sisters-in-law about the house, what was your reaction and that of your husband?

*MS: I did nothing but it was him who took the initiative of going to the police station to sign an affidavit about the will. In the will the house was given to the children and me.*

TJ: Did your husband continue consulting medical doctors to be cured?

*MS: No, he had lost hope in doctors. The messages that we heard from the news were that no hope was there for the person on full-blown AIDS. But as his last attempt, he went to one medical doctor in Bloemfontein. This was after he heard from the radio announcement that a certain medical doctor in Bloemfontein claims to have a cure for*

*HIV and AIDS. We agreed that he should go there. After three weeks he came back very optimistic and said he was given another appointment after a month. Unfortunately he heard from the radio news and read from the newspapers that that same doctor was murdered at one shebeen in Batho location in Bloemfontein. These news left him hopeless because his hope was now gone.*

*After all these, his situation deteriorated and he became very sick. One evening as we were talking, he asked me to fetch him some water from the kitchen. On my return, he had collapsed. I tried to revive him but with no help. I asked the help of my neighbors who informed me that he is dead. I cried for him.*

*What consoled me was his words when he told me not to expect a miracle for his healing but to accept his death. Hard as it was, I came to terms with the fact of losing him. With the money he left, we were able to bury him, buy food for mourners and unveil a tombstone.*

TJ: What was the cost of the funeral and how did you afford them?

*MS: The costs was just above R10 000.00. All the costs were catered for by the money he had saved for his funeral and for children's future. There were also the contributions from the church people, relatives and friends. I was very happy that we gave him a decent funeral.*

TJ: Knowing that you tested HIV positive, how is your health at this moment?

*MS: I am very sick I have been diagnosed with TB and I becoming weaker by day .The treatment that I get from the clinic make me weaker.*

TJ: Are you taking any medication and the anti-retroviral?

*MS: No, the only medication is that of TB. As for ARV's, I don't even know anything about it except what I hear from the news.*

TJ: Is there any support that you get from your church?

MS: *I have received a support from individuals in the form of prayers, financial contributions, and visitations that helped me to talk. But the church as an organization has not been of a help in any way. Our church does not have any ministry towards people with HIV and AIDS.*

TJ: What do you think the church should do to those infected and affected by HIV and AIDS?

MS: *In addition to the few I mentioned above, I think that the church should have ministry of counseling people infected and affected. The church should think about caring for orphans and widows in their midst. Giving food parcels to those who cannot afford can be of great help and would be appreciated by the needy. For people like us who have given all to the church and have nobody on our side except the church people, I think it is the church's duty to take care of us.*

TJ: Thank you for your time. Shall I pray for you before pronouncing the grace?

(We stood up as I laid my hands on her and prayed for her. I then left her. It is important to note that through our conversation, MS was coughing very strongly).

#### 4.2.4 Keeping in touch with MS

After this visit, I continued engaging MS by means of telephone. Three months after the interview, I was glad when MS called to inform me that that she was feeling better and that she was employed at a café in town. This was helpful for feeding her children. She then informed me that she had experienced a problem with the house. As I listened, she said that the lawyers want the money to 'pay-off' the house. This was surprising since the house was fully paid and she had no money to pay for anything.

I took it upon myself to visit her and hear more about this house issue. After listening to her, I visited and spoke to the previous owner to hear how this could be resolved. I then discovered the misunderstanding in this whole thing. The house was fully paid. The only thing remaining was the transfer of the ownership to the new owner. This

was not well communicated to MS. After this explanation, she was happy to raise the required amount for the house to be registered in her name.

#### 4.2.5 Themes evolving from MS' story

##### ○ Her husband

- He was a non-churchgoer who spent his time in excessive drinking and womanising.
- During the week he came home very late, while on weekends most of the times he never came back until late Sunday or early Monday.
- He was also physically abusive. When asked where he came from, he would beat his wife. This was the life MS was used to in her own house.

##### ○ His reaction to HIV and AIDS

- He knew his status long before MS was told by the medical doctor, but he made sure that he kept that secret.
- When MS wanted to know what was wrong with him when he was ill, he lied about his condition. He became abusive so that she would stop questioning him.
- At one time, possibly after he was informed about his condition, he threatened suicide. But MS was not aware why he was becoming suicidal.
- When there was no way of hiding his secret, he admitted to his wife about his condition, but he still wanted to keep it a secret. He revealed his status to very few people who were close to him.
- When he was very ill, he started attending church services and also gave his life to Jesus. After being 'healed', he returned to his old lifestyle.
- Realizing that he would not have many days to live, he drew up and signed a will for his family.
- He passed away in the year 2002. By this time, he had surrendered his life back to the Lord.

- HIV and AIDS
  - Needless to say, MS' level of education went only as far as Grade 4. She was illiterate and ignorant about many things. She knew nothing about HIV and AIDS except a little knowledge from TV or Radio.
  - When she tested positive, she was very hurt. She thought of nothing but death, her own death.
  
- Voluntary Counseling and Testing
  - She had no choice to make. When the doctor, out of the blue, informed her of her husband's status, she was advised by the same doctor to take the blood test.
  - When this doctor informed her of her husband's status, no counseling was done to prepare her. Again, when she underwent the test, there was no pre-test counseling. After being informed about her own status, there was no post-test counseling.
  
- Reaction to test results
  - Though she was not surprised to know her status, especially after her husband's, she wept. She thought that this was just a dream.
  - She hoped and prayed for the miracle of healing.
  - It was her husband who tried to console her after realizing that his wife would suffer because of his own wrongdoing.
  
- Protection
  - After they both knew their status, it was MS who insisted on condomising against her husband's wishes. But he never forced himself on her.

- HIV and AIDS and God talk
  - Her husband felt that his HIV and AIDS status was due to the fact of his promiscuity. He regarded this as a punishment from God.
  - After having lost faith in God for healing, he later changed his perspective on God. He gave his life back to God. He died a Christian.
  - Signs which showed his changed life were listening to tapes of preaching and gospel music, praying and at one time, after receiving his pension, he gave a large sum of money towards the church building project.
  
- Pastoral care
  - According to MS, pastoral care is the ministry of the church towards those infected and affected by HIV and AIDS. This ministry will include prayer, counseling, caring for orphans who have lost their parents and widows who have lost their husbands and have children to care for.
  - Furthermore, the church will have to donate food parcels to the poor who cannot afford a meal on the table.
  - Since most of the infected people are poor, financial assistance for medical treatment and funeral costs would be a good sign of what a Christian family should do.

### **4.3 The story of MX**

#### 4.3.1 Background information on MX and her family

As with the previous co-researchers, I got to know this family in 1996 when I became a pastor in this community. Unlike other co-researchers, this was the first family I came to know in our church. The main reason for this was that they were my neighbours. While the husband was not a member at our church, MX was. Both stayed with the husband's mother.

Most of the time when the husband was drunk, we would be woken up in the night by MX requesting a hiding place to sleep in our house until the next morning when the

husband was sober. Though we tried to cool the husband down, he never listened to any of our advice.

Apart from these instances, we related very well to this family. After leaving Tumahole for Soweto, we still connected and visited them whenever we were in the Parys/ Tumahole vicinity.

One day in 2002, when we were at Parys in a hall attending the wedding of a member of the local assembly, we met up with MX who looked very troubled. She requested to talk to my wife privately. She then requested my wife to inform me about what they spoke about. As we were driving back to Soweto, my wife informed me that MX told her that she had been diagnosed positive about four weeks earlier. She then requested me to call MX to talk to her.

It was late after the wedding and when I arrived in Soweto that evening, I called MX to enquire about what my wife had told me. She confirmed what I had just heard. I then asked her what her husband's reaction to this sad news was. She informed me that he did not know because she was afraid to inform him about the test results. (*I became angry with her husband, when realizing that this Christian woman who tried so hard to be faithful was infected with the virus and because of her husband's abusiveness she couldn't even talk to him about it. Be that as it may, I tried everything I could to bracket my emotions*). She then requested me to devise a way to come to Tumahole to inform her husband about her HIV status. Her request was difficult, nonetheless, we made an appointment for fortnight later. In these fourteen days I planned how I was going to approach this man about the news of his wife's status.

The long wait was now over and the fourteenth day had arrived. We drove to Parys to meet this family. MX had already informed her mother-in-law who was in support of her. When we arrived in Tumahole, the husband was not there and had to be fetched from a tavern the nearby. When he arrived, he was already drunk. He was very impatient, asking why he was called from where he was. After a few minutes, I informed him that I was there at the request of his wife. He was now becoming inquisitive, trying to know what the reason was. I then allowed his wife to inform us

why we were there. She informed him that she was diagnosed HIV positive and that she wanted me to inform him because she was afraid of him.

After hearing this, he changed. He became very aggressive, asking why his wife did not inform him, but waited until I was there before she could do this. His second problem was who gave her permission to go and see a doctor without his knowledge. He then started accusing his wife for befriending the wrong people of whom one of those ‘wrong’ people had been buried because of HIV and AIDS-related illnesses.

I tried to cool him down so that we could hear his wife’s side of the story. He refused to listen to any logic. When I realized that this was not taking us anywhere, I requested to leave, but asked him to call me whenever he was ready. He never called me for this purpose, but we met many times after this.

#### 4.3.2 Interview with MX

This interview was conducted six months after MX discovered her HIV and AIDS positive status. We met at MS’ home because she feared her husband wouldn’t let me interview her.

The interview started at 12h05 (five minutes after the appointed time). As on the previous two occasions, I explained the purpose of this interview. With her permission we began with the interview.

TJ: Would you please tell me about yourself?

*MX: I am 34 years old and I have been married for 10 years now. I am still staying with my mother-in-law as my husband is her only surviving child. My husband is a teacher and works at a farm school many kilometers from our home. He stays at the room near the school during the week and comes home on weekends.*

*I met him while I was a high school student doing Standard 9 (which is Grade 11). We met while I was visiting my sister at a farm where he was working. Ours was love*



*at first site. After few month of seeing each other, we got engaged and came to stay with his mother. I completed my Matric while in marriage.*

*I must point out that my husband is a drug addict and an alcoholic. He is jealous and abusive. He abuses both his mother and myself especially when he is drunk. To me this was not and is still not a problem because we only meet on weekends. An interesting thing is that when he is sober he is very good.*

*Apart from physical abuse, and other bad manners, we experienced another problem when he wanted us to have a child. This put a lot of stress on me since I could not conceive. We both each have a child outside the marriage. We do not have a child of our own. We tried everything to have a child but with no success. In the year 2002, I became sick and this made me to be suspicious. Realizing that my condition continued, I then decided to do some HIV tests. This was the hardest decision I took but I had no alternative.*

TJ: What compelled you to undergo HIV testing?

*MX: I had sexual transmitted diseases and this made me to suspect that I might also be HIV positive. I knew by listening to the radio that chances are very high for one to be HIV positive if that person has sexual transmitted illnesses.*

TJ: Tell us more about your testing.

*MX: I decided to test at the medical practitioner's surgery. This was easy for me because he was our family doctor and that we were on a medical aid scheme. After the pre-test counseling, my blood samples were taken and I was told to come after two weeks. From the moment I left the door of that clinic, I could tell that I was in trouble. My secretive waiting for the results for two weeks was not good. I tried to be happy but I had no joy. Deep inside I wished I could undo what I feared the most; to be told that I was positive. I tried everything to forget about this whole thing but I couldn't. I prayed for a miracle.*

TJ: What happened after the two weeks waiting period?

*MX: After the two weeks, I felt that I was not ready to fetch the results. After the third week had passed, I decided to go for the results. On my arrival I was ushered to the counseling room by one nursing sister. Before the results were read, I was counseled again. This is called the post-test counseling. The counselor asked me who would be the first person to tell about my results whether they were positive or negative. For me negative results would not be a problem. This would be news to rejoice about and I would be glad to share the news with whosoever. But thinking about the person to break news of HIV positive status was a difficult thing to think about. After some deep thought I remembered the name of my prayer partner and told the counselor that this will be the first person to inform. When she informed me that I have been diagnosed HIV positive, it was like my world was crumbling under my feet. What I feared had happened. All that was said in pre-test and post-test counseling just vanished. I lost it. I must emphasise that there is no amount of counseling that can wipe away the fact that one is positive and sooner or later one will have full-blown AIDS and this will lead to death. I cried. In fact, I wept like a baby.*

*After this announcement the counselor requested to pray with me and I came back home. I was very devastated. I had lost the joy of life. I knew that no matter what would be said, I was going to die. The fear of death gripped me. I started to think about my death and the pain of dying of AIDS.*

TJ: Did you inform your prayer partner as you promised to the counselor?

*MX: Yes, the following day early in the morning I went to meet her. Since she knew about the test, it was easy to break the news and inform her that the results came back positive. She felt sorry for me but she shared the Word of God (Bible) and then prayed with me. We then decided to meet everyday at a certain time for sharing the Word and praying.*

TJ: How did you inform your husband about your HIV status?

*MX: On Friday when he arrived, I was still very confused. This day he came home being really drunk. Before he even entered the house, we heard him in the street*

*insulting his mother and me. It was like somebody had told him something. But this was impossible. When he got into the house, he pushed us from one corner to the other. Mind you I was still confused. In that process, I literally lost my mind. I left the house and was found in the early hours of the following day (Saturday) by a motorist about 20 kilometers from Parys on the way to Sasolburg. With a little bit of sense, when he asked where I came from I told him and gave the address of my prayer partner and he took me there. During the day, after real praying, my prayer partner took me home. My mother-in-law was happy but shocked to see my condition. My husband was not at home. He had gone for more drink. During the evening when he arrived, he never asked anything until he left for work on Sunday.*

TJ: After informing your prayer partner about your status, did you also inform any other person about this?

*MX: The following weekend on Friday before my husband arrived, I informed my mother-in-law that I was visiting my parents. I had not informed yet about my HIV status. My main reason of going home was to inform my parents and other relative. When my husband arrived, I was already gone. When he phoned to inquire about my whereabouts, I told him that I was not feeling well so I came to see my parents. I was amazed when he accepted my explanation without any argument.*

TJ: What happened at your home??

*MX: On Saturday I called my parents and tell them about my situation. It was painful for them but as parents they seemed to understand. We agreed with them that before leaving I will have to inform other family members. On Sunday I called my brother and sisters to a meeting where I was going to disclose my status. Without any anticipation of bad news they all came. When they were all present I wasted no time but informed them about the reason why I called them. When they heard these, it was as though I was already dead. They wept like those who have lost their loved one. One of my sisters even fainted. Both she and my father had to be taken to a doctor the same day. When all this was happening, it dawned to me the seriousness of my condition. For their sake, I managed to control my emotions. Although this seemed*

*possible in my appearance, deep in my heart I was breaking. After praying with them I left for Parys.*

TJ: Now that your parents and family were informed, when were you prepared to inform your husband and or your mother-in-law about your status?

*MX: On my arrival, I was glad that my husband had already gone for work. Being in the high moods after informing my family, I called my mother-in-law and informed her. For an old person, with the only son, the news was real bad and shocking. For her to understand, she asked me many question about this 'HIV thing.' Later she responded by saying that although this was sad, her son is getting what he deserved. At this moment, my husband did not know anything and his status was also not known. We only assumed that he too must be HIV positive.*

TJ: In this discussion, did you inform your mother-in-law how you were going to inform your husband?

*MX: From the moment she heard about my condition, she sympathized with me. Knowing the character of her son, she tried to help to think on how we were to inform him. We both knew that if he hears this, he would be very violent and that he could do anything to harm us. We thought of many alternative ways of disclosing this to him because he needed to be informed so that he could be careful in how he conduct himself and for us to use a protection to avoid reinfection. In our thoughts the name of my pastor who had taken a transfer to another congregation came to our minds. We then agreed that he would be a relevant person to break the news to him because my husband had a respect for him.*

TJ: (recollecting my thoughts, I still remember when I spoke with MX about her condition. Breaking the sad news was terrible. Mind you, apart from being this her pastor, she was my neighbor. Her mother-in-law was like a mother to me. Although her daughter-in-law was the one who was a member of our assembly, when I informed her (mother-in-law) about my call to Soweto, she cried. She couldn't handle the news. When her daughter-in-law disclosed her status, my mind wondered. I thought of this old lady. I remembered the time when I promised her that I will pray

for them and his son will be alright one day. I then remembered the abuse they both suffered in the hands of this young man. I then agreed to go to Parys to listen to her and then break the news to her husband.

I remember that there was to be a wedding in Parys for one of the persons I knew. I used this as an opportunity to meet with them. The date and the appointment were set. We agreed that her husband should not be informed but it would be as though I was their visitor and when the situation was conducive, I would then allow MX to disclose the matter to her husband. She then disclosed her status as arranged and the rest has been mention in background information).

TJ: What happened after the pastor had left? Did your husband ever own up to accept that he was responsible or your condition?

*MX: A week after he left us, and when he was sober, we had our conversation and resolved to stay together. He accepted that if I was positive then he must also be positive. We agreed to be careful in our conducts. We even agreed to use a condom for sexual intercourse.*

TJ: Did he ever live up to this resolution of being careful?

*MX: Not at all. He just used this to show me that he is aware that he was responsible for my condition. Though we had agreed to use a condom, he came home one night and demanded that we have sex without a condom. I refused and he beat me. I ran to his mother to tell her but he chased me and told his mother to get out of his business. When the mother told him that condom was good for our life he refused and took me by force and had sex with me.*

TJ: Mme MX, do you mean he raped you?

*MX: No, he did not rape me but he forced me to have sex with me without a condom.*

TJ: Do you know that sex without another partner's consent is a rape?

MX: *I am his wife and there is no way that he could rape me when he wants to have sex. My only problem with him was to do it without a condom.*

TJ: What was his explanation about this problem?

MX: *The following day when he was sober I asked him about the last night. He then told me that he loves me a lot and he won't let himself die to leave me behind for other men. From that day, we never used a condom. Infected as we are, we have sex without a condom. Actually, I can say that after this incident, I realized how much my husband loved me. He has started to take care of me by giving me money, buying food and clothes for me. These he couldn't do before knowing our status.*

TJ (surprised): Mme MX! I don't believe that this comes from your mouth.

MX: *(showing no sign of remorse) It's true ntate moruti. HIV has 'restored' my joy of marriage. We enjoy each other's presence. Wherever I go, he goes with me except when I go to church.*

TJ: *(still shocked)* Do you have any support group that you attend?

MX: *Yes, I do have support group. I was advised by the counselor at clinic about the support group. When I went there, the group members welcomed me with open hands.*

*I found two married women and 8 youths. Presently we are eleven people. There are no men (married) in this group except two young gentlemen. We meet once every week on Thursdays. Our support group is in partnership with one NGO in the community known as Partuma AIDS Awareness Group.*

TJ: What roles does this group play in the lives of its members?

MX: *On some occasions pastors from different churches visit to minister the Word of God to us. On other occasions the health workers and social workers visit for counseling, support and any other matter related to our health.*

*Through the intervention of the social workers, we are supplied with food parcels monthly. These parcels we take to our families. Health workers also supply us with medicines.*

*We also use our meetings for sharing about our lives. We boost each other's morale as we go to different meetings to make the communities aware of the impact of HIV/AIDS.*

TJ: Does your husband belong to this support group?

*MX: No. He came once and he never went back again. The reason was that there were no older men like him in the group except the two gentlemen I mentioned before. These two brothers we have in the group do visit him sometimes. He seem to be enjoying their presence. They are unable to talk with him about condoms because they are too young to him. He taught them at school and they still regard him as their *menneer* (this is a reference to a teacher).*

TJ: Does your church know about your status?

*MX: Officially I haven't informed my church leaders or the congregation about my status. Our church's leadership especially in the absence of the pastor seems not to be concerned about social issues. When I was thinking about going public about my status, I thought it was good to declare to Sisters' Fellowship prayer meeting. It was a tough thing but I had to do it. This shocked these people because I did not use any tactic to announce it. It just came and I spoke as I felt it would help me. Even after this declaration to women, no member of leadership came to me. This is despite the fact that their wives were present in that meeting.*

*After the meeting and after some days, some women came to express their shock and to admire my boldness. They also pledged their support and prayers for me and my family.*

TJ: What support do you get from the church?



MX: *There is nothing that the church as an organization does except individual members in their capacity.*

TJ: What role do you think the church should play to people who are infected and affected?

MX: *What I think the church should do as a body of Christ, is the following:*

- *Counseling:*  
*The areas that need more attention would be spiritual, psychological and social support.*
- *Support Groups within the church;*  
*In our church I know more than 5 people who are living with the virus. If a support group that is based on common faith in Christ could be started, many would be helped and many unknown infected people would emerge.*
- *Material support;*  
*Some of the infected people do not have money for the doctor. Financial support, food parcels and clothes to these people and their children would be a great help.*

TJ: Thanks you for your story, and I hope that God will help you, your family and your church. Shall we stand for a prayer, please?

