THE FREE METHODIST CHURCH OF SOUTHERN AFRICA AND ITS RESPONSE TO HIV AND AIDS IN SOUTHERN KWAZULU-NATAL: POSTULATING A RECLAMATION OF WESLEYAN HEALTHCARE RESPONSE FROM A GENDER PERSPECTIVE

By

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DECLARATION

I, **Innocent IYAKAREMYE**,

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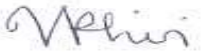
declare that unless specifically indicated to the contrary in the text, this thesis is the result of my own investigation and research and that it has not been submitted in part or in full for any other degree or to any other university, and that all sources used have been acknowledged by means of complete references.

12/07/2013

Innocent IYAKAREMYE Date

As candidate's supervisor, I hereby approve this thesis for submission



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12/07/2013

Dr. Roderick HEWITT Date

DEDICATION

I dedicate this work to my wife Nelly MUKAMPIRANYI

and our children Peace ALLIANCE, Emmanuelle Kevine NYAMPINGA and Shamma La Grace IRAKOZE

Your love and support will never be forgotten.

May God bless you.

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ABSTRACT

This study will explore and investigate the response of the Free Methodist Church of Southern Africa (FMCSA) to HIV and AIDS in the Southern KwaZulu-Natal region. It will also reflect on how the Wesleyan Healthcare Response (WHCR) can be used as an inspiration for this Church to fulfil its mission in engaging with HIV and AIDS from a gender-sensitive perspective.

With reference to the knowledge that religions possess assets for addressing HIV and AIDS and gender inequality, the study argues that the FMCSA possess the necessary resource to address these interconnected challenges which it is not profitably employing currently. This resource is the theological and practical healthcare response developed by the founder of Methodism, John Wesley, during his lifetime.

Using the *missio Dei* theory to explain the mission of the church in the world, and considering Jesus' healing ministry as patterns of the *missio Dei*'s materialisation in times of health crises, the study suggests that the FMCSA as a Christian church is expected to respond to HIV and AIDS, a contemporary health crisis in South Africa. The study also hypothesises that Wesley's healthcare response is a legacy to the Free Methodists that the FMCSA can appropriate as an effective asset to fulfil *missio Dei* in time of HIV and AIDS and its gendered nature in the South African context. Therefore, the question responded to in this study is: how can the Wesleyan Healthcare Response inspire the FMCSA to respond to the HIV and AIDS pandemic from a gender-sensitive perspective?

The following objectives were formulated in order to respond to this question:

1. to explore the discursive account of HIV and AIDS and its gendered nature in South Africa and the response of the FMCSA;
2. to critically reflect on WHCR as FMCSA's potential resource for *missio Dei*'s fulfilment in time of HIV and AIDS;
3. to examine the attitude and concrete response to HIV and AIDS pandemic in the Free Methodist Southern KwaZulu-Natal (FMSKZN);
4. to assess the extent to which WHCR has been used as a resource for addressing HIV and AIDS by the Free Methodist Southern KwaZulu-Natal;

5. to suggest insights to make WHCR a resource to respond to HIV and AIDS within the Southern KwaZulu-Natal context.

The data for the study was collected using empirical and non-empirical research methods. Therefore, in addition to the written sources, individual interviews with selected church leaders and caregivers and focus group discussions with ordinary adult and youth church members in five circuits of the FMSKZN were conducted. In examining the attitudes and concrete responses to HIV and AIDS in the FMSKZN, the study realised that this Church failed to learn from WHCR in order to fulfil *missio Dei* during this pandemic in terms of gender issues. It therefore postulates insights from WHCR that will help fill the gaps identified in the response of this Church to HIV and AIDS and its gendered nature.

The following key themes relating to this study were identified:

Annual conference; Archaeology; Foucault; Free Methodist Church; Free Methodist Church of Southern Africa (FMCSA); Gender; Gender sensitivity; Gender-Based violence; Gendered nature of HIV and AIDS; Genealogy; Healthcare Response; HIV and AIDS; Jesus' healing ministry; John Wesley; KwaZulu-Natal; Men; Methodism; *Missio Dei*; People Living with HIV (PLWHA); Rape; Retribution theology; Sexuality; South Africa; Southern Africa; Southern KwaZulu-Natal; Wesleyan Healthcare Response; Women.

GLOSSARY OF ACRONYMS AND ABBREVIATIONS

ABC	:	Abstinence, Be faithful, (use) Condom
AD	:	Anno Domini (the years after Jesus' birth)
AIDS	:	Acquired Immune Deficiency Syndrome
ANC	:	Antenatal Clinic
ANERELA	:	African Network of Religious Leaders living with or personally affected by HIV and AIDS
ART	:	Antiretroviral Treatment
BEAD	:	Business Exchange on AIDS and Development
CHART	:	Collaborative for HIV and AIDS, Religion and Theology
CDC	:	Centre for Disease Control
CWM	:	Council for World Mission
EHAIA	:	Ecumenical HIV and AIDS Initiative in Africa
Et al.	:	Et alia (and others)
HIV	:	Human Immunodeficiency Virus
FGD	:	Focus Group Discussion
FMC	:	Free Methodist Church
FMCNA	:	Free Methodist Church North America
FMCSA	:	Free Methodist Church of Southern Africa
FMSKZN	:	Free Methodist Southern KwaZulu-Natal
FMWM	:	Free Methodist World Mission
GDP	:	Gross Domestic Product
KZN	:	KwaZulu-Natal
MEC	:	Methodist Episcopal Church
MTCTP	:	Mother-To-Child Transmission Prevention
NACOSA	:	National AIDS Convention of South Africa
PeP	:	Post-exposure Prophylaxis
PLWHA	:	People Living with HIV and AIDS
PreP	:	Pre- exposure Prophylaxis

SAPS	:	South African Police Service
SAVE	:	Safer practice, Available medical interventions, Voluntary Counselling and Testing (VCT), and Empowerment.
SKZN	:	Southern KwaZulu-Natal
Stats SA	:	Statistics South Africa
STIs	:	Sexually Transmitted Infection
TAC	:	Treatment Action Campaign
TB	:	Tuberculosis
UCH	:	Ubunye Cooperative Housing
UFMC	:	Ubunye Free Methodist Church
UNAIDS	:	Joint United Nations Programme on HIV and AIDS
VCT	:	Voluntary Counselling and Testing
WCC	:	World Council of Churches
WHCR	:	Wesleyan Healthcare Response

OPERATIONAL DEFINITIONS

Some expressions used in this thesis need to be clarified in order to be contextually understood. These are: Annual Conference, gender-sensitive perspective, *missio Dei,* and Wesleyan Healthcare Response (WHCR).

Annual Conference

The concept of 'Annual Conference' is frequently used in this study, especially when locating and framing it geographically. Literally this concept is understood as a conference which takes place once a year. However, in the Free Methodist Church (hereafter FMC), this meaning is extended to another level. According to the *Book of Discipline* of The Free Methodist Church (FMCNA, 2000:31-34, 69-120), the FMC is hierarchically structured into four levels. The basic level is the 'Society' (or circuit) which is a fully organised church led by appointed minister(s). The upper level is the Annual Conference. This is a coordination of a number of circuits by elected superintendent (:99). The *Book of Discipline* specifies that "The pastoral charges embraced within each Annual Conference may be grouped into 'districts'" (:31). This means that the 'district' may become an intermediate level between the circuits and the Annual Conference, but this is not mandatory. If established, its power is directed by the General Conference (:31). At the highest level, there is a General Conference headed by the bishop(s). It therefore appears that the 'Annual Conference' concept in this context refers to a structural level of the Church.

However, this Annual Conference organises a conference meeting annually during which ministers of circuits report on their annual activities and new ministerial appointments are made (:104-106). It is here that the concept also takes on its literal meaning. In order to avoid confusion for non-Free Methodists readers of this thesis the use of this concept is separated. Therefore, the term 'Annual Conference' is used for the annual conference meetings and the 'Free Methodist Southern KwaZulu-Natal' (FMSKZN) for 'Southern KwaZulu-Natal Annual Conference' as a structure.

Gender-sensitive Perspective

This study analyses matters of HIV and AIDS from a gender-sensitive perspective. This implies that the study was conceived and developed with an awareness of and sensitivity to the notion of

gender and its role in the spread of HIV and AIDS, including the commitment to find ways of scrutinising and addressing this challenge. However, understanding this gender-sensitivity requires being informed about the notions of gender and gender (in)equality and their impact on the pandemic. In this regard, Momsen (2004:2) defines the concept of 'gender' as "the socially acquired notions of masculinity and femininity by which women and men are identified." In extending this explanation, Dube (2003:87-90) includes in these notions the concepts of the nature of women and men, their roles and their power relationships in the society. Likewise, Moyo (2004:72) extends these notions to the personality traits, attitudes, feelings, values, behaviours and activities ascribed to males and females by society. These authors therefore portray gender as a socially contextualised and constructed understanding of males and females as well as their roles and relations.

Dube (2003:89) emphasizes that the notion of gender becomes a crucial issue because of its inequity and its negative effects. She explains that women have been ascribed demeaning roles and disempowered in relations. In the context of HIV and AIDS, she elucidates that this unfairness has become a major driving force of the spread of the pandemic to which unfortunately both males and females are victims (89-90). In order to address this challenge, Dube (2004:12) proposes a gender-sensitive multi-sectoral approach to HIV and AIDS. Therefore, in her view, "the struggle against HIV/AIDS should not only just be factored in all sectors. Rather, each sector must also mainstream gender planning, analysis and monitoring in their prevention, care, mitigation of impact and the eradication of stigma programmes" (:12).

Dube's suggestion is to enable gender to cut across all boundaries and to underpin all the steps and ways of addressing HIV and AIDS. It is from this perspective that the present study has been conceived and developed. In this regard, issues of gender have been considered in this study from its conception up to its completion. In every chapter, the analysis on HIV and AIDS is accompanied by/coupled or interwoven with the analysis of gender-related aspects. In this way, the study proposes a gender-sensitive approach using the WHCR as a resource to fill existing gaps in the response of the FMCSA to HIV and AIDS in Southern KwaZulu-Natal (hereafter SKZN). This awareness and consideration of gender issues throughout this study is expressed from a gender- sensitive perspective.

Missio Dei

Missio Dei is a Latin expression literally meaning, 'God's mission.' The notion of *missio Dei* was suggested for the first time in 1932 by Karl Barth to mean that the mission of the church

originates from the Triune God and that therefore, the church has no other mission than participating in God's mission (McKinzie, 2010:11). In the present study, the theory of *missio Dei* is used to argue that the FMCSA is currently falling short of using available means to fulfil its mission in time of HIV and AIDS in Southern KwaZulu-Natal. Details of this notion and its role in this study are presented in chapter 3.

Wesleyan Healthcare Response

The expression, 'Wesleyan Healthcare Response', used in this work must be understood in terms of ministry, healing ministry and healthcare ministry. According to Hunter (1990:730) the notion 'Ministry' (*diakonia*) in the church was originally associated with services within the life of the church and the community. The word 'ministry' (*diakoneo*) literally meant 'feeding for guest' but later included other connotations. It variously meant employing God-given gifts, specific acts such as offering, assistance to prisoners, apostleship, and aid to a congregation (:731).

In the context of health, the ministry is called 'health [care]' or 'healing' depending on the way it is carried out. In the view of Maddocks (1981:9)

> A Christian can never discuss healing without having Jesus in mind. His very name, the equivalent of Saviour from the root save/heal, speaks of growth and enlargement, a process whereby a power is unleashed that brings the life of man (or society) back into a new spaciousness in which all the cells (or members) are released and delivered to perform their full and purposeful function.

In this statement, Maddocks associates 'healing' with Jesus' unleashed power in restoring wellness in human life.

Like Maddocks, various other authors associate 'healing' with spiritual powers. Hunter (1990:497) suggests that the Christian modes of healing are distinguished by "achieving a spiritual advance in connection with the healing process." Gous (1986) and Anderson (2003) use the word 'healing' when analysing the miraculous ways in which Naaman and Hezekiah were restored to wellness as portrayed in 2 Kings 5:1-27 and 2 Kings 20:1-11. Howard (2001) uses the same word when analysing Jesus' ministry of miraculously restoring the wellness of sick people as described in the New Testament. Schmidt (2007) also speaks of healing when explaining the action of 'Christ Healing Fellowship,' using prayer and other Christian rituals and practices to assist people in regaining their wellness in South Africa.

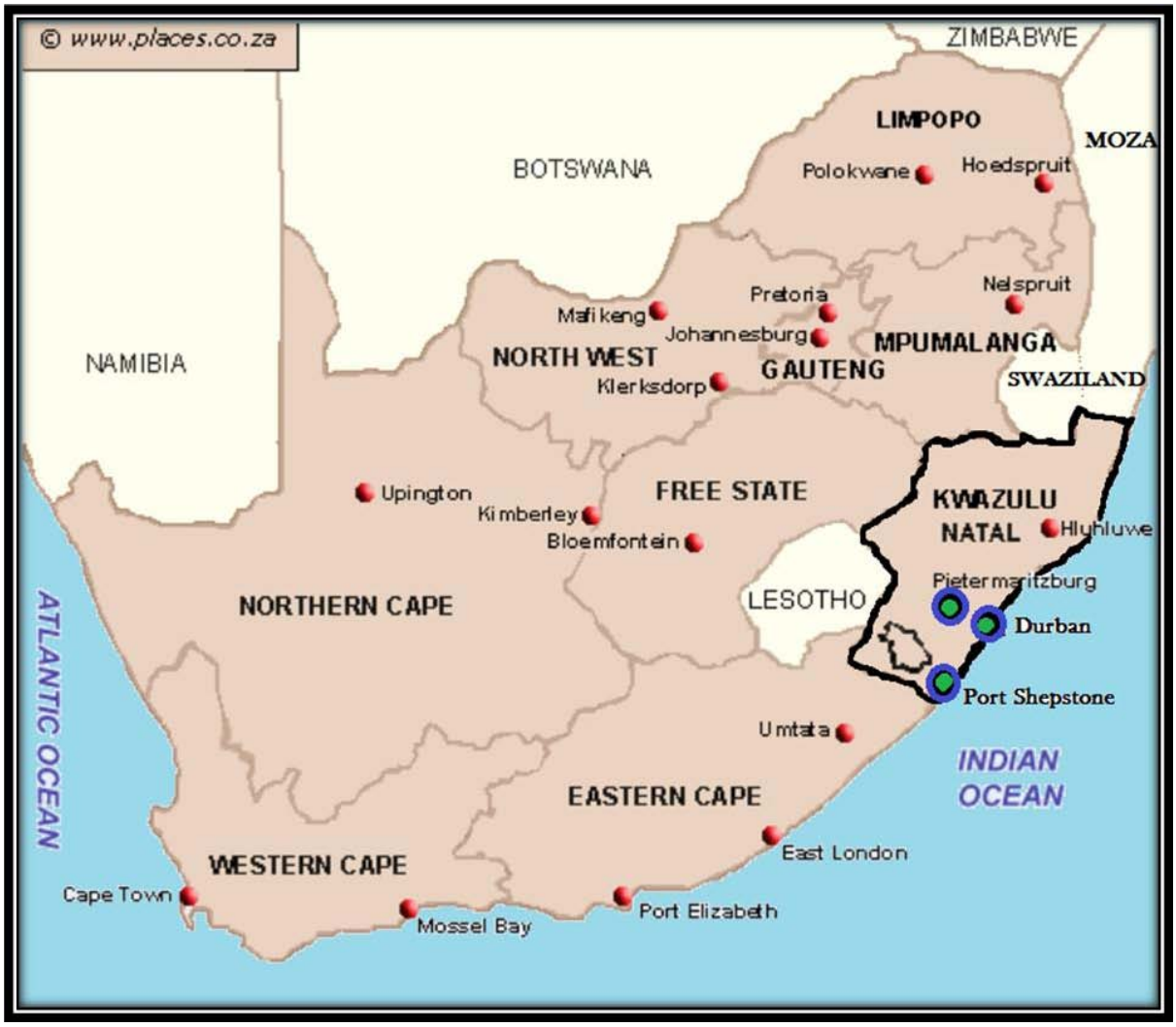
However, the meaning of 'healing' changes when the wellness does not rely (solely) on spiritual powers or the context of the church. Hunter (1990:505) employs 'healthcare delivery' to explain

health services provided in healthcare facilities such as hospitals. Pieterson (1993) also utilises the term 'ministry of healthcare' when analyzing the needs, resources and problems of the Christian Medical College of Vellore, South India. Long (2000) couples both 'Health' and 'Healing' terms when reflecting on biblical teaching, African tradition and bio-medicine. It emerges therefore that the word 'healing' is used when primacy is given to the use of spiritual powers, while 'health' or 'healthcare' is employed when other means such as bio-medicine are given importance. These different senses of the expression 'Wesleyan Healthcare Response' are also reflected in this study.

In this regard, it is reticent to simplistically refer to Wesley's ministry as a 'healing ministry.' Wesley developed simple and natural ways of addressing various afflictions (Wesley, 2004). However, in describing these ways in his book *Primitive Physic*, he uses the term 'curing' instead of 'healing' (Wesley, 2004). Likewise, Hill [1958] uses the term 'practice of medicine' in describing Wesley's healthcare response. Marquardt (1992:28-29) used the terms 'medicine,' 'treatment,' and 'medical care' when analysing Wesley's health practice in his social ethics.

Authors such as Maddocks (1988), Health and Healing (2001), and Maddox (2007) link both 'health' and 'healing' terms when referring to Wesley's health practice. At this point, Gadsby (1998) provides clues for the reasons for this admixture. In his literature review on Wesley's practice of medicine he often observes that prayer was mandatory. This means that Wesley believed in the power of God in healing. Based on Dock (1915)'s article, "The Primitive Physick of Rev. John Wesley" Gadsby (1998) urges us to refrain from calling Wesley's ministry a 'healing ministry' as defined above. He writes, "thoroughly as Wesley believed in some mystic forms of treatment, and firmly as he believed in the supernatural as he viewed it, he did not mix his medicine with religion, for his recommendation of prayer in treatment is very mild" (Gadsby, 1998). Therefore, in this study, Wesley's health practice is analysed not as a healing ministry but as a healthcare response. This response is not a separate institution in the form of an independent guild. Rather, it is characterised by a number of services of sickness prevention, care and treatment that Wesley offered to the community, as detailed in chapter 3.

MAP OF SOUTH AFRICA HIGHLIGHTING THE LOCATION OF THE STUDY



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CHAPTER ONE

INTRODUCTION

1.1 Introduction

The report of the Atlanta-based Center for Disease Control and Prevention (CDC) in June 1981 marked the beginning of awareness about the AIDS disease (Gottlieb, 1981; Carael, 2006:29-32; Karim and Baxter, 2010a:37-38). Given that the first clinical symptoms were found in men and that similar results emerged later in other countries such as South Africa (Denis, 2006:21, 22; Gouws and Karim, 2010:61-62), AIDS made its first appearance as a disease linked to male lifestyle. However, this picture has radically changed over the years. Though it is recognised that currently both males and females suffer from this disease (Hunter, 2008:569-571; Mills et al., 2009:5), global figures reveal that women bear the heaviest burden and consequences in infection incidences. In this regard, the UNAIDS (2010a:11) report revealed that of the 7000 people who were being infected daily in 2009, 6000 were aged 15 years and above and 51% of them were females. Similarly, in the four countries assessed during the same year as having the highest rate of HIV globally, the prevalence in young women between ages 15 and 24 years was always almost triple that of the prevalence in young men of the same age group (UNAIDS, 2010b:183)[1]. Mills et al. (2009:1-3) and Human Rights Watch (2004:11-12) also observe that once HIV is diagnosed, women are most often assumed to be responsible for its spread. The negative impact of the infection is also extended to women's access to health services, family properties and social integration (Phiri, 2003a:15).

Discourses attribute this shift to various factors. However, most of these factors relate to the culture in its definition of gender roles and power sharing between men and women (Phiri, 2003a:8-15; Haddad, 2003:151-154). Hence, HIV and AIDS pandemic is viewed as gender issue (Phiri, 2003a; Haddad, 2003). This therefore leads to the realisation that addressing the question of HIV and AIDS without addressing gender-related matters does not augur well for a substantial success in eradicating the disease (Karim, 2010:285).

With this concern in mind, scholars such as Parry (2008:8) and Denis (2011:58-62) indicate that as soon as the global community began to address this pandemic, churches also became

[1] For young women, the incidence rate was 15.6% in Swaziland, 11.8% in Botswana, and 14.2% in Lesotho, and 13.6 in South Africa. For young men, it was 6.5% in Swaziland, 5.2% in Botswana, 5.4% in Lesotho, and 4.5% in South Africa (UNAIDS, 2010b:183).

involved. They especially participated in caring for those infected and/or affected by HIV. These scholars do point out though, that churches were also found to be a hindrance in addressing the disease, particularly in the obstruction of prevention strategies such as condom use, and the promotion of judgemental attitudes and stigmatisation. In addition, although religions support the family as an institution and celebrate marriages (Statistics South Africa (hereafter, Stats SA), 2007:1), which can be viewed as the promotion of a partnership between men and women, research has shown that churches also promoted or condoned gender inequality as a result of their doctrines, beliefs, and interpretation of sacred scriptures (Mwaniki, 2011; Phiri, 2002; 2000).

Nonetheless, Maluleke and Nadar (2002:15-17) and Nadar (2005:20) argue that because it is difficult to be excluded from a culture or religion, it is within these contexts that the remedy of the problem is also to be found. Likewise, members of the Circle of Concerned African Women Theologians such as Phiri (2003a:4) and Kanyoro (2006:20; 2004:viii) suggest the use of resources such as the Bible, other sacred texts and doctrines in order to find redemptive alternatives of explaining, teaching and addressing issues of gender and HIV and AIDS. This study was initiated with this objective in mind. Questions which are pertinent in this regard are: What efforts are the churches making in order to be more effective in their response to the pandemic? How can they maximise the use of available resources for the maximum wellbeing of the community? In response to these questions this study investigates the FMCSA's response to HIV and AIDS in SKZN. This investigation also examines how the WHCR can be employed as an instrument for this Church's expression of ministry and mission in addressing HIV and AIDS from a gender-sensitive perspective.

Chapter 1 comprises the general introduction to the study, including an overview of the FMCSA. In developing this point, the focus will be on the origin of Free Methodism, its arrival and expansion in South Africa and its missional commitment as related to community social engagement. This will be followed by the background of the study, an outline of the research problem and the motivation for initiating the study on the FMCSA, SKZN region. An outline of the theory used in this study, the problem and objectives statements, and the methodology used in data collection and analysis will be presented. The chapter will conclude with a summary of the thesis.

1.2 Overview of the Free Methodist Church of Southern Africa

1.2.1 Genesis of the Free Methodist Church

Howland (1951:17-19) and Taylor (1960:7-25) bring into being the life tree of the FMC with Jesus Christ and the Early Church. Likewise, *The Book of Discipline* of The FMCNA suggests that, "the lineage of the Free Methodist Church begins with the people of God in the Old and New Testaments, and includes influences and contributions from the multitude of renewal movements in western Christianity" (FMCNA, 2000:2). However, it is beyond the scope of this section to discuss all the events and movements which have contributed to the existence and the character of this Church. Therefore, only four of the most memorable events in the history of this Church will be discussed.

The first event is the severance of ties between the Church of England and Roman domination. Bastian (1974:1-2) specifies that this reaction was the result of controversies between the Pope and King Henry VIII who wanted to divorce his wife, Catherine of Aragon. An Act of Parliament in 1534 officially ended England's submission to Rome. They formed a separate Church, The Church of England, and declared Henry VIII as its 'Supreme Head' (see also Howland, 1951:18-19).

However, various discourses show that the separation from Rome did not guarantee a sustained spiritual wellbeing. After a century of purging the Church from what they considered as 'Roman superstition,'[2] the Church of England returned in 1660 under the leadership of Bishops (Bastian 1974:3). Parliament established new Acts of Uniformity and in 1662 and imposed the liturgy of the Book of Common Prayer (Cracknell and White, 2005:5). Zealous reformers known as 'Puritans,' were also not able to continue their work as they were persecuted together with their supporters (Bastian 1974:3). By the early eighteenth century, Bastian (1974) notes, these changes led to the collapse of morals among both the clergy and the laity in the country. There was a marked difference between the wellbeing of the bishops and the rest of the clergy and the clergy indulged in sports and excess drinking (:3-4). Similarly, the laity was violent, drunkards and immoral (:4). Cracknell and White (2005:5-6) observe however that there were church members who had not followed this common stream. Of these were the families of Charles Wesley and John Wesley, the pioneers and pillars of the Methodist movement which forged the way to the formation of the FMC.

[2] As an example, the elaborate attire worn by the clergy and the sign of the cross at baptism (Bastian, 1974:2-3)

The second event is the foundation and the expansion of the Methodist movement. Cracknell and White (2005:9-10), suggest that the Methodist movement was initiated by a group of young men who regularly met for study, prayer and religious reading, and conversation at Oxford University under the name of the "Holy Club". On the agenda, this group included charitable works such as helping the poor, visiting the sick and the prisoners (:10). Discourses show however that the founder of the club was not John Wesley (1703 – 1791), the most recognised name in the history of Methodism – but rather his younger brother, Charles Wesley and other fellow students (Davies, 1963:34-35; Wesley, 1988:7). They founded the club in the spring of 1729 when John Wesley had gone back to Wroote village – close to Epworth – in the summer of 1727 to help his father, Samuel Wesley, in his expanding church ministry. John Wesley was invited and integrated into this group in November 1729, when he returned to Oxford where he was recruited as fellow of the college and soon became the leader of the club (Davies, 1963:35). According to Cracknell and White (2005:9-10) and Davies (1963:35), the reasons for choosing John as the leader of the group were that he was the only ordained individual in the group, he was senior to the others at the university and was naturally gifted in leadership.

The name 'Methodist' later given to this group also has a history. Davies (1963:35) and Bastian (1974:5) inform us that the Holy Club members were very methodical, regular and zealous in their lives and programs. Consequently, many sobriquets were given to them at the university, but only one, 'Methodists' held. This name was inspired in 1732 by John Bingham, a young student who, in viewing the way they were methodical in their lives, exclaimed, "Here is a new set of Methodists sprung up!" referring to the ancient physicians of Rome (Bastian, 1974:5).

What, might one ask, brings this group into the lineage of the FMC? Discourses reveal that the members of the Holy Club belonged to the Church of England (Bastian, 1974:7). Specifically, John Wesley was ordained as deacon in 1725 and as priest in 1728 in this Church (Cracknell and White, 2005:9) and converted on May 24, 1738 (Wesley, 1988:8; Newton, 1988:134). His brother Charles Wesley was ordained as priest in the same Church in 1735 (Semple, 1966:10). Whitefield, who joined the Holy Club in early 1738, was also ordained in this Church in 1739 (:11). Although the Holy Club had many members, these three men were fervent and had special gifts and significantly contributed to the revival and expansion of the movement. John was the teacher and leader, Charles a singer and Whitefield an eloquent preacher (Taylor, 1960:74-75).

While these young men initially operated from Oxford University, they began to feel the need to expand their work. Cracknell and White (2005:10) express Wesley's decision as follows: "Wesley

himself thought later that this Oxford 'Holy Club,' with its meditative piety, was the beginning of Methodism, and represented the first manifestation of God's purpose 'to spread scriptural holiness over the Land." Therefore, from Oxford University, they sought to be based within the Church of England in spite of difficulties with some church leaders (Davies, 1963:2-3, 98; 103; Cracknell and White 2005:22-23). From England they extended their movement abroad. According to Howland (1952:20) and Davies (1963:37-39, 127) John Wesley started this new mission in the American colony of Georgia, in 1735 with expectation to preach the gospel to the Indians. This particular mission that lasted two years did not produce much success but the work continued through other preachers (Bastian, 1974:12). It is through this expansion of Methodism in America that the mother church of the FMC, the Methodist Episcopal Church (hereafter MEC) was founded.

The third event is the foundation of the MEC in America. As Davies (1963: 129-131), and Cracknell and White (2005:25-29, 45-47) point out, the foundation of the MEC is linked to American independence and the resulting misunderstanding between John Wesley and the Church of England on the one hand, and between John Wesley and other Methodists in America on the other hand. These authors explain that when the Methodists departed for America they were still part of the Church of England, which was closely aligned to the state. Because of the defeat of the British military in America, most of the Methodist preachers and the Church of England's clergy returned to England, leaving the local people with a very critical sacramental need. Under the advice of Francis Asbury who had stayed in America, John Wesley asked the Bishops of the Church of England to ordain people who would be sent to respond to this need but they refused. John Wesley reacted and decided to confer upon Dr. Thomas Coke (1747-1814), his chief assistant in London, the power to ordain and consecrate Methodists in America and to serve there as an independent superintendent 'disentangled from the state and the English hierarchy.' He also gave him the authority to set apart Asbury as fellow superintendent in this country (Cracknell and White 2005:37).