MX: *Thanks, too, for your time. You may pray for me. (We stood and prayed).*

#### 4.3.3 Continued contact with MX

After this interview, we kept communicating with MX by telephone or used an opportunity to talk whenever we met on different occasions. Three months after the interview, MX called to inform me about the progress in her family. She informed me that her husband had changed and was back to what she knew him to be: an abusive man. All the romantic things and care he showed was just show-off. He started being more abusive than before. She then informed me that because of the abuse, she had decided to go back to her home-town, which is 20 kilometers from Tumahole, to stay



there. She had built her shack and was staying alone. Another problem that caused her to leave and stay alone was that her husband was transferred from a farm school to a local school and he was staying home. His everyday presence was not helpful to the family because he was always drunk or on drugs and was fighting them almost daily. Though she is staying there, she sometimes comes to visit her husband. She feels that things are much better in this way because they now meet once in a very long time.

Some months after this second conversation, we met with MX who informed me of the good news that she had volunteered her services for HIV and AIDS education in Parys and Vredefort local municipalities. She said that she had been trained by provincial and local health personnel for this task. Their support group had also expanded to include some areas in Fezile Dabi District municipality.

Many people call on her for counseling and motivation. One of these was a lady who used to belong to our church, but got married and stayed in Sasolburg. When she was diagnosed positive, she was able to call MX and disclosed her status to her. One of the pastors in our church was able to go and ask her to talk to his daughter when he suspected that her daughter was trying to keep it a secret that she was suffering from AIDS. Both the persons mentioned above are already dead, but she still plays a prominent role to comfort the parents.

#### 4.3.4 Themes evolving from MX's story

- Her husband
  - He is an alcoholic, drug-addict and a non-churchgoer.
  - He is also very abusive, both physically and verbally. He refuses to use condoms to protect himself and MX from being re-infected.
  - He is very jealous and does not want to see his wife in the company of other men.

- When informed about his wife's HIV and AIDS condition
  - He became angry, raised his voice and accused MX of befriending immoral and promiscuous woman.
  - He also blamed her for testing for HIV and AIDS without his permission.
  - He flatly denied that he is responsible for infecting his wife.
  
- Why did MX volunteer for the HIV and AIDS test?
  - On listening to the radio, she realized that she had the symptoms of sexually transmitted sicknesses. This condition forced her to go and be tested so that she could be sure of her status.
  
- Reactions after receiving results
  - Although she underwent the pre- and post-HIV counseling, she felt that she was not yet ready for HIV positive results.
  - As a result, she was shocked by the results and felt as though the world was crumbling under her feet.
  - She lost control of her emotions and wept bitterly when she thought about HIV and AIDS and death. She felt that this was the end of her life.
  
- Life after disclosing the news to her husband
  - Her husband firstly refused to own up, but later accepted his responsibility for infecting her. It was after this 'confession' that he became very romantic and caring. This was for a short time before he resorted to abusive behavior.
  - Due to this abusive behavior, they later had to be separated (only visit each other occasionally).
  - So as to know more about this disease, she had to join the community HIV and AIDS support group. She also had to disclose her status to the church and the community radio station.
  - Presently she is a volunteer for counseling the infected and affected.

- God-talk
  - She prayed for a miracle while waiting for her results and communicated the whole process to her prayer partner. They also shared the Word of God from the Bible.
- More caregivers needed
  - She feels that, concerning the problem of destigmatising HIV and AIDS, both the infected and affected members need to work with a Multi-Disciplinary Team (MDT) that includes pastors, social workers, health workers, legal advisers and other related professionals.
- Pastoral Care
  - There must be a prayer organized for the infected and affected members and Bible Study for spiritual support.
  - A support group comprising infected and affected Christians will be most important.
  - Hospital and home visits can play a very important supportive role.
  - The church can also play a role in family support for those infected and affected.
  - Where the church is unable to render help, it can refer cases to other professionals and members of a MDT.
  - Community education and HIV and AIDS awareness campaigns are essential.
  - Counseling.
  - Financial and material support are also important.

## **5. VERIFICATION OF THEMES EVOLVING FROM CO-RESEARCHERS' STORIES.**

As mentioned earlier, I had to visit my co-researchers from time to time to clarify my understanding of their stories. In this way, we changed and corrected any misunderstanding, added what was omitted or omitted what did not make sense in

the flow of the stories. It was during these visits that we picked up common themes which we felt were main ideas in their stories. The same themes were discussed by the support group and the MDT, but at separate occasions.

## 6. CONCLUSION

The stories of my co-researchers have given me very rich information which, if well managed and interpreted, would result in a good theological basis that will contribute to a faith organisation's education in matters relating to HIV and AIDS.

The following chapter will deal with data interpretation that came from these stories.

It is summarized as follows:

- Factors contributing to the spread of HIV and AIDS:
  - Ignorance
  - Religion and culture
  - Gender and women's rights
  - Stigmatisation
- Ethical issues: rights of the perpetrator versus rights of the innocent.
- Preventative education
- Effects of HIV and AIDS on families and the community:
  - Psychological
  - Social (generational gap)
  - Economic
- HIV and AIDS as good business for funeral undertakers while impoverishing the poor
- The challenges of HIV and AIDS to be met by our faith: the silence of God and the suffering of the innocent.

### CHAPTER 3. “THE BEGINNING OF THE STORY AT THE END”

*“The end of the story is not in the book. But it most certainly continues; as a matter of fact, it really begins at this point”* (Dietrich Bonhoeffer 1978:14).

#### 1. INTRODUCTION

While the focus in chapter 2 was on the co-researchers’ stories, in this chapter the story becomes more intense in the sense that I engaged other external sources like MDT which comprised of two of my fellow PhD students who are pastors in different church traditions and different communities, theological students from both Auckland Park Theological Seminary (ATS) and AFM of SA Theological Institute (AFMSATI), a clinic staff member (nurse) representing health, a role played by a medical doctors in the area, a social worker and one local funeral director (business) and support group members. The involvement of MDT covers the many aspects of the infected and affected person’s life. The fact that no one professional discipline is equipped to handle this situation alone makes it possible for all involved in the MDT to recognise that they are incapable of solving the problem alone without the involvement of the other (Field 1958:172). Their different roles in this inclusion were to help in interpreting the stories, applying the postfoundationalist methodology, and then mapping out what the role of pastoral care with regard to these stories will be.

##### 1.1 Different roles played by each member of the MDT

As mentioned above, my team members comprises of a nurse who will look at the medical implication of HIV and AIDS, my theological students doing a course on the “Church and HIV and AIDS” at both the AFMSATI and ATS, who also looked at the community voices in the stories, a community leader and a social worker who helped us to understand the impact of HIV and AIDS on the Tumahole society. Although no medical doctors were part of the team, their role in handling their patients would be scrutinised. The role of the funeral director would be to look at the business and moral side of the industry in relation to their poor clients. In this chapter I will try to cluster related themes that emerged in the previous chapter to have a common flow of logic.

As a result, I will end with fewer clustered themes without destroying the essence of the message from my co-researchers' stories.

In reflecting on and interpreting these themes, I will look at the deeper meaning of what the co-researchers are saying and relate that to the revelations of other researchers and professionals on the same themes. This will also be done by applying the traditions of interpretation and reflecting on God-talk in these stories. The MDT members will play the vital role in the reflection, interpretation and analysis of emerging themes.

## **1.2 Exploring the evolved themes**

After listening to different stories, I, the MDT and other members involved synergised the three stories into one story and came up with the following themes which will form the major part of this chapter. The following are the themes that will be discussed as they emerged from different stories and were synergised into one story.

### **1.2.1 Different stages of experiencing HIV and AIDS**

All my three co-researchers and their husbands underwent the following stages in their fight with HIV and AIDS. Although not all experienced each stage in the same way, the truth of the matter is that they have all experienced them.

#### *1.2.1.1 "Nobody will know, nobody has to know"*

In all the stories, my co-researchers' husbands were all aware of their status, but chose to keep this a secret so that their partners wouldn't know. These secrets were kept for over two to three years. In the process of nobody knowing, they continued with their promiscuous lives. As a result, many innocent people were infected. This included their partners (in the case of MX and MM).

In my research and interaction with the infected and affected people, I have discovered three different modes that make the HIV and AIDS virus spread more

quickly and undisturbed. They are secrecy, ignorance and stigmatisation. All the husbands of my co-researchers kept their status a secret to their partners and other people around them. As a result of this, MX and MS were infected by their husbands. There are also high possibilities that because of these secret statuses, other women involved with these husbands have been infected. Although the co-researchers were aware of their husband's promiscuous lives, they were ignorant of the possibilities of being infected. They were not aware of the fact that they could protect themselves from any possibilities of infection. As a result of this ignorance, they were caught in the infection web. The fear of stigmatisation has made it impossible for co-researchers and their partners to go out easily to disclose their status so as to protect more innocent lives. It is only MX who was bold enough to force and publicly declare her status. In a way, her husband was somehow put under the spotlight by those who knew her.

#### 1.2.1.2 *"No secret will remain hidden forever"*

As surely as the fact that the sun will rise again the next day, no secret remains hidden forever, especially not one that involves HIV and AIDS infections. Sooner or later, the truth is bound to come out. In all three cases of my research, it did come out. The truth did not come out through rumours, but from the health centres, the places where it could not be easily disputed. While the husbands kept their status secret, it was their wives who discovered these secrets.

How were the secrets uncovered? For MM, the secret was uncovered when she took a medical report of her husband to the clinic so that they could refer to it in filling in the grant for her husband. Innocently, she gave the report to the nurse who was shocked to read this report. When she inquired, the nurse informed her that the report said that her husband was HIV positive. This news was so shocking that she could not carry on with what she came to do at the clinic. She immediately went home to approach her husband about this secret that he chose not to inform her of.

For MS, the truth was uncovered when she took her ailing husband for a medical check-up. After many months of her husband's deteriorating state, she was bold on this day to ask the medical doctor what was really the problem with the husband. The

doctor was surprised that the husband had not told the wife. It was here that the doctor informed her that her husband was diagnosed as HIV positive and that he had known this for a long time. MS says that she was very shocked that her husband could not disclose his status to her even when he realised how she tried to help him to improve his health.

To MX, the truth was not that of her husband, but of her own status. She chose to take the HIV test because of the complications in her own body. The results of her positive status were very shocking to her. Her only problem was how was she going to face her own husband, even though she knew that this infection came from him.

#### *1.2.1.3 Denial of HIV status: "I do not know what you are talking about."*

One person said that 'no prisoners are convicted for what they committed'. They all deny having done what they have been convicted of. Even if they are already serving the sentence, most would say that they did not do it. This is exactly what happened to the husbands of my co-researchers. Even when they were aware that their secrets had been uncovered, they denied any knowledge of this. When MM angrily approached her husband about what was written in the medical report, he acted as though shocked by this. He further denied any knowledge of being HIV positive. To him this was a new thing. In the case of MS, though the doctor told her in the presence of her husband immediately after they left the surgery, he denied knowing anything that the doctor was talking about. He literally made a fool of her. With MX things turned out very differently. I was the one who informed her husband when she requested me to do so. The shocking thing is that the husband was very angry to hear this and started blaming his wife for being positive. He then went to the doctor to be tested in order to know her status. He started being violent towards his wife and me. We concluded the meeting with his voice very high as he was emotionally uncontrollable.

#### *1.2.1.4 Acceptance and forgiveness: "We are in this together."*

For any true forgiveness and reconciliation to take place, there needs to be acceptance of a wrongdoing by the guilty party. It is then that forgiveness will follow. In MM's story, this was different. She decided to forgive her husband long before he could



admit that he was positive. When she fetched her own results, she had already made up her mind to forgive him. The good thing was that her results came out negative. When her husband later admits that he was really positive, she was already ahead of him in doing what is needed from a true African woman. She was already taking care of him; washing him, using her little money to take him to the doctors and also feeding him.

In the case of MS, the husband admitted his wrongdoing when she fetched her own results and she tested positive. He was very sorry and the only thing he could do was to admitted and ask for forgiveness. Although they were both positive, the husband was more serious and MS had to take care of him. She nursed him in every way. Concerning MX, her husband admitted his wrongdoing a few weeks after being informed about his wife's status. He accepted the fact that he was the guilty party in this whole ordeal. Although she had to move out of the house due to continual abuse, she always goes to her husband whenever he needs her, especially when he is sick.

#### 1.2.1.5 Negotiation: *“If things would turn out differently...”*

This is the stage where all these men wished that things would turn out differently. MM and MS even accepted Jesus as their Lord and Saviour before their deaths. They both wished that they would have done things differently, but this was already too late. In their confessions to their wives, they admitted how guilty they felt about their promiscuous lives. In accepting their wrongdoings and turning their lives to Christ, they were, in a way, negotiating and bargaining with God to change things so that they could start all over again. Concerning MX, this stage has not being experienced, as he continues with his abusive behaviour, alcohol and drug usage.

#### 1.2.1.6 When all has been said and done: *“Till death do us part...”*

Nothing is as painful as caring for the person who never cared for himself or herself, or for a helpless person who was once very strong and abusive to the helpless. But these two women, MM and MS were true to their vows ‘till death do us part’. They cared for their husbands in health and in sickness. They manifested what true pastoral

care was all about. They used their Christian faith to influence their ailing husbands. As a result, they both died having accepted Jesus as Saviour and Lord of their lives.

An added pain to MS was the fact that she too was ill, having been infected by her husband. But she never blamed him for her situation. She really cared for her ‘killer’. In these two women, one discovers what it really means to care for those who need to be cared for.

### 1.2.2 HIV and AIDS and Gender

In a culture where being a male gives one an automatic dominance over females, HIV and AIDS spreads much faster, more especially if masculinity is regarded as a license to abuse women. All three partners of my co-researchers are very abusive people who use physical violence to settle any differences with their partners.

### 1.2.3 Social and economic factors

HIV and AIDS spread much easier and more quickly among those who are both socially disadvantaged and economically impoverished. The results of such conditions decrease any chance of fighting this virus through medication. It is very difficult for people with nothing to eat to be able to take any medication. Proper nutrition is vital in fighting against opportunistic illnesses. To add more fuel to the fire, the costs of funerals have increased among black people. All three women in this research were unemployed except where they worked as self-employed (MM) or as a domestic worker (MS) or just as a housewife (MX).

## **2. TRADITIONS OF INTERPRETATION AND REFLECTION ON GOD-TALK**

### **2.1 Is God saying anything to us through HIV and AIDS?**

It is at this stage that I would like to reflect theologically on my co-researchers’ stories. I concur with the definition of theological reflection by De Beer, *et al.* (1998:64) as the phase where we allow the Bible, our contextual analysis, our own

tradition, our spirituality and personality, to enter into dialogue with one another. This is the phase in which we listen to all these sources intentionally and in relation to one another, and on the basis of listening, we gain new insights and we make decisions. This reflection is where the researcher analyses the stories of the co-researchers, looks at the clues on ‘God-talk’ and relates that to the co-researchers’ context. The question I want to answer here is *‘Where is God when it hurts the most and when He is needed the most?’* What makes this the critical question is the fact that this is what my co-researchers and their partners struggled with. The following paragraphs will try to respond to the above concerns about God.

### 2.1.1 Divine presence amidst human suffering

It has always been very difficult for human being to equate God with suffering. The Omnipresent, Omniscient and Omnipotent God cannot suffer or experience suffering. This also suggests that if God cannot suffer, then those belonging to Him cannot suffer. But the reality dictates otherwise, because people of God are also suffering. Moltmann (1974:229-230) explains this better when saying that God cannot suffer like creatures who are exposed to illnesses, pain and death. God’s suffering is the willing and active suffering of His choice because of His love for His creation. God’s incapability of suffering will, in a way, contract this basic message of Christianity, which is love. The God who is capable of love is also the God who is capable of suffering.

In order for human beings to understand the voluntary suffering of God, one need not look further than the Cross of Jesus. It is at this Cross where we see the suffering of God. Crucifixion was a form of punishment by the Romans on their subjects. It was punishment for the blasphemers and rebels. To the Israelites it was a curse for one to be hanged on a tree (Gal 3:13, Deut 21:23). For Jesus to die in this way was an embarrassment to his followers and those who sympathised with him. On the Cross, his disciples fled from him because their hopes were deferred. They hid themselves and even doubted the report of His resurrection. They had returned to their old trade: fishing (John 21). To the civilised or educated despisers of Christianity, the belief in the crucified Jesus was in bad taste that was met with mockery (Moltmann 1974:34). Throughout its history, the church leaders have tried to move away from the scandal

of the cross by putting some roses around it. This was an attempt to move attention from the scandal of the cross to the roses around it. But later, the roses were removed and our faith was based on the One on the Cross and this resulted in the theology of the Cross. Christian faith stands and falls with the knowledge of the crucified God in the crucified Christ (Moltmann 1974:37,65).

What makes faith in the suffering and crucified God intact is that He did not end there. The Friday of crucifixion was not the determining factor of our faith. If all had ended there, Christianity would not have been born and Jesus would have died just like any other criminal. That would have been the worst scandal in the human history of faith. The Sunday of the resurrection is the determining factor of our faith. Our God did suffer, but He rose from the dead. The gloomy scandal of crucifixion became the radiant hope and celebration of His resurrection. It is at this point that one can look beyond human suffering to see the intervention of God in human history.

The other perfect example of God's reaction to human suffering is that of Job's suffering. After having lost all his possessions, children and health, he still maintained his innocence. Though he had doubts, he kept on believing in this amazing acts of God whom one could not fully comprehend. But can these examples apply to the suffering faced by those with HIV and AIDS?

#### 2.1.2 Where is God when HIV and AIDS is killing His people?

Most people with a fundamental Pentecostal background like that of my church, used to and others still associate HIV and AIDS with the punishment from God for promiscuity. The majority of students to whom I lectured, both at the AFMSATI and ATS echoed the same sentiments. MS' husband also confessed that he was suffering from HIV and AIDS because God was punishing him for his unfaithful life.

In one of her diary entries, Broadway (1998:161) had this to say:

*"I feel very lonely and insecure. I'm fighting this unbeatable battle all by myself and I feel at times I don't have the courage or the HOPE to carry on. .. Do I deserve it? Do I deserve anything more than that I have AIDS? Did I deserve life in the first place? I believe God*

*makes mistakes and I'm a living proof of that. You see, I don't think that I deserve to die. How much is one person expected to cope with? God is cruel to me and I don't think that he cares. God has no mercy, no sympathy and love."*

It is because of these sentiments and people's understanding of HIV and AIDS as a punishment from God that I want to use the three hypotheses from Nicolson (1996:29-80) to reflect God's picture in the midst of the HIV and AIDS pandemic.

#### *2.1.2.1 Is God punishing His children with HIV and AIDS?*

Those who have this view, claim that acts such as homosexuality, drug usage and promiscuity bring about the HIV and AIDS infection. Because of HIV and AIDS' close association with immorality, it seems to be a punishment from God. Since HIV and AIDS is viewed as a punishment from God, the conclusion is therefore self-evident that churches do not have to interfere in God's way of punishing sinners. The Moral Majority's executive criticised the United States Federal Government for spending money on research for HIV and AIDS vaccine, because this would encourage the homosexuals to go back to their perverted practices without any standard of accountability (Nicolson, 1996:29). To add more pain to those infected, Crowther (1991:1) states that HIV and AIDS is neither the problem nor the central issue, but a symptom of something deeper and more deadly. HIV and AIDS is but one of the many disastrous consequences of promiscuous sexual behavior. Promiscuity is the root cause of the present pandemic. It has always been sinful and it is rapidly becoming suicidal.

What is interesting about this view is that it fails to see that HIV and AIDS does not only affect the homosexual and the sexually promiscuous, but also the innocent partners and newly born babies. The cruelty of the propagators of the view is evident where one pastor whose family contracted HIV and AIDS through blood transfusion was forced to resign, and children with HIV and AIDS were sometimes forced to leave the Sunday School (Nicolson. 1996:29). In another instance, a minister informed one of his female HIV and AIDS patients, with a sweet smile that she was

no longer allowed to attend Sunday services as her presence would empty the church rapidly and he did not like to preach to empty pews (Kubler-Ross 1987:7). According to Nicolson (1996:33), there are Christian leaders who wholeheartedly believe that God has indeed sent HIV and AIDS among people as a plague, a punishment and a terror to recall people, when all else has failed, to God's law concerning sexuality. In a world which is becoming increasingly permissive about sexual 'vices', God must warn and punish. The above experiences and statements show what the '*better-than-thou*' attitude can lead up to. And if this attitude is left unchallenged, it can cause irreparable damage to the church as the body of Christ.

Another fundamentalist propagator of the hypothesis is Clarke (1994:20) who equated HIV and AIDS with immorality. He said that the HIV and AIDS crisis is directly related to sexual immorality, therefore Christians must address this crisis with biblical truth. Unlike many diseases, HIV is sexually transmitted and its development and rapid spread have resulted from specific sins committed by men and women. He further stated that the reason the HIV and AIDS plague continues to spread so rapidly throughout the world is simply because men and women want to continue in their sexual immorality.

As for those who have contracted the disease not by their own immorality, Clarke (1994: 21) says that they are in that situation because of other people's sin. According to him, sin and HIV and AIDS are 'cause-results' intertwined. This simply means that if there was no immorality, there would be HIV and AIDS. At a SACLA 2 (2003) conference held in Pretoria, Dr Bruce Wilkinson during the plenary session that dealt with HIV and AIDS as one of the 'giants' facing our society, strongly emphasised this notion of 'cause-results'. Immediately after his address, there was a serious commotion and dissatisfaction among most black pastors and church leaders, which disrupted and threatened to end the conference prematurely. These black pastors and church leaders felt that he (Bruce) insulted them by saying HIV and AIDS is high in Africa because Africans are immoral. The situation was saved when he was forced to write a public apology which was read to all conference delegates. The next session was addressed by Archbishop Ndungane (2003) who used the platform to respond to

Wilkinson's insinuation. In his address, Ndungane emphasised the human face of the church in dealing with those infected and affected by HIV and AIDS. He also emphasised the fact that HIV and AIDS was not a punishment, but a social and medical problem facing our society and the world as a whole.

Although there are some theologians who align themselves with the sentiments of this hypothesis, there are some who believe that those infected with HIV and AIDS shouldn't be rejected, but must be cared for by the Christian communities. They also say that if people decide that HIV and AIDS is God's punishment, then people are declaring that God is unjust, punishing the good along with the wrongdoers, because HIV and AIDS also kills innocent partners and babies (Nicolson 1996:32).

Surely, seeing HIV and AIDS as a punishment from God is to miss the reality of its contributory causes in Africa. In Africa and in most parts of the world, this virus kills innocent partners and children alike. Yes, it is indisputable that its rapid spread is due to distorted human life. The church should not overlook this fact of the suffering of the innocents. The true example of this fact is how two of my innocent co-researchers were infected by their unfaithful partners. These women are innocent victims; they did not get HIV and AIDS through any immorality, but it came into their homes through their husbands.

Nicolson (1995:27) says that, in its initial stage in the early 1980's, in some African countries like Kenya, those who died of HIV and AIDS-related illnesses needed to be buried immediately, not in a coffin, but in body bags. Some churches went further and refused them proper church funerals. Those who were known to be suffering from the disease were not even allowed to attend normal church or worship services. In these situations, people try to take God's position by judging others on their fallible mundane understanding of God. It is at this point that I fully agree with Nicolson (1995:29) who says that having HIV and AIDS is a very terrible way to die. There is increasing disability, loss of body function and increasing dependence on others for assistance with basic things such as feeding and going to the toilet. The situation turns a once responsible adult into becoming like a baby with total dependence on others.

This is punishment – and it would be spiritual blindness on the side of the church to add more punishment by judging the victims who have already suffered so much.

Although there are some links between HIV and AIDS and promiscuity (for some people due to their behaviour), that does not mean that the church is not called to love those who are infected and affected by the virus. The message that needs to be constantly echoed to the church is the same one which Jesus told the ‘self-righteous’ Pharisees *‘Let him (her) with no sin be the first to cast the stone’* (John 8: 7).

Our God forgives those who contracted HIV and AIDS through bad behaviour and who later repented. A repentant sinner stands cleansed before God, just as Adam and Eve were before sinning. As Nicolson (1995:32) states, our message to people with HIV and AIDS and to society in general should be one of divine compassion, of forgiveness for any personal irresponsibility or sin which has led to such dreadful consequences, and of supporting one another in mutual responsibility.

The incarnational theology focuses on creating a presence on behalf of God in the lives of those dealing with HIV and AIDS. In this approach, issues such as acceptance, affirmation and belonging are very important. An incarnational response centres around the people who are dying, rather than on how they became ill (Amos 1988:53). This response understands the biblical reality that we are indeed our brother or sister’s keepers. The response also accepts the fact that for some of the people, HIV and AIDS is due to their irresponsible life-style, but it further states that we must be careful to focus on people and not fall into the tempting trap of identifying them with groups and responding to that identity. Granted, it is much easier to let our theology focus on labelling people, than it is to let our theology move us into authentic biblical ministry. We must not let labels determine our ministry (Amos 1988:55).



### *2.1.2.2 HIV and AIDS is not a punishment but a consequence of freewill.*

According to the hypothesis, HIV and AIDS is not a punishment for sin, but its consequence. HIV and AIDS clearly is, in part, a consequence of humans disobeying God's life-giving laws. According to this view, HIV and AIDS became a killer disease because some human beings lead such irresponsible lives. The hypothesis further states that people are precious before God and HIV and AIDS is not a punishment from God. Because of God's justness, there must be consequences if God's laws are broken (Nicolson 1996:38).

This hypothesis differentiates between God's sovereignty and human responsibility in the sense that HIV and AIDS is not sent by God, but is an opportunistic virus like any other which normally does little harm, but became epidemic when conditions encouraged its spread. This spread has a great deal to do with a swing to a more competitive, less caring, political and economic ideology. As a result, the more it spreads, the greater is the cost to the economy in terms of health care, loss of personnel, lost time, the cost of orphans and in many other ways (Nicolson 1996:41-42). This further supports the notion that HIV and AIDS is closely linked to poverty. This was evident in the argument of the former State President of the republic of South Africa, Thabo Mbeki, about the cause of AIDS. He argued that the virus cannot cause a syndrome. He stated that factors such as poverty need to be taken into consideration in the spread of HIV and AIDS (Fourie 2006:140-141).

### *2.1.2.3 God neither sends HIV and AIDS nor permits it but He is powerless to prevent it*

The hypothesis states that because of the free will that God has given to people, God must be held accountable for the misuse of that choice. It further says that if God has all the power (*Omnipotent*), suffering must be viewed as part of His will. To put it more clearly, the hypothesis states that if God is all-powerful and all power lies in His hands, then HIV/AIDS is His fault, and people will tend to think that only God can do

anything about it. But if we see God and creation in a more interdependent relationship, if we see that suffering is not by God's will, nor even by God's permission, but happens because God has no power to prevent it, perhaps we shall understand how HIV and AIDS came about and perhaps we too shall see more clearly that we have a shared responsibility with God to try to overcome this pandemic. In the end, however dismaying initially, the concept of a limited God perhaps fits our experience of HIV and AIDS better (Nicolson 1996:53).

The process theodicy, which the hypothesis is based on, states that God does not allow free will, but it is part of reality. According to this concept, HIV and AIDS seems to be a virus that does its own thing in a random way which we cannot and God cannot control (Nicolson 1996:57).

In trying to respond to this question of theodicy, Kombo (2005:32) states that skeptics say that God either wishes to take away evil and is unable, or he is unable and willing, nor he is neither willing nor able, or both willing and able. He further states that if he is willing but unable, he is feeble, which contradicts the character of God from scriptures and history. On the other hand, if he is able but unwilling, it means he is envious and feeble and therefore fails to be God. Again, if he is both willing and able, then human beings need to ask what is the source of this pain and why doesn't God intervene.

Theodicy in the context of HIV and AIDS is increasingly gaining momentum within the Christian community because the pandemic is in the church. It is no longer a question of 'us' versus 'them', but it is the body of Christ that has HIV and AIDS. It is His church that asks in confusion for the power of God in the midst of this pain, death and hopelessness.

In responding to the question whether HIV and AIDS is a curse or punishment from God, Nicolson (1996:73) states that HIV and AIDS is not a punishment, although sinful human actions and attitudes are major contributing factors.

### **3. THEOLOGICAL DISCOURSES ON THE ISSUES AS THEY CHALLENGE THE COMMUNITY OF TUMAHOLE**

It is very important for churches to develop a theology of HIV and AIDS as a response to the current crisis caused by HIV and AIDS. The failure to respond means that the God of the Bible and Christianity as a whole are irrelevant and offer no saving power. In this way, He fails to love His creation when it most needs him. In order to respond positively to challenges raised by HIV and AIDS, churches must say clearly that HIV and AIDS is not sent by God to punish His people for sexual promiscuity. On the other hand, churches must not be afraid to point out that HIV and AIDS is often a consequence of having multiple sexual partners (Nicolson 1995:19).

#### **3.1 Church and sexuality**

I agree with Lindqvist (2005:59) when he states that, from the social standpoint, HIV and AIDS brings together many highly charged matters, images and feelings relating to guilt, sexuality and death. In images relating to HIV and AIDS, images of life and those of death are superimposed on each other. This image of death contradicts the image of sexuality as one of the basic forces of nature, a source of joy and procreation. In fact, in the era of HIV and AIDS, many associate this God-given gift with guilt and death because the disease is mostly transmitted through sexual intercourse and the infection leads to death. Unfortunately, in most of the African cultures, sex and sexuality are taboo, so dying of HIV and AIDS, which is usually associated with sex, is a taboo and thus it forces people to die with their little ‘secrets’ because they fear the stigma associated with it.

It is the responsibility of the church to affirm sex in all respect: pleasurable, social, as well as procreative. Sex in itself is a good gift from God. In this sense, virginity in both the males and females should be pursued at all costs. Sex needs to be located within the relationship of love, not of legalism. This would be done once sex has been demythologised from being men’s right and women’s duty. In fact, Christianity must

emerge as the champion of loving sex, yet it insists that its proper place is only in the context of a loving relationship (Dominican 1987:44).

### **3.2 HIV and AIDS and stigma**

As mentioned earlier, the stigmatization of people infected and affected by HIV and AIDS encourages them not to disclose their condition or status. Stigma can be defined as the belief that sometimes is disgraceful, thus unfairly impacting on the rights, life and opportunities of the infected persons (Patient & Orr 2003:3). The HIV and AIDS related stigma refers to a pattern of prejudice, judgementalism, differentness, blame, fear, power, exclusion, discrediting and discrimination directed at people perceived to be infected, their significant others and close associates, and their social groups and communities. Stigmatisation is the extreme end of discrimination, in this case galvanised primarily by knowing or suspecting that another person has HIV and AIDS. It harbours strong emotional rejection above the structural inequity. It is characterised by overt fear. Those stigmatised are people who, due to their positive status, are rendered impure, unclean, polluted, dangerous and unworthy of full inclusion in the community (Windhoek 2003:2).

The HIV and AIDS stigma has negative effects on people living with HIV and AIDS (PLWA), those at risk of infection and society at large. Because of this stigma, PLWAs must bear the burden of societal hostility at the time when they urgently need societal support. The stigmatisation can further deter people at risk from being tested to know their status and to seek information and assistance on risk reduction. Because of the stigma, people may distance themselves from the disease and deny their potential risk. Such behaviour serves as a serious obstacle to preventive education efforts (Smith 1998:628).

#### **3.2.1 The internal and external contexts of stigma**

According to Munyika (2005:76), there are two types of stigmatisation: internal or external. Internal stigmatisation comes from within an individual. It is a stereotypical discrediting judgement of oneself in a particular context. It is self-rejection. One starts

by feeling either guilty or bad about one's condition and then one thinks that is what other people think. As a result of this, many people choose not to get tested or to disclose their status after testing positive. The stigma of the disease has caused them to anticipate condemnation, rejection, shame and alienation. This is the exact situation I found myself in when my sister was diagnosed HIV positive. By then, I did not want anybody, especially those in the same assembly with me, to know about her status, because I thought they would react negatively towards me. When one of the elders prayed for her and asked her what was wrong, when she told me that she was tested positive, I became so furious that I ended up confusing her into trying to die because of her situation. This also applied to husbands of my co-researchers, none of them wanted anybody to know about their status, not even their closest relatives.

Contrary to internal stigmatisation, external stigmatisation is that which is perpetrated others. It is any negative thought or action against an individual or group on the basis of their actual or presumed HIV status. The consequences of this is a feeling of guilt, shame, loss of self-esteem, evil deeds and negative actions towards the self or other people. It perpetuates a downward spiral where one negative action leads to another negative action that is even worse or more damaging. Many people, when testing positive, resolve to 'not die alone'. They become vengeful and in the process, spread the disease to as many people as they possibly can (Munyika 2005:77).

The silence, secrecy, stigma, sex taboo and other related matters, play a vital role in perpetuating the spread of this killer virus. When people know that they are HIV positive and also know that they will not be in a position to access treatment, there is little incentive for them to seek help or change their behaviour. If they make such a move, they are risking the stigma attached to those who are known to be living with the virus and which spreads out in waves to their families, their survivors and those close to them. Treatment may be available to prevent mother-to-child transmission, but due to stigmatisation that follows their discovery of having HIV and AIDS, mothers prefer to take the risk of giving birth to an HIV and AIDS positive baby (Windhoek 2003:1, Munyika 2005:78).

When my sister died of HIV and AIDS related illnesses, what touched me most was not the fact that she had died (which we were all ‘ready’ to embrace when considering how she suffered from pain), but the problem of what to tell the people about the cause of her death. It was here that I realised that HIV and AIDS ‘kills the living more than it does the dead’. It is the living who have got to lie to defend the dignity of their dead ones. It is that ‘lying’ that fan the fire of the pain about the loss of one’s loved one. When one of my aunts wanted to look at the death certificate to verify the cause of my sister’s death, I was somehow ‘glad’ that HIV and AIDS was not mentioned as a cause, but an opportunistic illness like pneumonia was written. This is why I agree with Lindqvist (2005:62) who says that we have to understand how deep the feeling of guilt and shame involved in HIV and AIDS is, not only for the infected, but also for the affected. We need to be a caring community for those infected and affected by HIV and AIDS. This can be made possible by the concept of *UBUNTU* (meaning that a person is a person because of others). According to this concept, no one must suffer alone. We are all part of the broader human society. In emphasising the importance of caring among Africans, Masango (2005:916-20) states that, in the journey of life, people need others to take care of them. This concept of caring involves all the members of the village or community, family, relatives, tribes and ancestors. It is therefore the responsibility of the whole village to take care of life because that is a community effort. In this way, protecting the cause of one’s death that resulted from HIV and AIDS-related illnesses, is to protect oneself and the deceased’s dignity against a prejudiced and judgemental community.

### **3.3. HIV and AIDS and preventive education: “*It’s a matter of choice*”.**

In the church, particularly in Pentecostal churches, condoms are still a problem because they are associated with promiscuity. This idea was echoed by the South African Evangelical Consultation when they said that condom promotion is medically dangerous and a means to promoting promiscuity. Adding to this, Saayman and Kriel (Nicolson 1995:25,51) say that condoms alone cannot prevent the spread of HIV and AIDS. The programme to contain HIV and AIDS must not rely on condoms to solve this problem.

The commercial sex workers in their desperation to get money, will be unable to insist on the use of condoms. Campbell *et al* (Sowetan newspaper on 20<sup>th</sup> June 1999) interviewed commercial sex workers about the risk of their activities. They confirmed the fact that they do not always use condoms, but sometimes agree to unprotected sex with mine workers despite fears of HIV infection because some clients refuse to pay for sex with a condom. One even went further saying that they survive on a daily basis, waiting for their death. This is the risk many women (not only commercial sex workers) experience. Dependent on their husbands for daily provision, they find themselves disempowered to negotiate condom use with their partners. Some women in traditional African homes are culturally unable to make or even mention such a demand and will be unable to insist that husbands returning from town employment must use condoms. Those who suggest condoms risk not being given money or being physically abused. This is evident in MX's interview on how her husband would assault her for suggesting this kind of protection.

For a long time, churches have rated sins such as teenage pregnancy above any other. Teaching on sexuality has always been negative. Instead, churches promote simplistic and legalistic morality about premarital sexuality. Because of this legalism the church has lost its ability to demand a different attitude and behaviour from its members in sexual matters. Instead of these members obeying their church confession, they hide and continue in their 'old life-style'.

In order to play its role in prevention education, Dixon (1989:17) suggests that churches can persuade people to change from high risk living to low risk living. This can at least slow down the spread of the virus. Better still, if churches can persuade enough people to change to no risk behaviour, those who do not, may still eventually need care as they get ill and die, but the vast majority who change in time will be able to protect themselves from a similar fate.

### **3.4 HIV and AIDS reveals our fear and lack of trust in God's power**

Because of the fear of this disease, people have compounded their fears and in blind panic have sought, not a solution, but a scapegoat. It is therefore not HIV and AIDS which people need to address, but those fears which HIV and AIDS has awakened in

their lives, fears so great that even those who believe in a God in whom everything works to their benefit, can see nothing but divine retribution. Fear has cast doubt on those who were supposed to be comforting the wounded. Crowther (1996:16) calls this kind of fear the fear of contagion. He explains this as not just a fear of catching the disease, but perhaps a greater fear of being associated with the disease. He also suggests that it is this fear that has made the church slow to respond, half-hearted in its pronouncements on the need to care for those with HIV and AIDS, and quite unwilling to direct its many resources of people, skills, buildings and money to the benefit of those infected and affected. The church always wants to maintain its good reputation and integrity, and thus does not want to be involved in issues that would harm her negatively.

The second kind of fear is that of denial, pretending that HIV and AIDS could never affect us. We deny it in order to protect ourselves from it. We are forced by this denial also to deny the reality of people already suffering from the disease. We convince ourselves that those infected do not concern us. We therefore jump to the conclusion that those who have ‘caught’ the disease also ‘caused’ the disease. We see them as responsible for their situation and so relieve ourselves of responsibility to care for them. They are no longer our brothers and sisters, so we are no longer their keepers. We refer to them not as people but as numbers, not as suffering human beings but as victims. We label them and thereby distance them.

What needs to be taken into consideration here is what Crowther (1991:20) says that HIV and AIDS is not a curse from God, but the true curse of HIV and AIDS is our lovelessness, a lovelessness that desires to deny the disease and to separate ourselves from those who have the disease. It is this lovelessness that makes us want to point a finger of blame for the disease on those who have the disease and to dehumanize and ostracize them to the extent of denying our common humanity with them. It is this fear and lovelessness that has resulted in our failure to come to terms with our humanity. The HIV and AIDS pandemic has really challenged our theology of care and our concept of loving God to its foundations.



## 4. SOCIO-ECONOMIC REFLECTIONS

### 4.1 HIV and AIDS affects mostly the poor and the underprivileged

All three of my co-researchers are unemployed: MM is self-employed, MS had a part-time job as a domestic worker and MX has no source of income. They all depend on their husbands who give them money whenever they wish to. These women work very hard to make sure that there is food for their families.

As mentioned, Mr MM was self-employed after having been retrenched from the mines. His family lived with the little money they gained from daily profits from hawking. Mr MS received an early pension due to illness. He died unemployed, but had saved enough for his family to have a house.

The above statements show that these co-researchers were poor people. This is another factor that helps to spread the virus faster. Poverty is the fertile ground for the rife spreading of HIV and AIDS. In supporting this fact, Shisana *et al.* (2002:45) say that while all strata of society are at risk, the degree differs in different race groups. Black South Africans, both wealthy and poor, are equally at risk to contract HIV and AIDS. Among these, the poorer, the more vulnerable to the virus they are. Paterson (2009:19) stresses this fact by stating that poverty should be seen as both the driver of the transmission and of the consequence of HIV and AIDS. The reason for this is because poor people are unable to access balanced and nutritional meals which are necessary for the body's immune system to resist opportunistic infections. The stress linked to poverty and unemployment can further weaken the immune system (Gennrich 2004:16). The affected families spend a lot of money for the medication of the infected member. Though the clinic is free, it is very difficult for men to go and get the medication. Both the deceased Mr MM and Mr MS never attended the clinic. They preferred the general practitioners or the hospital. The stigma attached to a clinic is still very rife among Black men in Tumahole and other parts of South Africa. Most men prefer to suffer in their homes if they do not have money to go to the doctor. Although they could go to a clinic, they still need to consult a doctor when there are more complications with which nurses at the clinics cannot help. In general,

families spend a lot of money on health care for the infected and sick member. They need money for both the transport and the medication.

More money is also spent in consulting ‘HIV and AIDS specialists’ who promise total cure to the infected. These ‘specialists’ do not come cheap. They are very expensive, but with no evidence of desired results. A good example of this is when Mr MS spent the little money of his family for such a specialist consultation in Bloemfontein. Although he confessed when he came from there that the person was a bogus HIV and AIDS specialist, his money was never refunded. This raises the fact that the poor are vulnerable to new ‘schemes’ and ‘specialisation’ because they want easy solutions in order to be cured. Because of these ‘schemes’, most patients die poorer and with no money for the funerals.