However, matters did not turn out as anticipated by John Wesley. Cracknell and White (2005:46-47) state that Asbury opposed Wesley's appointment process, viewing it as anti-democratic in a new democratic dispensation. He organised elections during the 1784 'Christmas Conference' in Baltimore, where sixty of eighty-one itinerant preachers were gathered. Both Coke and Asbury were elected to the superintendency. During the same conference, they also put into practice earlier suggestions of turning the movement into an independent church. The name of the new church became the 'Methodist Episcopal Church' (see also Davies 1963:129). Cracknell and

White (2005:47) further explain that Asbury went on to refuse any domination or relationship from England's Church or Methodism. It followed that the MEC flourished in numbers and dignity but later declined spiritually (:53-65). It was because of this decline that the FMC was founded.

The last event is the foundation of the FMC. Howland (1951:25-26) indicates that controversies sprung up within the MEC in the 1850s. They opposed two groups in Buffalo Genesee Conference in New York State where Benjamin Titus Roberts, the founder of the FMC was appointed. As Howland (1951) elucidates, one group was composed of liberals, most of whom were in the Conference leadership. They were also ministers in secret societies, the Masons or the Odd Fellows or both. Because of their power and influence in Buffalo, they named themselves the 'Buffalo Regency.' The second group was composed of the rest of the church members, named 'Nazarites,' referring to the Old Testament Nazarites in Numbers 6:1-21 who vowed to be dedicated to the Lord (:25-26; 150 years of FMC, 2011:3).

Howland (1951) provides examples of moral and religious disagreements amongst these two groups. Buffalo Regency supported slavery at that time, and by way of sustaining the church ministry, they promoted church fairs and bazaars in order to raise funds. They were not strict on church discipline concerning amusement, dress and associations. They did not consider spiritual fitness but extolled talent in music in recruiting worship group leaders. More importantly, as Howland remarks, they did not promote the Great Revival that was happening within churches; in fact some of them opposed these campaigns (:26-27). Bastian (1974: 13-17) adds that Buffalo Regency opposed Wesley's 'distinctive doctrine of Methodist' according to which "believers are sanctified wholly not by the coming of death nor (sic) by accumulation of good works, but by an act of faith in the redeeming God" (:13-14). Buffalo Regency also supported the practice of renting pews in the Church. In all these examples, Lamson (1960:12-15) observes that the Nazarites held opposite views and claimed adherence to the early Wesleyan Methodism. B.T. Roberts belonged to this latter group.

The disruptions which led Roberts to establish the new Church were triggered by one specific cause. According to Howland (1951:28-32) and Bastian (1974:17-19), the disruptions were caused by the publication of the article, 'New School Methodism' by Roberts in the 1857 *Northern Independent* in which Roberts discussed the different points of views of the above opposing groups, which greatly incensed Buffalo Regency. Roberts was subsequently accused of 'unchristian and immoral conduct' at the subsequent Annual Conference. During this

conference, which was dominated by Buffalo Regency, they decided that Roberts was to be charged and committed to trial. In addition, he was moved from Buffalo to be appointed in Pekin, New York (Howland, 1951; Bastian, 1974). Roberts complied with the decisions, but his situation worsened in the next few months through the actions of a layman, Georges W. Estes, member of the Clarkson circuit of the MEC (Bastian 1974:19). Howland (1951:29) specifies that with the intention to expose the wrong done by the Conference to Roberts, Estes re-published, at his own expense and without consulting Roberts, the article 'New School Methodism' in the form of a pamphlet with some notes on Roberts' trial. This was used as a reason or pretext for the Annual Conference in October 1858 to expel Roberts along with Reverend Joseph McCreery from the MEC.[3] A few months later other members of the clergy who were sympathetic to Roberts were also expelled and lay people deprived of their church membership. Roberts' appeal to the General Conference of May 1860 was also denied (:29; Bastian 1974:19-20; 150 Years of FMC 2011:4).

Lamson (1960:14-15) provides insight into the resultant response by Roberts and his followers to their alienation as follows:

> A group of laymen and a few ministers committed to the Bible and the spiritual teaching of the New Testament, especially as they relate to the doctrine of full salvation in the entire sanctification, met in an apple orchard near Pekin, New York, on August 23, 1860. Here they sat on the grass to consider the will of the Lord for them. In these humble circumstances, after much prayer, they decided to provide a spiritual home for these persecuted people.

The decision mentioned above taken after prayer in humility laid the foundation for a new Church, the FMC, with Benjamin Titus Roberts as the first elected Superintendent (Bastian, 1974:20; Lamson 1960:15). Lamson (1960) also emphasises that these people

> were loyal to a way of life as taught and lived by John Wesley and the early Methodists, and sought in the newly organised Free Methodist Church polity to preserve this original heritage and to evangelize the entire world (:15).

It is noteworthy that in these two preceding quotes, the FMC reclaimed the Early Church of the New Testament and the early Methodism as its preferred model.

The two adjectives 'free' and 'Methodist' in the name of this Church, the Free Methodist Church, also has historical significances. As Bastian (1974:20) writes, the founders of this new

[3] It is noteworthy that 50 years later in 1910, the MEC, Genesee Conference has recognized the wrong done to B T Roberts and has presented the church's parchments to his son, Reverend Benson H. Roberts as sign of reconciliation (Bastian 1974:21; 150 years of FM 2011:4).

Church wanted it to be and remain in line with early Methodism. As for the adjective 'free,' the founders agreed on four notions of freedom, these being freedom from slavery; freedom from secret societies; free seats in all churches and freedom of the Spirit in worship.

From the Church of England through to the Methodist movement and the MEC, a new Church, The FMC, was established. It began to expand first in America (Howland, 1951:56), and later reached other continents (FMCNA, 2000:95, 109-115). In 2011 the FMC consisted of 962,289 members established in 81 areas (Brown, 2011:2) across 77 countries (Free Methodist Church of North America, 2012).

1.2.2 Free Methodist Church in South Africa

Lamson (1951:119-120), Burritt (n.d.:43), and Brodhead (1908:29) note that in South Africa, the FMC was started by missionaries who arrived twenty five years after the 1860 event. The first five missionaries stopped over in Durban in 1885 on their way to Liberia. However, Lamson (1951:119) points out that that Reverend and Mrs. A. D. Noyes were forced to return to South Africa due to the unfavourable climate and the unforeseen death of Miss Mary Carpenter in Liberia. Due to the lack of funds from the Free Methodist World Mission (hereafter FMWM), they worked under the American Board for three years (Burritt, n.d.:43). In December 1890 they started working with the FMWM, using their own savings (Lamson, 1951:119). In 1891, they bought Fairview Farm, an area of 2,265 acres[4] between the Umzumbe River and the Indian Ocean (South Coast/Port Shepstone area), for $2.44 per acre, to be repaid over twenty years. Later the land was purchased from them by the FMWM and became the FMC headquarters in South Africa (:119; Burritt, n.d.:44).

However, the Noyes did not remain alone for long, as according to Burritt (n.d.:43), a member of one of the 1885 missionary teams to Liberia, Miss Grace Allen, joined them in 1891 after she transferred to Portuguese East (Inhambane/Mozambique) (see also Lamson, 1951:120). They started their missionary work on Fairview Farm surrounded by the indigenous population, while progressively extending the field. By 1901, with the help of other missionaries who joined them later, they also established missions at Itemba, Ebenezer, Edwaleni and Pondoland (currently the Eastern Cape) (Burritt, n.d.:44-48). The first Free Methodist Missionary Conference, composed of missionaries and members of the indigenous population was held on Fairview in October 1905, presided by Bishop Sellew (Lamson, 1951:120; Burritt, n.d.:49).

[4] One acre equals to 4047 square metres or 4840 square yards.

In addition to the work in Natal, the mission was also started in the Transvaal (currently Gauteng). Brodhead (1908:29) and Lamson (1951:131) state that Reverend G. H. Agnew began this mission when he arrived in January 1897 for a rest and a change of climate after the death of his wife in Inhambane. Upon his arrival he met Mr A. W. Baker, a Christian lawyer and businessman in the mines at Germiston in Johannesburg, who employed him. Reverend Agnew was supported by Baker to initiate the Church and the Bible Training School, mainly for the local Mozambicans working on the mines so that they could return home later with the capacity to evangelise their own people. Their work united them with the Free Methodist Mission (Brodhead, 1908:29; Lamson, 1951:131). Later, the Mission Board bought a small plot of land and on January 1, 1899, built a small house and chapel on this land (Brodhead, 1908:29). From there, the work also expanded to other areas in Transvaal and reached Mpumalanga (FMCSA, 2011).

From these two starting points, Fairview and Germiston, the FMC principally expanded into the nearby regions. In 1994, when a democratically elected government was established in South Africa, the Church was composed of two districts under the governance of the missionaries: the Natal-Transkei District, geographically comprising the current KwaZulu-Natal (hereafter KZN) and the Eastern Cape, and the Transvaal District, comprising the current Gauteng and Mpumalanga (Msweli, 2012).

However, the change of political governance in South Africa was followed by a change in the FMCSA's governance. In 1995, the local community sought their own General Conference with their own bishop, which was granted to them. The two existing districts were later restructured into five regions, Goldfield (Gauteng) and Mpumalanga from the former Transvaal District as well as Northern KwaZulu-Natal, Southern KwaZulu-Natal, and Eastern Cape from the former Natal-Transkei District (Brodhead, 1908:29; FMCSA, 2009; Msweli, 2012). In 1997, the FMCSA also initiated a new Mission District in Zambia (Shembe, 2012). Up to the time of this study, this structure has not changed (Shembe, 2012).

The FMCSA has grown not only geographically, but also numerically. In 2010, it consisted of 80 pastors of whom 67 were ordained ministers, 7 were ministerial candidates[5] and 6 were supply pastors.[6] Furthermore, it comprised 6,465 lay members, of whom 3,282 were full members,

[5] Ministerial candidate are the people who are in the process of being ordained as pastors.
[6] Supply pastors are the lay people assuming responsibilities of leadership as local preachers of the circuit (basic structure of the church), mostly because of the shortage of ordained pastors.

1,475 were preparatory members[7], and 1,708 were junior members (aged between 9 and 15 years) (FMCSA, 2011).

1.2.3 The FMC's Missional Vocation and Commitment for Social Engagement

The missional vocation and commitment of the FMC for social engagement are discussed in *A Theology of Mission for Free Methodist World Missions* edited by D. Sheffield (2006). According to Sheffield (2006a:3), the mission of the FMC is informed by three affirmations, these being, that the church participates in the Triune God's mission of reconciliation and restoration of the world; that it is conferred by the Holy Spirit, the power of being Christ's visible body filled with grace and bringing the gospel of reconciliation to all people; and that it is sent into the world to reconcile all of the created universe with God.

Sheffield identifies various implications of these affirmations in the FMC's understanding and practice of mission. Therefore, the affirmation of the church's participation in the mission of the Triune God entails that a just reign will be established and evil be judged. It also means that all people reflect the image of God and have the capacity to serve, and that all the human cultures have something to contribute to God's mission. It likewise implies that God intends to reconcile all creation. It also shows that the mutual love of the Triune God is the source of the Christian mission. The other implication here is that Jesus offers healing which provides reconciliation and transformation on a personal, social, cultural and ecological level. (:4).

Sheffield observes that since the church is the visible body of Christ, all believers are ministers and have to witness mutual care, support, and *shalom*[8]. In this context, the church is expected to reflect unity in diversity, a body which suffers with the sufferers, rejoices with those who are happy, and is concerned about the poor, the marginalised and the oppressed. In a nutshell, Sheffield suggests that in the FMC there has to be adequacy between the gospel proclaimed and the visible actions (:4-6).

With the affirmation that the church is sent into the world, Sheffield maintains that therefore, Jesus is at work in all cultures before the church's efforts, that his Good News is for all people, and that "The church is to be 'incarnated' among the world's people" (:6). As Sheffield also

[7] Preparatory members are the people who normally attend the church's services but have not yet gone through all the required process to become full members.

[8] Capp (2006:54) explains the concept *shalom* as "what God wills human society to look like." In a more extended way, Yoder (1989) relates it to material well-being and prosperity (:13), social justice, and straightforwardness (:15-16).

mentions, the Free Methodists believe that the church is sent to all people to call them to the forgiveness of sin and restoration of God's intention. Concerning health and healing, Sheffield writes that the Free Methodists recognise Jesus as the Lord of Life. They accept the possibility and the call for various kinds of healing (physical, emotional, social and emotional) through preventive and restorative healing strategies, including appropriate technologies. At this point, the Free Methodists recognise the participation of all nations, traditions and religions in the healing of human ailments, caring for the created universe and the establishment of a just society. The church is also expected to participate in redemptive economic and political life (:6-7).

As described here, the FMC's understanding of mission entails various interwoven elements which can have positive implication for social engagement, especially in times of health crises such as HIV and AIDS and its gendered nature. Five themes can be identified in this regard. Firstly, the mission of the church is assigned by God, not by the church. This means that the church should not manipulate this agenda. Secondly, the church is expected to engage in providing holistic healing and care wherever and whenever this is needed. Thirdly, all people indistinctively are eligible for the church's services of *diakonia* and integration into the church community. Fourthly, all believers can minister and therefore have to be empowered and involved. Lastly, non-believers also have something to contribute to God's mission and their role should be recognised and honoured. It therefore appears that once the above affirmations are translated into actions, the FMC is expected to indiscriminately provide all the necessary care to the needy, to involve all believers in this action, and to value the contribution of external partners.

Sheffield (2006b) presents four priorities of the Free Methodists when engaging in the community. Firstly, they enquire the will of God through scripture and prayer and consider also the needs expressed by the community. Secondly, they try to restore and build a strong relationship between Christ and the people, between people, and between people and the physical environment. Thirdly, they minister to the whole person, responding to the needs of all the dimensions of a human being, namely the mind, spirit, emotions and body, including political and economic needs. Lastly they empower communities in order to assist them to be not dependent or independent, but interdependent (:10). These priorities may likewise support the idea that the FMC possesses a positive way of addressing the challenges posed by HIV and AIDS and gender. This is because they involve a response to the needs emerging from and

expressed by the community, development of good relationships, response to the needs of all human's dimensions, and the empowerment of assisted people.[9]

Snyder (2006) links the FMC understanding of mission with Wesleyan theology. He identifies four themes of this theology which have impacted on the development of that mission. The first theme concerns the image of God in humankind (and in all creation). According to Snyder (2006:22) Wesley believed that both men and women are created in God's image. Therefore, as Snyder observes, Wesley was not spreading the bad news of condemning people for their sinfulness but the good news of their likeness with God. Wesley considered that even though this image can be spoiled by sin, it is not a total loss because we are all sinners and all humankind has some inherent entity (God's likeness) which can be healed and restored. In this likeness, Snyder also finds that Wesley's theology does not neatly separate the spiritual and physical realms, which was Wesley's extension of salvation, not only to humankind but also to the whole created order (:22).

The next theme in Wesley's theology was salvation as healing. For him, salvation means being healed from the moral disease of sin. Wesley believed that people's sense of guilt because of their sins, ruins their relationship with God, with themselves, with each other, and with their physical environment. Therefore, he insists on Jesus' atonement or salvation as the healing of sin and its effects in all dimensions of human life. He did not focus on the juridical explanation of salvation as 'undeserved cancellation of penalties' because of our sins as western theologians of his time understood (:23-24).

The third theme is 'God's preceding grace'. Wesley explained that God precedes the church's work in all people, cultures, societies and religions. If people respond with faith, they are justified and if they remain, they are sanctified. The role of the church is therefore to inform people of the presence of God's grace so that they may respond and be saved (:22-23).

The last theme is the perfecting of the Christian character. In developing this theme, Wesley considered that the ultimate goal of salvation is Christian perfection. This is achieved through the Spirit which progressively transforms humankind into God's image by enabling them to love God with their hearts, souls and minds and their neighbours as themselves. According to Snyder, it is this demonstration of God/Jesus image by the church community that Wesley calls 'social holiness' out of which the church's social justice or social witness emerges (:24-25).

[9] More details on the strategies of addressing HIV and AIDS are discussed in the Section 3.3.4.

It therefore appears that the theology of Wesley and a derivative understanding of the FMC mission inherently encompass elements that are helpful for the church's engagement in the community, especially in times of health and social challenges. Among others, it is understood that the church has to minister to all humankind regardless of their gender, illness, culture and social status, since they all reflect God's image. The church is also expected to respond to all human needs, whether these are spiritual, social, emotional or physical. The church should not condemn or discriminate against people on the basis of their conformity to the church's structures or belief. In this respect this study draws attention to how the FMCSA has responded to HIV and AIDS and its gendered nature and how Wesleyan theology and practice can be used as valuable resources for the fulfilment of this Church's missional engagement.

1.3 Background and Outline of Research Problem

The research problem in this study is based on the above-mentioned notion that there is a close link between gender inequality and the spread of HIV and AIDS and that both challenges should be addressed simultaneously in order to achieve substantial results (Onyejekwe, 2004; Karim, 2010:285). The other idea involved is the researchers' suggestion that although culture and religion play decisive roles in promoting gender inequality and the spread of HIV and AIDS, they also have resources which can be used to address these problems (Maluleke and Nadar, 2002; Phiri, 2003a; Kanyoro, 2006, 2004). In this regard, it is believed that the FMCSA possesses a resource which can be useful in addressing HIV and AIDS and its gendered nature but that it does not effectively employ this resource, this resource being the Wesleyan Healthcare Response. According to Maddocks (1988:139, 147-149), John Wesley (1703 -1791), the founder of Methodism was ministering various methods of healing as part of his missional engagement. Maddocks also observes that Wesley focused on all the dimensions of humankind and sought to meet people at the point of their needs. In response to health crises, especially among the poor in England during the 18th century, Wesley had a well organised programme of visiting the sick and praying for them (Marquardt, 1992:28). He established dispensaries from which he provided healthcare for free or sometimes at minimal cost, thus challenging the government's medical structures and physicians whose services were inefficient and unaffordable for the poor (Hill, 1958:1, 4). Wesley wrote a manual on proper nourishment, hygiene, treatment of illness, and care for the sick (Wesley, 2004). He freely availed this book to Methodist and non- Methodist families and this action was of great assistance for those who could not afford physicians (Hill, 1958:12; Maddocks, 1988:144). Wesley also financially empowered the poor by providing them with interest-free loans and assisting them in creating jobs so that they were able to maintain healthy

lives at affordable medical budgets (Marquardt, 1992:29). In his ministry, Wesley also fought against slavery (Guy, 1988:117), oppression and the exclusion of women from families and pastoral ministry (Wesley, n.d.:125-126), and ministered to prisoners (Marquardt, 1992:24). It is felt that Wesley's initiative in developing the healthcare response and his approach of integrating it into his holistic pastoral ministry constitutes a resource and an inspiration for the church in addressing HIV and AIDS, which affects not only the physical dimension of human life, but also its psychological, social and spiritual aspects (Wittenberg, 2007:152).

Considering gender, Wesley's healthcare response can also be seen as a means to develop a sense of equality and just relationships between men and women. In this regard, the care for the spiritual and physical wellbeing of the human being, the financial empowerment of the poor, regardless of gender, the stance against slavery and women's exclusion and oppression, as well as the challenge against weak health infrastructures through the introduction of new and efficient healthcare approaches can play a crucial role in reducing the dependence of one gender on the other and the male/female power imbalance. Hence, it is argued that the WHCR can be usefully referred to by churches in order to address HIV and AIDS and gender-based challenges[10].

The existence of this resource leads one to enquire about the situation of HIV and AIDS and gender in the FMCSA's socio-ecclesial context. According to UNAIDS (2010b:28), South Africa has the largest number of people living with HIV (hereafter PLWHA). In this country, the FMC has expanded in provinces and communities severely affected by HIV and AIDS. Gouws and Karim (2010:62-64) estimate that the high prevalence of the disease is to be found throughout eastern KwaZulu-Natal, especially Durban and Hlabisa; Johannesburg, Carletonville and Klerksdorp in Gauteng; Port Elisabeth and East London in the Eastern Cape. Likewise, Kleinschmidt et al. (2010:1165) have traced high prevalence in north-western KwaZulu-Natal, southern Mpumalanga and the eastern Free State. Moreover, the Human Science Research Council's (HSRC) national population-based survey of 2005 (Gouws and Karim, 2010:70) shows that HIV prevalence among persons (15-49 years old) in South Africa was higher among Africans than amongst the other race groups. It was 19.9% in the African communities, 3.2% among coloured people, 1.0% among Indian people and 0.5% among white people (Gouws and Karim, 2010:70). According to Capp (2006:61), Msweli (2012), and Shembe (2012), Africans are the only communities on which the FMC missionaries have focussed their ministry and mission in South Africa.

[10] See detailed illustration of the usefulness of WHCR in time of HIV and AIDS in Section 3.3.4.

In South Africa, various gender-related settings likely to promote the spread of HIV and AIDS are also evident. Hawkinson (2009:2) refers to cultural role division where women are the most exposed to the care of PLWHA without preventive measures. Haddad (2003:152) and Dlamini (2005:61) raise the issue of men who, after paying the bride wealth, *ilobolo,* do not permit their wives to decide on their own sexuality. Men are also culturally allowed to have sexual relations whenever possible and to have numerous wives as part of their manhood (Hunter, 2008:567) and mostly do not protect themselves with condoms (Myer, 2010:193). In addition, South Africa records enormous numbers of rapes and domestic violence. In this regard, 64 514 cases of sexual offences were reported by the South African Police Service (hereafter SAPS) during the 2011/2012 financial year (SAPS, n.d.: slide 38). Likewise, Phiri (2002:22; 2000:105) has found that in Christian families in the KZN Province, her total sample reported violence in their households. On the other hand, the existence of HIV and AIDS in the family has been found to be a situation which promotes domestic violence (Mills et al., 2009:1-3). Given this situation, it is argued that the WHCR would be an important tool for the FMCSA in dealing with HIV and AIDS and gender challenges since it involves practices which can address most of these challenges.

However, the manner in which this Church is using this asset currently is questionable. Enquiries about the use of this asset emerged from my Master's research of 2009 in which the response of the FMCSA in Pietermaritzburg to domestic violence was assessed. The 2009 study confirmed that all the female participants, survivors of domestic violence assisted by this Church through 'The Haven' project (shelter), were also exposed to a high risk of HIV infection (Iyakaremye, 2009:58-63). The symbiotic connection between both realities was not examined because that was not the objective of the study. However, an attempt was made through a journal article (Iyakaremye, 2010) to address this issue. This highlighted that these women were more at risk because they were three times more vulnerable to exposure to HIV infection. Firstly, they were exposed during the abusive period when they could not negotiate safe sexual relations because of dysfunctional masculinities. Secondly, they faced further risk when fleeing from their abusers because there was no safe accommodation available and therefore they were open to further abuse and health risks. Finally, even in the place of safety where these women should feel protected, they were exposed when they left the shelter. The rules of the shelter states that after an accommodation period of six weeks, the victims must leave (:99-101). Then the cycle would start all over again.

Hence, although this Church was trying to address the problem of domestic violence, which is a gender issue, the manner in which it addressed HIV and AIDS was not clear. [Comment by researcher: During my third year (2010) as member of the FMCSA, I had no knowledge about any programme aiming to respond to this pandemic in this Church. No sermon that I heard referred to this problem. I also had the privilege to participate in the FMSKZN Annual Conferences where all the church leaders and lay representatives of the ten circuits of the FMSKZN reported on their annual activities. None of their reports mentioned any activity related to HIV and AIDS].

A systematic literature review[11] (Olivier, 2012; Armstrong et al. 2011; Arksey et al. 2005; Wilson et al. 2010) revealed numerous documents on the response of churches and other Faith-Based Organisations to HIV and AIDS in South Africa. For example, Govere (2005) used the Asset-Based Community Development approach to reclaim *ubuntu* values in the Southern African churches' methods of addressing HIV and AIDS. Mbogo (2004) conducted a study in the 'Springs of Hope' support group to examine the church's gender sensitivity in addressing HIV and AIDS in Pietermaritzburg. Manda (2006) analysed the role of the HIV and AIDS programme of the Evangelical Seminary of Southern Africa (ESSA) in addressing the pandemic. Guzana (2008) examined the Young Men's Guild as a space for HIV prevention in the Methodist Church of Southern Africa. Joushua (2010) wrote on the response of the Catholic Church in KZN from a historical perspective. However, no literature or documents on the FMCSA's response to HIV and AIDS were found. Apart from books on the Free Methodist Mission in South Africa, written before the advent of HIV and AIDS, other documents include the researcher's journal article by Iyakaremye (2010); two book chapters by D. Sheffield and K. Sheffield (1998) and L. P. Capp (2006); one PhD thesis by H. Le Roux (2001); three Master dissertations by E. Ntakirutimana (2004), V. Ntakirutimana (2009), and I. Iyakaremye (2009); as well as two Honours dissertations by E. Ntakirutimana (2003) and V. Musabyimana (2004). These documents focus mainly on one circuit of the FMCSA, namely the Ubunye Free Methodist Church (hereafter, UFMC) of Pietermaritzburg. They largely target two projects, Ubunye Cooperative Housing (hereafter UCH) and The Haven shelter for women and children who are survivors of domestic violence[12]. These writings generally discourse on the importance, the structure, the success or the failure of these projects without mentioning how the issue of HIV and AIDS is approached. There was therefore no evidence that the valuable resource, WHCR, was used by the FMCSA in order to deal with HIV and AIDS. Similarly, there was no

[11] See more about the way the systematic literature review has been used in Section 4.4.1.
[12] Some details on the content of these documents are provided in the Section 2.5.

evidence that the potential of this resource for addressing the pandemic and its gendered nature were known in the FMCSA.

Not knowing how the FMCSA responds to HIV and AIDS may have negative consequences. It may result in an absence of reference to appreciate this Church's contribution in addressing the pandemic. It may also handicap the reflection on strategies to engage this Church in responding or to improve efforts it may have already made. Likewise, not knowing how the WHCR has been or can be valued during the current critical time of HIV and AIDS and GBV in South Africa may result in not benefiting from the possibilities that it offers for managing these challenges. This may also prevent or slow down the involvement of the FMCSA in addressing the issues

Nevertheless, expounding on the usefulness of the WHCR in responding to HIV and AIDS and gender issues may enlighten the rationale and enrich strategies of addressing these challenges. Once known and used, this may also contribute to the increase in the number of effective participants in addressing them. This study therefore assesses the response of the FMCSA to HIV and AIDS and its gendered nature and reflects on how the WHCR can inform this Church's missional engagement in confronting HIV and AIDS and gender challenges.

1.4 Motivation for Undertaking this Study

Personal and academic reasons have motivated the researcher to undertake this study. On a personal level, he was motivated by his concern as an active member and church leader in the FMC. Since 2005, he has been involved in church leadership in Rwanda where he was one of the heads of two national commissions: the Commission of Education, and the Commission of Rehabilitation. He was also the Project Proposal Writing, Monitoring and Evaluation Technical Advisor and was involved in decision making for various programmes of this Church. When he came to further his studies at the University of KwaZulu-Natal in 2008, he was also involved in the FMCSA leadership in Pietermaritzburg where he served as an Assistant Pastor, member of the Management Committee of The Haven Project for women and children, and Director of the Children and Youth Ministry. During his studies he was offered opportunities to reflect on the link between gender and the spread of HIV and AIDS and various assets possessed by churches in order to address this problem. In both Rwanda and South Africa, gender and HIV and AIDS are among the main concerns for community development (Republic of South Africa, 2012; Republic of Rwanda, 2007). Therefore, as a church leader concerned about the involvement of the Church in promoting life in the community, the present study constitutes an opportunity to

reflect further on the FMC-rooted resources and to assess the extent to which they are useful for addressing HIV and AIDS.

From an academic perspective, he was prompted by the absence of literature about the way the FMCSA has responded to HIV and AIDS, as explained earlier. Literature appeared to be silent on the analysis of the usefulness of Wesley's theology and practice of healthcare in the context of HIV and AIDS and gender. At this point, some published and academic literature provides a medical analysis of WHCR. These include *Primitive Physic, or An Easy and Natural Method of Curing Most Diseases* of John Wesley (2004), *John Wesley among the Physicians: A Study of Eighteenth-Century Medicine* of Wesley A. Hill (1958), and the chapter on 'Electroanalgesia: Historical and Contemporary Developments' in Gordon Gadsby's PhD thesis (1998).

Other documents related to this response focus on its social aspect. These comprise literature such as *John Wesley's Social Ethics: Praxis and Principles,* of Manfred Marquardt (1992), the book, *To be and to do: Exploring Wesley's Thought on Ethical Behaviour* of L. D. Hulley (1988), and Wesley (1979)'s sermons such as, 'On the Danger of Riches,' 'On Riches,' 'On Charity,' and 'On Love.'