#### **4.2 More about HIV and AIDS and gender**

Denis (2003:75) is correct in saying that HIV and AIDS is ultimately a gender issue. Unlike at the inception of HIV when it spread through homosexual relations, in Sub-Saharan Africa the majority of infections occur through heterosexual relations. Research by Gennrich (2004:7) attests to this by showing that 79% of the major mode of transmission is through heterosexual relationship rather than through rape. Having observed this fact, we come to realize that marriages in Africa are threatened by this disease. This is proven by stories of my co-researchers who are all married women.

According to research findings of Hunger Project (2001:1), Sub-Saharan Africa is the only region in the world in which more women than men are infected with HIV and AIDS. Teenage girls in this region are five times more likely to be infected than boys. Gennrich (2004: 8) supports this finding by stating that 58% of the infected adults in the Southern Africa region are women.

##### **4.2.1 Some explanations concerning why more women are being infected**

#### 4.2.1.1 *Physiological differences*

In his rape trial, Jacob Zuma (Holden 2008:307 and Gordin 2008:156-7) admitted that he had unprotected sex with an HIV and AIDS infected woman. The media and the people felt that this was the most stupid act ever to be committed by an individual. To some this proved that he knew that he was positive and that was why he did not care. When he was asked whether he was not afraid of contracting the virus, he said he knew that his chances as a man sleeping with an infected person were very slim. This statement was interpreted as if he did not have any clue as to how one contracts the virus. The surprise came when he said he had been to a doctor after the whole ordeal, had tested negative and was also prepared to produce his results in this regard. The question most people ask is how one can have sex with an HIV and AIDS positive person and still test negative. Deducing from this example, it is evident that Zuma and his legal team understood something about women's physiological make-up.

These 'surprises' are supported by the research that was published on the internet by CBC News dated 16<sup>th</sup> December 2008, at 2:21 PM ET under the title

**“HIV PENETRATES GENITAL SKIN OF HEALTHY WOMEN, SCIENTISTS FIND”.**

*“This illustration shows how HIV particles slip between loosely connected skin cells to reach immune system targets such as Langerhans cells (orange), macrophages (purple), dendritic cells (green) and CD4 positive T cells (blue). (Ann Carias)*

*“According to the report, HIV can travel through a healthy woman's genital skin and reach its immune cell targets in four hours, researchers said Tuesday. Thomas Hope, who was the principal researcher and who is also a professor of cell and molecular biology from Northwestern University in Chicago, said that the results were unexpected but brought a new light in the medical field on how HIV can invade the female vaginal tract.*

*Contrary to scientists' long belief that the normal lining of the female genital tract worked as a barrier against HIV during sexual intercourse, the new results suggested otherwise.*

*In the study, researchers developed a new method to label HIV viruses with special fluorescent tags. The method allowed them to track the viruses as they entered the outermost lining of the female genital tract, a process that took four hours. The experiments were done using human tissue obtained during hysterectomies and tissue from rhesus macaque monkeys.*

*The virus tended to penetrate the barrier when skin cells were shed and were no longer bound as tightly. The HIV reached 50 microns beneath the skin, a depth where immune cells targeted by HIV are found”.*

The above research supports what Gennrich (2004:8) discovered in her research, indicating that women are at a higher risk than men to be infected with HIV through unprotected sex. The risk is increased by women’s physiological make-up concerning the large area in the vagina and the fact that semen stays in there longer, thus increasing the contact between the virus and the woman’s mucus membrane. Young women are at even higher risk since their membranes are not yet well developed. Gennrich (2004:8) further discovered that 16% of young black women between the ages 15 and 19 have HIV, compared to 6% among of the boys in the same age category.

#### *4.2.1.2 Social differences*

The African traditional upbringing tunes a boy or a girl to certain societal expectations. While men are taught to be home providers and women protectors, women are taught to look up to their husbands for support. While men are regarded as kings in their own right, women are more like servants with the sole purpose of serving their men (Phiri, *et al* 2003:9). Adding to this, Phiri (1998:143) states that the different roles between boys and girls are further emphasised through traditional initiation ceremonies where girls are taught sexual education on how to satisfy their husbands. As a result of the above, women are forced to accept this oppression by their men. The result is that most are afraid to negotiate the usage of condoms with their men even when they suspect that their husbands have multiple partners. The good example of this is the stories of three of my co-researchers. Their abusive husbands would not take “no” for the answer. MM says that she found a condom in her husband’s car after he was too sick to take care of himself. In their sexual history, there was no occasion on which they ever used a condom. MS says that, after discovering that they were both positive, she refused to have unprotected sex with her husband and he succumbed after trying everything to force her. With MX, it is even worse, because her husband beats her if she tries to give him a condom or if she

suggests it. His reason is that he does not want her to remain with other men when he is dead, but that they should both die at the same time. Gender violence also adds to the fast spreading of the virus.

Another contributory factor to women's high risk of being infected is their role as caregivers. They are the ones who wash their babies, their sick children and also their partners. The likelihood of being infected is very high, especially for the medically illiterate who never worry about putting on gloves while bathing their loved ones.

#### 4.2.1.3 *Cultural norms*

One Sunday, the City Press Newspaper exposed one popular talkshow host, Bonginkosi Dlamini aka Zola 7, as having his 4<sup>th</sup> child with four different women. When he was questioned about this by a journalist, his answer was "I am a Zulu, and therefore a polygamist". Zola knows very well that there is a difference between a polygamist and a man who is promiscuous and also involved in multiple relationships. But his answer unfolds the myth that African men cannot survive with one partner. It is common tradition among many African families that when older women advise newly wedded brides (*abomakoti*), they tell them not to ask their husbands where they come from whenever they arrive late. What is actually encouraged here is that a man can go and have pleasure outside, but the wife's responsibility is to keep the peace of the family by remaining silent. It is in this silence that many women suffer the consequences of adulterous relationships.

When MS' husband came from the hospital, assuming that he was 'cured', in a matter of two weeks, he started sleeping out again. When I approached him with his wife's permission, he was furious. He could not understand how his wife could tell me this 'secret' because, according to him, this was a norm. It was his way of life and his wife knew about it and had to accept it because he was a man.

All three co-researchers' husbands were involved in multiple extramarital relationships. The results of these relationships were HIV and AIDS and other sexually transmitted infections. All these occur in the name of culture. With MM, the

late coming was accompanied with physical abuse, while with MX it was accompanied by forced and unprotected sexual intercourse.

A myth associated with culture is men's masculinity. Gennrich (2004:14) states that masculinity is closely associated with sex in most men's minds. As a result, a refusal by a woman to have sex is interpreted as a rejection of man's manhood. This is interpreted by men as a serious offence. The result is forced sexual intercourse with a partner. In this myth, having multiple sexual partners is interpreted as proving man's masculinity. This practice further exposes men to infections and reinfection, especially if no protection is used.

Another myth associated with culture is that of dry sex and condom usage. Most men believe that if one has sex with a condom, it means that your partner does not love you. These men are of the opinion that a condom is something that withholds one from enjoying sex fully. Worse, even when men know that they are already infected, they still demand unprotected sex from their partners. The true example of this is MX's husband who does not take a 'no' or a condom suggestion from his wife.

The dry sex myth is also common in many parts of Africa (Denis 2003:70, Haddad 2002:95). The myth implies that most men prefer dry sex. Women go all out to use whatever is advised just to be dry when indulging in sexual intercourse with their partners. The danger of dry sex is that it increases small tearing around the entrance and it also removes the natural protection of the walls, thereby opening space for the virus to enter the women's blood stream (Phiri *et al* 2003:11).

Another myth associated with culture is that of male circumcision. This gained more momentum when the World Health Organisation released its research report conducted at the Orange Farms settlement. According to the research, circumcised men are at a lower risk of contracting sexually transmitted diseases, including HIV and AIDS. To some men, this is a licence for circumcised men to indulge in multiple sex partners with no form of protection because they are at a 'low' risk.

Both socially and culturally, women are carers and very forgiving. When their husbands are ill, even if it resulted from unfaithfulness, many women will take care of

their partners until death. This is evident from my research where all three of the co-researchers stood by their husbands. For MS and MM it was until their husbands died. MX is always there when her husband is ill. She gives him all the support that is expected from a wife.

#### *4.2.1.4 Socio-economic factors*

In his vehement denial speech, the former President of South Africa, Thabo Mbeki argued that a virus cannot cause a syndrome. Instead, he encouraged the researchers to look beyond the virus to contributory factors such as poverty in which most South Africans find themselves. What Thabo Mbeki was saying has a lot of truth in it, but cannot be used to dispute the HIV and AIDS cause-effect link. It is true that the relatively poor members of society are most affected by the epidemic (Gow & Desmond 2002:21). Heywood (1998: 34) further observes that the poor work at high risk occupations and thus expose themselves to threats of infection. Because of their material conditions, many do not have access to proper treatment for sexually transmitted diseases. Those who are HIV and AIDS positive cannot afford the medication and those on ARV cannot afford balanced and nutritional meals. This worsens their situation because the body needs this to strengthen its immune system. The stress linked to HIV and AIDS, poverty and unemployment can also weaken the immune system (Gennrich 2004:16).

As most women are the immediate family-carers, very few of them will let their family die of hunger. This results in some opting for commercial sex work in order to support their dependants. As some men promise more money for unprotected sex, many sex workers are tempted or fall into the temptation of making more money by risking their own health and that of their potential clients. Most men proposing unprotected sex with a sex worker suggest this because they know their status and are revengeful to 'kill' more people so that they do not die alone. Smith (1998:526) observes that poverty affects an individual's ability to make decisions regarding HIV and AIDS prevention and transmission. The culture of poverty can foster street and social behaviour often associated with self-destructive patterns of drug use, crime and sexual promiscuity. He further observes that the poor are marked by high rates of

sexually transmitted diseases, teen pregnancy and substance abuse, which are all fertile grounds for high risk of HIV and AIDS infection or transmission.

HIV and AIDS have also increased poverty in several ways. It affects the people's ability to work, often causing them to lose their jobs (Gennrich 2004:16). The results of loss of jobs affect the person's dependants. The children who were previously supported by their parents have become orphans or live on state grants (for very few) because their parents are no longer physically or financially able to care for them (Smith 1998:526).

Applying the above observations to my research, one observes that Mr MX is a teacher, but his wife is unemployed, thus totally dependent on her husband. This might be the reason why she chose to stay in this abusive relationship. On the other hand, Mr MM was self-employed and was able to feed the family. When he was too ill to work, it was MM who had to sell goods to feed the family. As for MS, her husband was given an early pension on the basis of medical unfitness. The money was used to pay for the house bond and the medication. After his death, MS had to work as a domestic worker to feed her family.

#### *4.2.1.5 Religious factors*

My observation is that religion can serve both as the oppressor and the liberator of the oppressed. By this I simply mean that the oppressors find their strength in religion, and in the same breath, so do the oppressed. If this be the case, those with more power are the ones to realize the power of religion working for them more than those in the disadvantaged communities. In most African churches, culture and religion are inseparable. One uses the other to advance its agenda. In both these situations, women are made to suffer and to obey.

When young women are married, the elderly in the family and the church advise them to obey their husbands. Adding to this, the church will also quote Ephesians 5: 22-24 where Paul urges women to obey their husbands in everything or 1 Corinthians 7: 5 where Paul says men or women should not deny their partners their conjugal rights. What is usually emphasised in the texts is the subordinate position of women versus



the headship of men as though this was the original intention of the text. When women complain about their husbands' unfaithfulness and how this might cause them to be infected with sexually transmitted diseases, they are advised to pray and trust God, but never to deny their husbands. When a man has an extramarital affair, the poor woman is made to suffer as if she is the one with a problem. Phiri *et al.* (2003:13,115) attest to this by saying that life becomes close to unbearable for African Christian women who choose to remain faithful to these two forms of authority, culture and religion, in the era of HIV and AIDS. These women witness in their daily lives how patriarchy reigns supreme when nurtured by the interpretations of the Bible and African culture.

On the positive side of the coin, my co-researchers used their faith to forgive their unfaithful partners and nursed them until death. It was their faith that made people realise the power of forgiveness. This is supported by Phiri *et al.* (2003: 115), saying that one of the reasons many women in South Africa are still clinging to the Bible as a spiritual resource is that not all male interpretations of the Bible have been detrimental to women's being and identity. But women have a responsibility to reinterpret the Bible in a more helpful way, particularly in the era of HIV and AIDS.

### **4.3 Socio-economic impacts of HIV and AIDS on societies**

#### **4.3.1 HIV and AIDS and the high cost of the funerals**

When one is tested and is found to be HIV positive, it is no longer a question of if this will lead to AIDS, but when will it lead to it and when will AIDS lead to death. To some people, it takes two years, some five years, some ten or even more than fifteen years before they succumb to AIDS related illnesses. It only depends on one's health, economic status or medication. But sooner or later, it does happen.

When death strikes, it becomes a serious problem for many poor people. The reason for this is that it is very expensive to die as a black person. Our value of ubuntu, (meaning that a person is a person because of others) also plays a major role in the extremely high cost of the funeral. People wait for all family members and friends from far and wide to come to the funeral. This, in itself, costs a family a lot. When a

member of the family dies, say on Tuesday or Wednesday, the funeral would be held the following week on Saturday (nine days in between, just waiting for others). This is meant for all the relatives and friends to come. The myth that is accepted as the truth is that the more people attend the funeral, the surer the sign that one has gone to heaven.

The problem is that for the whole week or more than seven days of waiting for the burial day, people will be coming to comfort the family, and they would be given refreshments (cakes and drinks or tea), while the relatives from afar would be fed proper meals daily until the burial. In some poor communities, people go to funerals for food more than to comfort the bereaved. While staying in Soweto, I realized that some people do not even bother to go to the graveyard, but go directly to the bereaved family and queue for food. This same ‘practice’ is common in many poor communities in South Africa. The high cost of the funeral also includes the coffin, a cow and other extras provided by the funeral directors.

There is no funeral cost that is cheap in the townships or Black communities. The poor add to these costs by buying costly coffins just to show their neighbours and community members that they are not too poor to take care of the funeral of their loved ones. For those few hours things look good for the family so that people can see that they can afford an expensive funeral. The real problem is encountered after the funeral when the members of the family are left with debts to settle which they acquired while trying to ‘impress’ the mourners and neighbors.

In the case of my sister’s funeral, we had to spend more than R10 000.00 to hold a decent funeral. She was buried in 1999. And ever since then, the prices of funerals have escalated. Two of my co-researchers, MM and MS also raised the issue of high funeral costs as a matter of concern that needs serious attention. They also experienced this when they buried their loved ones. MM was helped by her son who was working and money from her husband’s grant. MS was helped by the money her husband saved after being retrenched due to health reasons. But it was still expensive to bury their dead. None of their husbands’ funerals cost less than R10 000.00.

In some black communities, meetings have been held to advise people not to allow the funeral directors to rip them off and also to try to keep the funeral costs as low as possible. In one of the meetings held in Soweto under the auspices of the South African Council of Churches (SACC) and the Soweto Ministers' Fraternal (SMF), people seemed to agree with the suggestions from the meeting, but everything continues as before at many funerals. One person even suggested that the only way to stop the high cost of a funeral would be if the wealthy can start reducing high costs at their funerals. He said if it started with the poor, the whole community would mock that family, saying that they failed to bury their loved one decently. As such, this good deed would not produce positive results.

#### 4.3.2 The plight of orphans and vulnerable children

In my interviews with MS, one of her main worries was what would happen to her children when she died. She developed these thoughts after her husband had passed away and when she realised that she might not live to see her children grow to be adults. She knew that when she is gone, her children would be orphans. Orphans are the most tragic and long-term legacy of the HIV and AIDS pandemic. And apart from the human suffering of all these children, there are likely to be massive consequences in terms of the stability and health of all the affected communities (Gennrich 2004:9).

##### *4.3.2.1 Grandparent-headed households*

In cases where the deceased stayed with parents, the latter would take care of the grandchildren. In other cases where the deceased lived independent of their parents, grandparents would still be the first and most preferable option to raise the orphans. In supporting this option, the UNICEF research report discovered that 40% of AIDS orphans are raised by their grandparents (Guest 2003:18). Although this option is good, it has some shortcomings. Some of these will include the fact that most grandparents have no strength left to rear their children and their children's children. Secondly, most grandparents are poor and have little or no money to care for themselves and their grandchildren. The only source of income in these families is the government old age grant. The material deprivation of the grandparents worsens. In some cases, grandparents often find themselves grieving for more than one child and

looking after several orphans with the little money they have. As a result, the poor living conditions affect these children's upbringing and also their education.

#### *4.3.2.2 Cared for by relatives*

Where there are no grandparents, the orphans would be taken by other relatives. The uncles or aunts would be the preferable option. The UNICEF report found that 30% of orphans are in this category (Guest 2003:18). In the short term, this arrangement seems good, but as time continues, problems do appear. Some of the problems in this situation will include unhealthy competition for attention between parents and own children and these orphans. Other problems would be that some children are divided between different families. These children grow apart from one another, with different upbringing. There is also the likelihood of physical and sexual abuse by the uncles, cousins or other relatives. In supporting this fact, Guest (2003: 34) states that some women hesitate to take in their relatives' orphans because of the fear that their husbands will abuse them.

#### *4.3.2.3 Child-headed households*

The worst case scenario is where none of the relatives are prepared to take the orphans due to different reasons. In researching the lives of orphans, Guest (2003:131) met a 17 year old girl who said that their relatives have never visited them after the death and burial of their parents. The orphans are forced to start living on their own with no one to rely on. In this case, one realises that children orphaned by HIV and AIDS are more likely to remain impoverished, have unstable relationships and become infected themselves. These children are extremely vulnerable to exploitation and abuse. The children, especially girls, drop out of school to take over the adults' roles in the home. Many of these children end up on the street in an effort to find food and money. The only way to get money would be through prostitution for girls or crime for boys. In some other cases, this applies to both.

The social problem arising from this situation is that children who are abandoned or live with no or little parental guidance are unlikely to make good parents themselves.

They end up losing trust in relationships and may end up being unable to pursue healthy relationships (Gennrich 2004:10; Guest 2003:27).

#### 4.3.3 Caring for the care-givers

Having a member of the family infected by HIV and AIDS takes a serious toll on other members. It affects them socially, concerning how to relate to the community, spiritually, concerning how to relate to God and psychologically, concerning how one makes sense of the whole scenario. The worst thing is caring for the person who has infected you with the virus. In this case, one is both the hero and the victim.

In all three cases of my research, these women raised these sentiments. But their faith in the Lord helped them to care for their dying husbands while they were dying themselves. Both MM and MS cared for their husbands until they died, and MX is still caring for her husband.

Much as these women cared for their husbands, they too need to be cared for. They are like people bandaging the bleeding wounds of the victims while they are bleeding themselves. They too need a person to bandage their wounds.

## 5 CONCLUSION

In this chapter, I reflected on the themes that emerged from the interviews with my co-researchers. In doing so, I make sure that my understanding of the concerns and discussions with my co-researchers are confirmed by them. As I did in chapter 2, I took and discussed this understanding with them. As I explained in my introduction, this chapter went further than what I did in chapter 2 because I had to consult with some of my colleagues doing PhD, medical expert, and other professionals who formed my Multi-Disciplinary Team (MDT). I also consulted literature that dwells more on themes which emerged from the interviews.

Having done that, one is confronted with challenges faced by the church, as presented in this chapter. The next step is how the church can care for those infected and

affected by HIV and AIDS. The following chapter will therefore cover direct pastoral care responses to challenges raised in this chapter.

The following will be discussed;

- Pastoral care and preventive education: emphasis will be on effective preventive education to empower members of communities to protect themselves while caring for those who are infected.
- Pastoral care and the destigmatisation of HIV and AIDS: emphasis will be on how pastoral care can contribute to the destigmatisation of HIV and AIDS and those infected by it.
- Pastoral care and socio-economic empowerment: the emphasis will be on how churches can come up with developmental projects that will empower the poor to generate funds in order that they might take care of themselves.
- Pastoral care and the role of men in combating the spread of HIV and AIDS: realizing that men are the contributors in the spreading of the virus, the emphasis will be on how they can be encouraged to be part of the solution.
- Pastoral care to orphans and vulnerable children: the emphasis is on how Christians and communities could be mobilised to take care of the orphans among them.
- Pastoral care in caring for the carers: the emphasis is on how those who are suffering silently by caring for their loved ones would be cared for.

## CHAPTER 4: SHOUTING FOR HOPE: PASTORAL CARE IN THE CONTEXT OF MY CO-RESEARCHERS

“A woman of India

Described the wells which provide precious, life-giving water to her region:  
*‘They are old now, and through many generations have been dug deeper and deeper.*

*Not all the wells still produce.*

*And because they are so deep, one cannot tell simply by looking which are dry and which hold water.*

*The well is tested by casting a stone and then listening.’*

*‘AIDS,’ said the woman, ‘is the stone which has been cast into the well of the church, to test whether it still holds living water, or if it has gone dry.*

*A quiet thud tells the people infected and affected by HIV/AIDS to pass by, Thirsty though they be.*

*If people of God have life to offer,*

*They must make a noise that says so.’”*

(A handout distributed by Rev S. Abrahamse at Pastoral Training on HIV/AIDS)

### 1. INTRODUCTION.

In this chapter, the emphasis will be on ‘shouting for hope’ by all the needy to come and be helped. There is no doubt that the church of God has experienced difficult times since its inception. Every time the church was faced with a great challenge, there was a solution to the problem, though it came very late most of the times. Through all its experiences, the church has realised that the resources to meet the challenges always came from within: the people. The church has the following vital resources; human capital, theological education, infrastructure, finances and the trust bestowed on it by communities. The question is whether the church is able to utilise all the available resources to their maximum in order to meet the challenges at hand.

I am strongly convinced that the failure of the church to be relevant in meeting the challenges of those infected and affected by HIV and AIDS is in her theology. The more irrelevant our theology concerning modern crises, the less the positive life-

changing impact we will see from people's lives. It is at this stage that the fictitious story from world-renown African theologian, John Mbiti, about obsolete theology makes sense. It is a story of a young theologian who went abroad to study theology so as to help his own community (Dube 2003:60):

He learned German, Greek, French, Latin, Hebrew, Greek, in addition to English, church history, systematic theology, homiletics, exegesis and pastoralia (practical theology), as one part of the requirements for his degree. The other part, the dissertation, he wrote on some obscure theologian of the middle ages. Finally he got what he wanted: a doctorate in theology...

*He was anxious to reach home as soon as possible, so he flew, and he was glad to pay excess baggage which, after all, consisted only of the Bible in the various languages he had learned, plus Bultman, Barth, Bonhoeffer, Brunner, Buber, Cone, Kung, Moltmann, Niebuhr, Tillich,...*

*At home the relatives, neighbors, old friends, dancers, musicians, drums, dogs, cats, all gather to welcome him back. The fattened calves are slaughtered, meat is roasted... [He] is the hope of their small but fast growing church. People bear with him patiently as he struggles to speak his own language, as occasionally he seeks the help of an interpreter from English.*

*Suddenly there is a shriek. Someone has fallen to the ground... It is his older sister, now a married woman with six children and still going strong. He rushes to her. People make room for him, and watch him. "Let's take her to hospital." he calls urgently. They are stunned. He becomes quiet. They all look at him bending over her. Why doesn't somebody respond to his advice? Finally a schoolboy says, "Sir, the nearest hospital is 50 miles away, and there are few buses going there." Someone else says, "She is possessed. Hospitals will not cure her!" The chief says to him, "You have been studying theology overseas for ten years. Now, help your sister. She is troubled by the spirit of her great aunt." He looks around. Slowly he goes to get Bultmann, looks at the index, finds what he wants and reads again about spirit possession in the New Testament. Of course, he gets his answer: Bultmann has demythologised it (i.e. according to him, such a thing does not exist in reality). He insists that his sister is not possessed. The people shout, "Help your sister; she is possessed!" He shouts back, "Bultmann has demythologised demon possession! [It does not exist]."*



Our young pastor is surely educated, but unable to translate his knowledge into solving his people's problem. This is where postfoundationalist practical theology brings the difference to mainstream theology by being local, relevant and contextual. Like any contextual theology, it is the theology from 'below' as opposed to theology from 'above'. It is the theology that transforms a social order which breeds marginalisation and oppression (Assmann 1975:6). It is the theology that starts only from an analysis of reality and usually takes the following form, insertion into the particular situation, analysis of reality, theological reflection and pastoral actions (Assmann 1975:63), as reflected in De Beer *et al* (1998:15) in the pastoral cycle of action.

This chapter will focus on theology of pastoral care in the following areas: preventive education, socio-economic factors and relevance of pastoral care in general to those infected and affected by HIV and AIDS.

## **2. A THEOLOGY OF PASTORAL CARE IN RELATION TO HIV and AIDS**

### **2.1 Pastoral Care as Preventive Education**

Without information or knowledge, 'people perish'. In its proposal to churches in order to act as witnesses in relation to long-term causes and factors encouraging the spread of HIV and AIDS, the WCC Study Document (1997:90) made a special request to churches to educate and involve youth and men in order to prevent the spread of the virus. As mentioned in the previous chapter (chapter 3), ignorance plays a bigger role in contributing to the fast spread of the disease in our generation and in my co-researchers' community.

Both the infected and the affected members need information in order to deal with the HIV and AIDS crisis as the presence of a crisis often calls for the introduction of information (Amos 1988:77), because in most cases, medical personnel do not always take time to go into details about the information needed about HIV and AIDS, as is evident in the improper way MS was informed about her positive status without any pre- or post-counseling. It is in cases like these that the pastor's standing in the community and relationship with the family also has an advantage that goes beyond

that of a doctor- patient relationship. In most communities, the church is regarded as an educational agency. In Tumahole the church enjoys the support and the respect of the people. This in itself is a positive sign which can be translated into action if the church seizes this opportunity.

In order that relevant preventive education on HIV and AIDS be realised, the church will have to include in its Christian Education material sections that openly discuss sex and sexuality without restricting it to these two. I fully support Nicolson (1996:100) who says that sex education in the context of preventive education needs to be about information and choices, rather than about what people should avoid. Children should be brought up with healthy attitudes from the beginning. They need to learn a positive attitude towards their bodies and themselves, and not merely be warned against the dangers of sex in their teens. Many agencies' education programmes on HIV and AIDS encourage casual sex as long as condoms are being used. But the church in its teachings about preventive education will help to bring about an alternative approach. Throughout the world, traditional sexual ethical norms are broken down. Thus, HIV and AIDS spread because of the favourable condition we have created. It is in this kind of environment that the church has a responsibility to provide seasoned, sensible, achievable standards of sexual behaviour which may help the various societies and cultures of the world to provide the basis for personal and family stability which we have lost (Nicolson 1996:103).

#### 2.1.1 The role of men in preventive education

Dr Streets, in his address to the university of Pretoria's Practical Theology PhD students held at Good Shepherd Retreat Centre in February 2008 at Magaliesburg, related this story to us. He said that a certain basketball team in the USA decided to conduct a HIV and AIDS awareness workshop for its players. In order to make this more interesting, the team was booked at a very exclusive hotel. Added to that, was a panel of very beautiful and young-looking ladies who also served as facilitators. After the first day's deliberations had ended, the men and women were allowed to socialize. As they were socializing, the men, though warned about the dangers of HIV and AIDS, started to proposition the ladies and some even went further in suggesting unprotected sex. These women played along, but refused the proposals. On the next

day, as the session started, the women introduced themselves as they had done a day before. Surprisingly, they added the fact that they were all HIV and AIDS positive and had been living with the virus for a number of years. The news came as a shock to these men because they were so close to having sex with these infected women. This was a real eye-opening experience for these men. It is unfortunate that most men contract or infect their partners with the virus because they look at women and then conclude who has HIV and AIDS, without any medical proof.

I fully agree with Chitando (2007:30-1) who says that there is now an urgent need for the church in Africa to address aggressive masculinity. If the church is to become more gender sensitive, it needs to mount credible and effective programmes that target men. In the fight against HIV and AIDS, women should not be the only ones left in the forefront of the battle, but men and youths need to be involved in working together with them to conquer this monster and bring about the long-term solution. But the problem arises where the majority of men do not attend church services. How can a church play a role in ministering to men inside and outside the church? The church can start by organising activities where women whose husbands do not attend services would be used to invite their husbands to the church. These activities will include, among others, marriage seminars and sports days where men would be required to play against other men or to support their children. The marriage seminars would be held at a neutral place. In both these activities, the HIV and AIDS topic should be emphasised. The right of men or women to suggest the use of condoms should also be part of the program. The method for doing this must be group discussions where men would be encouraged to come up with the solution towards the reduction of the spread of the virus. These activities cannot guarantee men's involvement in the church and in HIV and AIDS programs, but it will surely be a starting point.

### 2.1.2 The “NEW”ABC approach of Preventive Education

The conventional and traditional method of ABC prevention seems to be failing. The more condoms are manufactured, the faster the spread of HIV and AIDS. The traditional ABC states that Abstinence is the first and best option. Secondly it states that Be faithful to one partner is better, but if the A and B fail, then one can consider

the use of Condoms. The loophole in this approach is that it gives people options of either this or that. I also agree with Paterson (2009:70) when stating the following as the variety of problems in the traditional ABC approach; firstly that the approach intensifies the stigma around HIV and AIDS by focusing only on sex. Secondly, it leads people to false hope and security by saying that as long as one is faithful to a partner then one is safe. Actually, marriage seems to be the riskiest way for transmission. This is true with my co-researchers who were infected while being faithful. Again, sex is not the only mode of transmitting of HIV. The ABC approach seems to focus on one aspect instead of on the whole.

In one youth service, I asked the youths how many could still say that they were virgins. Very few of the 100 youths present were able to answer that they were virgins. Most of those present just confessed and acknowledged that they had lost their virginity. The predicament for me as a pastor was whether to encourage them to stick to that one partner they had, and still maintaining a clear conscience. Surely one cannot do that. If married people still divorce or have extramarital affairs, will this be possible with the youth? Thirdly, some understand faithfulness to mean to be faithful to one partner at a time and when one is attracted to other partners, to dump the involved one to make space for the new one. At one point I differed with some good Christians who said that we need to go to council meetings and ask community leaders to declare one week an abstinence week. My main concern was on who was going to monitor people to make sure that they were faithful to their abstinence pledge and secondly, what would happen after the week was over. Should we tell people to start indulging in sexual activities? Our traditional methods have somehow becoming outdated and ineffective.

The C of the traditional prevention method is therefore encouragement for those who cannot control their sex drive. It is sometimes interpreted as a way to have multiple partners knowing that one is 'safe' and cannot be infected. At one conference of our church that was held in a community hall, the local HIV and AIDS activist had put boxes of packets of condoms in the toilets. The amazing thing is that, in less than 24 hours, there was not one condom left. No one knew who took them, but the truth is that church people subscribing to the same notion of "no condom" were the ones who took them, and probably used them.

At another church convention, unmarried people were asked to pledge 3 months' abstinence. Many responded and came to the front to pledge. After 3 months, the minister called those who were faithful to the pledge and, surprisingly, fewer people than those who pledged went forward. When they were asked how they managed to uphold their expressed intention, some confessed that it was very difficult, but they were happy that the period was over. An interesting observation was that these were born-again, '*Spirit-filled, and demon chasing*' Christians who proclaimed that sex before marriage was a sin, but they could not live by what they professed. To them the pledge was a celebrity show that lasted for a short time before going back to the old lifestyle. After Jacob Zuma's 'rape case', most people I spoke to were not worried about the outcomes of the case. Their main worry was about JZ having sex with an HIV positive person without a condom. This, in a way, implied that using a condom makes one a moral example. It is true that condoms have a role to play in combating the spread of HIV. But condoms alone cannot stop its fast spread. It takes more than an elastic condom to stop HIV and AIDS. It takes people's commitment to change their lifestyle.

I have said to many people in my HIV and AIDS workshops that if I 'knew' that my sister was sexually involved, I would have advised her to use a condom while still showing her how bad premarital sex was. She would have been angry with me, but would still be alive today. This is also what my co-researchers have expressed to me. They would have tolerated their unfaithful husbands who were sexually at low risk of a sexually transmittable infections (STI).

The different ABC method I am propagating and which I am convinced can bring a positive change to people is Attitude, Behaviour and Character. This is not an 'either' 'or' situation, but one package that has all in one. Taking one automatically implies that you take all others.

### *2.1.2.1 Attitude*

A positive attitude plays a very important role in combating the spread of HIV and AIDS. On the other hand, a negative attitude towards oneself, the community and those infected and affected by HIV and AIDS has far-reaching negative outcomes that fuel its fast spread. Changed attitude makes people accept who they are and then accept others in different conditions. A person with a positive attitude lives life in all its fullness. The positive attitude again influences one's behaviour positively. In her story about HIV and AIDS, Broadway (1998:2) says that after discovering that she had been infected by the man she loved, she was very angry. But she later realised that this could not help her. She decided to tell her story so that people could realize that love and attitude play an important role in strengthening one's willpower to live.

### *2.1.2.2 Behaviour*

It does not matter how vigorous the government, the community and the church's message of combating HIV and AIDS is: if people's positive attitude cannot influence their behaviour to change, then all our prevention methods are in vain. Christian faith is about changed behaviour, it is about repentance. To repent, one has to acknowledge one's wrongs, be prepared to own up to all the consequences resulting from that behaviour and then repent from the old lifestyle into a new life. New life brings with it new and changed behaviour. The changed behaviour will affect one's character positively.

### *2.1.2.3 Character*

Character is what we are when nobody is looking. It is the product of a positive attitude accompanied by changed behaviour. The world will bow to any person or follow any person with a good character.

People with a good character can play a very important role in 'preaching' the message of preventive education. Preventive education goes transcends prevention education in the sense that it does not encourage the use of protection without the

positive attitude that influences one's changed behaviour, impacting positively on one's character.

#### *2.1.2.4 SAVE approach.*

This approach has been developed by the African Network of Religious Leaders living with or personally affected by HIV and AIDS (ANERELA+). It stands for four principles: Safer practice, Available medical intervention, Voluntary Counselling and Testing, and Empowerment (Paterson 2009:71):

- Safer practice

This addresses all aspects pertaining to HIV transmission. It includes issues like prevention of mother to child transmission (PMTCT), post-exposure prophylaxis (PEP), abstinence, delaying sexual debut, male circumcision, condom usage and such related matters.

- Available medical attention

This will include among other medicines such as ARV's, monitoring of patients' viral load, monitoring of babies born with HIV.

- Voluntary Counselling and Testing

Congregants need to be encouraged to know their status so that they can lead a protected life. Churches need to play an active role in this matter. One way of doing this is during conferences like Youth Day, Women's Month and other related days.

- Empowerment

Men, women and youth need to be empowered in taking care of their lives and those of their loved ones. Women, in particular, need to be helped to say no to any abuse and abusive partner. They should be empowered to negotiate safer sex with their partners should they feel unsafe, with no fear of repercussions.

## 2.2 Pastoral care as the destigmatization of HIV and AIDS

The church is like a lighthouse with the main purpose of directing the lost to God's Kingdom. But when the lighthouse has no gas to generate power, ships from afar will be lost and many dangers will occur. When the church ceases to show His light to His people in the acts of love towards the marginalised and stigmatised, then the church is lost and so are those following its teaching and doctrines. Like the metaphor of the well: when there is no more water in the well, it is not worth being called a well of living water.

When Jesus saw the marginalised lepers, he went to them and healed them. He knew and understood the law that emphasised their exclusion, but he also understood that the law was made for people and not people for the law. He understood that love cannot be regulated, but must be shown to all who need it.

My co-researchers needed a real conviction in order to tell their fellow believers about their conditions. They feared that the church would ostracize or stigmatise them. They were prepared to tell the nurses and support groups, rather than disclosing their condition to their church which is supposed to be the community of love. Paterson (2009:27) supports this by stating that the fear of stigmatisation is the fertile ground for the spreading of the virus. When people are afraid to know and disclose their status, they live without knowing their status or those who know, silently become a danger to others. Because of this fear of being excluded, people fail to help or change their behaviour. The church should be encouraged to motivate members to know and disclose their status. It was after serious discussions with my co-workers that they opened up to most of the church members. MM disclosed her condition to an intercessory group meeting at her house, MX did so first to the women's prayer meeting on one Thursday and much later to the community radio. MS disclosed her condition after her husband had died and when she was already frail.

### 2.2.1 Theological root of stigmatisation of people with HIV and AIDS

In trying to trace the theological roots of stigmatisation, Munyika (2005:84) argues that the Bible presents two opposing views: the Mosaic theology of liberation and the



Davidic royal traditions. In explaining the differences between these schools of thoughts, he says that the Davidic tradition tends to legitimise the established structures which proclaim God who faithfully abides and sustains what is on behalf of the present order. The Mosaic tradition, in contrast, is a movement of protest rooted among the disinherited. It articulates its theology in terms of a God who decisively penetrates the impenetrable institutions and orders.

These traditions are also evident in the New Testament. The Davidic tradition is evident in the theology of temple leadership as recorded in Mark 11:27-13:2. The Mosaic tradition is evident in Jesus who embraced the pain of the outcast, excluded, exploited and marginalised. West (2003:9) adds that Jesus critiqued the dominant Davidic theology of structural legitimisation, and is inviting all believers to do the same. The unfortunate part is that most traditional church structures and leadership seem to be embracing the Davidic tradition and find themselves neglecting the Mosaic tradition. Unfortunately, this tradition (Davidic) is the one the missionaries brought to Africa and other parts of the world. This tradition has shaped the culture of the church and, as a result, the church finds itself unable to embrace with compassion the pain of those living with HIV and AIDS. This has resulted in affirming the accusation that the church in its fundamental tradition has contributed to the stigmatisation of God's infected and affected people (Patient & Orr 2003:2).

It is against the background mentioned above and in the context of the HIV and AIDS pandemic, where people are faced with severe stigmatisation, that theologians and church leaders are challenged to revisit the Bible more carefully in order to recover and reclaim the theological themes of inclusion (Windhoek 2003:3). It is in this careful reading of the Bible that the church will discover that it needs to change not only its attitude, but also its actions in minimizing or eradicating the stigma of HIV and AIDS. This action will broaden the role of the church and enhances our understanding of Christ as the embodiment of compassion who cares, without distinction, for all people (Munyika 2005:87). This is what postfoundationalist practical theology is all about: contextualisation, while freeing Christians from fundamentalist and traditional structural theology. Contrary to the traditional 'theology from above', postfoundationalist practical theology comes from 'below'. It is the theology based on people's everyday experiences.

### 2.2.2 Practical theology in the context of HIV and AIDS and stigma

The theology of liberation emerged in many parts of the world from Mosaic tradition (Munyika 2005:88). This was in response to the hopelessness born out of long-standing economic and social injustice. This theology has helped in liberating the minds of many theologians in contextualising the message of the Bible. While liberation theology is centred around race, class, gender and culture (West: 2003:1), the new theology must go further and include the experiences of people living with HIV and AIDS. This new theology needs to be contextual in nature and must be able to challenge theologians to do theology from the perspective of the infected and the affected. Like the oppressed and exploited, people infected and affected by HIV and AIDS should be allowed to read the Bible in their own context of stigmatisation. These people will, in this way, be comforted by reading texts in which a theology of love and compassion is upheld, as in 2 Samuel 21: 10-14, and where Jesus stands in solidarity with those whom society has marginalised and condemned as insignificant (John 4:1-25). Such texts form strong lines of connection with the faith-lives of people living with HIV and AIDS (West 2003:2).

### 2.2.3 Compassionate care as a remedy to stigma

Compassion in its original Latin concept means ‘to suffer with’. It is an invitation to all Christians to feel or show empathy and understanding for people who are suffering. Dube (2003:5) explains compassion as going where it hurts, entering into places where there is pain and sharing in people’s brokenness, fear, confusion and anguish. It challenges us to cry with those in misery, to mourn with those who are lonely and to weep with those in tears. It requires us to be there for those who need us the most.

To be compassionate, one has to make a shift from being ineffective and uninvolved to becoming effective and involved (Munyika 2005:90). It denotes engagement, involvement and activity (Dube 2003:5). The theology to support this action will be the one that moves us from the pulpit to the dusty streets and into the shacks of the neglected and forgotten. It is our Christian calling and duty that when one member suffers, we should all suffer with him/her (1 Cor 12:26). True compassion should be

able to force people into active association with the marginalised, the excluded and the stigmatised, and to seek means and ways to right the wrongs by ending their pain and suffering and by protesting in solidarity against their inhuman condition.

For Christians, the source of our compassion is God's redemptive work at the cross of His Son, Jesus Christ. His unconditional love (*agape*), which is manifested at the cross, is for all and accepts all, regardless of their human condition. In the Golden Rule (Luke 6: 27-38), Jesus says that we should do to others as we would want them to do to us. The basis of the theology of compassion, according to Jesus, is the compassion of God.

Surely, if Christians are to be so compassionate to their fellow believers and human beings as a whole, people would be enabled to decide to receive voluntary counselling and testing (VCT), and provide those infected with a solid platform to tackle opportunistic infections better. This action would help the infected to live positive, qualitative and long lives. Above all, the vibrant ministry of compassion would go a long way in crushing negative stigma and discrimination (Munyika 2005: 92). As a result, most would be free to disclose their status with no fear of being ostracised.