The third type of documents emphasise the religious context of the WHCR. These involve articles such as: 'Health and Healing in the Ministry of John Wesley' of Morris Maddocks (1988) and 'John Wesley and Death' of Wesley A. Chambers (1988) as well as Wesley (1979)'s sermons like 'On Visiting the Sick' and 'On Mourning for Dead.'

Although these documents provide substantial information about the WHCR, they do not analyse it in the context of HIV and AIDS, since most of these were written before AIDS was diagnosed. Documents which link HIV and some aspects of Wesley's theology and ministry focus directly or indirectly on his overall social engagement without mentioning his healthcare response. A sample of these documents includes the Master's thesis of Lubunga (2007) on the doctrine of social holiness and its implication for HIV and AIDS in the Democratic Republic of Congo (DRC); the document dealing with the response of the Methodist Church of Southern Africa (MCSA) to HIV and AIDS (Jacob, 2006); and a Master's thesis by Kisaalu (2007) analysing the MCSA's policy of HIV and AIDS in Swaziland from a theological perspective. Hence, in initiating this study, the researcher sought to document literature on how the FMCSA had so far responded to HIV and AIDS during the three decades after the diagnosis of AIDS in South Africa. He wanted also to document literature on the potential of the WHCR for addressing HIV and AIDS and gender issues within a contemporary South African context.

1.5 Principal Theory

This study employs one theory of *missio Dei.* Bosch (2011:399) argues that this concept indicates that the church does not have any mission in the world other than participating in God's mission. The ministry of Jesus Christ was a model of participating in God's mission as demonstrated in his response to the health needs of the poor. Maddocks (1981), Dube (2007), and Schmidt (2007) observe that in fulfilling God's mission, Jesus initiated a healing ministry through which He cured physical, emotional, social and spiritual ailments[13]. Chapter 3 will show how He was sensitive and attentive to the conditions of the marginalised and disadvantaged such as women and children (Folk, 1990:105). It is argued that, like Jesus, Christian churches are expected to engage in addressing health issues, including HIV and AIDS and its gendered nature. In particular, the WHCR is viewed as an instrument of *missio Dei* engagement embedded in the essence of the FMC. Perspectives from *missio Dei* have been appropriated to reflect on how the WHCR can inform the FMCSA in fulfilling *missio Dei* in confronting HIV and AIDS and gender challenges.

1.6 Problem Statement and Objectives

This study seeks to respond to the question: How can the Wesleyan Healthcare Response inspire the FMCSA to respond to the HIV and AIDS pandemic from a gender-sensitive perspective?

This question gives rise to the following three operational questions:

1. In which way is the FMCSA responding to the HIV and AIDS pandemic in Southern KwaZulu-Natal?
2. To what extent has the WHCR been used by the FMCSA as a resource to respond to HIV and AIDS in SKZN?
3. How can the WHCR function as an effective resource for addressing HIV and AIDS in the context of the FMSKZN?

Therefore, the objectives formulated for this study are to:

1. explore discursive accounts of HIV and AIDS and its gendered nature in South Africa and the response of the FMCSA to this;

13 See details of these explanations in Chapter 3.

2. critically reflect on the WHCR as the FMCSA's potential resource for *missio Dei*'s fulfilment in HIV and AIDS;
3. examine the attitude and concrete response to the HIV and AIDS pandemic in the Free Methodist Southern KwaZulu-Natal;
4. assess the extent to which the WHCR has been used as a resource for addressing HIV and AIDS in the Free Methodist Southern KwaZulu-Natal;
5. suggest ways of employing the WHCR as a resource to respond to HIV and AIDS within the Southern KwaZulu-Natal context.

1.7 Brief Methodology

This study includes a mixture of empirical and non-empirical qualitative and descriptive research applied in the form of a case study. Data was collected in five circuits of the FMCSA, SKZN region in 2011 and 2012. The study includes three communities in Pietermaritzburg, Durban and Port Shepstone. Participants included church leaders, caregivers and ordinary adult and youth members. Research tools were two semi-structured interview guides, one designed for church leaders and caregivers, and the other for the rest of the participants.

The sample comprised 17 church leaders and 15 caregivers who were interviewed individually as well as 8 focus group discussions (hereafter FGD) of which 4 were with adults and 4 held with the youth. The sampling methods used to select the participants were purposive sampling (William, 2006), Snowball sampling (Hall and Hall, 1996), and convenience sampling (Hall and Hall, 1996).

The analysis and interpretation followed the model of qualitative research which consists of organizing the data, identifying categories, familiarizing and coding the data, generating themes and interpreting them, and searching for alternative understanding (Rossman and Rallis, 2012:273-287).

During the process of this study, research ethics have been taken into consideration as defined by researchers such as Wassenaaar (2006), Hesse-Biber and Leavy (2011), Rossman and Rallis (2012), and the University of KwaZulu-Natal (2009). Chapter 4 will provide the details of the methodology.

1.8 Concluding Remarks and Outline of Chapters

Chapter 1 serves as the introduction to the thesis and provides an overview of the FMCSA. This chapter highlights some events depicting the genesis of the FMC and its expansion in South Africa. It also presents this Church's missional vocation and commitment for social engagement. This chapter emphasises the importance of this study by outlining its background as well as the research problem and motivation. It also briefly presents the theory of *missio Dei* which serves as the analytical framework for the study, viewed through the lens of the WHCR. This is followed by stating the problem and objectives as well as a brief methodology on the collection and analysis of the data.

Chapter 2 is dedicated to the discursive account of HIV and AIDS in South Africa and the FMCSA's response to this pandemic. This forms the contextual background of the study. Three central issues will be developed in this chapter, namely, HIV and AIDS in South Africa, the gendered nature of HIV and AIDS in South Africa and the FMCSA in an HIV and AIDS discursive debate. This chapter will show that the response of the FMCSA to HIV and AIDS has not yet been documented conclusively.

Chapter 3 will present the WHCR as the FMCSA's potential resources for *missio Dei*'s fulfilment in addressing HIV and AIDS. This chapter constitutes the theoretical and theological framework of the study. It also explores the *missio Dei* paradigm in the context of HIV and AIDS and its gendered nature. The WHCR as the fulfilment of *missio Dei* in HIV and AIDS is also discussed. Following on from these two concerns, the chapter will demonstrate that the WHCR is the FMCSA's potential resource in addressing the HIV and AIDS pandemic. It is also in this chapter that the lack of studies on the WHCR in the context of HIV and AIDS will be noted.

Chapter 4 provides the overview of this study's methodological design. This chapter contains the geographical location of the study, the theoretical paradigms which have informed the study, the process of data collection and analysis, as well as ethical considerations and methodological limitations. The chapter depicts how various assumptions have shaped the design of the study.

Chapter 5 concerns the attitude of the FMCSA towards HIV and AIDS and its gendered nature. It describes the attitude of the FMCSA towards the necessity of the Church to respond to HIV and AIDS as well as the attitude of this Church towards HIV and AIDS and its impact. The other theme discussed here is the knowledge of the participants about gender and its influence on the spread of HIV and AIDS. It is in this chapter that gaps in the use of the WHCR by the

FMCSA in addressing HIV and AIDS begin to manifest, especially in the area of attitudes and theology.

Chapter 6 considers the concrete response of the FMCSA to HIV and AIDS and portrays the results of the study about the response of the FMCSA to the attitude of the community towards HIV and AIDS. It engages in a discourse on the response of this Church in terms of prevention, care and treatment as well as its response to the gendered nature of HIV and AIDS. It also presents the results concerning the health and social initiatives of this Church based on its response to HIV and AIDS. Partnerships in the context of addressing HIV and AIDS will also be discussed here. This chapter identifies shortcomings in the evaluation of the WHCR resource in the HIV and AIDS pandemic, especially in its practical response.

The focus of chapter 7 is the relevance of the WHCR in the FMSKZN's response to HIV and AIDS. This is an evaluation of the fieldwork results based on the study's framework. The FMCSA's use of the WHCR as resource to respond to HIV and AIDS will be assessed. The inspiration of this resource in developing supportive attitudes towards HIV and AIDS, in concretely responding to the pandemic, and in developing gender sensitivity will be explored. In this chapter, various insights from the WHCR will be proposed in order to fill those gaps identified in the FMCSA's response to HIV and AIDS.

Chapter 8 concludes the study by briefly reviewing the main features. An evaluation of this study will be presented using various assumptions proposed by qualitative researchers. The chapter will end with recommendations to future researchers in order to fill the gaps identified through the present study.

CHAPTER TWO

DISCURSIVE ACCOUNT OF HIV AND AIDS IN SOUTH AFRICA AND THE RESPONSE BY THE FMCSA

2.1 Introduction

Chapter 1 provided an introduction to the thesis including an overview of the FMCSA and the background and outline of the research problem. The motivation for the study as well as the principal theory, questions and objectives, brief methodology and a comprehensive outline of the study were also presented.

The intention of chapter 2 is to provide a discursive account of HIV and AIDS in South Africa and the FMCSA's response to this pandemic. The outcome here is the overall context of the present study and the *raison d'être* for undertaking it. In order to achieve this, three subjects that emerge from the title of this study will be examined, namely, HIV and AIDS in South Africa; HIV and AIDS as gendered issue in South Africa; and the FMCSA.

The development of this chapter follows a systematic process. Borrowing from the analysis methods of archaeology and genealogy of the French philosopher, Michel Foucault (Shumway, 1989), two steps are used to analyse each subject. Firstly, the historical emergence and changes to the phenomenon covered by the subject with respect to genealogy are traced (Ossen et al., 2004:47-49). Secondly, various discourses are analysed in order to show the depth of the documentation of the phenomenon with respect to archaeology (Ossen et al., 2004:45-47). In this way, the first discursive gap to be addressed in this study will be identified.

This chapter is organised into four sections. Section one presents a Foucauldian analysis of archaeology and genealogy while underlining their importance and use in the present study. Section two explores discourses on HIV and AIDS in South Africa to highlight the need for further research in this area. In section three HIV and AIDS is analysed as a gendered issue in South Africa. Section four explores the literature on the FMCSA in order to clarify the extent of the documentation of the FMCSA's response to HIV and AIDS. The contents of this chapter are resourced from existing literature.

2.2 Analysis Methods: Foucauldian Archaeology and Genealogy

The objective of this section is to explain the Foucauldian analysis methods, 'archaeology' and 'genealogy' and to highlight their role in this study. These methods have been widely discussed and applied by many scholars, including Shumway (1989), Apperley (1997), Harootunian (1998), Barrett (1991), Thacker (1997), Preece (1999), Besley (2002), Ossen et al. (2004), Salanjira (2009), Scott (2009), Veyne (2010), and Chrulew (2010).

Besley (2002:11) states that Foucault began using the concept of archaeology in his early works, especially in *The Order of Things* (1970) and *The Archaeology of Knowledge* (1972). The specific meaning of this concept can be retrieved in the interview between Foucault and Brochier in which Foucault (1989:45) states:

> After all, this word "archaeology" can almost mean – and I hope I will be forgiven for this – description of the archive. I mean by archive the set (l'ensemble) of discourses actually pronounced; and this set of discourses is envisaged not only as a set of events which would have taken place once and for all and which would remain in abeyance, in the limbo or purgatory of history, but also a set that continues to function, to be transformed through history, and to provide the possibility of appearing in other discourses.

Four salient points can be drawn from this excerpt, these being, the object of archaeology is discourse; archaeology describes discourses already pronounced about events or phenomena; these discourses and events/phenomena may have passed or are still on-going; these discourses and events/phenomena may change with time and require new approaches.

In addition to the term 'discourse' as the subject of archaeological analysis, Ossen et al.(2004) suggest other terms such as 'presuppositions of a given system of thought' (:45), 'ways of looking at the world' (:46), and 'theoretical knowledge' (:47). Moreover, they specify that the attempt in archaeology is, "to trace links between the different domains of 'life, work, and language', revealing relationships that are not readily apparent" (:47). As they elaborate, they also present these 'links' and 'relationships' as "rules of formation of discourses, or discursive systems" (:46). Convincingly, their argument is that archaeology is concerned about thought and knowledge as well as their connectivity.

While the meaning and the object of archaeology are specified, the literature goes on to delineate what archaeology is not and what it does not do. In the above-mentioned interview, Foucault (1989:46) elaborates on this point:

> It is always the relative beginnings that I am searching for, more institutionalizations or the transformations than the founding or foundations. And then I am equally bothered by the idea of excavation. What I am looking for are not relations that are secret, hidden, more silent or deeper than the consciousness of men (sic). I try on the contrary to define the relations on the very surface of the discourse; I attempt to make visible what is invisible only because it is too much on the surface of things.

It emerges that archaeology is not concerned with what is 'hidden and invisible', nor is it concerned about the very origin of discourses or thought. Instead, it is concerned about what is not perceived because there is no established order of considering them.

In the same vein, Shumway (1989) and Besley (2002) highlight the difference between archaeology and the history of ideas. While the latter uses models of consciousness, creation, evolution or development to explain changes and differences, the former strives to discover the transformation system which shapes changes in human sciences (Besley, 2002:13; Shumway, 1989:98).

Within this debate, Ossen et al. (2004) express the veracity of discourses which are analysed. They point out that in fact, archaeology analyses, not what is claimed to be true in knowledge, but rather the truth game. This means that, as they clarify, archaeology analyses operations of rules that bring discourses into being as well as the way discourses are ordered (:46). For Ossen et al. (:46) some core questions of archaeology are: "Why at different periods specialists in knowledge perceive objects differently?" and "how is it that one particular statement appears rather than another?" In addition, Shumway (1989) evokes three other questions suggested by Foucault in order to define enunciative modalities: "who is speaking?"; "From what institutional site is he *[sic]* speaking?" "What is his *[sic]* [author] relationship to the objects of his discourse?" (:101). It therefore appears from this account that archaeology provides a range of issues to consider when analysing discourses. These issues have inspired the present study, in particular, the development of this chapter.

Besides archaeology, genealogy is another Foucauldian method of analysis which has informed the shape of this study. Apperley (1997:17), Thacker (1997:30) and Besley (2002:13) locate Foucauldian genealogy circa 1970s. They explain that this method constitutes a Foucauldian shift in emphasis from discourses and discontinuity as well as rules that govern the formation of discourses to social practices, institutions, and technology. Their point here is that at this time, Foucault was no longer interested in mere archaeological analysis and had begun to embrace a new approach. In addition, authors such as Shumway (1989), Besley (2002) and Ossen et al.

(2004) observe that the word genealogy was borrowed from the biological field by the German philosopher, Friedrich Nietzsche in his work *The Genealogy of Morals* edited in 1956. He was describing "morals as having an historical 'descent' rather than being 'immobile forms' existing from the beginning of time" (Ossen et al., 2004:109). According to Besley (2002:13), Nietzsche's works, in particular, *The Genealogy of Morals* profoundly influenced Foucault, which resulted in him maintaining and using the term 'genealogy.'

Concerning genealogy as a method of analysis, Besley (2002:13) suggests that it traces "the historical process of descent and emergence by which a given thought system or process comes into being and is subsequently transformed." Besley implies that the genealogist explores historical aspects of a given thought. It appears that although discourses may be used in genealogical analysis, they are not the focus which has now become the historical background of a phenomenon.

However, as such, genealogy is not interested in the past. As Besley (2004:14) elaborates further:

> Genealogy seeks to explain present-day cultural phenomena and problems by looking to the past and analysing how it was derived and constituted historically. It not only looks at who we are at present but also opens up possibilities of what might be and from where we might start to be different in the present.

This method therefore regards the past that explains the current phenomenon under scrutiny.

Shumway (1989), Besley (2002), Ossen et al. (2004) have also pointed to the difference between genealogy and traditional historical analysis. From their observations, two main differences emerge. The first difference resides in the search for the origin of a phenomenon. According to Shumway (1989:109) and Ossen et al. (2004:48), unlike historical analysis, genealogy avoids the search for origin or essence. The reason for this rationale is that this would be an attempt to capture the exact essence of things, which in turn would be an assumption of the existence of "immobile forms that precede the external world of accident and succession" (Shumway, 1989:109) or would simply be reinstating Platonic essentialism (Ossen et al., 2004:48). According to genealogists, "what is found at the historical beginning of things is not the inviolable identity of their origin; it is the dissension of other things" (Shumway, 1989:109). Hence, in order to avoid this essentialism, genealogists focus on tracing processes of descent and emergence (Ossen et al., 2004:48).

The second difference is found in historical elements observed during the analysis. Foucault (1971) warns that genealogy differs from the evolution of a species and the map for people's destiny. In this way, it avoids focusing on the evolution and process of development (Besley, 2002). As was seen above, its emphasis is rather on the descent and emergence (Ossen et al., 2004:48). However, Besley (2002:14) points out that, "the analysis of descent involves a move backward in time to reveal the many events, struggles, complexity, fragility, contingency, and continuities that exist behind historical beginnings." Likewise, Smart (1985) rejects the meaning of emergence as "a culmination of events, or as the end of a process of development." Instead, he takes it "as a particular momentary manifestation of the 'hazardous play of domination' [...] as transitory 'episode in a series of subjugations,' or embodiments of dynamic relationships of struggle"' (:57).

Reading from these two different perspectives, it appears that genealogy does not provide the entire history of a phenomenon from its very essence up to the current situation. Instead, it rather selects certain episodes and events that mark changes during the evolution of the phenomenon.

It is now clear that while archaeology focuses on discourses, genealogy focuses on phenomena. However, although some critics argue that in the 1970s, Foucault's priority shifted from the field of knowledge to practice, thus from archaeology to genealogy (Apperley, 1997:17; Shumway, 1989:107-108), Ossen et al. (2004:45, 47) warn that genealogy must be viewed as supplement to, and not as an alternative to archaeology. This warning reiterates exactly what Dreyfus and Rabinow (1983:104), emphasised twenty-one years ago that '*There is no pre- and post- archaeology or genealogy in Foucault.*' Their remark therefore is in agreement with Foucault's own observation that:

> [A]rchaeology and genealogy might be complementary, and hinted that each might be mapped on to a branch of the power/knowledge dyad, genealogy concerning itself with power whilst archaeology concerns itself with knowledge (Foucault, 1980).

This means that in his view, Foucault suggests that the two methods, archaeology and genealogy, should be applied in parallel because neither one is complete on its own to produce a reliable analysis.

In view of these remarks, both methods are referred to in order to analyse the social and discursive context of the present study. Five points summarise the inspiration of these methods in the present study. Firstly, each contextual subject emerging from the title of the present study

in both vertical and horizontal ways is explored. The vertical analysis consists of regarding the phenomenon in its historical emergence as permitted by genealogy. Likewise, the horizontal analysis consists of looking at the range of discourses about the subject in its different aspects as made possible by archaeology. Secondly, in the present study, the historical analysis does not necessarily provide the origin, evolution or development of the phenomenon analysed, but some episodes that mark shifts. Thirdly, the analysis does not excavate unknown or hidden events of the phenomenon, but instead deals with what is already known and pronounced through previous discourses. Fourthly, the content of analysis may not reflect the whole truth about the phenomenon but emphasis is placed on analysing what is assumed in the available discourses. Lastly, all the analysis is conducted with the intention to understand the current phenomenon of HIV and AIDS in South Africa and the response of the FMCSA. In this chapter, the social and discursive analysis concerns HIV and AIDS and its gendered nature in South Africa and the involvement of the FMCSA in responding to this phenomenon. In the next section, these methods will be used to explore the social and discursive context of HIV and AIDS in South Africa.

2.3 HIV and AIDS in South Africa

2.3.1 Introduction

In this section, two questions of importance will be asked: (1) how has HIV and AIDS emerged in South Africa, and (2) What have previous and current discourses revealed about HIV and AIDS in this country? In order to respond to these questions, two steps inspired by two Foucauldian analysis methods, archaeology and genealogy will be followed. The historical emergence and changes of HIV prevalence in South Africa (genealogy) will be discussed. In addition different discourses will be analysed while identifying areas already covered by research with regard to HIV and AIDS in South Africa (archaeology), highlighting gaps that are considered as being in need of further research.

2.3.2 Emergence of HIV Prevalence

According to Denis (2006:21, 22), HIV and AIDS reached South Africa a decade later than in Central and Eastern Africa, but developed more rapidly than in those regions. In his study, Denis notes that while the first two cases of HIV and AIDS infection were diagnosed in South Africa in 1982, the prevalence of infection was estimated at 0.73% in 1990. He asserts that from

that time a rapid increase of infection manifested which was estimated at 10.44% in 1995 and above 20% in 2006 (:22).

As with Denis, Gouws and Karim (2010:61-62) also locate the first documented cases of HIV and AIDS in South Africa in 1982. They conveniently divide the progression of the pandemic into five periods. The first period is situated between 1983 and 1987. During this time, HIV and AIDS was found among male homosexuals and people receiving infected blood products. Zero HIV and AIDS prevalence was observed in rural communities in 1985, amongst sex workers in 1986, and antenatal clinic (*hereafter*, ANC) attendees in 1987. Only three cases of infection were identified among 29,312 mine workers in 1986 (:61). The second period is located between 1988 and 1993. This period was marked by the beginning of a generalised epidemic of HIV-1, subtype C, with the prominence of transmission amongst heterosexuals (:61). They locate the third period from 1990 to 1994. According to their analysis, this period was marked by a steep increase in infections where the rate doubled in one year and reached 10% among ANC attendees in 1995 (:61). 1996 to 1999 denotes the fourth period. According to Gouws and Karim (2010:62), it is in this period that new infections peaked among ANC attendees (See also Gouws, 2010:78). They state that the youth, especially young women, were the most vulnerable. The prevalence was estimated at about 29% among ANC attendees. However, AIDS-related mortality was still low (:62). They identified the last period from 2000 to the present where HIV and AIDS is claimed to have reached saturation. According to their analysis, by 2005, infection rates reached a plateau with the number of new infections, more or less balanced against the number of deaths (:62; Karim, Karim, and Baxter, 2010:46).

It is noteworthy that the numbers suggested by Denis, Gouws and Karim agree with the statistics reported by UNAIDS in 2010. UNAIDS (2010b:28)[14] shows that South Africa had the largest number of people infected with HIV in the world, which was estimated at 5.6 million. According to the report, HIV and AIDS prevalence was 17.8% within the population aged 15-49 years. UNAIDS also reported that South Africa had the fourth highest prevalence rate globally after its three neighbouring countries, Swaziland (25.9%), Botswana (24.8%) and Lesotho (23.6%) (:180, 181). Furthermore, Gouws and Karim's analysis is confirmed by the testimonies of eyewitnesses as reported by Nxumalo (2010) and Sikhosana (2010) who both asserted that in the period 1999/2000, "people were dying like flies" because of HIV and AIDS. Similar information was also suggested in 2011 by Fröhlich (2011:17) who reported that HIV prevalence among ANC attendees had begun to decline from 2005.

[14] These are the figure of 2009 reported in 2010.

While the data provided by Gouws and Karim mostly describe the situation among ANC attendees, Stats SA (2011:5) reveals a different picture in the general population. Its figures portray that for the period 2001-2011, HIV and AIDS prevalence and the number of PLWHA always increased, even among females and males aged 15-49 years. (:5). A similar evaluation was also presented by Karim (2011:4) for the period 1990-2010.

With regard to the emergence of HIV and AIDS in South Africa, it appears that the prevalence rate is increasing in the general population. However, at least three shifts, two of which suggest an improvement, have become evident among ANC attendees. Hence, after the slow pace of prevalence since 1982, the first shift shows a steep increase since 1995 (Gouws, 2010:78). The second shift shows a peak of incidences between 1996 and 1999 and the third with a decline of HIV and AIDS prevalence in 2005 (Gouws, 2010:78; Fröhlich, 2011: 17). It is noted that it is the rate of decline that all the interventions in HIV and AIDS seek to promote and enhance, even among other groups. Therefore, in initiating the present study, the intention was to contribute to this end by reclaiming the WHCR in the FMCSA's response to the pandemic.

2.3.3 Situation of HIV and AIDS

Following this overview of the emergence of HIV and AIDS in South Africa, it is appropriate to ask the question: what has been covered by discourses with regard to HIV and AIDS in this country? The response to this question is divided into four sections. The first section includes an overview on HIV and AIDS prevalence. According to Gouws and Karim (2010) there have been three key research programmes on the spread of HIV prevalence in South Africa. The first is that of ANC surveys. This programme comprises anonymous national annual ANC surveys initiated by the Department of National Health and Population Development in 1990 which involved women attending ANCs for their first pregnancy visit. It also includes annual anonymous ANC surveys in the rural Hlabisa Health District, KZN, conducted between 1992 and 2002 by the South African Medical Research Council in the same months as the national ANC surveys (October and November), to provide consistent comparative data from rural areas (:58-59). The second programme consists of population-based surveys. These were the three population-based surveys conducted in conjunction with the Malaria Control Programme between 1990 and 1992 in rural KZN; the national population-based household surveys undertaken by the Human Sciences Research Council (HSRC) in conjunction with other partners in 2002, 2005, and 2008; and the Carletonville/urban population baseline survey in 1998 and follow-up surveys in 1999 and 2000 (:59-60). The third programme mentioned by these authors

is the research conducted over several years by the HSRC with sex workers at truck-stops in the KZN Midlands and the 1998 cross-section HIV sero-prevalence study with their clients (:60).

Whiteside and Sunter (2000) have also acknowledged the role played by surveys with ANC attendees and commercial sex workers in providing HIV and AIDS prevalence data in South Africa. In addition, they mention that surveys also included blood donors, and people with sexually transmitted infections (hereafter STIs) and Tuberculosis (hereafter TB) (:33). They further recognize the role of the UNAIDS' yearly estimates available on the UNAIDS website, www.unaids.org, and the projections done in 1998 by Metropolitan Life (:54; 69). Those projections also analysed by Love Life during the same year (Love Life, 2000), provide the situation on cross-sectional HIV prevalence in South Africa, including prevalence per sex, race, and provinces as well as AIDS-related mortality and orphan rates.

In addition, there are sporadic researches on HIV prevalence in selective communities such as those conducted by Myers (2010:6) in higher education, as well as by Lane et al. (2011:626), Rispel et al. (2011:69), and Baral et al. (2011:1) with male homosexuals respectively in Soweto, Johannesburg and Durban, and Cape Town. However, Gouws and Karim (2010:55, 59) note that the most extensive data are those provided by ANCs although these data are subject to bias as they exclude males and females who do not use ANCs (see also Love Life, 2000:2; Stats SA, 2011:4). It therefore appears that there exists a gap in the systematic knowledge about HIV and AIDS prevalence in groups other than ANC attendees that research needs to fill. This gap is likely to have a negative impact on responsive strategies.

The second section of the response concerns factors determining the spread of HIV and AIDS. Authors such as Barnett and Whiteside (2006), Echenberg (2006), and Kocheleff (2006), identify South African economic and political systems as key role-players in the spread of HIV and AIDS, especially among black people. They show that the apartheid system prevented black people from having sufficient access to healthcare and other resources (:149) and had created a migrant labour system under which black workers could not be accompanied by their spouses, which encouraged prostitution (Echenberg, 2006:89). Kocheleff (2006:150) also points out that under the de Klerk government, the structure established to diffuse information on STIs and HIV and AIDS was stopped and media messages changed into English and Afrikaans languages that many black people could not use. This government was also said to have hired HIV positive men to infect sex workers in Hillbrow, Johannesburg (Barnett and Whiteside (2006:165-166).

However, no study has been able to provide conclusive researched estimates determining the apartheid system's role in the spread of HIV and AIDS among Black communities.

As regards the South African National HIV and AIDS Survey (2008), Gouws and Karim (2010), and Fröhlich (2011), age is another important factor in the spread of HIV and AIDS, with the youth being the most vulnerable. At this point, Fröhlich (2011:17) demonstrates that from 2001 up to 2010, age groups 25-29 and 30-34 always registered the peak in HIV prevalence among the Vulindlela ANC attendees. According to the HSRC (2002:69) and Harrison (2010:307), this high HIV prevalence among young people is due to bodily changes brought on by puberty and curiosity about sex whilst sexually inexperienced and unable to negotiate safe sex. For Warren and Hajiyiannis (2008:8), it is due to the shortage of financial means among the youth which adults take advantage of to impose unprotected sex on them. One may ask, what makes the prevalence of HIV and AIDS lower among adults that engage in unprotected sex with these youngsters? One can argue that some infected young people die of AIDS-related diseases before reaching adulthood and that the current adult population are those who have survived. However, more clarification is still needed in this regard.