As a compassionate community of believers, the church must venture into righting the wrongs which cause human suffering. Compassion must lead us to tackle the underlying causes of human suffering such as structural causes of poverty, hunger, thirst, homelessness, sicknesses and death (Munyika 2005: 93).

#### 2.2.4 The *Imago Dei* and human dignity in the face of HIV and AIDS infection

It is true that every human being bears the image of God. The *Imago Dei* within us refers to that character which enables every human being to be responsible in their stewardship of what has been entrusted to them by God. This, of course, includes all human beings whether infected or affected by HIV and AIDS. The *Imago Dei* is inherent in every single human being, and this quality cannot be destroyed, not even by sin or disbelief. This image of God in us must always be understood in terms of human relationships with God and with fellow human beings. Whenever we violate any human being, we do not only violate that particular person alone, but we are also

violating God Himself (Munyika 2005: 94, Almedal 2003:1). All humans have inherent human dignity. This is irrespective of their economic, social, gender, ethnicity or health status. Therefore, no one deserves to be segregated due to these human conditions. Thus, any violation of inherent human dignity is the same as violating the image of God in which all people are created. Every person deserves the right to fully enjoy his/her inherent dignity. This further implies that not even HIV and AIDS has any power to take away our human dignity or wash away the image of God with which we are all created. Stigmatisation in this context will therefore mean snatching away fellow human beings' right to live and suffocating them. An expectant mother who shies away from voluntary counselling and testing due to fear of stigmatisation, discrimination and exclusion has had her own dignity violated as well as that of her unborn child (Munyika 2005:95). Blaming and shaming a person with HIV and AIDS is the worst thing we could ever do as Christians because we violate that person's human rights and inherent human dignity (Almedal 2003:1).

It is therefore the duty of Christians to shy away from any language, attitude and tendencies of any person or group of people that tries to stigmatise people due to their health status. The Christians' *Kairos* moment in this age is to get involved in human rights activities. This can be done through advocacy programs where the church is heard proclaiming and advocating prevention and healing and also ensuring that all people have equal access to medical care (Munyika 2005:97).

In standing in the gap for those infected and affected, the church will be reconfirming and reclaiming the image of God in all humans. Christians need to instil among fellow believers a deeper understanding of who a human being is in the light of God's Word.

#### 2.2.5 Unconditional acceptance of those with HIV and AIDS

It is the responsibility of the church to reflect the true nature of God to those infected and affected by HIV and AIDS. That nature of God is the unconditional acceptance of all human beings just as they are. This unconditional acceptance of all human beings affirms their inherent human dignity and grants them all the rights and reasons to exist. It also radicalises respect for human dignity (Munyika 2005:102). This acceptance empowers and kindles faith. Being aware of this acceptance, those

infected and affected by HIV and AIDS will be able to trust in the solidarity they have in the Triune God so that they, in turn, will not fall into the temptation of marginalising others (Tamez 1993:43).

The church needs to be an inclusive, healing and accompanying community engaged in efforts of caring for the poor, the sick, the orphans, the dying and also those living with HIV and AIDS.

### **2.3 Pastoral care as combating HIV and AIDS through economic empowerment**

As one of the recommendations to churches in their ministries as a witness to the world, the WCC Study Document (1997:90) requested the churches to recognise the link between HIV and AIDS and poverty, and to advocate measures to promote just and sustainable development. As mentioned earlier, there is a close link between HIV and AIDS and poverty. It is this position that the former president of the Republic of South Africa, Thabo Mbeki, took when defending his view on whether HIV causes AIDS. He emphasised that people should also look at factors such as poverty in the causal-effect link discussion on HIV and AIDS (Fourie 2006:140-2). Some people, because of the poor condition they find themselves in, resort to prostitution, which puts many people at high risk of being infected with this disease. In support of this fact, the WCC Study Document (1997:13) states that the socio-economic and cultural contexts are determining factors in the spread of HIV and AIDS. Because these circumstances differ from place to place, countries, districts and even villages may have quite different HIV and AIDS stories and current profiles. The World Health Organisation (WHO) has estimated that nine out of ten people with HIV and AIDS live in areas where poverty, the subordinate status of women and children, and discrimination are prevalent. The church, in trying to curb the social imbalances like poverty that have led to HIV and AIDS, will have to fight against the culture that led to unfair sexual relations where men are favoured to dominate over women. This can also be done through nation-healing programs like debates, open talks and symposiums on respect between people of different genders.

### 2.3.1 Skills development and job creation.

While we are aware that the church is not a business or job creation sector, we need to realize that the church can play a very important role facilitating skills development and job creation projects. The church, as a Faith Based Organisation (FBO) and also a Non Profit Organisation (NPO), has the integrity to be trusted as the custodians of human security. Many private sector organisations would be more than willing to partner with any legitimately registered FBO in issues of community development. The church as the facilitator cannot do everything, but can do one good thing: refer the community to where it can get help.

When the AFM in Tumahole started a dressmaking school, two of my co-researchers, MM and MS, joined to learn how to make and sell clothes to generate funds for themselves. Projects of this nature are vital in communities where there are no firms to employ the majority of the community members.

### 2.3.2 Possibility of low-cost but dignified funeral

#### *2.3.2.1 Facilitating the reduction of the high cost of a funeral*

As mentioned in chapter 3, it is very costly to die as an African. Funeral parlours are mushrooming to most parts of our communities. As a matter of fact, five new funeral parlours have been opened in Tumahole in the last five years. Some grocery shops are converted into mortuaries. Death, while being very painful to bereaved families, is welcomed as business by funeral directors. This is well captured in the song, *Lefu la hae le ya mphedisa* (direct translation: His/her death gives me life or benefits me). The more deaths due to HIV and AIDS opportunistic illnesses, the more business opportunities for the undertakers. In most cases, the poor have themselves to blame for impoverishing themselves by enriching the funeral undertakers, due to wasting money on unnecessary expensive funeral services.

It is my sincere observation that it is very expensive to die as a black person. In most cases Black people live to satisfy other people to their own detriment. Our value of ubuntu, of waiting for all the relatives and friends to come from all corners of the

country to attend the funeral, is costing us a lot. When a member of the family dies, say on Tuesday or Wednesday, the funeral will be held the following week on Saturday. This is meant for all the relatives and friends to come so that there are many people. There is also a myth that if more people attend one's funeral, that is a sign that one has been a good person and is going to heaven.

Although I am not against waiting for 'all' the people to attend the funeral, the problem that is encountered here, is that, for the whole week or more than seven days, people will be coming to comfort the family and they will be given refreshments while the relatives from afar would be fed daily up to the burial. Some of the relatives will come without money and after the funeral they will request to be assisted with transportation back home. It has been my observation for a long time now that some people go to funerals for food more than to comfort the bereaved.

In most cases one realises that after the funeral the members of the family are left with debts acquired when they were trying to 'impress' the mourners. As HIV and AIDS patients lose a lot of money during their illness by attending a doctor or being hospitalised, there is no need to waste more money and to leave the widow and/ or the orphans with nothing.

I cannot forget a story I read about one very poor person who died with nothing. The members of his family made an offer to the community that, whoever would give this person a 'decent funeral', would be given the family land as a reward. A full funeral means a dignified and expensive coffin, hearse and a family car, and cattle to be slaughtered. The problem encountered here is; what is the use of all these things (a proper funeral) when, after the funeral, the family would have no property (a home)?

It is high time that the funeral should be treated with the dignity it deserves. It should be seen more in its mournfulness with those attending, doing so to comfort and to be with the bereaved family. The people should start realizing that the simpler, but more dignified the funeral is, the more it would reclaim its cultural humanness (ubuntu). Dignity and respect are more important than the show of material wealth at funerals. All funerals can be affordable if people can do away with unnecessary expenses.



The new crusade of bringing down the cost of a funeral should be ‘preached’ in the churches, community gatherings and ministers’ fraternal. The more the preaching, the louder the message will be, and the more it will be understood and practised by many.

*2.3.2.2. Other ways of reducing the funeral costs will be the following;*

- *To **lobby** the local government and funeral undertakers*

This will be to lobby for the standardization of the cost of funerals. The funeral undertakers will need to be lobbied further to act responsibly and counsel families to act within their means when planning for the funeral, instead of referring them to the nearest loan ‘sharks’.

- ***Enlisting** the local church leaders*

Since the church leaders are a link between members and the funeral undertakers, it is essential to enlist them to promote a change of mindset on how the funeral practices might be interpreted without losing their essence and meaning (Gennrich 2005: 146). It takes a special kind of leadership to help churches to deal with challenges like the one of HIV and AIDS. It is, among others, church leaders’ responsibility to protect God’s flock from the sharks that use funerals to enrich themselves (Paterson 2009:34).

- ***Encouraging** community members to start food gardens.*

For any meal to be healthy, it needs to include vegetables. Whether one is HIV positive or not, vegetables are necessary for the body. Good vegetables boost one’s immune system. The former minister of health, Manto Shabalala-Msimang, was booed at the HIV and AIDS conference for propagating healthy eating as one way of fighting HIV and AIDS. The booing was because of the misunderstanding in both parties about the role vegetables play in boosting one’s immune systems. She encouraged the eating of garlic, spinach, beetroot and other vegetables. Some newspapers even called her “Minister Beetroot”. Much as I agree with the minister on the issue of vegetables, I disagree with her when she tries to substitute medicines with



vegetables. Both vegetables and medicines are necessary for boosting one's immune system. We cannot play one off against another, but should use one with another.

Having supported the importance of vegetables, churches can play a vital role in food gardens. Seedlings are very cheap. Churches can sponsor families and encourage them to plant vegetable gardens in their own yards. Apart from being a healthy nutrition, vegetables can also be the source of income. Together with the government, churches can apply for sponsorship for food tunnels and plant vegetables in their communities. This is simple, but needs good coordination and dedication from the church's project leaders.

#### *2.3.2.3 Another alternative: Cremation and the African culture*

One of the less expensive and financial less stressful type of funeral is cremation. Irion (1966:207) argues that cremation has the same purpose as that of a burial. The major difference between burial and cremation is the time of the dissolution of the body. While with cremation the body takes a short time to dissolve, with the burial takes long, often more than years. Cremation, in a way, speeds up the process of nature: dissolution of the body.

But this method of the dissolution of the body was vehemently rejected as a solution by the co-researchers and some members of the MDT. My co-researchers associated cremation with a sign of rejection, anger and revenge towards the deceased. They felt that it is a form of punishment. This fact is cited by Masango (2005:1293) that reference to cremation in the Old Testament is associated with punishment.

Other argument against cremation is that the bodily resurrection would be impossible, that this custom was pagan and therefore against Christian practice and has no scriptural backing (Masango 2005:1291-2). My group felt that proper burial is a proper way of disposing of a body and is more Biblical and African. To many Africans, the body of the deceased is honoured and handled with care. A day before the burial, elders in the family, depending on the gender of the deceased, go to the mortuary to wash and clothes the corpse.

The practice of washing and clothing a corpse makes it even more impossible to argue for cremation. When the corpse arrives home a day before the burial, members of the family welcome and view the corpse for identification. Either the pastor or church elder is expected to welcome the corpse with a prayer. Throughout the night vigil, elderly women sit on the mattress in the same room with the coffin. A few hours before the burial service the members of the family and those closely related to the deceased are invited to view the corpse for the last time.

Since a death associated with HIV and AIDS is stigmatised and associated with punishment for immorality, cremation will then be associated with the fact that the deceased is already being punished for an immoral life. The alternative route of cremation was not just an option to my team and the co-researcher, but an unacceptable solution that will create more problems for the families and relatives of the deceased.

#### **2.4 Pastoral care as caring for orphans and vulnerable children**

Knowing how HIV and AIDS have negatively impacted the lives of orphans and vulnerable children, the church cannot remain silent. The church will have to influence other churches and the community as a whole to act. In Africa, a child belongs to the community. It is the role of any adult to care or show children the way.

The following are practical examples of the church in action in intervening in the plight of its community's orphans.

##### **2.4.1 Access to basic education**

It is not any child's fault that his/her parents are dead because of HIV and AIDS-related sicknesses. It is not for the church to judge which child deserves the best care above other children due to a personal relationship the church enjoys with such a person. But it is our Christian duty to listen to the cry of HIV and AIDS orphans and vulnerable children. Giving these children life skills to take care of themselves when the need arises is the greatest gift Christians can offer. This great gift comes in the form of education.

With education, the poor can become empowered and this may result in their being wealthy and becoming '*a somebody*'. The church, in this instance, can raise funds among its members and local businesses to support the education of the orphans and vulnerable children (OVP) whether in primary, secondary or tertiary education. Investing in the future of these children will be investing in our own future and that of our country. The church has people and material means, therefore the church can surely take care of the needy in communities. It is our Christian calling and our mandate to take care of the needy.

#### 2.4.2 Foster care and adopt-a-child

The families with means of survival need to be encouraged to be foster parents to the orphans and vulnerable children. As foster parents, that family will have to be referred to social workers to follow legal procedures. A fostered child will have to stay with foster parents.

In failing to get foster parents, the church can still encourage members to adopt children. The difference between the two is that, in adopting a child, the family takes care of the child in another child's place. In this case, parents can invite the child over for the weekend or when schools are closed and still materially support that child with things like school fees, uniforms, clothes, food, etc.

Churches can also become centres of refuge after school and on weekends where the children can be given food and be helped with their homework. Not only this, but children can also play here.

Furthermore, the church can relieve the children taking care of parents by allowing them to go to school while taking care of the sick parent. Children do not have to become agitated or traumatised by bathing their parents while we have many unemployed members in our churches who can do this work.

### 2.4.3 Child support grant

For many fostering parents or grandparents, the fact that there is a child support grant for their orphaned children does not work out well. Grandparents feel that it is their responsibility to take care of the orphans even if they do not have the means. The role the church can play here is being a link in referring the grandparents or foster parents to the necessary department (e.g. Social Welfare) in order to access the grant. The grant can then be used to support the child in his/her education.

### 2.4.4 Post-traumatic stress syndrome and counselling

Losing parents is very traumatic to children. It does not matter whether you are already a parent yourself or a child, losing a parent is certainly painful. If losing a parent is traumatic to grown ups, one can just imagine what it does to children who will be left to care for other children. It is our responsibility in this case to use the church facilities to counsel children traumatised by illness or the loss of parent(s). It is in the church where the message of hope and care needs to be preached and demonstrated.

In the church, the orphans should not be left to feel alone. Involving these children in church activities will, in a way, confirm their humanity and acceptance. This will in a way make them feel important and valuable.

## **2.5 Pastoral Care as a ministry of presence to those living with HIV and AIDS**

One of the basics of pastoral care is the ministry of home visitation. For one to understand the real meaning of visitation, one has to go to its roots in the Greek language. The English language has watered down the visit to mean an act of calling to see another, or paying a visit in the sense of a social call, to look upon or after, to inspect or examine with the eyes, to look upon in order to help or benefit, to care for, to provide for (Wuest 1941:61). It takes more than a social call to make an impact through our pastoral visit to persons affected and infected by HIV and AIDS. For the church to administer this ministry fully, Christians need to be properly trained in home or hospital visitation ministry.

In their training program, Christians need to realise that the pastoral visit is actually spiritual care-giving. This will help to make denial unnecessary and the objective of a pastoral visit is nothing but pointing the needy to the hope that we get from Jesus Christ. True spiritual care acknowledges human dignity and treats all people equally (Phiri *et al.* 2003:191-4).

The church will also have to organise more material support and give to needy families and those family members they are visiting. Home and hospital visitation to affected families and the infected members would have to be prioritised in every department and all ministries in the church. I therefore fully agree with Amos (1988:94) who says that good, solid and biblically based pastoral care is vital in the ministry to persons and families dealing with HIV and AIDS. Good pastoral care begins with the reaffirmation of the need to respond to people with HIV and AIDS as persons and not to see them primarily in the context in which their disease was contracted. This is very truthful to HIV and AIDS sufferers. Our response must bring good news to them. In facing death, the presence of a minister can create acceptance for the infected. One's presence can offer hope that the infected is not abandoned by God even in the face of a hopeless situation. The presence needs to be strengthened by praying and reading the scripture together. More than just sermonising or giving a lecture, the carer needs to be a good listener as this can be of vital importance to the infected. Together, Christians need to show their skills, experience and resources ecumenically in the face of HIV and AIDS. Whatever the care-givers do, they should begin by listening to those living with HIV and AIDS (PLWHA).

The churches will also need to coordinate their united efforts. I must emphasise that, for the ministry of presence to be successful, we must accept that no church can do it alone. The fight against HIV and AIDS is a united effort among Faith Based Organisations (FBO), Non-governmental Organisations (NGO), and Non-Profit Organisations (NPO), government and private sectors. Putting back the issue of HIV and AIDS in the public arena in community meetings is therefore the responsibility of the church.

### 2.5.1 Sacramental ministry

The sacramental ministry means ministry to one's spirit. In the context of this thesis, it means Christian activities such as prayer services, the laying on of hands to the sick and serving communion as a healing process to those living with HIV and AIDS.

Prayer services should be held for those infected and their families (the affected). For a Pentecostal preacher, the laying of hands on the sick plays a very important part in any worship service. Before the end of each service, the sick are called to the altar for the healing service administered through the laying on of hands. This practice does not end in a church service only, but Christians are commissioned to continue this act whenever they meet sick people. This ministry of the laying on of hands has an important psychological impact on the HIV and AIDS-infected people especially where most people do not want to touch the infected people, let alone those with full-blown AIDS, in the fear that they might contract the disease. When Jesus reached out and touched the lepers, he was calling on us as Christians for the ministry and the power of the laying on of hands. In the book of Mark, He instructs His disciple to lay hands on all those who are sick and they would recover. It is our call and His command to us as believers to physically and with our lives touch those infected by the disease. We need to come out of our comfort zones to touch and reach out to those in need.

Those who are known to be in the stage of full-blown HIV and AIDS should be visited and served with communion frequently. The communion would only be to those who confess the Lordship of Jesus Christ. Those who do not confess this, will still be visited, but for counselling purposes. But the church does not have to stop showing them that the love of God reaches out to all the people regardless of their conditions. The services held for those infected should be for the purpose of reconciliation between themselves and their God (salvation). The relevant Bible study lessons would have to be prepared and discussed at meetings of the different cell groups or support groups as a way of concretising the Christians for their responsibility towards those infected and affected by HIV and AIDS. The messages of hope for the present and also beyond this life would be the central themes for preaching and counselling. Spiritually, those infected with HIV and AIDS and who

are at the terminal stage of their lives need revival and assurance that beyond the here and now there is another life (Rev. 21:1-3).

One thing that the church can give beyond material things is to genuinely love those with HIV and AIDS as Christ has loved them (John 13:33-34). The WCC study document (1997:29) clearly states that the response of Christians and the churches to those affected by HIV and AIDS should rather be one of love and solidarity, expressed both in care and support for those touched directly by the disease, and in efforts to prevent its spread. I agree with Nicolson (1996:157) who says that HIV and AIDS brings a judgement to the church in the sense that the church fails to do what it was called to do which is to love all of God's creation unconditionally. Those infected with the disease do not only need to be cared for. They too have something to offer and if we treat them as objects of our pity, we humiliate and disempower them. The church is being called to be able to listen and hear what help is required by the people we are concerned with. Their needs set the agenda for us.

The church is called to love those who are hurting and who are sinners because HIV and AIDS are rarely spoken about in church. Thus persons who are infected and affected have no way of knowing how acceptable they would be. Because of the conspiracy of silence in the churches, most people with HIV and AIDS choose to tell only their closest friends for fear of ostracization (Nicolson 1996:195). In a survey I conducted among Christians, I was very shocked when I discovered that all Christians who were surveyed by the research I conducted said that if they discovered that they were tested HIV-positive, they would rather inform close friends and counsellors and support group members than divulge the matter to their churches, for fear of being labelled promiscuous. In one workshop we held, I asked whether any of them would be in a position to trust fellow Christians by revealing if they had been diagnosed positive. All of them denied this and said they would rather trust those outside the church, because Christians cannot be trusted with confidential things most of the times. The HIV and AIDS crisis in our churches shows where the church has failed, but also gives us reason and motivation to try all the harder.

In their ministry to two of my co-researchers' families (MM and MS), I was informed how members of the church were there to pray for them. As a result, both MM and

MS's husbands died, having given their lives to Christ. The cell leaders who led prayer services testified about this. Every service held was an opportunity to help these who were already at their final stage of full-blown AIDS to have an opportunity of setting things right with God. The good thing is that the message of salvation was not directed only to those who were ill, but to all who were present in the service. As a result, many came to accept Jesus as Lord and Saviour of their lives. Some of these newly converted, are still part of the church long after their friends have passed way.