Discourses also identify the kinds of sexuality practiced as factors in the spread of HIV and AIDS. Phiri (2003a), Denis (2006), and Buvé (2006) include here the practice of dry sex. According to their research, the HIV infection risk resides in the tearing of the vaginal mucous membrane that provides entry for viruses (Phiri, 200a3:10-11; Buvé, 2006:47-48). Denis (2006:24) also observes that dry sex contributes to the high prevalence of HIV in the KZN Province. Moreover, authors such as Love Life (2000), Kenyon et al. (2010) and Karim (2010) suggest concurrent sexual partnerships, arguing that one man can infect many women. But Mcetywa (2000) and Denis (2003) reject this factor if the traditional rules of the practice of polygamy are respected. In responding to them, Phiri (2003a:12) rejects their suggestion, stating that African culture encourages men to have sex with limitless partners, even when one is already in polygamous relationships. Furthermore, Makhubele and Parker (n.d: 2, 6) also mention anal sex as increasing the vulnerability to HIV infection. However, with all these authors, no statistical evidences were provided to show the actual role played by the kind of sex practiced in HIV infection. It is therefore argued that the risk of HIV infection does not lie in the *kind* of sexuality practiced but in the practice of unsafe sex itself.

Moreover, Gouws and Karim (2010) suggest population density as another factor in the spread of HIV and AIDS in South Africa, the most vulnerable being areas of high population density.

Hence, they find high rates of HIV in Durban and Hlabisa in KZN, Port Elisabeth in the Eastern Cape, Johannesburg in Gauteng, Cape Town in the Western Cape, and Welkom in the Free State (:53-65). Here, they share some views with Denis (2010:134) who suggests that the KZN Province is greatly affected because of its strategic location through which the N3 national highway runs. However, their mapping leaves several unanswered questions. Does this imply that in southern Africa where HIV prevalence is estimated the highest globally, the population density is also the highest? Is it in KZN, the province known as the most affected by HIV in South Africa that the population density is the highest? Data on population density displays negative responses to these questions (Population Density per Square Mile of Countries, 2007; The Nine Provinces of South Africa (n.d.)).[15] In the same vein, Kleinschmidt et al. (2007:1165) observe that population density is not sufficient to determine HIV prevalence because other factors such as race and socio-economic aspects also play a decisive role here. As a result, research has yet to clearly show the exact role that population density plays in HIV and AIDS prevalence in South Africa.

Barnett and Whiteside (2006) suggest that social cohesion combined with financial wealth also constitute a contributing factor (See also Manning, 2002:24). They argue that HIV infection is high in communities with low social cohesion and low wealth as well as in low social cohesion and high wealth communities. They therefore classify South Africa in the latter category (Barnett and Whiteside, 2006:96). They elaborate that South Africa is the third wealthiest country in Africa after Gabon and Botswana (high wealth) but with institutionalized inequality characterized by racial discrimination after 1948, a mobile population, breakdown in social structure, wealth and lifestyle inequality, crime, violence, and rape (low social cohesion) (:131-132; 159-167). This analysis has similarities with the socio-political factors as described earlier, especially concerning inequality in wealth and limited access to health facilities. This indicates that addressing the problem of inequality and low social cohesion in South Africa would have a positive impact on the response to HIV and AIDS.

Furthermore, De Waal and Whiteside (2006) regard HIV and AIDS in South Africa as a Darwinian event. They demonstrate that some people, especially those who habitually think or act in the short term, are not sufficiently equipped to profitably respond to the natural selection

[15] Data of 2007 show that Southern African countries do not appear among countries with high population density globally (See Population Density per Square Mile of Countries, 2007). Likewise, data on population density in South Africa show that though KwaZulu-Natal Province is the second in high density after Gauteng, it is far from being considered the first in HIV prevalence if only the population density is considered. This is because the density in Gauteng is 5.5 times higher than in KwaZulu-Natal (See, The Nine Provinces of South Africa (n.d.)

in which only the fittest survives, and thus are at high risk of infection (:62). They conclude that demographically, the HIV and AIDS pandemic is a Darwinian event but they recognise the existence of other economic and social consequences (:72). This shows that much effort is needed to help people to successfully survive during this natural selection. But viewing this factor as well as all other factors described above, no author was able to statistically evidence the role of any factor in HIV prevalence. Therefore, further research is required to clarify this issue.

The third section concerns the impact of HIV and AIDS. Gray et al. (2010) locate the impact of HIV and AIDS in physical life. For them, in the absence of treatment, HIV and AIDS weakens the immune system of the body leaving the infected person open to many diseases and associated sufferings thus exposing them to premature death (:127). Similarly, Stats SA (2009:11) demonstrates that since 2001 up to 2011, the KZN province, as the most affected by HIV and AIDS in South Africa, has had the lowest life expectancy at birth, estimated at 50.6 from 2001 to 2005 and at 51.0 from 2006 to 2011 in females. The highest life expectancy at birth was estimated at 66.5 between 2001 and 2005 and 67.9 between 2006 and 2011 in the female population of the Western Province known to be the less affected of HIV and AIDS. In the same vein, Dubula (2011) compares South Africa with Brazil, highlighting that from 1991 to 2011, the life expectancy at birth in South Africa has fallen from 63 years to 52 years while it was 71 years in Brazil. Dubula attributes this decline to the HIV and AIDS pandemic.

The impact of HIV and AIDS on social structures and relations is also discussed by Skinner and Mfecane (2004), Peltzer (2008), Fröhlich (2010), and Du Preez and Niehof (2010). Flöhlich (2010: 374) observes that HIV and AIDS undermines the fundamental social fabric by changing roles initially played by particular categories of people. Here, she refers to the dropout rate of scholars in order to take care of adults suffering from AIDS related diseases; the education of children by single mothers or widows instead of both parents and by grandparents instead of parents because the adults are no longer able or have died (Flöhlich, 2010: 374. See also Stats SA, 2006:16, Teljeur, 2002:59). Regarding social relations, Parker and Aggleton (2003:14-17), Parker and Birdsall (2005:5), Gill (2007:19-20), and Wittenberg (2007:152) focus on HIV and AIDS related psychological disturbances, stigma and discrimination against people infected and their relatives.[16] Likewise Haber et al. (2011:545) point to the stigma by association experienced by healthcare providers who offer services to HIV positive people. However, although these

[16] As an example, Skinner and Mfecane (2004:160) recall people threatened because they are HIV positive, including Gugu Dlamini murdered in 1998 in Durban when she disclosed and Lorna Mlofane murdered in 2004 by her three rapists when they learnt that she was HIV-positive.

authors confirm the existence of a HIV and AIDS-related stigma and discrimination, Lamula (2011) underlines that the discriminative behaviour is declining.

According to Booysen et al. (2003), Whiteside (2010), Seeley et al. (2010), and Du Preez and Niehof (2010), the HIV and AIDS impact is observed at both micro- and macro-economic levels where the number and capacity of producers and providers decreases while the expenditure increases. As an example of the effects on the micro-economy, du Perez and Niehof (2010:47, 49) cite a case from KZN in which, Bongi, a 47 year old HIV-positive woman lived with eight dependents. She was initially employed in a small shop and used to sew and grow vegetables. As she gradually lost the capacity to work, she stopped these income-generating activities to depend only on one child's support grant. In this household, some dependents were also HIV positive and needed special attention. As to the effects on the macro-economy, Whiteside (2010) quotes ING Baring's predictions as follow, "AIDS will cause the economy to grow more slowly. GDP [Gross Domestic Product] growth in 2001 will be 0.3% lower because of AIDS, and for the period 2006 to 2010 it will be 0.4% lower each year" (:421). It is therefore clear that the pandemic affects the South African economy at every level.

Discourses indicate the HIV impact on many other sectors. The Department of Health (2002), Metropolitan Holdings Limited (MHL) (2006), Ministry of Health (2008), and Colvin (2010) highlight the impact on the health system (see also Healthcare in South Africa, n.d.). Myers (2010) underlines its impact on education, Strand and Chirambo (2005) and Barnett and Whiteside (2006) on governance, and Singh (2010) on ethics. The overall observation in these discourses is that HIV and AIDS has negatively impacted on almost all aspects of life. Hence, a concerted response is required in order to preserve the wellness of the people.

The last section of the response to the question pertains to the reaction to HIV and AIDS in South Africa. Van Houtain (2006) conducted research on the behaviour of South Africans in reaction to HIV and AIDS. Using the model developed by the Business Exchange on AIDS and Development Group (hereafter, BEAD), he found four gradual stages in the population's acceptance of the disease. In the 'invisible epidemic' stage, the population was denying the disease and the need for practicing safe sex. During the 'awareness' stage, they recognised the disease's existence but thought it affected 'others' only. During the 'acceptance' stage, they accepted it as threat and began caring for the sick but did not change their sexual behaviour. In the last stage of 'behavioural change,' they fully understood that any sexually active person is at risk of being infected (:167-168). This description is unfortunately not distributed according to a

timeline. However, it can assist in locating phenomena identified by other authors on a timeline. Therefore, the second period of 'awareness' mixed with denial may correspond with the murder in 1998 of Gugu Dlamini in the KZN Province after the disclosure of her HIV positive status (Fröhlich, 2010:377). As with this event, one can also confirm the suggestion by Denis (2006:2) that the spread of AIDS occurred later in South Africa than in East and Central Africa, because by that time, a broad and collective response to the pandemic had already been initiated at international level (Carael, 2006:20-37).

In addition to the population's gradual acceptance of the pandemic, authors such as Hickey (2002), Kocheleff (2006:150), Heywood (2010), and Gouws and Karim (2010:61-62) point out similar attitudes among the country's leadership. They underline reluctance, opposition and the negligence of apartheid leaders to effectively respond to HIV and AIDS, as well as their active participation in infecting the population (Barnett and Whiteside, 2006:165-166). Karim and Baxter (2010a) inform that because of this attitude, the African National Congress's members in exile and within the country as well as other anti-apartheid organizations, expressed through the Maputo Statement (Maputo Statement, 1990) the need to prioritize HIV prevention. As a result, the National AIDS Convention of South Africa (hereafter, NACOSA) was created in 1993 with joint coordination of apartheid and anti-apartheid AIDS activist representatives (Karim and Baxter, 2010a:41).

However, as Karim and Baxter (2010a:41, 42) remark, the democratically elected government in 1994 did not significantly support the NACOSA plan of addressing the pandemic, although it had adopted it as credible for the country's reconstruction and development. In 1998, the African National Congress-led government also failed to fund the provision of the zidovuzine, antiretroviral used to prevent mother-to-child transmission (:41). As to the second government instituted in 1999, Van Houten (2006:166-167) and Karim and Baxter (2010a:42-43) recall former president Thabo Mbeki and health minister Dr. Manto Tshabalala-Msimang's denial of HIV being the cause of AIDS. However, because of the Treatment Action Campaign (hereafter, TAC) and its supporters, antiretroviral therapy (hereafter, ART) has been available since the 2000s (Echenberg, 2006:95; Karim and Baxter, 2010a:42). According to Karim and Baxter (2010a:43), the Jacob Zuma-led government elected in 2009 was an improvement on the previous dispensations, especially in promoting ART. In 2003 a decision was made to provide ART free of charge in public services (Karim and Baxter, 2010a, 42-43) but the treatment only began to expand in mid-2005 (Fröhlich , 2011:7). In August 2011 under the Zuma government, ART was extended to all patients with a CD4 count of 350 (:7). It is therefore evident that there

has been an improvement in the attitudes of the South African population and the Government towards the pandemic.

In addition to the attitude towards HIV and AIDS in South Africa, various discourses also inform about effective responses, especially with regards to prevention and treatment. Concerning prevention, authors such as Myer (2010) and Kalichman and Lurie (2010) conducted research on behavioural strategies including sexual **A**bstinence, **B**eing faithful to a sexual partner and use of (male and female) **C**ondoms (hereafter ABC). Heath (2009:71) criticises this strategy of feeding stigma by focusing on sex and sustaining a false belief of total safety once faithful. However, according to UNAIDS (2010b:64, 70) and Gouws and Karim (2010:66), the use of condoms has contributed significantly to stabilising the HIV prevalence in ANC attendees since 2005. Within behavioural strategies, Kalichman and Lurie (2010) also include the 'Behavioural Positive Prevention' consisting of working with PLWHA, but noting that this can be effective only if implemented as part of a broad HIV and AIDS prevention plan rather than in an isolated fashion (:265).

Nattrass (2004) and Coovadia (2010) have also discoursed on bio-medical-based preventive strategies that comprise of mother-to-child transmission prevention (hereafter, MTCTP), pre-exposure prophylaxis (hereafter, PreP) and post-exposure prophylaxis (hereafter, PeP). At this point, UNAIDS (2010b:10) appreciates that in 2010, South Africa covered almost 90% of MTCTP. However, studies on PreP and PeP remain scarce in South Africa (Aidsbuzz, 2012; Whiteside, 2012; Hallett et al. 2011; Cohen et al. 2011; and Kim et al. 2007).

Prevention strategies appearing in discourses also include those mainly applied to sexual matters, namely, the control of STIs, microbicides, and male circumcision. For Coetzee and Johnson (2010:216), studies have not yet conclusively determined the level of effect of the control of STIs on HIV prevalence. As to microbicides, Karim et al. (2010:1168), estimate their capacity to reduce HIV infection by 39% overall and by 54% in women with high adherence. Karim and Boxter (2010:268) observe that microbicides fill the gap for female-controlled prevention methods and are likely to be available before the effective vaccine. However, this strategy is still on trial in order to definitely determine its effect at national and international levels (Joint summary, 2007; The Lancet papers for the year 2010, 2011; Whiteside, 2012). Concerning male circumcision, Auvert et al. (2005:112) suggest that it can play a definitive role in the protection against HIV infection. Whiteside (2012) estimates this protection at 64%. However, the

implementation of this strategy is still facing cultural obstacles and health services limitations (Karim and Baxter, 2010b:268).

Discourses also mention preventive strategies in dealing with blood and needles, namely, vaccines, needle exchange, and blood control. At this point, Karim and Baxter (2010b:269) admit that despite clinical trials of HIV vaccines having started two decades ago, no promising result is available to date (See also Nieuwoudt, 2008; Jones, 2009; Brand South Africa, 2009; and Chibba, 2011). Legget (2010:246) explains that the needle exchange strategy consists of encouraging users to return old needles and obtain new needles free of charge, hoping that if they always have new needles, the need to exchange these will be reduced. Legget (2010:240) observes that this strategy has not yet been tried in South Africa because injecting drug use has not yet become a major threat in spreading HIV in this country. As to blood control, Heyns and Swanevelder (2010:226) note that South Africa has a single blood transfusion service administered by the National Health Act. The country ensures a safe supply of blood donated by volunteers selected among people at low risk of HIV infection. Because of this, South Africa has maintained a safe blood supply comparable to most wealthy countries (:239).

What emerges from this exploration of discourses on HIV prevention is that most of the strategies are still under scrutiny and no one strategy is expected to suffice on its own. Therefore, as long as there are new infections taking place in South Africa (Karim, 2011: 4), research on HIV prevention needs to continue.

As with prevention, another discursive insight regards the treatment of the AIDS disease. According to Van Houten (2006:166) the TAC fought for ART since its launch in December 1998. As a result, ART adherence has steadily improved, albeit slowly, due to the resistance shown earlier by the erstwhile Mbeki government (Karim and Baxter, 2010a:41-43). As shown by Stats SA (2011:4), the number of adults (15 years and older) and children adhering to ART has increased since 2005 and new adherents were more than one hundred thousand from 2006 and more than two hundred thousand from 2008 onward. In 2005, estimates for adults on ART were 101,416 and 11,959 for children. In 2008, they were 609,762 for adults and 68,788 for children. In 2010, they were 1,058 399 for adults and 105,123 for children.

As part of the treatment, ART is enhanced by other programmes. In this regard, Maartens (2010) and Churchyard and Corbett (2010) underline the importance of treating opportunistic infections and its allied efforts to address tuberculosis in South Africa. Likewise, Visser (2010) points to

some studies conducted on the nutrition of PLWHA emphasizing the importance of nutritional intervention in the early stages of HIV infection.

One can therefore argue that the pace of ART improvement constitutes a sign that South Africa is dedicating much more effort to addressing the HIV and AIDS pandemic. Even though, discourses show that the provision of ART has faced some obstacles. Mitchell et al. (2007) raise issues of stigma which has been preventing people in the Eastern Cape from freely using public clinic services or following the advice of their physicians. In KZN, obstacles to ART were associated not only with stigma but also with alcoholism, poverty and the excessive distances to public clinics (Sikosana, 2010).

Before concluding this overview of the response to HIV and AIDS in South Africa, it is noteworthy that discourses manifest some strategies overlapping both prevention and treatment. These include the Voluntary Counselling and Testing (hereafter, VCT). In this regard, a recent study conducted by Maheswaran et al. (2012) in KZN compared the effectiveness of home versus mobile VCT. They concluded that both services are to be promoted as each one was found appropriate to a particular category of population, namely adults and people living in partnership for home services, and young singles and males for mobile services. Another recent study was that conducted by Nglazi et al. (2012) in rural Cape Town, comparing the effectiveness of mobile VCT with and without incentive to clinic-based VCT. This study also concluded that mobile services with incentive may reach more people previously not tested than the other two services. These studies reveal that much research is needed in order to allow more people to benefit from programmes addressing HIV and AIDS in South Africa.

Another strategy overlapping prevention and treatment is SAVE, which refers to the use of **S**afer practices, **A**vailable medical interventions, **V**CT, and **E**mpowerment (Heath, 2009:71-72; PACSA, n.d.:12). According to Heath (2009:71), the SAVE strategy was developed by the African Network of Religious Leaders living with or personally affected by HIV and AIDS (hereafter, ANERELA) as an alternative to the ABC strategy, which was proven to be inadequate as discussed above. The SAVE strategy seems to be a combination of all the preventive, curative, socio-economic, cultural, religious and political strategies.[17] In this way, it responds well to the claim of Karim and Baxter (2010b:268) and Whiteside (2012:2) that in order to be effective in addressing HIV and AIDS, no single strategy is able to address HIV and AIDS - all the strategies need to be applied at the same time.

[17] To be discussed further in Chapter 3.

Concerning the notion of taking into account all the strategies, Fröhlich (2011:11), Whiteside (2010:418), and Low (2011:20) find the allocating of funds problematic. They complain that a lot of money is allocated to treatment while prevention programmes are underfunded. In this regard, Low (2011:20) compares the health systems in South Africa and Brazil considering that both countries spend almost the same percentage of their GDP per capita on healthcare. Low therefore observes that infant mortality, life expectancy and HIV prevalence are far worse in South Africa because this country focuses on care whereas Brazil prioritizes prevention. When considering the HIV and AIDS and STI Strategic Plan for South Africa 2007-2011 (Stats SA 2007:111-112) this imbalance of funding between HIV prevention and treatment becomes evident. Here, provision for prevention is 12% for low cost and 11% for high cost while it is respectively 88% and 89% for treatment. However, in the South African development plan for 2030 (Republic of South Africa, 2012), both preventive and therapeutic interventions for HIV are being planned.[18] The question here is to know what financial provision is allocated to each strategy. It is therefore argued that if all the strategies are to be equally valued, the South African allocation of funding in prevention and treatment should be reviewed.

The other challenge raised by Low (2011) and Wilson and Fairall (2010) consists of the imbalance in accessing health facilities. According to them, much money, the best equipment and health professionals are concentrated in the private sector used by a minority of the population. However, the government has begun to address this problem by suggesting the creation of a National Health Insurance (NHI) scheme (Low, 2011)[19].

In conclusion, HIV prevalence has been and constantly increasing since the discovery of the first cases in 1982. However, it has started to decline among ANC attendees who are systematically monitored. It has therefore been argued that research is yet to provide systematic information about HIV and AIDS among other categories. The other argument is that more research in all aspects of the pandemic is needed on an ongoing basis in order to document the development of strategies to adequately address the pandemic. As a consequence, this study presents an additional potential strategy to address HIV and AIDS in this country by proposing the WHCR model to respond to the needs of the people. Since this study embodies a gender-sensitive

[18] The target for HIV for 2030 is: "Average male and female life expectancy at birth increased to 70 years as a consequence of progressive improvement in evidence-based preventive and therapeutic interventions for HIV." Strategies to achieve this target are: "All HIV-positive individuals on ARVs; consistent condom use; effective microbicide routinely available to all women 15 years and older; universal availability to pre- exposure prophylaxis" (Republic of South Africa, 2011:297).

[19] The National Health Insurance (NHI) scheme is a new model of health insurance by which the money will be collected and used on health services and will allow everyone to be cared for without paying for medical treatment (Low, 2011:3; Republic of South Africa, 2011:307-308).

perspective on dealing with the health challenge, it is important to also consider the gendered nature of HIV and AIDS in South Africa.

2.4 The Gendered Nature of HIV and AIDS

2.4.1 Introduction

The aim of this section is to explore the gendered nature of HIV and AIDS in South Africa. Inspired by Foucauldian analysis methods as introduced in the previous section, this section will respond to the following two questions: How has HIV and AIDS emerged among males and females in South Africa? What have discourses thus far revealed about gender aspects of HIV and AIDS in this country? In order to respond to these two questions, the emergence of HIV and AIDS among males and females in South Africa will be identified, and discourses on different gendered aspects of HIV and AIDS in this country will be explored.

2.4.2 Emergence of HIV and AIDS among Males and Females

Whiteside and Sunter (2000), Denis (2006:22) and Gouws and Karim (2010) affirm that the first AIDS cases discovered in South Africa in 1982 were among male homosexuals. According to Gouws and Karim (2010:61), the spread of HIV remained mainly among male homosexuals between 1983 and 1987. Indeed, studies conducted among female sex workers in Gauteng in 1986 and among women attending ANCs in KZN in 1987 did not diagnose any cases of HIV (:61). In 1986, a study diagnosed only three cases among 29,312 male mine workers (:61). Gouws and Karim (2010:61) note that HIV spread among heterosexuals after 1986. The higher prevalence among male homosexuals than among heterosexuals in the early years of the disease in South Africa was also suggested by Whiteside and Sunter (2000:47). They maintain that in July 1991 HIV positive cases were equal among these two groups. From there on, they argue, HIV positive cases continuously increased among heterosexuals (:47). Drawing from these complementary findings, it becomes clear that until 1991, HIV prevalence was higher among men than among women.

A cross-sectional study (Ramjee, 2010:337) conducted in 1998[20] to compare HIV prevalence among female sex workers and their male clients at five truck-stops in the KZN Midlands found both groups with the same prevalence of 56%. For other studies conducted in Carletonville in

[20] Ramjee does not specify the year of the study. However, according to Gouws and Karim (2010:60), a cross-sectional study on HIV prevalence among sex workers' clients at KwaZulu-Natal truck-stops was undertaken in 1998 to compare the prevalence in both sex workers and their clients.

1998 and in three cities of South Africa in 1999 and 2000 (Ramjee, 2010:331), the prevalence was shown to be increasing among the females. It was respectively 68.6% and 78% among female sex workers. Studies among women attending ANCs also displayed a high prevalence of HIV among females. For example, Fröhlich (2011:17) demonstrates that in Vulindlela, KwaZulu-Natal Province, HIV prevalence was 32.4% in 2001, 42.6% in 2004, 40.9% in 2008, and 40.0% in 2010. This shows that when heterosexuals started being infected with HIV, females also became affected. However, other studies show that HIV was not only high among females but also higher than among males. Stats SA (2010:6,7) reports that HIV prevalence in women aged 15-49 has always been higher than in the total population of the same age during the decade 2001-2010 with a steady difference of approximately 3.5%. HIV prevalence estimates for these women were always nearly double the estimates for the total population. As to the study conducted by Kleinschmidt et al. (2007:1165) among young people aged 15-24 in 2007 and Myers (2010:6) in higher education in 2010, HIV prevalence in females was three times higher than the prevalence among males. Finally, following the whole trajectory since 1982, at least two shifts are observed. One change occurred after 1986 where homosexuals and heterosexuals, which included many females, were also infected. The other shift occurred after 1991 where before, males were the group most infected; after that year females superseded the male infection rate

In addition to the higher infection rate of HIV among females when compared to males, discourses stress that females are infected earlier than males. In a study conducted in Carletonville in 1998 (Gouws and Karim, 2010:69) an HIV prevalence close to zero was observed among both males and females under 15 years of age. However, it reached 39% among females aged 20 years while it was 8% among males of the same age. It peaked at 24 years with 58% and at 32 years with 45% respectively. Early higher HIV prevalence among females than among males was also confirmed by studies conducted by Parker and Hajiyiannis (2008:7) in Orange Farm, Gauteng; Laura Myers (2010:21) in South African Higher Education, and The South African National HIV Survey (2008).

Moreover, the gendered imbalance of HIV and AIDS was observed in the mortality rates. According to Stats SA (2006:7, 19, 20) the mortality rate is normally higher in males than in females[21]. But Stats SA reports that between 1995 and 2005 the rate of maternal orphans rose more rapidly than that of paternal orphans (:6). At the same time, Stats SA shows that from 1997, the death rate was rising more rapidly in females than in males. By 2004, the death rate was

[21] The high mortality in males is due to unnatural causes of death such as homicide, suicide and accidents which are normally much higher for young adult males than for young adult females and this is observed in almost all countries (Stats SA, 2006:7).

higher in females than in males aged between 20 and 34 years even though in both sexes the mortality rate was dramatic (:7, 20). Stats SA attributes this inverted curve to the high rate of AIDS-related deaths in females (:7, 19). Therefore, drawing from these accounts, it is argued that HIV and AIDS in South Africa is primarily a gender issue, with women being the most affected in many ways. The question arises: how can discourse explain this imbalance?

2.4.3 Gendered Aspects of HIV and AIDS

The response to the above question is threefold. Discourses explain the reason for female vulnerability to HIV infection through their biological constitution. Phiri (2003a) and Kubai (2008:51) suggest that females naturally have a large surface area of mucosa which is exposed to the sexual secretions of the male during sexual intercourse. These secretions have a high viral load if the male is infected. In addition Phiri (2003a:9) points out that the male semen remains in the vagina for a longer period, and that the infection may continue even after the sexual act. It is therefore possible that under these conditions, the probability of being infected by sexual partner is higher for females than for males.

Secondly, discourses extensively elaborate on cultural aspects that are likely to increase the prevalence and impact of HIV in females than in males. Some of these aspects regard life in partnership and family. Myer (2010), Mills, de Paoli and Gronningsaeter (2009) include here the use of condoms. They argue that many South African men do not want to use condoms during sexual intercourse as they claim it reduces sexual pleasure (Myer, 2010:193). Other reasons that motivate them to prefer unprotected sex is the belief that they are invulnerable and thus do not need to protect themselves with condoms (Mills at al., 2009:1, 7) as well as the meaning given to the marriage as an investment in the future through children (Barnett and Whiteside, 2006:23-24). It is argued that this refusal to use condoms may therefore play an important role in the spreading of HIV and AIDS if it takes place between polygamous partners or among those who also practice dry sex (Phiri, 2003a:10-11; Kocheleff, 2006:151).

According to Phiri (2003a), Momsen (2004:67, 141, 224), and Hawkinson (2009:2) the gendered role division in the family may also contribute to making women more vulnerable to HIV infection than men. As an example, Phiri (2003a:15) considers that gendered role assignment exposes women to HIV infection when they have to care for PLWHA while they are unaware of the fact that without protection they can be infected by the diseased person's blood. Further, as Hlela (2010) points out, some women who care for PLWHA in Pietermaritzburg still ignore this

transmission mode. This may imply that some women are being infected when caring for their household members suffering from AIDS-related diseases.

Besides the family, discourses extend the high exposure of women into the wider community. According to the South African Police Service (SAPS), during the financial years 2010/2011 and 2011/2012, the number of reported incidents of women's sexual abuse respectively totalled 35,820 (2011:3), and 31,299 (n.d.:slide 38). With regard to this, Phiri (2002; 2000), Onyejekwe (2004), and Amnesty International (2009) argue that due to cultural reasons, not all cases of abuse are reported. This means that the actual number of abused women within and outside the domestic relationship is higher than the estimates based on reported cases. Connecting abuse to HIV infection, Human Rights Watch (2004:12) states that when the vagina or anus is dry, as in the case of rape, forced sex causes physical injury, thus creating the possibility for infection if the abuser or the victim of abuse is already infected. Moreover, they show that in the case of abuse, condom use is rarely an option (Human Rights Watch, 2004:13). As confirmation to this, Karim (2010:300) finds that in some locales in South Africa, HIV-positive women attending health services are "about ten times more likely to report violence compared with similar aged HIV-negative." One can therefore infer from these figures and studies that violence or abuse within and outside the family is an important factor in HIV infection among women.

Apart from women, discourses show that female children are much more exposed to HIV infection than male children. The earlier mentioned report of the SAPS (2011:11) shows that in 2010/2011, 51.9% of the contact crimes committed against children were sexual offences. Of these, 76.1% were committed against children aged between 15 and 17 years, 60.5% (for the year 2008/2009) to children below 15 years and 29.4% to children aged between 0 and 10 years of age. This situation was repeated in 2011/2012 where of 50,688 offences against children, 25,862 (51%) were sexually related (n.d.:slide 36). This shows that no single category of child is spared from sexual abuse in South Africa. And, as they explain, sexual offences against children under 18 years have been on the increase since 2008/2009 (2011:12). While these reports do not differentiate between male and female children, the study conducted on Childhood Forcible Sexual Abuse in Northern Province (Madu, 2001:1, 5, 15-16) has shown that 15.7% of girls had been abused as opposed to 8.8% for boys. These statistics add credence to the notion that female children face a higher risk of exposure to HIV than male children.

Speaking on the exposure of girl children to HIV infection, Phiri (2003a), Vitillo (2007:35), and Ackermann (2008:105) also refer to girl-child marriages normally arranged by families with or

without the child's consent[22]. Two issues link child marriages to HIV infection. Firstly, children are not able to negotiate safe sex. Secondly, a child's genital membranes are under-developed and likely to bleed during sexual intercourse, thus creating an entry for the HIV (Kubai, 2008:52; UNAIDS, 2010b:132; Karim, 2010:286, 287, 294-295; Siwila, 2011:10, 34, 44-45). Linked to marriage is that of bride wealth, *ilobolo*. Here, Haddad (2003:152) and Dlamini (2005:61) observe that because it is expensive in South Africa,[23] a man who pays the 'bride price' regards his wife as his possession. Such a bride cannot negotiate when it comes to choosing safer sex. In this debate, Bruce (2003:52) points to virginity testing, a common practice in KZN. She argues that HIV infection risk resides in that girls assumed to be virgins become the targets of HIV-positive rapists who think that having sex with a virgin will bring a cure (:51-52). According to Phiri (2003b:72) and Karim (2010:299, 300), some girls opt for anal sex in order to preserve vaginal virginity, while the use of condoms is far from being an option since there is no perceived expectation of pregnancy. Therefore, although culturally privileged, these practices are likely to increase the risk of HIV infection among young women and children.

Parallel to the HIV infection among females is the HIV-related impact. Mills et al. (2009:1-3) and Human Rights Watch (2004:11-12) argue that women are the ones compelled to go for HIV testing and that once HIV is diagnosed, they become the ones blamed for spreading the virus. In order to avoid this oppression, some women do not disclose their status and keep practicing unprotected sex, which obviously worsens the situation. According to Phiri (2003a:15), some widows and women living with HIV within abusive relationships are dispossessed by their in-laws. The main problem however is that, as Mills et al. (2009:3) argue, once HIV infection is associated with psycho-socio-economic problems, HIV-positive women are more likely to develop AIDS-related illnesses than men. It is therefore noted here that as a result of a cultural worldview, gender imbalance resides not only in HIV infection but also in its impact.

The third discursive explanation of gendered imbalance of HIV prevalence and impact is found in wealth inequality. Barnett and Whiteside (2006:165) observe that as a result of an unfair economic system developed since the apartheid era, there is a noticeable wealth inequality among South Africans (:419). Consequently, poor people, especially women, desire economic mobility but they do not have the resources, a situation which often results in their becoming more susceptible to HIV infection. Such a desire for financial wealth can be seen, for example, in a young woman's need for expensive mobile phones, clothes, beauty lotions, cars or study fees. As

[22] Forced child marriage is called *ukuthwala* in Eastern Cape (see Nine Campaign and Coalition for African Lesbians, 2010:20[22]).

[23] For example in Zulu community, the bride wealth is ten cows or eleven if the girl is virgin (See Bruce, 2003:52).

they are not always able to afford these items, they resort to transactional sex (Carton, 2006:97-98; Karim, Karim and Baxter, 2010:50; Baloyi, 2010; Bridget, 2011). Moreover, financial inequality impoverishes some who, in order to survive, initiate paid sexual relations. With regard to this, Myers (2010:21) found that in the higher education sector some poor South African female learners who struggle to meet the basic requirements, engage in materially supportive relationships without the power to negotiate safe sex (see also Barnett and Whiteside, 2006:89; Karim, 2010:289). It is therefore plausible that these conditions of transactional sex are likely to expose such women to a higher risk of infection.

In collating the above insights, it appears that HIV and AIDS is a gendered issue in South Africa, with women the most vulnerable to HIV infection and its impact, while biological, cultural and economic factors play an important role in this imbalance. Nevertheless, King (1995) remarks that because the gender concept includes women and men at the same time, a holistic anthropology of gender must pay attention to both females and males (:6). Therefore, since women constitute a higher vulnerability to HIV and AIDS than men, the following question must be asked: What is the status of men with regards to HIV and AIDS?

While systematic studies on HIV in women started in the early 1990s (Gouws and Karim, 2010:58-59), studies on men have always been selective and limited (Snow, Madalane, and Poulsen, 2010:1060). Soon after the discovery of the first AIDS cases amongst homosexuals in 1982, this population held the attention of researchers for a while (Karim, and Baxter, 2010a:39). However, since heterosexuals were also found vulnerable to HIV infection, researcher shifted their attention to focus predominantly on women, especially those attending ANCs (Whiteside and Sunter, 2000:47-53). The few men who were of particular interest to researchers during that time were those closer to sex workers in the mining and transport industries, even though population-based surveys initiated since the 1990s confirmed that both males and females were vulnerable to the pandemic (Gouws and Karim, 2010:59-60). However, the few studies on HIV in males have uncovered significant realities which expose the need for further research within this category. These researches have been grouped into three areas, namely HIV prevalence, factors playing a role in HIV infection, and the impact of HIV and AIDS.

With regard to prevalence, it was noted earlier in this chapter how the study on truck-stops found HIV prevalence to be 56% among male drivers (Ramjee, 2010:337). Three recent studies conducted by Lane et al. (2011:626), Rispel et al. (2011:69), and Baral et al. (2011:1) also found a high prevalence of HIV in male homosexuals: 33.9% in Soweto, 49.5% and 27.5% in

Johannesburg and Durban as well as 25.5% in peri-urban Cape Town. This sample shows that men are not exempt from HIV infection but are also infected and suffering.

Secondly, discourses allow for the identification of factors that play a role in exposing men to HIV infection. Hunter (2008:567) notes that a traditionally respected and courageous Zulu man, *isoka,* can marry and support many wives. Likewise, Hadebe (2010:40) has demonstrated that manhood in traditional Zulu culture is marked by aggression, authority and violence. These 'ideal virtues' of masculinity have been proven to be the very ways by which HIV infects males (and females). It was explained earlier how men are reluctant to use condoms during intercourse for socio-cultural reasons (Mills et al., 2009:7; Barnett and Whiteside, 2006:23-24; Myer, 2010:193). However, in a study conducted in Cape Town, Kalichman (2005:299, 302) found that 16% of men had been subjected to sexual assault and more than one in five had participated in sexual assault. Another study by Kalichman et al. (2006:551) also discovered that coital bleeding and HIV risks in Cape Town were associated with some factors that included having multiple partners and unprotected sexual intercourse. Also in Cape Town, the study of Kenyon et al. (2010:35, 37) showed that 21% of young men between the ages of 14-25 had already engaged in concurrent sexual partnerships. In KZN, Hunter (2008:569-571) discovered that because of poverty, the meaning of *isoka* had shifted from being the man able to take care of many wives to being the man able to woo many girlfriends, which is much more likely to expose men to HIV infection than ordinary polygamy because of the instability of the relationships with girlfriends (Denis, 2003). In the Eastern Cape, the study by Dunkle et al. (2006:2107) found that 31.8% of men in their sample had committed physical or sexual violence against numerous partners, a behaviour associated with the high risk of HIV infection. From these studies, it is fairly reliable to assume that the above cultural 'ideal virtues' have lured men into the trap of HIV infection. Thus, it can be said that men are victims of culture.

Last, but not least, studies identify the negative impact of HIV on the lives of men. Hunter (2008:569-571) demonstrates that HIV and AIDS has brought humiliation and shame upon men who are no longer able or free to perform what they view as ideal for manhood, namely, having many sexual partners. Likewise, Mills et al. (2009:5) depict men's humiliation resulting from their portrayal as the purveyors of HIV and women as the victims. For Mills et al., this humiliation and shame also instil in men the fear of being tested, utilising medical services for HIV prevention or treatment, and seeking any other assistance when needed, thus preventing them from participating in addressing the disease (:5). This observation is also shared by Fitzgerald et al. (2010:355), Snow et al. (2010:1060), and Venkatesh et al. (2011:151). This reiterates the

conclusion that men in South Africa are suffering like their female counterparts. It also appears that although they are viewed as agents of women's high vulnerability to HIV and AIDS, they are under the constant pressure of culture and they also need help. This implies that although a gendered issue with women as being the most affected, HIV and AIDS is a threat to both men and women in South Africa. As a consequence research has to increasingly document strategies to complementarily involve and assist both women and men.

In summarising, the analysis has confirmed that women are proportionally the most affected by HIV and AIDS. Considering practices such as virginity testing, child marriage, rape, gender-based violence, role division, the practice of unsafe sex and wealth inequality, cultural practices are likely to conspire and promote HIV infection and impact mostly on females rather than males. Looking at public health services provided to ANC attendees, women benefit the most from government systems that address the HIV and AIDS pandemic. For this reason, this is the only category in which the HIV prevalence is declining. With regard to the virtue of having sex with many women and issues of masculinity in South Africa, men are the most likely victims of the invisible pressure of culture while they publicly appear as perpetrators and bear this shame.

Drawing on these insights, this thesis argues that both males and females in South Africa suffer from HIV and AIDS because of a culturally-established worldview. It is also clear that, because men and women are in permanent interrelationships, strategies that neglect any gender-based struggle are not likely to eradicate the pandemic. In this regards, Karim (2010) makes a valid point that, "if we are to make an impact on the current trajectory of this epidemic we will need to adopt more gender-sensitive approaches in all aspects of our response to the HIV epidemic" (:285).[24]

[24] While speaking about the influence of the culture on HIV infection and impact among men and women in South Africa, it is also important to note the interaction and shared perception between the culture and the church with regard to the pandemic. This interaction was underlined by Velayati, et al. (2007:491) who inform that over 80% of residents in sub-Saharan Africa affirm drawing their moral and behaviour standards – including those related to HIV and AIDS – from established belief. Some aspects of such interaction are also observed in South Africa. In this regard, whereas the above analysis unveiled men's reticence of using condoms advocating that they hamper sexual pleasure and the affirmation of manhood, Joshua (2010) realises the same attitude in Catholic church in KwaZulu-Natal but the reason advanced here being that they contribute to sexual immorality and to the spread of HIV. Catholic Church rather encourages abstinence, a position displayed also in the idea of cultural value of virginity. Like Catholic Church, Methodist Church of Southern Africa (Sigaba, 2011:64) and Shembe church (Krakauer and Newbery, 2007:31) restrict members to sexual relations within marriage. In addition to sexual practice, the church, like the culture, in South Africa conceives roles that men and women are expected to play as well as the power relationships that govern them within the family ans the community. Hadebe (2012) assesses here that some churches in South Africa still support male professional and relational hegemony. Church and culture therefore have some commongrounds and influence each other in perceptions and practices regarding HIV and AIDS. However, studies still need to specify the extent of this influence. In chapters 5 and 6, some aspects of the mutual influence between the culture and FMCSA in perceiving and responding to HIV and AIDS also emerge.

In the light of the above analysis, the next section will focus on how the FMCSA has responded to the HIV and AIDS pandemic that is threatening South Africa's social fabric and geographical context. It will also consider the available literature on the subject.

2.5 The FMCSA in HIV and AIDS Discursive Debate

In this section, the discursive analysis methodology of archaeology will be employed to critique the foci of literature with regard to the FMCSA's response to HIV and AIDS.

There are limited books and articles on the FMCSA's mission and ministry in South Africa. Among these, one article by Iyakaremye (2010) based on fieldwork resulting from a Master's research project, links this Church's ministry to HIV and AIDS. As referenced in chapter 1, the researcher confirmed through this article the existence of a direct correlation between domestic violence and the risk of HIV infection among women and children assisted by the FMCSA in Pietermaritzburg. Further studies were recommended to investigate how this Church has responded to this reality. The present study has been initiated in response to this demand.

As with this study, other discourses focus on the FMCSA in Pietermaritzburg and do not mention or refer to HIV and AIDS. Sheffield and Sheffield (1998) published a chapter in which they analyse the impact of the UFMC's social ministries, namely, the UCH and The Haven Shelter for women and children survivors of domestic violence. They explain that these ministries were initiated after the 1994 democratic election as the church leaders responded to the need for a multiracial community newly installed in Pietermaritzburg, a former white city and the capital of the KwaZulu-Natal Province. They maintain that after a need assessment was conducted by church leaders in order to identify the priorities, housing and the safety of women were among the four main concerns. In particular, women were being raped and subjected to domestic violence while the authorities, including the police and court agents, were inadequately trained to address these problems. In 1995, the Church purchased a three-bedroom house and in 1996 a sixty-five-room building which formerly served as a residential hotel and transformed these into affordable rental accommodations for low income families. In 1997, the first shelter for women and children survivors of domestic violence in Pietermaritzburg was opened (:2-6). Sheffield and Sheffield (1998) argue that this and other similar projects have had a pronounced impact on the community because the leadership did not follow the traditional notion of a church that revolves around liturgy and associated structures, but instead has meticulously identified areas that could allow for the improvement of people's lives (:10).

Similarly, Capp (2006) published a chapter entitled, 'Shalom: God's Unreasonable Mission' in a book on the FMC's theology of mission. Capp presents the Free Methodist working model for Shalom communities. He illustrates the principle of Shalom communities with three examples, one of which being the UFMC. Capp explains the way the Church began in Pietermaritzburg and also describes its two projects, the UCH and The Haven shelter. The point made in this chapter is that these projects were established out of a *shalom* focus in its mission.

In addition to the published discourses, there are academic dissertations and theses. In his PhD. thesis, le Roux (2001) examines the South African context of the church and its involvement in addressing poverty. With reference to Wesleyan social ethics, he analyses the initiatives of three Wesleyan-based local congregations. These congregations had limited resources but were making measurable advances in empowering the poor in urban areas with provision of housing and job creation. The UCH project of the UFMC was much acclaimed for its success in empowering the urban poor in Pietermaritzburg.

Likewise, E. Ntakirutimana (2004), in his master's dissertation, uses the Wesleyan social teaching and pastoral care and the work of Paulo Freire on dialogical action to critically reflect on the UCH initiated by the UFMC. As with le Roux, he applauds the work accomplished through the UCH. Moreover, Iyakaremye (2009) uses the concept of the mission of the church as *missio Dei* to analyse the response of the UFMC to domestic violence. He observes that whilst this Church is progressing in all its caring activities, it is unfortunately, falling short in challenging oppressive structures. Furthermore, V. Ntakirutimana (2009) examines how two faith-based organisations, one such being the Haven shelter of the UFMC, are empowering vulnerable children to regain their self-esteem. She appreciates that interventions of these two organisations involve children in decision-making and go beyond addressing children's needs to embrace programmes that prevent them from falling into poverty.

The final documents are the two Honours dissertations on The Haven shelter. E. Ntakirutimana (2003) analyses the historical background of the project and critically reflects on the shelter's role in a time of domestic violence. He identifies key issues for the Church and establishes an appropriate agenda for the UFMC. In the same way, Musabyimana (2004) uses the Haven shelter as a case study to critically reflect on the lives of women after leaving the shelter. She reflects on the role of shelters in the lives of the survivors of domestic violence and establishes an agenda for the UFMC.

These discourses focus primarily on one circuit of the FMCSA, namely the UFMC of Pietermaritzburg. It is particularly striking that these studies were conducted almost exclusively on one gender-related project: the Haven shelter for women and children survivors of domestic violence. Additionally, they generally speak about the importance and success of this project. This shows that both the authors and the Church are concerned about gender issues and the associated problems existing between males and females in South Africa. It is therefore argued that this particular Church of Pietermaritzburg is gender-sensitive.

However, these discourses do not provide information on gender-sensitivity in other Free Methodist circuits in South Africa. In addition, they are silent about the response of this Church to HIV and AIDS while, as was seen in chapter 1, there is a close correlation between gender-based violence and the spread of HIV and AIDS. This silence constitutes one of the gaps that this research project intends to address. Consequently, this study investigates the FMCSA's response to HIV and AIDS in order to argue for the development of more life-saving strategies.

2.6 Conclusion

The aim of this chapter was to provide the context for the present study and thereby justify the reason why this study was initiated. Using two Foucauldian analysis methods, archaeology and genealogy, three points emerging from the title of the present study, (i) HIV and AIDS in South Africa, (ii) HIV and AIDS as a gendered issue in South Africa, and (iii) the FMCSA were explored.

With the genealogical analysis, it was demonstrated that since the first diagnosis of AIDS in South Africa in 1982, HIV prevalence has steadily increased in the country, although some decrease has been observed among women attending ANCs. It was also established that the HIV and AIDS pandemic in South Africa was started with male homosexuals but subsequently shifted to also include male heterosexuals as well as females who are currently the most affected.

As with archaeology, it was shown that although research on HIV and AIDS is progressing in South Africa, there are still many areas that need to be addressed. These include gaps in systematic studies of HIV prevalence in the population other than women attending ANCs; in ascertaining all the factors that play a role in the spreading of HIV infection in South Africa; in developing strategies to address the pandemic; and in required or effective involvement of both men and women in responding to the pandemic. Likewise, research still has to unveil the way

men and women can complementarily work together without criminalising each other and the way they can overcome factors related to their culture.

In this archaeological analysis, it was also observed that HIV and AIDS is a gendered issue in South Africa, mostly because of the cultural definition of gender and that both males and females require exhaustive and sustained assistance. It also appears in the findings that some strategies have been undertaken to assist and to be controlled by each gender. These include male circumcision and male condoms for males as well as microbicides and female condoms for females.

The archaeological analysis also allowed for the realisation that the FMCSA operates in those provinces highly affected by HIV and AIDS. It is there that it recruits adherents and preaches the gospel, and is thus expected to respond to the needs of the community. These provinces are KwaZulu-Natal, Mpumalanga, Gauteng and the Eastern Cape (Gouws and Karim, 2010:62-64).[25] The question remains whether the FMCSA's numerical and geographical emergence involves a response to the problems faced by the community, namely, HIV and AIDS. However, the analysis found discourses to be silent on this point. They only present some data on the Church's response to gender-based violence. It is therefore the intention of this study to bridge this gap by showing the extent to which the FMCSA has responded to HIV and AIDS and has potentially valuable resources which could allow it be efficient in this endeavour, namely, the WHCR. Before discussing the fieldwork research and findings, two questions need to asked: Why should the FMCSA respond to HIV and AIDS? Why should the WHCR be reclaimed in the FMCSA? Chapter 3 will deal with these two questions.

[25] This is described in the section 1.3.

CHAPTER THREE

PROPOSING THE WHCR AS A MODEL OF MISSIONAL ENGAGEMENT IN A TIME OF HIV AND AIDS

3.1 Introduction

In the previous chapter, Foucauldian analysis methods, genealogy and archaeology were used to provide an overall context for the present study. It was demonstrated that since the diagnosis of the first cases of AIDS in South Africa in 1982, HIV prevalence showed a steady increase in the general population. However, since 2005 some decrease was observed among women attending ANCs. Likewise, it was pointed out that HIV started in this country as a male problem and that it has shifted to women as the most infected and affected. It was also argued that as long as there are new infections and a noticeable impact of HIV among the populations, research needs to cover all the discursive gaps in order to find effective strategies to address this pandemic. The other argument is that strategies that concern and involve both men and women are also necessary.

Furthermore, it was argued in the conclusion that the FMCSA operates in provinces highly affected by HIV and AIDS, although discourses remain relatively silent about how this Church deals with this pandemic. As discussed earlier it is this silence which has motivated the initiation of this study. Chapter 2 concluded with questions regarding a response to HIV and AIDS in the FMCSA and why the WHCR should be reinstituted in the FMCSA. Chapter 3 will serve as a response to these questions.

In developing responses to these questions, it is postulated that the WHCR should be seen as FMCSA's potential resource for *missio Dei*'s fulfilment in time of HIV and AIDS. This chapter will argue that the mission of the church in the world is to participate in *missio Dei* and that it includes responding to HIV and AIDS. It is maintained that the proposed WHCR is an expression of *missio Dei* and a potential resource to respond to HIV and AIDS that is embedded in the identity and calling of the FMCSA.

The development of this chapter is inspired by the two Foucauldian analysis methods, genealogy and archaeology. Therefore, in presenting the notions of *missio Dei* and WHCR, two steps will be

followed for each. Their historical emergence (genealogy) will be traced and discursive accounts will be explored to establish how the FMCSA is expected to respond to HIV and AIDS (archaeology).

Section one of the chapter will introduce the *missio Dei* paradigm in the context of HIV and AIDS. Section two will argue that the WHCR can be used as an instrument in the fulfilment of *missio Dei* in addressing HIV and AIDS. The final section will argue that the WHCR constitutes a missional model to equip the FMCSA for contextual gendered response to HIV and AIDS. The chapter is resourced from existing literature.

3.2 *Missio Dei* paradigm and HIV and AIDS

The objective of this section is to present the *missio Dei* concept and its contribution to the holistic understanding of the mission of the church in the world, and to suggest its significance in the time of HIV and AIDS.

3.2.1 Emergence of *Missio Dei* Concept

Theologians such as Latourette (1938-1945; 1946; 1953), Newbigin (1958), and Barth (1956:743-884) have shown interest in missiology (Verkuyl, 1978). They have shaped the current theological understanding of the mission of God and of the church. Following in their footsteps, Bevans and Schroeder (2004) show the development of the mission by examining Jesus' ministry and the Early Church (See also Niemandt, 2010:4-7). Smith (2007) observes the integration of women in the mission since the New Testament up to the contemporary western Catholic Church. Likewise, Duncan (2007) focuses on the growth of the partnership in mission since the 1910 Edinburgh International Missionary Council up to the 2000s. The description by Bosch (2011) of this development is, however, crucial to the present study because in addition to an extensive discussion on various missionary paradigm shifts for a period of twenty centuries since the time of Jesus' ministry, he integrates the contemporary missional concept of *missio Dei*. As he elaborates, the first paradigm is apocalyptic developed by primitive Christianity. This includes the Matthean Great Commission of 'disciple making' found in Matthew 28:18-20 (:57-84); the Lukan practice of forgiveness and solidarity with the poor regardless of class and race as referred to in

Luke 4:18-19 (:85-124); and the Pauline invitation to join the eschatological community as referred to in the seven letters written by Paul himself[26] (:125-181).

The three following missionary paradigms are the 'Good ideas of life and love' and invitation of people to the loving church as developed by the Hellenistic (Greek and Eastern Mediterranean) Church during the patristic period (AD 100-600) under inspiration of John 3:16 (:195-218); the 'filling of the master's house' developed by the Roman Catholic Church during the medieval period (AD 600-1500) inspired by Luke 14:23 (:219-243); and the 'justification by faith' developed by the Protestant Reformation during AD 1500-1800, guided by Romans 1:16-17 (:244-267).

The fifth paradigm is a '*Fragmented Missionary Paradigm(s) of Protestantism'* developed during the Enlightenment (AD 1800-2000). Here religious faith is questioned and attacked but a theology of mission is also developed. Bosch finds nine motives of the spread of the Word of God during the Enlightenment, of which four are theological, namely, the *'Glory of God'*, *'Jesus' Love,'* the *'Millennium,'* and the *'Obedience to the Great Commission'* (:268-353; Iyakaremye, 2009:42-44).

The last paradigm of mission stated by Bosch (2011:185, 357-522) is the current emerging understanding of mission which is ecumenical. As he elucidates, it results from the failure of Enlightenment thinking which emerged during devastating events such as the two World Wars, Fascism, the Western colonial empire and the increasing gap between rich and poor. From this 'crisis,' Bosch mentions that the church is trying to rediscover the essence of its missionary nature and calling and different kinds of answers are emerging, thus it is an ecumenical missionary paradigm (:375-376).

Bosch (377-553) identifies thirteen interrelated elements that are already emerging in the current missionary paradigm. These are mission such as: Church-With-Others, *missio Dei*, Mediating Salvation, Quest for Justice, Evangelism, Contextualisation, Liberation, Inculturation, Common Witness, Ministry by the Whole People of God, Witness to People of Other Living Faiths, Theology, and Action in Hope. Reppenhagen and Guder (2011:552-553), and Isaak (2011:342) believe that these elements illustrate how currently all faiths and aspects of human life are viewed as crucial in the fulfilment of God's mission and that they can only succeed if they work in synergy. This chapter will elaborate on the *missio Dei* concept since it serves as the theoretical framework of this study.

[26] Bosch (2011:125-181) informs that the seven letters known as written by Paul are Romans, 1 and 2 Corinthians, Galatians, Philippians, 1 Thessalonians, and Philemon.

According to McKinzie (2010:11), the idea that gave rise to the *missio Dei* concept was suggested for the first time by Karl Barth in the paper he read at the 1932 Brandenburg Missionary Conference (see also Bosch, 2011:399). Barth revived the idea of the Triune God as the source of mission. This idea appeared as a response to the then missional crises. The two immediate crises were Chinese president, Mao Tse-tung's removal of foreign missionaries and the involvement of Christian missions in colonialism under the influence of the Enlightenment (:10). The third crisis was ecclesiocentrism where the church was seen as the sender of missionaries and the mission as the church's agenda (:10). As McKinzie (2010:10-11) specifies, there were also various theological dispositions about mission, the main contenders being traditionalist and humanist. Traditionalists argue that God is the source and the agent of the mission while the church is God's means (theocentrism). As for the humanists, God has already inaugurated the kingdom and the role of the church is to proclaim that reality. Their common ground was that, "Mission is ultimately God's affair." (:10-11).

Before this situation, ecumenical leaders were striving to identify the motivation, the means, and the goal of their mission (:10). Therefore, the influence of Barthian missionary thinking manifested itself in the preliminary report from the United States at the 1952 Willingen Missionary Conference:

> The missionary movement of which we are a part has its source in the Triune God Himself (sic). Out of the depths of His love for us, the Father has sent forth His own beloved Son to reconcile all things to Himself. . . . On the foundation of this accomplished work God has sent forth His Spirit, the Spirit of Jesus. [...] There is no participation in Christ without participation in His mission to the world. That by which the Church receives its existence is that by which it is also given its world-mission. 'As the Father hath sent Me, even so send I you' (McKinzie, 2010:11).

With this paradigm shift, the mission was no longer understood as originating from churches as institutions but from the Triune God only (See also Engelsviken, 2002). The implication of this shift is that the church has no mission for itself. Rather, the church participates in God's mission. In this way, the understanding of mission as God's agenda was also reinforced. McKinzie (2010:11) elucidates that the Latin expression, *missio Dei,* was used to name God's mission by Karl Hartenstein, in another document after the conference.

In describing the relationship between the *missio Dei* and the church, Avis (2005:6) observes that God's mission precedes the church and is greater. As to Reppenhagen and Guder (2011:539), the church is not merely an outcome of the mission, but the medium of the mission. This implies

that there is no church mission without God, since God is the one who sends the church. It also suggests that the church is not an end to a mission but its means. This study subscribes to such an understanding of the church's mission that will guide the analysis of the response of the FMCSA to HIV and AIDS.

3.2.2 The Goal, Activities and Agents of *Missio Dei*

Bosch (2011:9) warns about the challenges that manifest when seeking to define mission. He states that, "we may …. never arrogate it to ourselves to delineate mission too sharply and too confidently". He points out that mission is indefinable and therefore should not be narrowly framed in our own partiality. He maintains that people may only "formulate some approximations of what mission is all about". Taking this remark seriously, it is hoped that this chapter will provide a holistic picture of *missio Dei* by providing aspects that will facilitate the analysis of the response of the FMCSA, which is the ultimate object of this study.

According to Verkuyl (1978:197-198), the biblical goal of the *missio Dei* is to bring "the kingdom of God to expression" and to restore God's "liberating domain of authority." He specifies that God's kingdom is the achievement of the goal of the creation where chaos will be overcome, anti -messianic tendency erased, and God's liberating acts will reach their final goal. Verkuyl (1978:198) identifies two components of the kingdom: the individual's inner salvation and the satisfaction of human needs, including the destruction of evil (:197). Nadar (2009:85) also uses expressions of 'conversion' and 'justice' to juxtapose these two components. She writes: "The consistent call in missiological circles to understand mission as not just conversion but indeed as spreading the good news of justice and love, requires an understanding of mission which seeks to transform (gender) injustice in the world" (:85).