## **2.6 Pastoral care as counseling to those living with HIV and AIDS**

The WCC Study Document (1997: 85) describes counselling as a process of empowering the person to make decisions about his or her own life. In his approach to counseling in the face of HIV and AIDS, Clarke (1994: 89-90) states that there are four goals of counselling and they are: 1) conversion (Gospel presentation to prepare one for heaven), 2) repentance (from negative damaging emotional responses such as bitterness, guilt, depression and self-pity), 3) change (of moral behavior), and 4) encouragement (to the sufferer to face challenges in life). He further says that, pastors, lay people and church workers, who are filled with the Holy Spirit and have the Bible as the inspired Word of God, can achieve the above goals. The HIV and AIDS sufferers are counselled to make peace with God before dying. Much as the goals are what the church's mission is all about, the problem with Clarke is that he is judgemental and has no room for people to make up their own minds in decision-making. Still in this process, people should be allowed to make choices whether to accept Christ or not. They can only be encouraged towards the positive, but not forced. Amos (1988:23) warns against this kind of approach and says that it is better for the patient or family to face death alone, rather than face the presence of an insensitive, judgmental or overzealous minister. I fully agree with Amos in this statement and totally reject Clarke's approach of not counselling the non-converted person. His idea is contrary to the Gospel message that he is propagating. When Jesus approached or was approached by the needy person, without judging he would ask: "*What do you want me to do for you?*" and after the miracle of healing, he would say, "*Go and sin no more*". Jesus always valued every person he met. And with this approach, many followed him. He never judged nor condemned a needy person.



The other problem with this approach is that most people, when told of their HIV and AIDS status, think of nothing but death. In that case, one will also agree to ‘accepting Jesus’ as a way of ‘bargaining’ with God for healing. Once they come to reality, most return to their previous life-style. My personal experience in this case is the story of MS’ husband who was ‘just about to die’ and accepted Jesus, but ‘recovered’ after spending more than four months in hospital. Two weeks after returning home, he started sleeping out and continued with his old lifestyle of promiscuity. He then stopped coming to church until the day of his funeral. Though I believe in presenting the Gospel to all people, I do not accept misusing it against a defenceless person and refusing to counsel him/her if he/she does not accept Jesus as Saviour. To me, counselling is counselling and has a specific purpose and Gospel presentation for proselytizing is something else with its specific purpose. Contrary to Clarke’s counselling strategies, I align myself with goals as presented and mentioned in the WCC Study Document of which some are:

#### 2.6.1 To help the infected persons to come to terms with their situation

As has been indicated from the interviews I had with my co-researchers, once one has been tested and diagnosed positive, he/she becomes bitter, vengeful, self-condemning, guilty and many other negative characteristics. Knowing the negative reception one will be facing among the members of the family, friends and, most regrettably, the partner and the community, one is left with the option of suicide or revenge. This was very evident to the husbands of my co-researchers. When MS’ husband discovered his status, a long time before anybody could know, he started mentioning the fact that he would commit suicide. After being released from hospital, he knowingly continued with his promiscuous life and, in the process, infected other people. This, in a way, was taking revenge ‘because he could not die alone.’

In the case of attempted suicide, the pastor can play a very vital role. It is at this stage that the pastor can help the infected to come to terms with the situation. The counselling does not help only the infected, but also the affected family and partner.

Failing to accept the situation leads, in most cases, to revenge. Those infected innocently say that since they got this disease without being promiscuous, the only

option for them is to spread this to others. Since some sufferers are the victims of revenge, it goes without saying that the church and Christians have a lot of work to do in counseling these people to deal with it rather than blaming a partner because this won't help one to better the situation (Woodward 1990:75). In its counselling, the church has to help the infected persons to accept the new condition and its limitations, follow its commands and obey the code of behaviour it prescribes, in order to be able to live with it, or else they may be destroyed by it (Field 1958:45). The denial of infection destroys one from inside.

In MS' husband's story, one clearly traces this revenge mentality. He rejoiced when he informed one of his partners that he was positive and that this implied that she was also positive. MX' husband also revealed this tendency. Instead of stopping his promiscuous life, he continued worse than before. Though they are guilty of infecting their partners, they felt that they were victims since they did not know who infected them.

#### 2.6.2 To promote coping strategies for the infected and the affected, including preventing or reducing HIV and AIDS transmission

Being tested positive does not mean the end of the world, though it might seem so for a short time. After the denial stage has passed, one realises that he/she is as normal as any other person. One is still as healthy as anybody else. Lives and feelings do not stop after the test. Different from any person, one knows one's status. It is this knowledge that has to 'force' a person to change his/her lifestyle. It is at this stage that condoms must be emphasised and used permanently by the married couples to avoid re-infections. Diet and daily bodily exercises would also be a new survival strategy to prolong one's life.

Members of the family and/or partner would be prepared through the counseling to cope with accepting and caring for the sufferer, especially in an hour of great need when one is in a state of full-blown AIDS. When one can't do what he/she used to do, the support from those close to the sufferer is essential.

Mother Teresa was quoted saying that there is no greater pain than that of being rejected by the family. To support this saying, Lucky Mazibuko in his article in Sowetan/Sunday World newspaper of 14 May 2000, quoted a lady, Lucia Nhlapo, saying:

*“I phoned my mother for moral support and she gave me a cold shoulder when I told her that I was HIV-positive.. When got home my two children became strangers. They were ordered not to come near me. They were not supposed to hug or kiss me or even touch me...*

*“I had to have my special cup and plate that nobody will touch, and my clothes were kept in a coal box outside the house. The big blow was when my aunt told me to pack my things and leave because I was a health risk to the family”.*

An amazing thing, according to Lucky, was that at Lucia’s funeral, the same people who rejected her while she was alive, were there mourning as if they had lost an important member of the family.

It is in cases like these that the church has got to be a ‘home’ to the homeless, a place where love is found and given to those in need. It is unfortunate that, most times, things are different and sometimes people with HIV and AIDS find more love and acceptance outside the church than within (Nicolson 1996: 65).

### 2.6.3 Different stages of HIV and AIDS infection require different counselling skills and approaches

HIV and AIDS, like all chronic illnesses, has effects that go beyond the physical. It raises emotional issues related to death and dying, relationships, finances and body image. The progression of HIV and AIDS brings with it certain neurological changes that have a direct impact on the mental functioning of the persons with HIV and AIDS (Machanic 1998:176). The stigma attached to HIV and AIDS also adds more stress on people living with HIV and AIDS (PLWHA). Families get affected in the process. Counselling will therefore cover the individual, the family members and the members of their immediate community, like a church. The specific approach used in counselling varies, ranging from a psychodynamic approach to cognitive and systemic therapies, but focuses on issues specific to the stage of illness.

Each stage of HIV and AIDS infection brings with it different emotional issues to deal with. The early stages often focus on lifestyle changes that are needed to stay healthy as long as possible and also with the person coming to terms with the diagnosis and its meaning. Later sessions may deal with changes in status at work, coping with declining health and overcoming depression and related feelings of hopelessness and helplessness. This stage not only interrupts the ordinary pattern of living, but also affects the person's feeling of himself. Something happens to the ego of the person who feels that his customary way of coping with life is slipping from him. The feelings of hopelessness, utter inadequacy and sometimes resignation, present a variety of problems, particularly in the area of marital and family relationships (Field 1958:43,47). Later the counsellor needs to talk to the person on matters of '*end of life*'. This stage helps individuals to deal with emotional, legal and practical issues of impending death. The importance of counselling in different stages helps one to cope with oneself and one's illness, and helps one to come to terms with the changes in one's relationships, including ongoing losses in many areas of one's life (Machanic 1998: 177).

In my pastoral counselling of my co-researchers and their partners, I experienced how important it is for one to recognise the stage the person is, so that one can be relevant to the needs of the person in that particular stage. When I first met MX and she informed me about her status, she was very fragile. I had to start by helping her to understand what HIV and AIDS were and how to cope with the infection. Today, after 8 years, she is healthy and is a volunteer counsellor. With MM's husband it was not easy at the beginning, but as his days were becoming shorter, he opened up to me and other members of the church. He even received Jesus as Lord and Saviour of his life in one of the prayer services I conducted. He died reconciled to God and his family. With MS and her husband it was different with her husband at the beginning, but later things turned out positive. With him I was able to discuss end-of-life issues like what was going to happen to his house when he was no more. He was bold enough to accept that he could not live long. He informed me of his Will which was at the police station. With MS, it was difficult to discuss the issues related to the end of life. I still believed that she would live longer to raise her children. I still expected a miracle for her. She died a believer, with a great testimony to her family and neighbours.

## 2.7 Pastoral Care as caring for the caregivers

One of the greatest challenges brought about by HIV and AIDS is the lack of space at the hospitals to cope with all the ailing people. As a result, the sick are sent back home to be taken care of by family members. The challenge here is that most of the family members are not trained in how to take care of HIV and AIDS-infected patients. The slightest mistake can endanger the lives of the care-givers.

It is very traumatising for family members to see their patient losing weight and shape in their presence without their being able to help. The deaths which result from this experience add more strain to the family or the carers. Unless a special program is established by Christians that will take care of the carers, the likelihood is there that we will live with wounded people (*wounded healers*) who are emotionally a danger to themselves and to society.

If the dying member adds strain to the carers, how much more the knowledge that the dying person is the same person who has infected you and that you, too, will be in the situation he/she is now? This has been the pain I picked up from my interaction with MS. The pain of seeing her husband in a shapeless and deformed condition took a serious toll on her. True to the fact, just after 2 years of her husband's death, she also died. In her dying days, there was nothing the church could do, except to pray. In the case of MM: she devotedly cared for her husband until his death. For her it was better, because she was not infected. MX still takes care of her husband when he is ill (The situation changed since she filed for divorce and later divorced him).

When I asked them how it was possible to take care of people who have infected them, (MM and MX), their response was very simple: their Christian faith compelled them to forgive. They believed in caring for their husbands to the end according to vows taken on their wedding day. Christians need also to establish a support group that will visit the bedridden people and relieve members from their chores at least once a week. There also needs to be counselling and debriefing sessions for carers affected by their ailing members. We need to supply them with home-based care kits to do their work proficiently and with monthly food parcels.

### 3 CONCLUSION

In this chapter, we have looked at the metaphor of the church as the body of Christ and as the Image of God (*Imago Dei*). As all people are created in the image of God, it is our Christian responsibility to emulate God in our actions towards those who need to see God through them.

As the body of Christ, the church has hands and feet to use in meeting the needs of the infected and affected. With feet, the church can reach out to the community and members in need and with hands the church can work, pray and feed the infected and affected. In this case, the church does not only mean the community of believers, but also the individual Christian's acts in pastoral care. Ubuntu as an African concept of caring is vital in caring for those in need.

In the next and final chapter, the focus will be more on conclusion and recommendations. More emphasis will be on revisiting my co-researchers for final reflection of the work so far as to find out what has changed on their side and on my side, and to make recommendations to my readers. Finally, I will look at the role of resilience in pastoral care within the postfoundationalist practical theology paradigm.

## CHAPTER 5:“LOOKING BACK, GOING FORWARD”

*“We have drugs for people with diseases like leprosy. But these drugs do not treat the main problem, the disease of being unwanted. That is what my sisters hope to provide”.* (Mother Teresa in Yancey & Brand 1993:327)

### 1. INTRODUCTION

In this chapter, I will reflect more on my personal journey as a researcher in the course of this research. The journey will also include that of my co-researchers, their development during this research and what happened to each of them. In these reflections, I will look at my journey before, during and after the research, the lessons learnt and the mistakes committed and how I could have handled the research differently.

#### 1.1 Critical self-reflection

When I started with this research, I thought that it was going to be very simple research with the sole purpose of acquiring a PhD degree which is a very important achievement in the academic world. I really looked forward to my graduation. My prior experience of being involved in HIV and AIDS education since 1992 was an added advantage to completing the research and achieving my goal. In my mind this meant that I was armed with years of activism in my battle against HIV and AIDS. What I was not aware of was that it is easy for people to theorise and write books on issues that they do not have first-hand experience in. I also fell within this category.

But as I continued with my research, I became hooked on my co-researchers’ stories. Their willingness to disclose and share their stories compelled me to come out of my ‘cocoon’. Their story became my story and their experiences became mine. It is in their story that I discovered how much I needed healing and closure after losing my own sister to HIV and AIDS-related illnesses. My bitterness, ‘hatred and vengefulness’ was exposed. In the process I realised that my anger was directed towards the wrong person. Though ashamed to admit it now, I waited patiently to hear

of the day when my deceased sister's boyfriend would be ill. This did not happen as expected. The guy is healthy and taking care of his son.

It is through my co-researchers' ability in handling matters related to their partners' infections, willingness to forgive and caring for them 'till death' that exposed my poor handling and management of my grief. When I look back on pain I incurred in the process, I wonder how I managed to survive up to this stage. It is at this stage that the words of old Negro spiritual become real:

*“How I made it over,  
my soul looks back and wonders  
on how I really made it over”.*

I also find myself in the Negro's position to ask how I really managed to continue with this research. My co-researchers' stories made me realise that somehow I could have handled things differently. Their stories also exposed my weaknesses in dealing with a family member infected with HIV and AIDS while I was able to be there for other people in the similar position in the church or in the community. It has not been easy for me to deal with a family member dying of AIDS-related illness, but my co-researchers managed this task with distinction.

In the following paragraphs, I will explain how my own life was positively influenced by this research.

## **2. LOOKING BACK**

### **2.1 My own experiences**

I was in the middle of the annual week-long conference in December 1998 when I received the call that my brother was on his way to fetch me because our sick sister wanted to see us. We travelled from Parys to Meyerton to see why she wanted to see us. There was very little conversation in the car. Back in Parys, the conference continued praying for us.



Arriving at Meyerton where she was staying with our mother, I was shocked on entering the room she was in. I felt that there was a smell of death all over the room. There was no sign of hope and life in this place. When I looked at her, I saw a disfigured ‘skeleton’ of somebody I did not know. Her frail and deformed body was undesirable to look at. One could tell that she would not hold on for long. She could not do anything, not raise her hand or just speak. She tried to whisper something, but just mumbled and no words came out of her mouth.

Trying to be brave, I encouraged her to fight and hold onto life. After praying, we left so that I could be on time for the evening session. After the evening service and more prayers for her by the congregation, one felt ‘very strong.’ I still had a little hope in the midst of doubt and frustration. I had put all my trust and faith in the living God.

It was at 22h30 that same evening that I received a call from my younger brother. Normally, a call at that hour and after seeing the situation my sister was in, meant one thing: disaster. Picking up the phone, listening to his voice, one could tell that something had happened. Truth be told, he confirmed the worst of my fears. It was a call informing me that Thoko was no more. He informed me that she passed away a few minutes after 18h00. This was hardly one hour after we left her. With the clear mental picture of what I saw earlier that day, ‘I was at peace within my soul.’ I knew that she was now out of pain and in the hands of the living God. She was out of this temporal life and in the everlasting arms of the eternal God. That was the hope that I had and which I still hold dear to this day.

It was on the first Saturday of January 1999, that I stood next to the open grave and witnessed the coffin with the remains of my sister being lowered. As the coffin was lowered, I thought of her 8-year-old son who would remain without a parent. It was at that same moment that I made a covenant in my heart to do whatever it takes to help fight or find a solution to HIV and AIDS.

As a way of finding a solution, I started learning more about this monstrous disease. My MTh degree was based on the ‘Pentecostal response to HIV and AIDS in Tumahole.’ Much of my interest that developed in the area of HIV and AIDS

preventive education was due to the covenant that I made while standing at that open grave of my sister.

## **2.2 Lessons learnt from my co-researchers**

All three co-researchers were there when my sister was ill. I suppose they all knew that she had HIV and was now at the AIDS stage. Apart from being their pastor, the experience I went through with my sister has somehow contributed to their openness to talk about their husbands' illness and HIV and AIDS infections. They expressed the fact that I could relate to their pain because I had already travelled that road before.

### **2.2.1 Forgiveness is necessary for one's healing**

Although the co-researchers were my congregants, I had to learn from them the simplicity and the power of forgiveness. I knew and preached a lot about this subject, but needed a real conversion in applying it to those who have hurt me the most. When my co-researchers realised that they were infected by their partners and that these partners had been unfaithful, they decided to forgive them. For me, it was very difficult to make peace with the fact of my sisters' death due to AIDS-related illnesses. My raging anger was directed at the guy who impregnated and dumped her after the child was born. I wanted to blame that guy for her frustration that later resulted in her meeting the person who infected her.

Two years after her death, the father of her son and his uncles came asking for the boy to have access to them and vice versa. I saw this as an opportunity to raise the unresolved issues about my sister. It was after a serious soul-searching debate that I realised that I was acting out of anger. Later that day we resolved the matter and the child was allowed to visit his father. This has borne positive results in the sense that the father is supporting him financially and morally. I then realised that pastoral care and counseling is the united work of all Christians. It is not only pastors' responsibility, because pastors and church leaders are also vulnerable and have unresolved issues in their relations.

### 2.2.2 *“Till death do us part”*

While MX is still caring for her husband even to this day, MM and MS cared for their husbands until death. They never shifted their focus and responsibilities onto other people. They were there for them. In my case, it was very difficult to be there for my sister, especially in her last months when she needed me the most. I took her to my brother who also passed her to our mother. What seemed difficult to do for my sister, these women did exceptionally well for their husbands. They wholeheartedly cared for them to the end.

### 2.2.3 *“Total disclosure brings healing”*

Although in the beginning stages of their infection or that of their spouses, these co-researchers found it difficult to disclose their status to their fellow Christians, they later did. By declaring their status, they received help in different forms from other Christians. In disclosing their status, they actually healed themselves. They became stronger. To this day, MX is a recognised peer counsellor in the Fezile Dabi District. People with problems and need counseling with regard to HIV and AIDS consult her for help. She sometimes goes to the radio to address the public about this disease. Her CD4 count has risen from 76 to 960. She looks very healthy and is not afraid to talk to people about HIV and AIDS. MS also declared her status and many Christians rallied around her to care for her both physically and financially.

While they were bold enough to go public, it was not so with me. I tried all I could to make sure that nobody knew what killed my sister. The more I tried to keep the cause of her death a secret, the more I realised that many people knew the cause already. The more secretive I became, the more pain I carried. No secret heals a person, especially in case of death. Secrets only make the situation worse. It was during these times that I realised that HIV and AIDS kills the living more than it does the dead. While the dead do not worry about what people will say when they hear about the cause of their death, it is we, the living, who worry about what will be said. It took me almost four years to start talking about the cause of my sister's death. My regret in all this is that I missed a real opportunity to have used her funeral to warn young people about the danger of HIV and AIDS so that they could protect themselves.

### **2.3 Co-researcher, MS, succumbs to her final call to the ‘*Gloryland*’**

Although death is the final destiny of all people, and for Christians it is promotion to ‘*gloryland*’, hearing the sad news that MS had passed away did not go well with many who knew her. Her husband had been buried for two years and two of her children were still at school. She was the person who was taking care of her children. Adding more pain to this, was the fact that she was not responsible for her present bodily condition.

It was MM who first informed me that MS had passed away. I could not believe what I was hearing because I had some hope that she would be healed and live to see her children grow up. Although I failed to attend the funeral due to other engagements, I made sure that I travel from Soweto to Parys a day before, just to pray with the family and give them my support. I arrived at Tumahole a few minutes after 15h00. It was at the time her corpse was delivered to the family. Most of the people who were there to receive her body were sobbing. I could not help myself as I also found tears rolling down my cheeks. Her death touched many people’s lives. Some people who saw how she took care of her husband who totally disrespected her, came to realize that her faith was more genuine than that of many who profess to be Christians when the situation favours them. Because of that act, some neighbours decided to accept Jesus as Saviour and Lord.

### **2.4 Co-researcher, MM, is a leader of Interdenominational Intercessors**

After the death of her husband, MM opened her house to be a house of prayer where the intercessors from different denominations will gather every Wednesday to pray and intercede for churches, communities and the nation. This intercession is growing yearly and has spread to far places such as Mafikeng. Apart from weekly meetings in different communities, thrice in a year intercessors meet: firstly for a week of fasting and prayer in first week of January, secondly for a weekend of fasting and prayer in September and lastly for a weekend conference in October.

## **2.5 Co-researcher, MX, divorced and remarried and is community peer counselor**

Sometime in September 2009, MX called me to inform me that she had filed for a divorce from her husband. This was surprising, considering how she had accepted this abusive relationship. In December of the same year, she took the divorce papers for her husband to sign. Instead, she ended up being arrested for a week. The reason was that her husband claimed that when she went into his room, she stole R10000.00 from under his pillow. She was helped by her mother-in-law who told the police that her son was lying. This is how she was released.

The observation here is that her husband wanted to control her life even when they were no longer staying together. But this attempt failed. He later started stalking her.