The third component is defined in terms of relationships. For Verkuyl (1978:198), God's Kingdom is the new order which restores humans' relationship with God and between themselves. Raiser (2002:475) also refers to 2 Corinthians 5:19-21 to consider the *missio Dei* as the healing of the breakdown in the relationship between God and human beings. Through the death on the cross, a new covenant has been established between God and human beings and the world and the basis for reconciliation between human beings [has been] layered (:475). For Raiser, the outcome of *missio Dei* is the reconciliation that [re]establishes the fellowship between God and people, between people themselves, and a peaceful coexistence with the whole of creation (:475; Groody, 2009). Likewise, Avis (2005:57) expresses that "*missio Dei* is to bring about God's Kingdom of love and peace, justice and freedom, in and through Jesus Christ".

Bringing these insights together, it results in the aim of the mission being the spiritual (salvation) and physical/social (justice) harmony between people, people and God (the Father, the Son, and the Holy Spirit), and people and the universe (Kirk, 2006; Duncan, 2007; Scott, 2009; Chung, 2010:143, 144; Boyd, 2012). In the present study, initiatives leading to this expected harmony are investigated in the FMCSA's closeness to PLWHA and in the way it strives to minimise stigma and discrimination of these people and their relatives. Likewise, activities that are likely to result from this harmonious state of being are investigated through the church's contribution to HIV prevention and to the spiritual, social and physical welfare of people infected or affected by HIV[27].

The second element observed here pertains to activities carried out when accomplishing *missio Dei*. Raiser (2002:476) views the act of reconciliation as an indication of being in God's mission. Raiser (2002:474-475) contends that it is with such acts that the church or Christians bear witness to God's mission of sending Jesus to reconcile God with the world, thus being Himself a message of reconciliation.

Richebacher (2002:592) focuses on the evangelisation and any other actions that bring progress as part of God's mission. His view is based on the account of the 1952 Willingen International Missionary Council in which the understanding of the mission of the church as *missio Dei* was confirmed. Richebacher explains that in this Council, the mission was understood as being within and beyond evangelisation. He points out that some delegates understood that the mission was even independent from the Gospel preached. They were thus seeing it as progress in world history.

However, Walls and Ross (2008:3-104) are more explicit. They consider five characteristics of mission, these being: to proclaim the Good News of the Kingdom; to teach, baptise and nurture new believers; to respond to human need by loving service; to seek to transform unjust structures of society; and to strive to safeguard the integrity of creation and sustain and renew the life of the church. These characteristics include evangelising, providing sacraments, developing social actions, creating a just society and protecting the ecosystem (See also Kirk, 2000:56-204; Meyers, 2010). Bearing in mind the warning sounded by Bosch (2011:9) earlier, one can simply consider the above insights as admissions that activities of *missio Dei* involve acts of reconciliation, justice evangelisation and any other good actions aiming at the well-being of humans and their universe. It seems therefore that these activities are likely to promote the

[27] See chapter 5 and 6.

attainment of the dimensions of harmony and (spiritual, physical, social) well-being, viewed as components of the goal of *missio Dei* and as an ideal pursued by the present study.

The third element concerns agents of the *missio Dei.* Who participates in God's mission and who does not? For Bosch (2011), agents in God's mission include the Christian church (:372-398; 472-481; see also Flet, 2010), other faiths communities (:485-501), and non-faith-based structures (institutions, governments, movements, and people) (:481-485). It is in this explanation that the ecumenism is widely observed. According to Bevans and Schroeder (2011) and Kirk (2000:75-95; 2006:26-45), the church in God's mission has to engage in dialogue with culture and other secular beliefs which also carry valuable elements of that mission (see also Karingadayil, 2011). These scholars understand the church as an agent among other agents in God's mission. They share this understanding with contributors to the book, *Postcolonial Mission,* edited by Van der Water (2011). In their evaluation of the missionary journey of the Council for World Mission (hereafter CWM) since 1977, they assert that people of all ages (Hewitt, 2011), all faiths (Keum, 2011; Lewis, 2011), and both genders (Phiri, 2011) all over the world are entitled to be agents in God's mission.

However, in the context of the present study conducted on the FMCSA, a Christian church, particular attention is paid to the Christian church's participation in *missio Dei.* This leads to the question: who in the church, is involved in *missio Dei* and who is not? For Avis (2005:2) and Kok (2011) the mission of the church in the world is accomplished as a form of ministry and this ministry is entrusted "to the whole church, not just ordained." However, Avis believes that there are some restrictions. According to him, only baptized believers are potential ministers. For him, non-baptised individuals do not participate in *missio Dei.* But also, he argues that not all those who are baptized are ministers. What he contends here is that whatever a Christian does in dedication to the Lord necessarily becomes ministry and that individuals are the ones to decide what their ministry is. For him, all believers are called for ministry, but their ministry is taken as an "act in the name of Christ's Church" when it is recognized or owned by the community (church) either informally or formally (:52-53).

Avis' understanding can be interpreted as discriminative on three levels. Firstly, it excludes church members who have not yet undergone the process of baptism. Secondly, it ignores believers who take the initiative under God's guidance without necessarily passing through the church's hierarchy. Thirdly, it is not theologically sound to judge 'true ministry' on the basis of human interpretation, as if these church members who carry out the interpretations are the only

ones entrusted to know God's will. As an example, Avis' criteria for acts of ministry and of God's mission exclude the act of a new convert who would take the initiative to repair a bridge damaged by heavy rain because the person is not yet baptised and no church community is present to acknowledge what the person is doing.

In this regard le Roux (2011) seems to be more inclusive. For him all members of the congregation are primary agents of mission. Le Roux does not interpose barriers based on the level of church membership. He states this in an inclusive way, "Every member should adopt St Paul's challenge that all members of a congregation are ambassadors for Christ and each one should have a vision of participating in the mission of God" (:107). Like le Roux, the present study expects all categories of church members to participate in *missio Dei*. For this reason, interviews were conducted among people who identified themselves as church members without taking into account their level of administrative church membership[28]. However, what is observed in the present study is the response of the church as an institution, not the separate initiatives of individuals. The question here is: what is the significance of *missio Dei* in the context of health and healing?

3.2.3 *Missio Dei* and Healing

This section explores the significance of *missio Dei* in the context of health and healing. Four points are developed here. Firstly, Jesus as exemplar of an agent in fulfilling God's mission is identified. Folk (1990), Verkuyl (1993) and Dube (2007) identify God (the Father), and Jesus Christ and the prophets as agents of God's mission. In the context of health and healing, Anderson (1986) and Gous (1986) mention the sick such as Moses, Miriam, Naaman, Jeroboam, and Hezekiah as well as the deceased sons of Zeraphath's widow and the Shunammite woman who miraculously were restored to life through God's power and, in most of the cases, through the intervention of the prophets. Likewise, Maddocks (1981) and Howard (2001) attribute healing in the Gospels and the book of Acts either to Jesus or to people inspired by Him, namely his disciples and the early Christians. These authors portray God the Father, Jesus and prophets as agents in fulfilling God's mission through acts of healing. Oduyoye (2001:51-65), Rakoczy (2004:114), and Veldman (2006:12-13) argue that Jesus is God whereas Maddocks (1981:30) and Dube (2007:89-91) show Him as a prophet. In this way, they attribute to Him characters of both God and the prophets. Moreover, Jesus identified Himself as one sent by God to establish the kingdom of God on earth and has included a healing ministry in his agenda (Maddocks, 1981:45-

[28] See chapters 4, 5, and 6.

48). Since the FMCSA, as Christian church, takes Jesus Christ as a model of its life and work, it is important to reflect on Jesus' understanding of the *missio Dei*.

Secondly, the concerns Jesus' healing ministry responded to will be considered. Schmidt (2007:5) commenting on the leper's healing in Matthew 8:1-4 suggests that one disease can be the cause of several kinds of sufferings. Schmidt observes that this person was physically healed of leprosy, emotionally healed of fear and depression, relationally healed because he then could return to his society and spiritually healed as he was allowed to join the community of God's people. According to Howard (2001) and Dube (2007), Jesus intervened in all such ailments and conditions. Dube (2007:91-95) states that Jesus healed physical, social, psychological, and spiritual illnesses. Social illnesses include isolation and fear surrounding the illness while spiritual illnesses comprise sinfulness and possession by evil spirits (:91-92). She also mentioned that Jesus' healing involved freedom from racism and social and economic injustice. Jesus advocated justice in favour of the weak; challenged ungodly scriptures that were used to support injustice and challenged religious leaders and structural conditions that were affecting human health. She therefore qualifies Jesus' healing ministry as holistic healing. Maddocks (1981:30-52; 58) agrees with her view of Jesus' healing as holistic and asserts the existence of many other healings done by Jesus but not recorded in the Bible. From these assertions, Jesus' healing ministry may be described as holistic, addressing physical, psychological/emotional, spiritual, and social conditions affecting human well-being.

Thirdly, the way in which Jesus carried out his healing mission is considered. According to Maddocks (1981:60-61) Jesus in his healing mission, addressed the sick, touched them, smeared their bodies with oil, applied saliva and mud poultices to the diseased parts of the body, addressed the individual's faith and their prayer for thanksgiving and for the forgiveness of sins. In some instances, Maddocks mentions that Jesus also allowed people to touch Him or to touch the fringes of his cloak. Schmidt (2007:13-15) also remarks that God has integrated a built-in system that the body can automatically use to heal infection. These examples of Jesus' methods of healing illnesses are incomplete. Jesus' act of feeding people (Mark 6:30-34; 8:1-10), changing water into wine at Cana (John 2:1-11), and raising the dead (e.g. Lazarus in John 11.1-44 and Jairus' daughter in Mark 5:35-43) (see, Maddocks (1981:40-41) are also acts of healing, since their aim was to return people to a healthy state. However, it is crucial to draw from this account that, as part of fulfilment of *missio Dei,* Jesus was using various ways, including the basic elements of medicine (saliva, earth), to restore people's health.

A critical reflection on Jesus' healing ministry by physicians Stumpff (1986:215, 217) and Howard (2001:290) concluded that Jesus healed both psychological and physical illnesses but that there was no genuinely physical and truly organic illness that was healed (:290). However, the view held by Maddocks (1981) is different. For him, it is a "distortion of the New Testament evidence to say that Jesus pronounced more on morals than on physical and mental, health" (:58). Maddocks maintains that Jesus' ministry ranged far beyond illnesses, their underlying causes and human control. He understands that Jesus' intervention aimed not only to heal the illness but also to replace it with something worthy in order to recreate the person in God's image (:59-60). According to Maddocks, these physicians use their limited knowledge to explain something beyond their capacity and that they should rather admit that Jesus was healing all the diseases and related ailments using divine techniques not necessarily controlled by human beings.

Various diseases were healed by Jesus during his earthly ministry. Whether or not infection was removed from the body, what matters is that the person recovered their strength and returned to normal life in the community. Nevertheless, Badenhorst (1986:214) and Anderson (1986:178-179) suggest that even modern medicine is God's revelation and a means to alleviate human suffering, and that physicians are inspired by God in their profession. This insight draws everything together under the control of and obedience to God. The advantage is that both physical and non-physical healings are taken as components of one unit and transpire because of God's intervention, and thus are part of *missio Dei*. This therefore displays the necessity of collaboration among all the agents in human healing. It is with this understanding in mind that, according to Mkhize (2011), the South African government has started a national programme of collaborating with various religious denominations to help patients who have been hospitalised.

Lastly, emphasis is placed on the reason why Jesus initiated a healing ministry. Four reasons are presented here. A according to Maddocks (1981), the healing ministry was part of Jesus' master plan for the *missio Dei*. Maddocks (1981:45) identifies this agenda in Luke 13:32-[33] where Jesus announced that he would cast out demons and perform cures 'today' and 'tomorrow' and finish his course on the third day. Maddocks also traces healing ministry in Luke 4:18-19 referring to Isaiah 61:1ff where Jesus affirms having been anointed to release the captives and to recover the sight for the blind and claimed that, "Today this scripture has been fulfilled in your hearing" (Luke 4.21) (:45-46). The consistence of this ministry in Jesus' plan was also recognised by Maddocks (1981:52, 53), Jonker (1986:143), and Schmidt (2007:29). In exploring the gospels of Matthew (9:38; 10:1), Mark (3:13ff; 6:7-13), and Luke (10:9), these authors realise that casting out

demons or unclean spirits and healing diseases had always been part of Jesus' commission to his disciples and was part of his agenda of fulfilling the *missio Dei.*

Secondly, Badenhorst (1986:212) and McCauley (1986:226) specify that healing was not an activity added to the core mission but a well-reflected upon and planned component emanating from God's will. Gous (1986), König (1986), and Ramaila (1986:219-221) expand on this notion by insisting that healing comprises much more than mere physical health. Rather, the physical effect is a door to a meaningful life. König (1986:79-83) also insists that Jesus' ministry of healing and feeding people was not an incentive for salvation but part of salvation. As for Ramaila (1986:219-221), healing is the inauguration of the kingdom of God and a restoration of the whole of creation's original state and human domination that was stolen by Satan after Adam's fall and divine curse. These observations therefore make the healing ministry an integrated, central and required part of *missio Dei* which thus implies that Jesus had to initiate it.

Thirdly, Maddocks (1981), Gous (1986:17), König (1986:92), Jonker (1986:144-150), and Schmidt (2007:28) link the healing mission to the life of Jesus. To illustrate their point, the profile of the church's mission which entails six major salvific events portrayed in the New Testament as defined by Bosch (2011:524-530) will be used. These are the *incarnation* understood as Jesus' identification with the weak and oppressed and Jesus who is interested not in eternal salvation but in the suffering of victims; *the cross* symbolising Jesus' death because of his identification with those on the peripheries; *the resurrection* portraying the joy and victory over death; *the ascension* ensuring the sharing of the throne with the living God; *Pentecost* meaning the power and boldness in the face of adversity and oppression; and *the parousia* giving hope in the primacy of the future. In the same way, each of these authors links the healing ministry to some of these events to give it a spiritual meaning. As an example, Jonker (1986:144-151) introduces three shifts of emphasis in Jesus' healing ministry: from a theological emphasis on the cross to Easter and Pentecost; individual ministry to ministry of the Lord's body (*Koinonia*); and healing sickness to the current healing of the whole person with emphasis on the spiritual. For Maddocks (1981: 45-47; 64-71; 166-167) Jesus was crucified not because he evangelised but that he performed healing miracles and thus this ministry is more on the forefront than the other components of the *missio Dei.* Likewise, Schmidt (2007:28-29) uses Jesus' death to explain that our healing comes from Jesus' stripes and God's Love. The aim of these authors is to identify the healing ministry with Jesus' life and thereby justify its centrality to Christians' and Christian churches' mission.

Lastly, Ackermann (2008) and Maddocks (113-116) find the reason for the healing ministry in the Eucharist. For Ackermann (2008:121-122), the Eucharist reminds us of the betrayal and the pain that Jesus went through and assures his presence in the midst of the sufferers. It also symbolises an invitation of the partakers to the feast, together with the crucified and the risen and a foretaste of the messianic banquet. In this way, it creates togetherness where all people are welcomed and rejoice, support and suffer in relationship with one another and with God while they resist the evil and affirm life. Similarly, three points relating to healing with the Eucharist may be found in the views of Maddocks (1981:113-114). He suggests that through the Eucharist, we are enfolded in Christ's love and assisted to proclaim the beginning of the Kingdom and time of salvation/healing. Therefore the Eucharist recalls the invitation to the holy banquet in heaven. Maddocks (1981:116) also refers to the ancient church's practice of offering fruits which was a sacrament of creation and redemption to suggest that the church should do the same, making the Eucharist become "the anticipatory celebration of a healed creation, a foretaste of the Kingdom of God." In addition Maddocks (47:52) portrays Jesus' miracle of Cana of changing water into wine and the miracle of feeding people as, like the Eucharist, a symbol of messianic salvation/healing, a foretaste of things to come. These meanings and metaphors link Jesus' (holistic) healing ministry to the Eucharist's meaning of the past, the present and the future, and this displays the necessity of healing within the scope of *missio Dei*.

Given this exploration, it is argued that the healing ministry was initiated by God as a component of *missio Dei*. In fulfilling this, Jesus envisioned the holistic healing of the person and used various methods to achieve this. Therefore this ministry is very important and a requirement of *missio Dei* agenda. Hence, any church claiming to be Christian and wishing to participate in building God's Kingdom like Jesus did, should, in the words of Maddocks (1981:60), 'be true to its Lord.' This church should have a sound theology of healing translated into visible action and embracing all aspects of the human existence and world. This leads to the core question: How does HIV and AIDS, which is the central focus of this study, finds a place in the scope of the healing ministry as a component of *missio Dei*? This question will be addressed in the next section.

3.2.4 *Missio Dei* in the time of HIV and AIDS

Chapter 2 shows how HIV is a retrovirus which infects the human being and disturbs the circulatory system that normally protects the body from infections. It is explained that if not treated, HIV opens the door to many diseases and that it is at this latter phase that the illness becomes known as AIDS (see also Morris and Cilliers, 2011; Gray, Malatsi, Riou and Rosa,

2011). It was also extensively elaborated on how HIV and AIDS impacts negatively on the physical life, social structure and relations, and the economic situation of people infected in their community. Physical discomforts from different diseases, stigma, discrimination, poverty, resulting psychological afflictions and even death were identified among the consequences of HIV infection. Wittenberg (2007:154-155) and West (2011:135) also add a spiritual dimension. They remark that in many cases HIV infection is interpreted as a punishment inflicted by spiritual powers (God, angels, ancestors, universe) on the infected persons for having defaulted on some requirements or having sinned. These conditions are similar to conditions in which Jesus' healing ministry intervened in order to fulfil *missio Dei*. Jesus healed physical, emotional/psychological, spiritual, social, structural, and economic conditions that were affecting and afflicting human health and life (see Dube, 2007:91-95). It is evident from Akintunde (2003:96-100) and Afework (2008:159-160) that Jesus forgave those accused as 'sinners' such as prostitutes and healed them from shame and the frustration of being so labelled thus restoring their relation with God. From this observation, it is submitted that the *missio Dei* embraces the wellbeing of all persons suffering from HIV and AIDS and therefore the church has no option but to be a partner in the agenda of the *missio Dei*. Therefore responding to HIV and AIDS is an opportunity to fulfil the *missio Dei* and the church in God's mission should not fail to respond to this invitation. How willing and ready is the FMCSA to respond to HIV and AIDS which besieges the communities that it serves? In the next section an exploration will be made of the extent to which *missio Dei*'s fulfilment, as exemplified by Jesus, embraces gender-sensitivity and assess its implication for the FMCSA's participation in the *missio Dei*.

3.2.5 *Missio Dei* and gender sensitivity

Gender sensitivity in Jesus' ministry (*missio Dei*) is observed in his teachings and deeds and the place he gave to both males and females. Jesus lived in a patriarchal society (Folk 1990:104, 105). However, Folk (1990:104-106) and Rakoczy (2004:104-106) explain that during his ministry, Jesus challenged this system and honoured both men and women. In his preaching, he addressed the message to men and women (Rakoczy, 2004:104). In representing the kingdom of God, he juxtaposed images picturing both men and women so as to show that God's mystery is beyond culturally gendered considerations (Rakoczy, 2004:104; Folk, 1990:104)[29].

[29] One example of this is in Matthew 13:31-33 where he compares the kingdom with a mustard seed planted by a man and yeast mixed in the flour by a woman (Rakoczy , 2004:104; Folk, 1990:104).

These authors also assert that Jesus had male and female disciples. According to Rakoczy (2004:104), the number twelve that refers to the male disciples does not mean male privilege but refers to the Twelve Tribes of Israel. She further elucidates that the posture of Mary of Bethany at Jesus' feet (Luke 10:39-40) was a disciples' posture and therefore she was also a disciple. Likewise, Folk (1990:106) observes that in the story of the empty tomb, the angel or Jesus Himself sent women to tell the male disciples about the resurrection. For Folk, this makes them apostles of apostles.

Jesus' gender-sensitivity is also observed in his healing ministry. Maddocks (1981), Howard (2001) and Schmidt (2007) state that Jesus healed both males and females. According to Folk (1990:105), Jesus contested sexism in the synagogue when he healed a crippled woman on the Sabbath day (Luke 13:10-17). When the religious leaders grumbled, he defended his actions in calling her the 'daughter of Abraham', a title of honour which was normally used as 'son of Abraham' for a 'male member of the chosen people.' Folk interprets the use of this term in this case as Jesus' way of reflecting the reality of equality and mutuality in God's Kingdom.

Jesus' vision of equality of male and female was moreover captured in Jesus' way of imaging Himself. As suggested by Folk (1990:105) and Rakoczy (2004:105), this was shown when he compared Himself with a mother hen desiring to gather her chicks under her wings (Luke 13:34; Matthew 23:37-39). Rakoczy argues that such an example portrays that he possessed dimensions of both male and female and that his message of God's reign could be heard by all.

Lastly, Jesus challenged men and women any time he deemed necessary. He regularly challenged the male religious leaders and his male disciples. He also challenged a woman who, moved by his teaching, exclaimed, "Blessed is the womb that bore you and the breast that you sucked." Jesus responded that blessed "are those who hear the Word of God and keep it!" (Luke 11:27-28) (Folk, 1990:104). For Folk, this means that Jesus denied blessedness based on the biological functions of women and men.

It appears that Jesus was not privileging any one particular gender although he was a male ministering in a patriarchal society. This implies that his ministry had a vision of equality between men and women. Hence *missio Dei* as fulfilled by Jesus was gender-sensitive and therefore Christian churches such as the FMCSA should, in obedience to Jesus, also be gender-sensitive.

Since *missio Dei* is one of the main paradigms of the contemporary church's mission which stipulates that the church does not have any other mission than to participate in the mission of

God as discussed in this section, the church must work together with other agents in order to fulfil God's purpose for all creation, animate and inanimate. If Jesus constitutes our model in the *missio Dei*'s fulfilment then healing is a core component of the mission that he bequeaths to his followers. Therefore, HIV and AIDS, as an urgent health and healing matter constitutes a fundamental concern of the *missio Dei*. Like Jesus Christ, Christian churches must claim their identity and vocation as participants in God's mission. This means that they are expected to have a healing ministry on their agenda, particularly one that deals with HIV and AIDS in their local and global contexts. The section has also revealed that in fulfilling *missio Dei,* Jesus was aware of gender bias, even in healing and has set an example for Christian churches such as the FMCSA to follow. However, since this study is postulating WHCR as an exemplar of response to HIV and AIDS, how does the WHCR qualify as a genuine and practical instrument of fulfilling *missio Dei* in time of HIV and AIDS?

3.3 WHCR as Instrument of *Missio Dei* in Time of HIV and AIDS

The aim of this section is to highlight the significance of the WHCR in the fulfilment of *missio Dei* in the time of HIV and AIDS.

3.3.1 Emergence of the WHCR

The Wesleyan Health Care Response is a model of addressing HIV and AIDS postulated in this study, based upon Wesley's medical involvement. The heritage within the WHCR may have been inspired by twofold figures in Wesley's both paternal and maternal lineages as religious and medical practitioners[30] (Coppedge, 1987:20; Gadsby, 1988; Newton, 1988:132; Maddox, 2007:5, 7-8). This background would have therefore prompted Wesley, at seventeen years of age, to attend Oxford University where he later obtained his Bachelor of Divinity degree in 1724 and Master's degree in 1727 (Maddox, 1994:15; Wesley, 1988:7; BBC, 2004; *Seven Church*). As glimpsed in the section 1.2.1., we learn from Davies (1963:33, 35), and Cracknell and White (2005:9) that he was ordained as deacon in 1725 and as priest in 1728 and from Wesley (1988:8)

[30] As religious, Coppedge (1987:20[30]) enlightens that in the 1660s, Wesley's paternal great- grandfather, Bartholomew Wesley, his paternal grandfather, John Wesley, and his maternal grandfather, Dr. Samuel Annesley represented zealous reformers, the Puritans who fought for changes in the Church of England and who consequently were ejected, gaining the name of Nonconformists or Dissenters. They therefore organised their groups and continued with religious activities outside the Church. With regard to his parents, Samuel and Susanna Wesley, Gadsby (1988[30]) remarks that they had rather conformed to the Church of England. His father was Rector at Epworth while his mother, Wesley's first and main educator and role model, was "well-educated and an able theologian" (Newton, 1988:132[30]). As to medical practices, Maddox (2007:5[30]) articulates that after Bartholomew Wesley has refused to sign the Act of Conformity to the Church of England and then ejected, he worked as physician as an alternative career. Likewise, Dr. Samuel Annesley had a library in which, according to Maddox (2007:7-8), were about twenty volumes of medical references.

and Newton (1988:134) that Wesley was converted on May 24, 1738. Hill (1958) and Maddocks (1988) elaborate on how he practiced medicine.

For Marquardt (1992:23-24), Wesley started healthcare activities at Oxford after the spring of 1729 when he had joined and begun to lead the Holy Club. The agenda of the Holy Club at Oxford included bible study and social actions consisting of preaching and providing pastoral care in two city prisons and eventually providing clothes and financial support to prisoners who wanted to initiate a new occupation. The same services were provided to poor families, workhouse and underprivileged children's school (:24). In the course of their ministry, the Holy Club faced serious challenges from deprived families where the parents were ill. It is in responding to this challenge that they started securing medicines as part of the support package (:24).

However, Gadsby (1988) and Marquardt (1992:24) state that the Holy Club was dissolved and the ministry ceased after Wesley accompanied Oglethorpe to Georgia and remained there as missionary from 1735 to 1738. When he returned to England, he was shocked by the suffering of the poor (Gadsby, 1988; Stephens, 1988:23). Here, Hill (1958), Maddocks (1988), and Marquardt (1992) present a series of Wesley's subsequent initiatives that explain the new and gradual involvement in and improvement of healthcare. He established dispensaries in London, Bristol and Newcastle during 1746-1747 where he served people while referring complicated cases to specialist physicians 'that fear God' (Hill, 1958:1, 13; Marquardt, 1992:28). Though he had gained basic skills in medicine at Oxford before going to Georgia (Marquardt, 1992:28; Hill, 1958:11), he furthered his knowledge through practicing medicine and reading medical books authored by Dr. Tissot (Hill, 1958:54-82) and Dr. Cheyne (Wesley, 2004:v-vi) on preventing and curing diseases using easy and natural means. His learning culminated in skills using electrical energy for curing diseases which had already interested him in 1747 (Maddocks, 1988: 142-143; endnote 6 at page 235). These skills helped him to be consistent in what he was doing and to publish his own publications in the medical field. Wesley's publications include *Primitive Physic* (Wesley, 2004) that appeared in 1747 and contains easy and natural ways of curing several afflictions. According to Hill (1958:111) and Wesley (2004:1-57), this book informs on more than nine hundred recipes and directions for addressing two hundred and eighty-eight afflictions. To draw attention to the usefulness of this book, Hill (1958:111) remarks that during Wesley's lifetime, twenty-three editions were published and reached its thirty-second edition in 1828 (see also Marquardt, 1992:29). Therefore, viewing all that Wesley has learnt in healing and the way his ministry developed, it could be argued that he was an (amateur) physician (Hill 1958:7, 32).

Moreover, as part of this ministry's expansion, Wesley carried out three more steps to ensure its usefulness and sustainability amongst the poor. He offered free medical care not only to the Methodists but to the whole community (Marquardt, 1992:29); he distributed his book, *Primitive Physic* to the poor in England at little or no cost in order to help them not always to seek a physician whenever there was affliction, which was costly (Maddox, 2007:27)[31]; he financially empowered the poor in order to help them maintain a healthy lifestyle and pay the physicians' bills. At this point, he gave them interest-free loans and helped them find or create jobs (Marquardt, 1992:29). Upon his death in 1791, his ministry was known throughout in England as were his curing methods applied by himself, his family, and the community (Maddocks, 1988:142-143; Maddox, 2007: 9-10; Malony, 1995). Although this ministry was inspired by people of Wesley's lineage, there is room to ponder on what motivated him to invest so enthusiastically in healthcare and the kinds of afflictions he addressed. Perspectives gleaned from these questions have shaped the understanding of the WHCR and its potential for empowering the FMCSA's response to HIV and AIDS.

3.3.2 Motivation and Practice of the WHCR

This section will focus on what motivated Wesley to invest in healthcare, the kinds of afflictions he addressed, how he addressed them and some critics of his ministry. Literature indicates two reasons that led Wesley to initiate healthcare activities. The first impetus was the pitiable living conditions of the poor in England. Marquardt (1992), Guy (1988), and Health and Healing in the Ministry of John Wesley (2001) point out that during the eighteenth century, there were a large number of starving, unemployed poor in this country. Marquardt (1992:20) states that these people left their communities for the newly developed industrial areas or the slum districts. According to Guy (1988:119) Wesley was very concerned about these conditions.

According to Marquardt (1992:20-23), Wesley's other concern was that the majority of the rich who had dispossessed the poor in the rural areas by introducing modern agricultural methods, were not concerned about their social well-being. They viewed the condition of the poor as of their own making and as a divine punishment. For Gadsby (1998) and Marquardt (1992:20), the entire community, including its political leaders, was corrupt and bore the same attitude towards the poor. Marquardt (1992:21) furthermore informs that when these deprived people tried to organise demonstrations in order to make their problem officially heard, military forces

[31] Wesley distributed copies of this book to the community when, few years after the creation of dispensary in London, he was short of resources to continue running it (Maddox, 2007:27).

intervened and imposed severe punishment on the initiators. According to Hill (1958:8), there were also Methodists among these people.

Besides socio-economic and political conditions, the other concern of Wesley was the impact on the health system and the inaccessibility of the poor to health services. Hill (1958) informs that many diseases resulted from "the overcrowded, insanitary dwelling-houses, the open sewers, the packed, disease-ridden prisons, the degrading gin-drinking, the neglect of the poor, the indifference to the welfare of children, the general brutality" (:4). The health institutions were also subjected to filthy conditions. As Hill (1958) mentions, hospitals and infirmaries were filled with offensive smells, beds were covered with straw mattresses and dirty linen and were "breeding-grounds for the lethal typhus fever usually referred to as 'hospital' fever" (:3-4).

Hill (1958), Gadsby (1998) and Health and Healing (2001) point out the scarcity of physicians in health services. For Hill (1958), Oxford University produced on average four physicians per year; Cambridge could produce more while Edinburgh produced the most, an average of sixteen per year (:2). There were some apothecaries and surgeons scattered about in the more populated centres but were hardly accessible because of the sparsely inhabited country districts (:2-3).

Added to this scarcity was the approach used to study medicine which, according to Wesley, was resulting in incompetent healthcare physicians (:3). As Hill (1958:3) explains, they were spending time in philosophical theories of diseases, astronomy and astrology and neglecting anatomy and physiology and the factual cause of diseases while this was affecting also the kinds of drugs distributed by pharmacopoeia of which few were of therapeutic value (:3, 5). Related to this were the difficulties experienced by ordinary people to use the drugs because they were expensive or named in complicated technical terms (:5). Wesley (2004) observed that physicians were arrogant and this created a divide between their services and their potential beneficiaries, thus making themselves "something more than human" (:iii). Wesley (2004:iv) also observed that physicians were making unnecessary combinations of many products that could result in poisons rather than medication driven by their greed for more money. As these authors observe, it is this inaccessibility of the poor to health services in the midst of an unconcerned and corrupt society that contributed to Wesley's decision to initiate a healthcare response as an alternative. In his initiative, Wesley intended to provide the poor communities with cheap and easy-to-use remedies (Malony, 1995; Wesley, 2004:iv; Maddox, 1994:146, 148). It will be argued later that these same life-denying conditions that shaped the environment in which Wesley served the people of his time are also relevant to the socio-economic context of South Africa. Therefore, this has the

potential to serve as a model for the emergence of the WHCR to equip and empower the FMCSA's response to HIV.

As for the second motivation, literature also attests to Wesleyan theology of healing. Wesley (2004:i) understood sickness as result of human sin. In the preface of his book, *Primitive Physic,* he explains that when God created human beings, their body and soul were meant to live eternally without pain, passion or injury and they would peacefully interact with the whole universe since they were at peace with God (:i). However, as Wesley further explains, when they rebelled against God by falling into sin, the relationship changed. The universe conspired against them, producing poison everywhere. Likewise, immortality changed into mortality and all the creatures contributed to hurrying the realisation of God's curse against human beings, that of returning to the dust where they came from (:i). For Wesley, it is because of this fall that human beings became vulnerable to sicknesses (:i).

Wesley believed that God is involved in lessening this suffering though it is not completely removed (:i-ii). For him, God's willingness to soften the suffering resides within the phrase pronouncing the curses, "In the sweat of thy face shalt thou eat bread, 'till thou return to the ground"' (:i). Wesley finds here the power to preserve and restore life, especially for those who control their diet (:i). In addition, Wesley suggests that God provides and reveals medicines to treat the diseases though, according to him, some people call it an accident (:ii).[32] In analysing Wesley's sermon on 'God's Love to Fallen Man,' Maddox (1994) also remarks on Wesley's argument, that if humans had not fallen, "we would not have known God as the one *providing healing* for our wounds" (:62-63). Maddox (2007) moreover mentions that in discussing about people who were seeking medical treatment for their family members converted during early Methodists' preaching assuming that they [the converted] were lunatic, Wesley suggested that their emotions were "genuine expression of religious conviction" and that they rather needed the "pardoning touch of the Great Physician" who is God (:12). From these explanations, it is clear that Wesley fully believed that God is the supreme healer and provider of remedy for diseases (see also Maddocks, 1988:143-144).

Wesley also believed that healing was part of the holistic process of salvation. According to Maddox (1994:145), Wesley insisted that salvation must involve both 'inner holiness' and "the

[32] To explain this, Wesley gives the example of someone who was passing through a grove of pines reading a book while suffering from little sores in the mouth. When a drop of gum fell onto his book, he intuitively applied it to one sore which immediately stopped the pain. He tried it on other sores and obtained the same results. And from thereon, this became a remedy that helped all the people who were suffering from that affliction (Wesley, 2004:ii).

recovery of actual moral righteousness in our outward lives." At this point, he linked holiness and social life to salvation. In explaining this further, Maddox (1994) remarks that Wesley's conviction of inclusion of therapeutic transformation of the mortal human body in the understanding of salvation was expressed through deeds and his interest and involvement in physical health and healing. Like Maddox, Atkins (2011) also acknowledges Wesley's conviction and extends it to all Methodist and Wesleyan communities when, during World Methodist Conference in 2011; he stated:

> *A Methodist and Wesleyan understanding of healing is deep and wide. Healing holiness, wholeness and salvation are for us all of a piece: indissoluble; the sum being more significant than the parts [...]. Our understanding of healing involves us as able to be renewed and changed. Body. Mind. Spirit. Each is important, but incomplete in itself and unable to be fully healed without reference to the others [...] it's not like changing the batteries or the hard drive! (:48).*

Based upon Wesley's understanding and practice of the healing ministry all Methodist churches should include both physical healing and holiness ministries on their agenda when accomplishing their mission of salvation.

Wesley considered that all kinds of afflictions – spiritual, emotional, and physical – are interrelated and need holistic remedy. Wesley's attitude to this interrelation is observed in the preface of his book, *Primitive Physic* where he includes some rules on maintaining life which he borrowed from Dr. Cheyne (Wesley, 2004:vi). These rules recognise the influence of passions on physical life. In interpreting this, Maddox (2007:14) argues that the concept 'passion' includes both psychological dynamics and spiritual dimension, thus joining together the emotional, physical and spiritual dimensions of sickness (see also Gadsby, 1998). For Maddox (1994:147), in the same way that the body can be disordered by the mind, the reverse relation is also possible. As to Health and Healing (2001:7), it is such interrelation that explains the current understanding of psychosomatic illness. It is because of this interrelation that, according to Maddox (1994:146-147; 2007:6-7), Health and Healing (2001:8), and Wesley (n.d.:120), a holistic response to diseases is also needed and that in some settings, a spiritual response can heal emotional or physical disorders and vice versa.

Wesley believed that participating in healing is respecting God's commandment to love God and one's neighbour. Hulley (1988:69, 77) explains that Wesley understood that the mark of being altogether Christians is the love of God with all affections and the use of every faculty to express this love, as well as the love for the neighbour as the self (:69). Hulley (1988:77) explains that for Wesley, Christians love God because God loved them first and their love extends to their

neighbours seeking both their physical and spiritual health. This understanding is also found in Wesley's sermons, 'The Danger of Riches' (Wesley, n.d.:1-15), 'On Charity' (Wesley, n.d.:45-57), and 'On Love' (Wesley, n.d.:492-499). In these sermons, Wesley warns his audience that if they lose the love of the neighbours they lose all (Wesley, n.d.:12), if their faith is not based on love, they are on the way to destruction (Wesley, n.d.:56), and giving without love does not profit anything (Wesley, n.d.:495). According to Wesley, all is done for God, which means that we love God for God's own and the neighbour for God's sake (:495). It is therefore in the respect of this order to love that Wesley felt compelled to engage in healthcare, especially for the benefit of the poor[33].

In addition to the account on the social and theological motivation of Wesley's involvement in health and healing, literature also informs about the practice of his ministry, namely, the kinds of afflictions he addressed and the way he did it. Hulley (1988) observes that, "Wesley certainly practiced what he preached" (:69). He supports this argument showing that Wesley recognised and addressed all kinds of afflictions and was using various kinds of remedies. In the same vein, Gadsby (1998) mentions that Wesley valued and promoted the best medical advice and the rule of the six 'non-natural' factors known during his time as determining health or disease, depending on how they were used or abused. These six factors are air, food and drink; sleeping and waking; motion and rest; evacuation and repletion/retention; the passions of the mind/soul. One can therefore argue that it is because of the importance given to these factors that he included in his book, *Primitive Physic,* preventive advice proposed by Dr. Cheyne regarding food/drink, exercises, rest, cleanliness, bathing, clothing, passion management, prayer and faith (Wesley, 2004:v-vi; Maddocks, 1988:143-144; Health and Healing, 2001:6; Maddox, 2007:13-22).

Besides preventive advices, Wesley also developed easy and natural methods of treating diseases as they appear in the above-mentioned book and his other publications[34] (Maddox, 2007:4, 6, 13-14. See also Wesley, 2004; Health and Healing, 2001:4; Hill, 1958:1-2). In his ministry, Wesley used all these curative methods and preventive advice. In his curative prescriptions, he included simple and natural recipes such as clean air, water, milk, whey, honey, treacle, salt, vinegar, some common English herbs as well as some foreign and common cheap and safe medicine (Wesley,

[33] In Chapters 5, 6, and 7, I use insights from these five points explaining the theological motivation of Wesleyan healthcare ministry to assess and to reclaim the relevance of this ministry in the FMCSA.

[34] Other publications of Wesley include: A Letter to a Friend Concerning Tea (1748); The Desideratum, or Electricity Made Plain and Useful (1760); Thoughts on the Sin of Onan, chiefly extracted from [Tissot] (1767); Advice with Respect to Health, extracted from [Tissot] (1769); "Extract from [William] Cadogan on the Gout" (in vol. 26 of his Works, 1774); and An Estimate of the Manners of Present Times (1782)" (Maddox, 2007:4, 6, 13-14. See also Wesley, 2004; Health and Healing, 2001:4; Hill, 1958:1-2).

2004:vii; Hill, 1958:10-11), called 'Cool Regimen' (Maddox, 2007:17-19). Maddox (2007:22-23) observes that Wesley always preferred simple and natural remedies. He relates one account in which Wesley prescribed 225 treatments of which 184 were from plants, 17 from animals, and 24 from minerals (:22-23). This therefore corroborates the view on Wesley's preference of simple and natural remedy.

In his recipe, Wesley also included electrotherapy. Malony (1995) informs that Wesley bought an electrical machine in 1753 in order to use it for curing diseases by shocking suffering parts of the body. According to Malony (1995), Wesley started this experience by shocking himself for lameness and neuralgia. He then used it for other ailments such as fever and cramps (Hill, 1958:96-97). Later, he provided these machines in his clinics, three in London and one in Bristol (Malony, 1995). Malony (1995) also explains that Wesley liked this machine, especially for curing anxiety-related disorders. For this reason, he called it "a thousand medicines in one". Therefore, because of the manner in which he was experimenting with it, Malony (1995) proposes that Wesley deserves to be classified among the four best-known electrotherapists of the eighteenth century.

However, Wesley did not limit his medicine to these natural remedies. He was also using pharmaceutical, emotional and spiritual treatments. As Maddox (2007:9-10) recounts, when his brother Charles was sick, he suggested a consultation with a physician, exercises on a wooden horse and electrotherapy. In many cases, he combined pharmaceutical treatment with hygienic and nutritional advice (Maddox, 1994:146-147; Hill, 1958:12; Gadsby, 1998). Sometimes the electroshock was also combined with other medicines (Maddocks, 1988:144). He was also visiting homes and engaging in pastoral counselling (Maddox, 2007:7-9; Maddocks, 1988:141). For every affliction he recommended the combination of remedy with prayer, not only because he believed that God can miraculously heal (Maddox, 2007) or that God can provide the right medicine (Malony, 1995) but also that the causes of the diseases are interconnected, the spiritual and emotional being manifested physically and vice versa (Maddox, October 2007:15-17). Another feature of Wesley's healthcare is that he was not working in isolation. As mentioned in the previous section, he referred complicated and acute cases to specialist physicians (Hill, 1958:1, 13; Marquardt, 1992:28) while concentrating on chronic diseases (Maddox, 2007:26-27; Health and Healing, 2001:3; Hill, 1958:11). As Gadsby (1998), Guy (1988:122), and Maddox (2007:9-10) also mention, he involved other preachers in this work. It is therefore evident that Wesley's belief of healing as part of the whole salvation process plays a role in his combination of pharmaceutical, natural, emotional, and spiritual remedies and his collaboration with other

people who possessed special skills. In the previous section, it is also shown how this healing ministry involved poverty alleviation or financial empowerment. This therefore leads to the realisation that Wesley understood that the individual is to be treated as a whole person, hence the holistic aspect of his ministry (see also Health and Healing, 2001:7).

Nevertheless, Wesley's medical practice did not escape criticism. Malony (1995), Gadsby (1998), and Hill (1958) observe that Wesley was criticised for providing medical services and publishing books on medicine while he was not a licensed physician. Another criticism according to Gadsby (1998) and Health and Healing (2001:4-5) is that Wesley was influenced by traditional herbalists: "he collected old women's nostrums" (Gadsby, 1998). With regard to these criticisms, Gadsby (1998) understands that Wesley did well because his books and services were needed during that time. For Gadsby (1998), the usefulness of his book *Primitive Physic* was proven by its immediate and lasting popularity. Another supportive point is that Wesley responded to the perceptible problems of the poor who had no access to the health system. His healthcare response therefore constituted a new system which accommodated them in their poor means. For him, it was not a matter of being a physician or only using orthodox medicine, since he was certain of the effectiveness of his treatments.

Besides Wesley's practice of medicine, his attitude towards social structures was also subjected to criticism. According to Marquardt (1992:133-134) and the Latin American liberation theologian, Bonino (1981:58, 61-63), Wesley did not seek structural change in his society. As for Bonino's colleague, Runyon (1981:10), Wesley's theology was limited to the confines of individualised pietism and could not allow changes in the society (Eli, 1993:28). One can see the relevance of these critics in Wesley's health ministry. Instead of seeking change of the health system in order to accommodate the poor, he found a way of helping them while the oppressive system was prospering. But before these critics, Marquardt (1992) is not categorical. For him, although Wesley did not demand the change of law or Parliament reform, he denounced the evil that was happening[35]. Moreover, Marquardt (1992:134) mentions that Wesley awoke society's social conscience and activism that nourished reform initiatives. As an example illustrating Marquardt's view, Wesley's sermon, 'On Visiting the Sick' (Wesley, n.d.:125-126), is mentioned in which he encouraged women to seek their freedom, to renounce the silence and to take part in church services. This sermon was preached on 23 May 1786 (Smith, 1982:108), a century before the feminist movement began to reclaim women's political rights in Europe and North America

[35] Here, Marquardt (1992:134) mentions evils such as "the deprivation of many farmers by land enclosures, the catastrophic conditions in the prisons and poor houses, the luxury of the rich, the economic distress of broad strata of the populace, injustice in the penal system and in tax collection, and many other abuses [...]"

(Rakoczy, 2004:12). Since Wesley was well-known in this part of the world, his teachings may have nourished feminist consciousness. In addition, besides the indirect role of social change, Wesley actively participated in the anti-slavery movement (Marquardt, 1992:67-75, 134; Guy, 1988:117). Although he was not a virulent structural reformer as Latin American liberation theologians would expect, he took part in social transformation.

As to the health and healing profession, some contribution of Wesley's health ministry can also be identified. Gadsby (1998) enumerates his safe, holistic and experimental approaches as well as his use of electricity in addressing sicknesses. For Gadsby (1998), these approaches may be seen as a, "template for contemporary orthodox and unorthodox practitioners" and an inspiration to researchers in the field of medicine. One could add to this the use of natural and cheap recipes which is considered as stimulation to current medical systems to give value to local resources[36].

3.3.3 The WHCR's Relevance of *Missio Dei*

This section focuses on the Wesleyan Healthcare Response serving as an instrument of *missio Dei.* In the present study, the WHCR represents the exemplar of accomplishment of *missio Dei* which is inherent in Free Methodism. *Missio Dei* is understood as God's initiative accomplished by God in which many agents, including the church, participate. In the same way, Wesley's healing ministry was theologically motivated by an understanding that real healing is done by God and he was involved in it for the sake of God and out of respect for God's commandment. Healing was also part of the core vision of *missio Dei* as portrayed by Jesus and was on his agenda of holistic salvation. Similarly, Wesley viewed various aspects of afflictions affecting humans and ways of addressing these as being interconnected and took each one to be part of the holistic ministry of salvation. In his healing ministry, this being part of the *missio Dei* accomplishment, Jesus addressed physical, emotional, spiritual and social illnesses, using elements such as saliva, mud, the Word of God, forgiveness, touch, and the casting out of evil spirits. Likewise, Wesley was concerned about illnesses of all kinds. To address these he used natural means, orthodox medicine, counselling, electrical shock, and prayer. The holistic approach of Jesus' healing ministry included advocacy for the marginalised and dealing with issues of injustice, stigma, hunger, and racism. Equally, Wesley's healing was in line with social support and the opposition to social, health, economic and political systems that were not accommodating all the people. Jesus in his ministry was showing love to and acceptance of everybody, unlike the religious leaders of his time. By the same token, in initiating the health ministry, Wesley was respecting

[36] See Chapter 7.

God's commandment of love of one's neighbour and he served all people, Methodists and non-Methodists alike. Lastly, although all the social classes benefited from Jesus' healing ministry, preference was given to the marginalised in the society. In the same way, Wesley developed a ministry that was able to deliver a service to people excluded from the health, political and economic systems of England.

These six aspects illustrate the connectivity between *missio Dei* and the WHCR. Therefore, because the close relationship between the two notions has been identified, it is argued that the WHCR is an accomplishment of *missio Dei* and that reclaiming the WHCR - or at least some aspects of it - means reclaiming the *missio Dei.*

3.3.4 The WHCR's Relevance in the Time of HIV and AIDS

This study reclaims and postulates the Wesleyan Healthcare Response as a missional instrument for the FMCSA to respond to the contemporary health challenges of HIV and AIDS. The question that this section seeks to examine is how relevant is this instrument in addressing HIV and AIDS? According to Wittenberg (2007:152), HIV and AIDS involves three dimensions that need to be taken into consideration when addressing this disease. The first is the physical dimension manifested in the breaking down of the immune system by the virus, thus creating in the body an entry for many other diseases. The second dimension is the psychic dimension which requires mental and spiritual resources in order to cope with the absence of a cure for the disease. The third is the social dimension, manifested in the patient's relationship with their social environment; most often seen in the rejection of or by friends and family, loss of financial resources and ostracism in society. In this regard, the strategy already proposed to address these three dimensions will be used and how it interrelates with the WHCR illustrated.

The strategy currently recognised as addressing these dimensions is 'SAVE', developed and proposed to the church by the ANERELA[37] (Heath, 2009:71-73; PACSA, n.d.:12). According to Heath (2009:71), the letter '**S**' in the SAVE strategy stands for *safer practice.* This means that addressing HIV and AIDS must include all HIV preventive measures, these being the Prevention of Mother-To-Child Transmission, PreP and PeP, abstinence, male circumcision, vaginal mocrobicide, condom use, and sterile implement in public health institutions and traditional healers. This component on strategy deals with the physical dimension of the pandemic. It finds

[37] As introduced in Chapter 2.

support in the WHCR where, as previously explained, Wesley advised people on several kinds of prevention strategies, especially through controlling the six non-natural factors (Gadsby, 1998).

The letter '**A**' stands for *available medical interventions*. This implies that the response to HIV and AIDS should consider using medical products and services already proven useful in addressing the pandemic. These include ART, treatment of opportunistic infections and STIs, healthy nutrition and blood tests (Heath (2009:72). This component also deals with the physical dimension of the pandemic. In the WHCR, it corresponds with Wesley's use of orthodox and natural recipes for healing afflictions, including the use of electrical energy (Hill, 1958; Malony, 1995; Wesley, 2004; Maddox, 2007).

The letter '**V**' stands for *Voluntary Counselling and Testing* (VCT). There is a requirement to know one's HIV status in order to develop suitable responses at the right time (Heath, 2009:72). This component combines the physical and psychic dimensions of the pandemic because although the test is done on a physical level, the person tested needs to know his/her status and to positively accept and deal with it. Exhaustive research has revealed that there are no references in documents that show that Wesley carried out blood tests in his healthcare. However, he diagnosed diseases and discussed these with his patients (Hill, 1958:12) and also counselled the sick (Maddox, 2007:7-9; Maddocks, 1988:141). The very fact that people continuously came to seek care from him, revealing their illnesses and accepting his advice demonstrates that he encouraged people to know their health status and to deal with it accordingly.

The letter '**E**' stands for *empowerment*. This component suggests that addressing HIV and AIDS includes also dealing with factors that promote HIV infection or may hinder an adequate response. These factors may comprise religious and cultural factors, gender inequality, poverty and economic imbalance, illiteracy, marginalisation, conflict and violence, migration, and racism (Heath, 2009:72-73). This component deals with the social dimension of the pandemic. In the WHCR, it goes hand-in-hand with Wesley's effort to address social problems that were hindering people's health and their access to health services. These include his initiative to assist people with donations or to alleviate poverty (Marquardt, 1992:29) and to oppose slavery (:67-75, 134), his opposition to gender inequality (Wesley, n.d.:125-126) (to be discussed later), his efforts to promote education (:49-66), his concern for prisoners (:77-86), and his encouragement of rich to help the poor (Wesley, n.d.:1-15).

This overview therefore points to identifiable components of medi-care that the Wesleyan heritage has which bequeaths to and equips the WHCR to respond to the three dimensions of

HIV and AIDS pandemic. The added value of the WHCR resides in that as holistic approach, it is also embedded in the foundation and the faith of the FMCSA and supports strategies already suggested to churches. In the next section the WHCR will be examined in relation to gender equality.

3.3.5 The WHCR and Gender Equality

In this section, literature on Wesley's holistic ministry will be explored and will show his outlook on the relationship between males and females, and the positions and roles they are expected to hold in the church and in society. A scholar who displays an interest in this subject is Maddox who, in his article, 'Wesleyan Theology and the Christian Feminist Critique' (1987) and in his book, *Responsible Grace: John Wesley's Practical Theology* (1994), examines Wesleyan theology from a feminist perspective. His findings are summarised as follows: Concerning the doctrine of God, Maddox (1987:103; 1994:64) points to Wesley's 'sexist' language when he names God in masculine terms, particularly when he refers to God as "Father Physician". An attitude similar to this is also found in other speeches where Wesley was confusing people in general with the term 'men'. As an example, in his sermon, 'On Visiting the Sick' he said: '"To beg I am ashamed; but never be ashamed to beg for the poor; yea, in this case, be an importunate beggar ... at the same time trusting in Him that has the hearts of all men in his hands" (Wesley, n.d.:121). Although Wesley was advocating for the poor, he was using chauvinistic language to signify God and God's people. In a further appraisal of the Wesleyan doctrine of Christ, the Holy Spirit, creation, humanity, sin, and redemption, Maddox (1987:101-107) finds more critical points.

However, Maddox does not denounce Wesley for his perceptions because he believes that Wesley was not consciously construing God as more male than female (1987:102; 1994:64). He concludes,

> While we also noted several areas of traditional Wesleyan theology and practice which feminists would view critically, none of these areas were necessarily implications of essential Wesleyan convictions [...]. Wesleyanism presents Christian feminists a theological tradition with which they will find strong affinities and on which they can build (1987:107).

This conclusion lends credibility to the Wesleyan doctrine in relation to gender as understood by feminists. The argument by Maddox on the basis that Wesley was living in a patriarchal society when the current consciousness of gender equality was not yet developed is supported in this work.

Maddox (1994:72) also notes Wesley's position on male and female social equality. He suggests that Wesley assumed that differences between men and women extended beyond their anatomy. He reproaches him of describing women as, "more passionate, less intellectual, and less courageous than men". In his note 56 (:72; 291), Maddox shows that Wesley places women, children and slaves in the same category of people who are unable to participate in government. In note 57 (:72; 291), Maddox refers to Wesley's letter to his wife, telling her that disobedience to him is akin to a rebellion against God and the king. However, in spite of this notably sound evidence of Wesley's negative attitude on gender equality, Maddox realises that Wesley's position was not stable. As an example, he indicates that Wesley rejected physical abuse of women by their husbands (:291) and the supposition that women were originally to be subordinate to men (:72). From this combination of attitudes, Maddox finds at least one positive outcome: "The possibility of advocating restoration of the social equality of women as one aspect of the Christian healing of the damage" (:73).

Maddox (1987; 1994) scrutinises Wesley's understanding of male and female positions and roles in the ministry. Wesley does not deny the spiritual equality of men and women (:72; see also Grider, 1982:49-50). Maddox (1987:106-107) indicates that Wesleyan churches were among the first to ordain women. He also remarks that, like feminists, Wesleyan tradition emphasizes "empowerment and services rather than exclusiveness and authority", sharing this view with many others. For Newton (1988), Wesley gave women positions of genuine leadership. As examples, Grace Murray was in charge of Orphans House at Newcastle, Hannah Ball of organizing pioneer Sunday School work at High Wycombe, and Nancy Bolton of exercising pastoral care and leadership in the Society at Witney (:134-135). He also encouraged them to use their varied gifts and advised them while receiving their advices as co-workers (see also Wesley, n.d.:123-126). Newton (1988:136-137) also states that Wesley admired women's work and challenged Paul's teaching which hindered women's participation in the ministry. For Marquardt (1992:29), Wesley's financial empowerment (loans and job creation) was extended to both men and women. In Wesley's health ministry, Hill (1958), Maddocks (1988:141) and Newton (1988:136) show that he treated men and women equally in providing medicines, counselling and advice on health. In his sermon, 'On Visiting the Sick', as seen earlier Wesley also strongly encouraged women to seek their freedom from being silenced or abused (Wesley, n.d.:125-126).

It appears from this analysis that Wesley's attitude was diverse, containing aspects that could both hinder and promote gender equality. But the most limiting disposition is found in his view on social life. However, looking at his family life, one can argue that this predisposition was due

to his misunderstanding with his wife than his attitude to gender equality. As observed by Newton (1988), Wesley had a powerful mother, Susanna, who shaped his life in beliefs, worldview and social life (:131-133). Bowen (1937:278-285) and Harrison (1944:137-145) also recount that at the age of 45 Wesley prepared to marry Grace Murray who could embrace Susanna's characters, but his brother Charles did not like her because she was not formally educated. He then secretly married her to Wesley's rival. Because of this deception, Wesley, at the age of 48, married a wealthy widow Molly/Mary Vazeille, without much preparation and without informing his family (Bowen, 1937:298-301; Harrison, 1944:180-190). Molly found it difficult to always travel with Wesley on horseback in cold or hot weather and at risk of bloodshed violence, robbery and riots. She was used to a life of high standards and stability, unlike Wesley, who was born into a family of nineteen children [only ten survived to adulthood] and who were used to going hungry (Harrison, 1944:13; Bowen, 1937:300; *Susanna Wesley's Biography*); and who was spending much of his time in preaching and distributing his small wealth to the poor (Soper, 1988:183-189; Bowen, 1937:274; Guy, 1988:118-119). For Bowen (1937:302-305) and *Seven Church*, she "offered him little comfort"; she left him fifteen years later without a biological child, to stay with her former children; and he accepted her as "a cross by the Lord". Newton (1988:129) remarks that their union was disappointing to both parties. It can be argued here that since Wesley afforded due respect to both men and women in his ministry and in his teaching, and encouraged women to seek their freedom, this family challenge should be considered as an isolated case. Despite the problems he experienced in his own family, Wesley, in his holistic ministry, was a promoter of gender equality. It is for this reason that it is argued that the WHCR should be reclaimed and become an integral part of the FMCSA's response to HIV and AIDS from a gender perspective.

3.4 The WHCR as FMCSA's Potential Missional Resource

In this section the Wesleyan Healthcare Response as a potential missional resource for the FMCSA in time of HIV and AIDS is examined. This reclaim is based on the way of life taught by John Wesley as the heritage that his followers committed to preserve[38] (FMCNA, 2000: 2; Lamson, 1960:12-15; Howland, 1951:33-34). WHCR is part of Early Methodism and Wesley's life and teaching and whose initiation was motivated by theological and social conditions that are comparable to those exposed to the FMCSA.

[38] See Chapter 1.