In July 2010 I was invited to MX's wedding with a person who is also positive and met with at the same support group. For a few weeks now she has claimed that she is happily married. Her current husband is a lay preacher who is also HIV positive. Both work together in their support group and counseling sessions.

## **3 PICKING UP THE PIECES**

My co-researchers taught me that helping a person one step at a time, is better than helping 1000 people without being monitored. I also realised the treasure of information that helped me to value their impact in dealing with this disease. Though I came with the confidence that I knew more than they did, I was humbled in realising that experiences with people who have family members suffering from HIV and AIDS is worth more than thousands of books with no such live experience. In short, I can say that this research exposed my lack of real knowledge about HIV and AIDS. I became a student of my co-researchers. It is their stories that have made this research a success.

If I were to do this research again, I would make sure that the whole process can be concluded within a maximum of three instead of the many years that I took. The longer the dissemination takes from the time of the interview, the more things change

and the more the research becomes outdated. In my experience, the more I delayed in concluding the research, the more things happened in the process. My co-researcher, MS, died before she could realise what impact this research work would make on those reading it. Delayed research report dissemination is like delayed justice to those whose lives would be positively impacted by such a report.

The second thing I felt would have helped is to combine the pastoral care experiences (praxis) with research practices (theory). This would have been possible if I also came with relevant material goods to meet my co-researchers' needs, instead of just being there to listen, feel pity and report their stories. I think this is the area which the next research needs to emphasise: combining theoretical knowledge with meeting physical needs of the co-researchers by facilitating the establishment of community developmental projects. My feeling towards these women was that my role to them was not only that of a mere researcher: I was also their pastor. It is this pastoral role in the research that I felt was overshadowed.

#### **4 MOVING FORWARD**

In moving forward, I would like to propose the theology of resilience as a perfect example of pastoral care in postfoundationalist practical theology.

##### **4.1 Theology of HIV and AIDS resilience**

Luthar *et al.* (2000:543) define resilience as a dynamic process that individuals exhibit with positive behavioural adaptation when they encounter significant adversity or trauma. Resilience is a two-dimensional construct concerning the exposure of adversity and the positive adjustment outcomes of that adversity. Adversity refers to any risks associated with negative life conditions that are statistically related to adjustment difficulties, such as poverty or a family dealing with members infected by HIV and AIDS. Positive adaptation, on the other hand, is considered in a demonstration of manifested behaviour in social competence or success at meeting any particular tasks at a specific life stage. Resilient people are expected to adapt successfully even though they experience risk factors that are against good development. Risk factors are related to poor or negative outcomes. Risk factors may

be cumulative, carrying additive and exponential risks when they co-occur. When these risk factors happen, resilient family members are capable of having minor or no behavioural problems and developing well.

Van Breda (2001:1) states that the resilience theory is a multifaceted field of study that has been addressed by social workers, psychologists, sociologists, educators and many others... This theory addresses the strengths that people and systems demonstrate that enable them to rise above adversity. This ability to cope and show strength in the midst of adversity is what this research wants to suggest as pastoral care for those faced with the adversity of HIV and AIDS.

#### 4.1.1 Pastoral care as resilience during the pre-infection stage

This is the most critical stage that is neglected by many organisations and churches involved in HIV and AIDS preventive education. It is at this stage that many innocent lives can be saved and also empowered to deal with the pandemic. When I worked with Frank Chikane, between the years of 2001 and 2005, I learnt one of the great lessons he taught me, and that was that in all the situations that may result into crises, one must not relax, but prepare for the ‘worst case scenario’. By this he meant that nobody can relax and predict the positive outcomes from a crisis. Rather, one has to prepare thoroughly so as not to be caught with one’s ‘pants down.’ A thorough preparation is better than no preparation at all.

In order to be proactive, pastoral care as Christian education in the local church has to come forward with lessons on HIV and AIDS-related topics. These have to be part of the church’s programme. This education has to teach and prepare Christians to have a positive attitude towards those infected and affected by HIV and AIDS. One has to realise that this has been the necessary education before we even knew of anybody with HIV and AIDS.

Christians will also have to be involved with other Christians or community-based organisations dealing with HIV and AIDS preventive education. These Christians together with those already involved in HIV and AIDS activism will visit the homes of those who are bed-ridden due to HIV and AIDS-related illnesses. In this way, one

will learn how to deal with the situation in one's church when the need arises. This can also prepare one to cope when the family member is to be diagnosed HIV and AIDS positive or when one's family is suffering from the disease.

The pre-infection stage affords one an opportunity to learn without any pressure to cope with the crisis caused by HIV and AIDS. The relevant metaphor to this is that of the preparation of a soldier. Soldiers are not trained during the time of war, but during peace time, but they are trained to be combat-ready when war erupts. It is in this stage that the church can vigorously engage and encourage its members to undergo HIV and AIDS voluntary counseling and testing (VCT).

Although my co-researchers had no knowledge of HIV and AIDS before they discovered that their partners were positive and then learnt the hard way that they were also infected, they later handled their situation very positively. One still feels that if they had more knowledge about HIV and AIDS, they could have handled their situation differently and perhaps they could have prevented being infected. Knowledge is power and power changes the *status quo*.

#### 4.1.2 Pastoral care as resilience during the infection stage

If Christians are well equipped to handle HIV and AIDS infection during the pre-infection period when they are faced with the infected or are infected themselves, they will behave differently. Pastoral care during this period has to focus on the particular stage of infection one is in. Each infection stage requires different counseling techniques. Gennrich (2005: 170) describes five different phases of infections, the emotional experiences, human needs in each phase, counseling and spiritual focus during each stage. I therefore want to discuss these phases and the pastoral care needed in each stage.

##### *4.1.2.1 Pastoral care for people during the diagnosed phase*

Due to lack of knowledge, many people discover that they are HIV and AIDS positive when they are already at a critical stage. When this happens, they react with disbelief, fear, denial, anger and frustration. The result is revenge against other people. This was



realised in the lives of my co-researchers' partners. Their failure to accept the condition they were in resulted in their having more than one partner even though they knew their status. It is at this stage that one needs security.

Pastoral care and counseling at this stage is that of empathy. This simply means looking at the other person's situation from his/her point of view and without prejudging him/her. This is a good time to listen to someone's frustration.

It is after this listening that one can start helping the infected person to embrace his/her condition and face the future with no fear. Pastoral care can also be seen as acts of compassion by Christians towards those who have been tested positive. How one handles this stage will determine how he/she will handle the next stage.

#### *4.1.2.2 Pastoral care during the symptomatic phase*

At this stage a person feels lonely and isolated and sometimes guilty because of past acts. The need at this stage is that of connection with family that one has neglected in the past. One also looks for forgiveness from God (Hennrich 2005:170). In the lives of MM and MS' partners, this was very clear. Before they both died, at different times and in different places, they had sought reconciliation with their families. MS' partner had even gone further to make a will in her favour. His actions at this stage were far different from what they used to be. These actions are also evident in the story of MM and her partner.

Pastoral care and counseling at this stage means focusing on relationships. The infected has to be assisted in setting right what he/she neglected in their lives. The forgotten relationships to be restored have to be with themselves, others and God. The Christian churches must also be assisted to welcome back their prodigal sons and daughters. The AFM in Tumahole was very helpful to MS and MM's partners at this stage. They conducted weekly prayer services for them and also contributed financially to their physical or medical needs.

Coupled to counselling and prayers, it is crucial at this stage that the infected member should be assisted in drafting up a will according to how he/she would like his/her

possessions to be distributed in case of death. Actually this act must be encouraged among all church and community members during the pre-infection stage. Death does not come to those infected only, but to all people. I can still recall how one prominent politician died without a will. The lady for whom he had paid *lobola* took everything, claiming being customarily married to the deceased. His own child from a previous wife could not get anything. MS' husband made sure that the will was there to avoid a family feud after his funeral.

The creation of the memory box of how one would like to be remembered needs to be encouraged at this stage. This box helps the remaining members to focus, not only on the final state, but on one's entire life. The successes, the joys, the good and the not-so-good of life need to be captured in this box.

#### *4.1.2.3 Pastoral care for people who are in a full-blown AIDS phase*

Some of the emotional experiences of persons in the full-blown phase are those of self-rejection, depression, hopelessness or worthlessness. The person wastes away with no help from him/herself or from others. One becomes totally dependent on others. A once strong body loses its shape and is disfigured. The worst is when an old man has to be washed and uses napkins that must be changed from time to time. That is the most humiliating situation to both the patient and the carer. If the carer is your partner, this situation adds more strain. The partner is more stressed by seeing her partner defenceless and wasting away. The more one wastes away, the more one is reminded of the impending death of the partner. Being around the bed of a member in this phase brings only the picture of death. I experienced this when I went to see my sister on the last day of her life. Two of my co-researchers also experienced this with their partners. With MS it was worse because what she witnessed in her husband's deteriorating body, was what she thought of her own situation since she was also positive.

The human need in this phase is the restoration of human dignity. But in this frail state, one still feels that he/she needs to be respected or shown respect by family members and/or anybody visiting him/her.

Pastoral care in this phase is to give hope and meaning to an individual. The Christian faith is the custodian of hope. It is this hope that restores human dignity. Our Christian hope is not only for this temporal life, but also for life eternal.

Pastoral care and counseling in this phase focus on helping individuals and family members to have hope. People need to be reminded that death can only be authorised by God and be certified by the medical personnel. Until then, there is still hope for a miracle.

#### *4.1.2.4 Pastoral care for those in the terminal phase*

During this phase, the patient's emotional experience is that of wasting away, uncertainty and fear. The human need at this stage is for peace and acceptance.

Difficult as it may be, it is in this phase that the carer needs to help the sufferer and the family to let go. This is when the sufferer and the affected family members realise that they have done all that they could and they now need to face the inevitable. The spiritual focus here is that of peace: peace from pain and peace in the loving arms of the loving heavenly Father.

Pastoral care and counseling at this stage focus more on letting go by the infected and the affected members. Our hope at this stage changes from that of being temporal to embracing the eternal. The spiritual focus here is to have peace with God, family and self.

It is at this stage that Moltmann emphasises the eschatological theology of hope. He postulates (Moltmann 1967:17,21) that the Christian eschatology sets out from a definite reality in history and announces the future of that reality, its future possibilities and its power over the future. It is this future that gives hope. To have this hope, one has to have faith in God through Jesus Christ. Hope finds in Christ not only a consolation in suffering, but also the protest of the divine promise against suffering.

#### *4.1.2.5 Pastoral care as resilience during and in the post-bereavement stage*

The emotional experience of the affected family members at this stage is that of sadness and longing, anger and depression. Though these emotions are necessary for those who have lost their loved ones, they are short-lived due to the fact of a resilience program that prepared the family members for the worst case scenario.

Pastoral care and counseling focus on helping members to accept their loss and to focus and continue with life. The message of comfort plays a vital role in helping members in their healing.

### **4.2 Pastoral care as the embodiment of Christ to those infected and affected by HIV and AIDS**

To His disciples in John 21, Jesus said that people will know that they are his disciples if they love one another. Love is the first characteristic of the manifestation of pastoral care for the communities. As God is love (John 3:16), so must His followers be. The true love (agape) of God is the love that sacrifices for the needy and downtrodden. Those with HIV and AIDS are waiting eagerly to be embraced with love by the followers of Christ. The body of Christ has friendly feet and anointed hands.

#### 4.2.1 Friendly feet

I fully concur with Chitando (2007:38) who says that African churches need to be welcoming if they are to accompany people living with HIV and AIDS. He further states that churches which are open, warm and welcoming are a key resource in responding appropriately to those infected and affected. These churches do not only welcome those infected and affected, but they also send a caring team to the community to demonstrate the love of God through their actions. It is always very difficult for those who are at their late stage of infection to attend a church service. Pastoral care for these people is when Christians come to them, talk or wash them.

Pastoral care also involves Christians being at the forefront marching in support of the plight of the HIV and AIDS-infected and affected members. The church must lead in advocacy programs and be part of the South African National AIDS Council (SANAC). If the church positions itself in this way, it can surely influence policies in favour of those infected and affected by HIV and AIDS, advocating for indiscriminatory social grants for the infected members in their last stages and also for their families where parents and partners are involved as breadwinners. Pastoral care can also be in the form of medical care. This can be done by churches establishing VCT centres and distributing ARV's to those whose CD4 counts are very low.

#### 4.2.2 Anointed hands

As mentioned above, friendly feet and anointed hands are inseparable. With the feet the church goes to where the need and/or possible solution are, and with anointed hands, both the infected and affected members are touched and healed. The anointed hands are there to wash those who cannot wash themselves and also to give them their daily prescribed medicine. By showing such acts of compassion, the recipients experience healing. The act of touching the stigmatised person plays a vital role for the person in need. This very act confirms one's humanness and the fact that we are all created in God's image (*Imago Dei*) and therefore need to be treated equally and be respected by all, regardless of any human condition.

The anointed hands are for healing and wholeness purposes. The following are some activities performed through anointed hands: prayers, laying on of hands, visiting the sick and pastoral care and counseling are vital components of the healing process. I found the definition of healing in the context of HIV and AIDS by Chitando (2007:64) to be very relevant in saying that healing can take place in the absence of cure. The healing he is talking about here is in terms of restoration and reintegration. These occur when those with HIV and AIDS no longer have to experience exclusion, stigma and discrimination. When people living with HIV and AIDS receive love and acceptance, then healing occurs. Healing in this instance entails overcoming alienation and brokenness. It entails the idea of recreating a sense of belonging and community. Dying, to a person whose wholeness has been restored, is not a fearful

act, but comes as a completion of life and promotion to the eternal. This is the eschatological hope, as mentioned earlier.

## **5 RECOMMENDATIONS**

### **5.1 Towards a resilient theology of HIV and AIDS**

One of the shortcomings of the church to minister effectively to those infected and affected by HIV and AIDS is the lack of relevant theology. This is caused by the fact that HIV and AIDS is just about 28 years old. This means that it is a new challenge and that most churches were caught unprepared. The theological seminaries were still caught up in their traditional curriculum prescribed to prepare ministers for a particular church. What is needed is the contextual theology that addresses the whole person in his/her context. This is what postfoundationalist practical theology can do: not prescribe the same solution to all people, but as the context dictates.

#### **5.1.1 Pastoral care as liberation of both men and women from ‘religious’ and ‘cultural’ enslaving and enslavements**

Both men and women need to be liberated from religious and cultural bondages. While men can see themselves as free to use culture, masculinity and religion to oppress women as weaker vessels, women also need to be psychologically free not to allow any abuse in whatever form. This can be done by re-reading the Bible from a transformed and liberated perspective.

#### **5.1.2 Pastoral care towards orphans and vulnerable children**

Orphans and vulnerable children are a constant reminder of how terrible and devastating HIV and AIDS is. It is merciless and destructive. It kills and destroys families, communities and nations.

Pastoral care for these children can be in the form of feeding them after school, buying uniforms and books, and also funding them in their educational needs. No

community can afford one more child going hungry while many families throw food away into dustbins.

### 5.1.3 Pastoral care as caring for the care-givers

Most of the carers are women who happen to be victims of their abusive partners. It is traumatising to these women to care for the same men who have abused them and, in some cases, who have infected them with this virus.

As is the case with my co-researchers, it is vital to have a special ministry to people like these who have chosen to care for their partners until the end of their days. These women really need support. Pastoral care might be helping them as they care for their partners, or relieving them and giving them days off while Christians are helping to care for their partners.

The help can also be in the form of finances, food or simply referring them to where they can be helped.

### 5.1.4 Pastoral care as better health for all: towards a healthy living

Pastoral care does not only mean ‘giving the needy a fish,’ but helping and teaching them how to fish for themselves. The cheapest way of helping the needy to take care of themselves is the planting of vegetables. Every home in the townships has a backyard. Buying the seedlings and distributing them to members of the congregation can be a solution towards healthy eating. Members of families can eat from the garden, sell to the community and give to the needy. In this way, every home can be involved in healthy eating. Vegetables strengthen people’s immune systems. Every home and family can be involved equally in taking care of themselves and of other members of the community.

5.1.5 Pastoral care and *'the tree of life'*: “Each HIV and AIDS-related death, leads to one new tree planted.”

One of the greatest legacies the infected can leave behind for the families and communities is the unforgettable reminders of those who lived and died. The best memory can be that of the planting of trees.

This can be done if the infected persons can be supplied with a small tree that they can plant during Arbour and WORLD AIDS Day. Most organisations involved in HIV and AIDS prevention use World AIDS Day as a day and a week to distribute condoms. But we can turn this to be more effective by encouraging infected members to leave a legacy. If every infected person can plant one tree per year for five years (as long as they are alive), many communities would be green, gases would be absorbed by tree leaves and more oxygen would be manufactured. What more can the dying give to the living than giving back life?

The trees would offer shade for human beings and animals, protect watersheds and bind the soil, and if they were fruit trees they would provide food and income generation. The trees would also heal the land by bringing back birds and small animals and regenerating the vitality of the earth. No one needs an educational qualification to plant trees (Maathai 2006:125). More planted trees will help in reducing the dangers of global warming. This is the greatest gift to give to the world. For the trees to be known in terms of who gave them, the plaque and the message from the planter need to be written and put next to that tree. Members who are too weak to do the actual planting can be helped by an affected family member who can plant a tree on their behalf. Every time people pass next to or sit under that tree, they will read the message and remember the person who planted it. Even after years when HIV and AIDS would hopefully be a thing of the past, these trees will be the communities' constant reminders of where we came from.



## **6 NEW NARRATIVE**

### **6.1 Has the aim been met?**

When I started with this research, I declared the project's overall aim as reaching the holistic understanding of the stories of these three Christian women who were infected and affected by HIV and AIDS and experienced pastoral care in their church and community. The question, as I come to the end of the research, is whether the aim has been accomplished. I can boldly say that the aim has been met in the sense that these women's stories have been listened to, interpreted and given proper attention. The whole research has been about these women and their stories of pastoral care.

### **6.2 Have the objectives been met?**

#### 6.2.1 To facilitate the telling of the “unstoried” parts of the narrative

This objective was met in the sense that my three co-researchers were able to tell their stories about pastoral care. The whole project is about the untold stories of pastoral care for women infected and affected by HIV and AIDS. It is true that we have, for the first time, penned and read about these women's stories. Through these stories, many people have come out and disclosed their status. The more people come out, the safer the world for our next generations.

#### 6.2.2 To research alternative ways and means of making these stories known

This objective was also met through dissemination meetings where the stories were read and discussed among the community members. What needs to be done is for the stories to be heard in many communities. This process could be accomplished through the thesis being read by professionals who could disseminate lessons suggested in the projects to their institutions, communities and research projects. The media, both print and electronic, would be invited through the dissemination to ensure coverage.

### 6.2.3 To strengthen the network of organisations and churches working among the infected and affected people

At the moment, many churches have started working together and people are being encouraged to tell their stories so that people and communities could be helped. I can boldly state that this objective has been realised.

### 6.2.4 To disseminate research findings on the unheard stories

Though the process of dissemination is not complete, I have had a chance to disseminate the research findings to three of my church's conferences, one at the University of Johannesburg, and two at our church's Theological Institutes. At both institutes, I was given the power to draw up and develop a theological curriculum related to HIV and AIDS. Much of the research findings from this research project is included in my syllabus.

Through the theological training on HIV and AIDS, most of our students have started HIV and AIDS-related projects in their respective assemblies and communities. As a result, I am of the opinion that they are influencing these communities and the influence is being accomplished on policies related to people living with or affected by HIV and AIDS (PLWHA).

## 7 FINALLY

The fight against HIV and AIDS infection and affection is not the duty of the pastors alone, but the responsibility of the whole church. Pastoral care happens when Christians come together to influence communities to show love and care to those in need. This refers not only to Christians in the church, but also to their families and communities. Without the family working together, the infected would still feel stigmatised and in a way feel like a burden on the members of the family.

Pastoral care in this case is the responsibility of the family. The relevant scriptural text is that in 2 Kings 5. It is the story of Naaman, the Syrian Army commander who was a leper. His servant is the one who suggested to her mistress, Naaman's wife, to

advise him to go to God's prophet in Samaria for healing. The wife told the husband who then went with his male servant to see God's prophet. When Naaman refused to obey the prophet's command, it was the servant who advised him just to obey. He listened to the servant and was cured. The story behind the story is the involvement of the family in the healing of Naaman. People involved here were his wife, the female servant in his house and the male servant. All these worked together as a team to support the sick Naaman. This is what I call pastoral care: a family working together for a better solution.

The battle against HIV and AIDS cannot be won until the families of those infected and affected start working together in caring. It is through these families that churches and communities would be impacted. The impacted communities would impact the continent and, ultimately, the universe. When this has happened, the role played by Christians as individuals and collectively would not go unnoticed and those in need of caring would be cared for.