During Wesley's lifetime, there were many diseases in England caused by inadequate infrastructures (Hill 1958:3-4). Similarly, the FMCSA ministers in South Africa where HIV and AIDS constitutes a real challenge to the community (Gouws and Karim, 2010; Kleinschmidt et al., 2010).

It can also be shown that in the eighteenth century, there were many poor people in England and their misery was not the concern of the rich and the leaders of the nation (Marquardt, 1992:20-23; Guy, 1988:119; Health and Healing, 2001; Gadsby, 1998; Hill, 1958:3-4, 8). It was previously argued in chapter 2 that although South Africa appears among the three wealthiest countries in Africa, wealth is unevenly distributed and this inequality contributes to the spread of HIV and AIDS in this country (Barnett and Whiteside, 2006:96, 131-132, 159-167; Manning, 2002:24; De Waal and Whiteside, 2006:62, 72)[39].

In addition, the poor in England had no access to the health system due to expensive health services, scarcity of health professionals and the physicians' 'incompetence' and greed (Hill, 1958:2-5; Gadsby, 1998; Health and Healing, 2001; Wesley, 2004:iii-iv). This situation recalls the complaints mentioned in chapter 2, that in South Africa, money allocated to health as well as the best equipment and professionals are concentrated in the private sector used by the rich minority (Low, 2011; Wilson and Fairall, 2010).

Finally, the initiation of the WHCR was theologically motivated especially by Wesley's understanding of healthcare as part of holistic ministry of salvation that includes conversion for holiness and social justice; healing as God's will and work; involvement in healing in response to God's commandment of love; and the interconnectivity of spiritual, physical, emotional and social ailments and their treatment. It was explained in section 1.2, that the Free Methodist founders were committed to preserve ways of life as taught and lived by John Wesley, and this life includes his theology and response to health challenges.

Therefore, since all these conditions have prompted Wesley to engage in healthcare, it may be expected that those committed to follow his way of life and teaching will engage in this valuable response under similar conditions. Therefore, because literature is silent about the way the FMCSA has responded to the HIV and AIDS pandemic, the present study was initiated to unveil this matter and to ensure that the WHCR is used as a valuable resource in this Church.

[39] Here, Whiteside (2010:419) also shows that the Gini coefficient of South Africa was 57.8 in 2007. In his explanations, he shows that Gini coefficient is used to measure the distribution of wealth. It becomes zero when the wealth is perfectly distributed and 100 when wealth is in the hands of one person (Whiteside, 2010:419). If therefore Gini coefficient for South Africa is 57.8, it means that the wealth is in the hands of few people.

3.5 Conclusion

This chapter presented the framework of the study. It considered two questions on the expectation of the response to HIV and AIDS and the need to reclaim and postulate a missional response of the WHCR in the FMCSA. This thesis has argued for the WHCR as a missional tool to equip and empower the FMCSA in a time of HIV and AIDS.

Taking Jesus' ministry as a model (among various ways) of *missio Dei's* fulfilment, the thesis argues that his healing ministry was an expression of the *missio Dei's* component that can accommodate issues of HIV and AIDS. In this discussion, it was suggested that health and social conditions in which Jesus' ministry was carried out are similar to the conditions that facilitate HIV infections. Therefore, responding to HIV and AIDS is an opportunity to participate in *missio Dei* because Christian churches like the FMCSA, claiming to be partners in God's mission and following Jesus' way of building the Kingdom of God, are expected to engage in the healing ministry and address HIV and AIDS.

Since the WHCR, which reflects Jesus' ministry, is an accomplishment of *missio Dei,* it is a suitable missional resource to use to respond to HIV and AIDS in the South African context. It was also shown that both *missio Dei* and the WHCR possess insights that can promote gender equality when addressing HIV and AIDS. Since the FMC founders have promised to preserve the heritage of Early Methodism and ways of life taught and lived by John Wesley, it is imperative that this Church honours its missional commitment. This commitment involves using insights from the WHCR in its ways of participating in *missio Dei* in times of HIV and AIDS which is a serious problem in South Africa, and to consider this pandemic's gender dimension.

CHAPTER FOUR

METHODOLOGICAL DESIGN

4.1 Introduction

In the preceding two chapters, emphasis was placed on the context and the framework of the study. A discursive account of HIV and AIDS and its gendered nature in South Africa and the FMCSA's response was presented in chapter 2. This was followed in the next chapter with a presentation of the WHCR as a model of missional engagement in a time of HIV and AIDS. The following three chapters will focus on the way in which the FMCSA has responded to HIV and AIDS in SKZN. In particular, chapter 4 will explain the process used to collect, analyse and interpret the data.

This chapter is organized into six parts. Firstly, the geographical location and the population of the study are presented. The study is then framed in its theoretical paradigms and the data collection process is discussed as well as the data analysis and interpretation. Finally, the ethical considerations and the study's methodological limitations will be dealt with. This chapter is mainly resourced from existing literature.

4.2 Geographical Location and Research Population

The present study is located in the FMSKZN region. According to the working document of the 107th FMSKZN Annual Conference (FMCSA, 2012), this region is composed of four districts, Pietermaritzburg, Durban, Coastal and Inland. Each district is divided into circuits which are the basic structures of the Church. Pietermaritzburg District comprises one circuit of the UFMC. In the Durban District, there are three circuits, Clermont, KwaMashu, and Umlazi. There are two Coastal District circuits, namely, Fairview and Hibberdene in the north-east neighbourhood of Port Shepstone City. The Inland District consists of four circuits, Edwaleni, Gamalakhe, KwaNyuswa and Themba located south-west of Port Shepstone City.

There are other sub-structures under the circuit level. In this regard, the circuit follows four steps before becoming a fully independent entity. According to *The Book of Discipline of the Free Methodist Church* (FMCNA, 2000), the first step is the *church planting project* initiated by the *society*. The second is the *fellowship* status after the *church planting project* has developed and established a group

of organised people, regularly gathering for the church services. This level has a parallel option of *affiliate congregation* status, whereby a full congregation is organised out of the Free Methodist sponsorship and seeks to be integrated into the Free Methodist structures. The last step is the *society* status which is a fully organised entity, financially independent and eligible to elect its leadership (:74-77). In the language of the FMCSA, *preaching point* is used for the *church planting project*, *organised church* for *fellowship* and *circuit* for *society*. Therefore, the above document (FMCSA, 2012) shows that in 2012 the FMSKZN had 35 *organised churches* and 10 *preaching points* initiated by some of its circuits.

In addition, the document specifies the statistics of church leaders and members. In 2012 FMSKZN's circuits had 23 ministers, of whom 17 were ordained pastors, 4 were supply pastors and 2 were ministerial candidates. Likewise, it registered 1,855 members, of whom, 344 were junior members, 576 were preparatory members, and 935 were full members[40]. The Church was also regularly attended by 702 children (under 16 years of age) organised into 50 Sunday schools. These children are not counted as church members because they are considered too young to be able to choose their religion (FMCSA, 2012:63). Each circuit is led by a senior pastor, and in some cases, assisted by supply pastor(s) or ministerial candidate(s). The entire FMSKZN region is under the leadership of a Superintendent.

Three facts are worth mentioning about this population. Firstly, it is located in KZN, which, according to Stats SA (2006), is the province the most affected by HIV and AIDS (:4-5). Secondly, though all categories of South Africans benefit from this Church's services[41], its current members are black Africans, who, according to Human Science Research Council (Gouws and Karim, 2010:70), form the community that is the most affected by HIV and AIDS. Thirdly, while these statistics do not provide information about gender, it appears that this Church is attended by more females than males. As an example, the report of the Superintendent of the FMSKZN during the 108th Annual Conference held at Edwaleni from 20 to 24 February 2013 stipulated that women are dominant in the church and that their weakness appears as that

[40] The meaning of these titles is given in the Section 1.2.2.
[41] As an example, The Haven shelter of women and children survivors of domestic violence in Pietermaritzburg receive all the categories of the people living in South Africa.

of the whole church[42] (FMCSA, 2013:5). And in all the gatherings the researcher attended in the FMSKZN, the number of females was always greater than the number of males[43].

It is therefore argued that the FMSKZN should exercise its missional mandate in addressing HIV and AIDS which threatens the greater majority of its community. The rest of this chapter presents the process followed to investigate how this Church has responded to the pandemic but firstly it will delineate the theoretical design of the study.

4.3 Theoretical Paradigm Frame

Durrheim (2006) suggests four series of decisions to make when designing research, among which, the theoretical paradigm that informs the research and the techniques of data collection and analysis resorts (:37).

According to Rossman and Rallis (2012:35), the concept 'paradigm' refers to shared worldviews or "complete, complex ways of seeing and sets of assumptions about the world and actions within it." The complexity of the meaning of this concept was also mentioned by Durrheim (2006) who argues that its elements can allow the exploration of various assumptions to guide the research design. He states that "paradigms are the systems of interrelated ontological, epistemological, and methodological assumptions" (:40). This explanation contains three elements which impact on the understanding of this study's design. The first element is ontology. As suggested by Hesse-Biber and Leavy (2011), this concept denotes a "philosophical belief system about the nature of social reality" (:4). They explain that it includes the belief as to whether the social world is already established or continually constructed (:4). The second element concerns epistemology. This is a "philosophical belief system about who can be knower" (:4). As Hesse-Biber and Leavy (2011) explain the knower refers to the researcher or the research participant (:8). The last element regards the methodology. In his PhD thesis, Saranjira (2009:135) uses this notion to designate the approach to data production or analysis. In this way, it is regarded as part of the research process. Hesse-Biber and Leavy (2011:8) agree with his understanding and specify that it is an account of social reality or some of its components which is furthered wider than empirical investigation. Therefore, with Durrheim's definition of paradigm, the interconnection of assumptions formulated on the basis of these elements form a system which informs the research design. Hence, in the next paragraphs, six systems of

[42] The original text of the report was in IsiZulu: *"Omama mphathisihlalo yibo abaningi la ebandleni. Uma uMalihambe engathi uhlala phansi uyayeka ukukholwa kungasho ukuthi kuphelile ngembandla lama Free Methodist."*
[43] In Chapter two, it is extensively explained how in South Africa, females are much exposed than males to HIV infection and to the suffering of its consequences.

assumptions are presented which illustrate how they relate to or have shaped the design of present study.

4.3.1 System Based on Research Approach.

The first system is based on research approach. Hesse-Biber and Leavy (2011:8) distinguish two paradigms here, the quantitative and qualitative research approaches. Williams (2003:4) defines them in terms of processes they follow to gain knowledge, the extent of their application and their aims. For him, quantitative research is mainly conducted at macro level and is interested in the measurement of quantities and the use of these quantities to explain or predict aggregate behaviour and characteristics (:4). As to qualitative research, it is conducted at micro level and interprets the social world, aiming to understand intentions, meanings and actions (:4).

Durrheim (2006:47) identifies them in terms of information on which researchers conclude, techniques they employ to analyse data, and the level of analysis. He highlights that in quantitative research, data is collected in the form of numbers and statistically analysed in order to make a broad and generalisable comparison. For qualitative research, as he further explains, data is collected in the form of written or spoken language or observation and analysed by identifying and categorising themes. He also mentions that qualitative research is deep, open and detailed (:47).

Based on these explanations, this study embraced a qualitative research approach. Research work was conducted in three communities of the FMSKZN. It was carried out with a limited number of participants[44] ('micro level' according to Williams, 2003:4), and investigated the attitudes and concrete response of the FMSKZN to HIV and AIDS (seeking understanding of meanings and actions). Data was collected through interviewing the participants and analysed using categories and themes. Although some quantitative data in the analysis of the results[45] was generated, this was obtained through identification of categories and themes within the findings, and not from predetermined variables as it is done in quantitative research (Durrheim, 2006:47).

4.3.2 System Based on Ontology and Epistemology

The second system of assumptions is based on ontology and epistemology. Various authors who write about this system use a range of categorization but fundamentally express similar ideas. For

[44] The details of the number of people involved in this study is given in section 4.4.4.
[45] See Chapters 5 and 6.

example Anderson (1998:4-5) identifies positivism and post-positivism. Williams (2003:11-17) uses concepts of positivism and humanism. Hesse-Biber and Leavy (2011:5) distinguish positivist, post-positivist, and critical assumptions. Rossman and Rallis (2012:43-45) discern positivism, critical humanism, critical realism, and descriptive interpretivism. In this section, this last classification is discussed as it comprises all these other categorisations and illustrates their genesis.

In illustrating the structure of this system, Rossman and Rallis (2012:35-45) part from Burrell and Morgan (1979)'s typology of paradigms in sociology and identify the interconnection of two continua of assumptions, one about research, and the other about the social world. With regard to the research continuum, they isolate two polar extremes of the nature of knowledge and knowing the truth, namely, subjectivity and objectivity. Subjectivists argue that the notion of truth is problematic and that there is a scarcity of truths which constitute universal knowledge; rather, there are human perspectives about the world (:36). As to the objectivists, Rossman and Rallis (2012) stress the existence of a determinable Truth about particular circumstances (:36).

In terms of the social world continuum, Rossman and Rallis (2012) discern two polar extremes of models of society and social process, the status quo and the radical change. For them, the status quo model "presumes that society is basically well-ordered and functionally coordinated." In this model, researchers assume that the function of the society is predictable and that knowing social process is a means to the improvement of social and organisational life (:41). Conversely, the radical change model assumes that "social processes deprive individuals and organisations of important satisfaction" (:41). Thus, researchers holding this perspective seek the possibility of social transformation (:41).

Therefore, in the intersections of the four polar extremes of these two continua, Rossman and Rallis (2012) discovered four categories of assumptions that they named 'four paradigms' as shown in the Table 1.

Table 1: Four Paradigms According to Rossman and Rallis.

Knowledge of Truth / Model of Society	**Subjectivity**	**Objectivity**
Radical Change	**CRITICAL HUMANISM**	Critical Realism
Status Quo	Descriptive Interpretivism	Positivism

Source: Adapted from Rossman and Rallis (2012:43)

In explaining these paradigms, Rossman and Rallis (2012:43) observe that positivists see the social world as oriented towards the status quo and their research aims to explain and improve its function. In their research, they apply methods from natural science assuming objectivity obtained through experimental and quasi-experimental designs and quantitative analysis (:43). As to descriptive interpretivists, they try to understand the social world as it is from the participants' individual and subjective worldviews. Researchers from this perspective use in-depth interviews and observation to generate "thick description…of actor's worldview" (:43-44). With regard to critical humanists, Rossman and Rallis (2012) elucidate that individuals are viewed as agents to "empower, transform, and liberate groups from dominating and imprisoning social processes" (44). Critical humanists believe that radical change happens at individual level and transforms social relation at local level (:44). As Rossman and Rallis (2012) also observe, researchers who hold this perspective use the same methods as the descriptive interpretivists but differ from them in terms of position. Here, instead of studying the social world as it is, researchers explicitly participate in the research project by sharing initiation and collaborating with research participants (:44). Concerning critical realists, they analyse power relations of political and economic structure rather than individual human consciousness. Rossman and Rallis (2012) clarify that researchers use large numbers of data quantitatively gathered and represented in order to highlight the extent of inequality in areas such as gender, race or wealth and power distribution (44-45).

This system of assumptions based on ontology and epistemology has similarities with the preceding one based on research approaches whereby quantitative research is ascribed to positivists and critical realists while qualitative research is ascribed to critical humanists and descriptive interpretivists. It is however noteworthy that, as Rossman and Rallis (2012:35) remark, there are no clear-cut boundaries between these paradigms because each research project is located on a particular point of these continua.

With this brief explanation the challenge is to know where the present study is located. On the continuum of the nature of knowledge of the truth, it weighs on the side of subjectivity. Therefore, in investigating the response of the FMSKZN towards HIV and AIDS, it is assumed that there is no imaginary response to the pandemic. It is assumed that people refer their beliefs, background and social context to initiate and develop an adapted response. It is at this level that the WHCR is reclaimed as an inspiring resource for equipping the FMSKZN to respond to the pandemic because this resource is embedded in the essence of being a Church. On the continuum of the model of the society, this study weighs on the side of radical change. In

initiating this study, there was scepticism regarding the Church's response to HIV and AIDS and the research project was initiated to reflect on the possibility of discovering what changes if any were needed.

Therefore this study falls within the critical humanistic paradigm. However, since it is based on the continua, it has ramifications in other paradigms, although not in all aspects. As an example, although in-depth interviews were used to collect the data as descriptive interpretivists would do, the possibilities of improving the current attitude and concrete response to the pandemic[46] were discussed with the participants, which descriptive interpretivists do not do. Also, although a change in the FMSKZN's current way of addressing HIV and AIDS was advocated,[47] which critical realists would do, a small number of participants were used and the arguments were based not necessarily on the frequencies of the participants' responses, but on the deep description of the situation under scrutiny[48], unlike what critical realists would do.

4.3.3 System Based on the Goal of the Research

So far, the systems of assumptions which implicitly or explicitly differentiate qualitative and quantitative research approaches were discussed. But within each approach, there are other systems of assumptions which also inform research. Since the present study falls under qualitative approach, other systems of assumptions developed within this approach and which have informed this study will be discussed. Therefore, the third system of assumptions is based on the goal of the research. As Durrheim (2006) and Hesse-Biber and Leavy (2011) show, there are exploratory, descriptive and explanatory research. Exploratory studies are conducted as preliminary investigations of under-researched areas in order to orient future research. Descriptive studies provide abundant descriptions of social phenomena from the perspective of the research participants. Explanatory studies aim to establish causal explanation of social phenomena (Durrheim, 2006:44-45; Hesse-Biber and Leavy, 2011:10). Using this classification, this study corresponds more to descriptive research. In this regard, results obtained through in-depth interview were used to provide descriptions of the attitude and concrete response of the FMSKZN to HIV and AIDS. This description has aided in the identification of the gaps in the

[46] See interview guides (appendices 4, 5).
[47] See Chapter 7.
[48] See next section, Chapter 5 and 6.,

Church's fulfilment of the *missio Dei* in this health crisis and insights from the WHCR is suggested for the improvement of its response[49].

4.3.4 System Based on the Use of Research

The fourth system of assumptions is based on the use of research. Durrheim (2006) and Rossman and Rallis (2012) distinguish basic and applied research. They explain basic research as that where results are used to advance the fundamental knowledge of the world and to generate theory. As to applied research, its results serve as basis to make informed decision on practical issues such as developing policy or solving a given problem (Durrheim, 2006:45-46; Rossman and Rallis, 2012:5-6). Therefore, since the present study was initiated in the context of addressing HIV and AIDS, it is informed by applied research. In particular, as part of the FMC leadership, the researcher hopes to be inspired by the results of this study in developing an improved response to HIV and AIDS which is negatively affecting the communities.

4.3.5 System Based on the Locus of the Researcher's Interest

The fifth system of assumption is based on the locus of the researcher's interest. Discourses present a range of categories here. Rossman and Rallis (2012) identify phenomenological studies in which researchers seek to understand the lived experience of people, and case studies whereby they intend to understand a larger phenomenon or organisation through the intensive exploration of a single incidence or component. They also include ethnography in which researchers envision understanding the culture or subculture, and Socio-communication studies in which they search for meaning in signs, words and gestures (:89-106). A similar categorization was also proposed by Minichiello and Kottler (2010a) under the title 'Major Qualitative Methodologies.' However, while they do not mention Socio-communication studies, they discourse on Grounded Theory whereby researchers are interested in developing a proposition or a theory in order to promote the understanding of a problem or a topic, and narrative studies in which researchers envisage describing major plots within people's life stories (: 29).

Considering these models, the present study finds its inspiration from case studies. Although the study was conducted in the FMSKZN, the intention was to understand the full FMCSA's response to HIV and AIDS. However, there are no clear-cut boundaries between these

[49] See Chapters 5, 6, and 7.

categories and so it is too for this study[50]. Therefore, all the framings of the present study as illustrated in this section do not have rigid boundaries.

4.3.6 System Based on 'Some Important Theoretical Traditions'

The last system of assumptions is based on what Minichiello and Kottler (2010a) call 'some important theoretical traditions.' These authors present seven theories, namely, constructivism, symbolic interactionism, postmodernism and feminism, ethnomethodology, phenomenology, discourses analysis, and grounded theory (:22-27). While it is beyond the limitations of this section to discuss each theory, only those which have shaped the design of this study, namely postmodernism and feminism will be examined. As Minichiello and Kottler (2010a) explain, postmodernists reject clear cause and effect assumptions, rather holding that reality is often "fragmented, indeterminate and chaotic" (:24). They also take seriously the influence of the culture, language, gender and power on human belief. For Minichiello and Kottler (2010a), feminism is similar to this postmodernism but with much more focus on gender issues while challenging assumptions of male dominance (:24-25).

In view of this account, this study was initiated based on the notion that the FMCSA was not adequately responding to HIV and AIDS (fragment and chaos). This idea took root in the realisation that women and children survivors of domestic violence assisted by The Haven Project of the FMCSA in Pietermaritzburg were also highly exposed to HIV and AIDS; yet this dimension was not being addressed[51]. It was therefore this concern resulting from a culturally constructed gender issue (domestic violence, male domination) which prompted the design of the study from a gender perspective.

After the overview of systems of these interrelated assumptions (also called paradigms) which have shaped the design of the study, the data collection methods will be explained.

4.4 Data Collection Methods

The concept of method has been sometimes confused with that of methodology (Saranjira, 2009:135). Recent discourses, however, converge at a clear meaning. Saranjira (2009) uses it to designate "a way or technique of data production or analysis" (:135). Similarly, Hesse-Biber and

[50] As an example, in Chapters 2, 5, 6, and 7, I speak about the culture and its influence on the spread of HIV and AIDS, which would interest ethnographical researcher. In Chapter 5, I also highlight how people express negative attitude to HIV and AIDS by using ridiculous naming of HIV or PLWHA, which would draw attention of socio-communication researchers.
[51] See Chapter 1

Leavy, (2011) explain methods as tools or techniques of data gathering (:5). Rossman and Rallis (2012) also mention it in their title 'Design and Methods' under which they explain research rationale and procedures for sampling, data gathering and analysis (:135-141). These authors relate this concept to the tools and techniques utilized to collect research information. This meaning has been retained and the concept used to imply tools and techniques of data collection, analysis and interpretation. Hence, in this section, the data collection process followed in this study is explained, using written documents and fieldwork research. In the fieldwork research, the units of analysis; categories of participants and research techniques and tools; sampling; and interviewing process are specified.

4.4.1 Use of Written Documents

Written documents used in this study were obtained by means of a systematic literature review (Olivier, 2012; Armstrong et al. 2011; Arksey et al. 2005; Wilson et al. 2010). Using various keywords related to the present topic (see the section, 'Abstract' in the preliminary pages), the main search engines were Google Scholar, the EBSCOhost research database, EBSCO electronic journal service, SABINET and Web of Knowledge. Websites of research centres and other institutions such as SAHARA (Social Aspect on HIV/AIDS Research Alliance), CADRE (Centre for AIDS Development, Research and Evaluation), HSRC (Human Science Research Council), and WCC (World Council of Churches) were also explored. The library of the University of KwaZulu-Natal and its inter-library services were also used. Other written sources were the books and journals available from the School of Religion, Philosophy and Classics as well as papers presented in various seminars organised by or through this School. The HIV and AIDS database of the Sinomlando centre based in this School was also gainfully utilised.

Two kinds of written documents formed the nexus of this study. Documents containing primary data such as reports and other non-academic and unpublished documents on the FMCSA were consulted. These documents were drawn on to shape sections 1.2.2, 1.3, 1.4, respectively on the overview of the FMCSA, background and outline of the research problem and the motivation of the study. They have also served in shaping section 4.2 on the location and population of the study and Chapters 5 and 6 dedicated to the fieldwork results. They include the Book of Discipline of the FMC which informs on the doctrine of this Church (FMCNA, 2000). They also involve HIV and AIDS project proposal which reveals an attempt of the FMCSA to address HIV and AIDS (FMCSA, 2005). They also comprise working documents of the FMSKZN Annual Conferences from 2008 to 2013 which are the compilations of annual minutes from

circuits and superintendencies. Other primary documents are 'Articles of the Rights, Power and Functions' which is The Haven Project's Constitution (The Haven, 2008); the minute of the UFMC's Board Meeting on Sunday 13 March 2011 (UFMC, 2011); the minute of the 4th General Conference of the FMCSA from 07-09 January 2009 (FMCSA, 2009); and the Statistics of the FMCSA from 2009 to 2011 (FMCSA, 2011).

Primary sources also involved interview transcripts on 'memory of AIDS' in KwaZulu-Natal Midlands existing in the database of Sinomlando Centre. In particular, interviews with Baloyi, Briget, Hlela, Lamula, and Nxumalo were used. Primary sources also include academic dissertations and theses. The most accessed are the PhD theses of Gadsby (1998), especially the section on Wesley and his healthcare strategies; Le Roux (2001) on Wesley's social ethics as referred to by South African local congregations to empower urban poor; and Longwe (2012) on the experience of pastors' wives in the Baptist Convention of Malawi. They also included the Master's dissertations of Iyakaremye (2009), Ntakirutimana (2009), Ntakirutimana (2004), as well as the Honour's dissertations of Musabyimana (2004) and Ntakirutimana (2003) on the response of the FMC to social challenges in Pietermaritzburg, South Africa. Interview transcripts and academic theses were particularly used in the development of Chapters 2 and 3 on the context and the framework of the study.

Documents containing secondary data were also studied. These include published books, journal articles, government/departmental reports, papers presented in conferences or seminars, and Internet articles. In particular, documents on HIV and AIDS and its gendered nature in South Africa to develop the contextual background of the study[52] were consulted. The most prominent are the chapters from *HIV/AIDS in South Africa*, edited by Karim and Karim (2010), *The HIV/AIDS Epidemic in Sub-Saharan Africa in a Historical Perspective*, edited by Denis and Becker, and various books written or edited by members of the Circle of Concerned African Women Theologians.

Moreover, secondary data to explain the framework of the study[53] were included. The article, 'An Abbreviated Introduction to the Concept of *Missio Dei*' of McKinzie (2010), *Transforming Mission: Paradigm Shifts in Theology of Mission,* of Bosch (2011), *Mission in the 21st Century: Exploring the Five Marks of Global Mission* edited by Wall and Ross (2008), *What Is Mission: Theological Exploration* (2000) and *Mission under Scrutiny: Confronting Current Challenges* (2006) of Kirk, *A Ministry Shaped by*

[52] See Chapter 2
[53] See Chapters 3 and 7

Mission of Avis (2005), *Constants in context: A theology of mission for today* (2004) and *Prophetic Dialogue: Reflections on Christian Mission Today* (2011) of Bevans and Schroeder, *The Church and Mission* of Le Roux (2011), as well as *The Renewal of All Things: An Alternative Missiology* of Scott (2009) and *Women in mission: from the New Testament to today* of Smith (2007) have served as key documents to explore the concept of the *missio Dei* and the mission of the church. Important recent articles from journals such as *International Review of Mission, Missio Dei, HTS Teologiese Studies/Theological Studies*, *Dialog: A Journal of Theology, Theology Today,* and *The Expository Times* have been used also for this end.

With regard to Jesus' healing ministry, *The Christian Healing Ministry* by Maddocks (1981), *Yes, You Are Healed: A Journey of Healing* by Schmidt (2007), *Doing Theology, Doing Justice* by Folk (1990), *Introducing African Women's Theology* by Oduyoye (2001), chapters from *Healing in the Name of God* edited by De Villiers (1986), and the article 'Counselling AIDS Patients: Job as a Paradigm' by Wittenberg (2007) have been extensively used. Inclusion of the gender aspect of this ministry was inspired by the book *In Her Name: Women Doing Theology* of Rakoczy (2004) and journal articles, 'Deep in the Flesh' Women, Bodies and HIV/AIDS: A Feminist Ethical Perspective' by Ackermann (2008), and 'Jesus, Prophecy and AIDS' by Dube (2007).

Regarding the, WHCR, the most prominent documents are John Wesley's various sermons and his book, *Primitive Physic* (Wesley, 2004). Other documents most referred to are the *John Wesley among the Physicians: A Study of Eighteenth-Century Medicine* of Hill (1958), *John Wesley' Social Ethics: Praxis and Principles* of Marquardt (1992), and various books and articles of Maddocks and Maddox on Wesley's theology and practice of healthcare.

Secondary data have been used also in developing the methodological landscape of the study. *Michel Foucault* of Shumway (1989), *Counselling Youth: Foucault, Power, and the Ethics of Subjectivity* of Besley (2002), *Education Policy: Globalization, Citizenship and Democracy* of Ossen et al. (2004), and the article, 'Foucault and the Problem of Method' of Apperley (1997) were included. These documents have assisted in building onto two Foucauldian methods of analysis, genealogy and archaeology, in order to outline Chapters 1, 2, and 3. Still concerning methodological design, four books, *Research in Practice: Applied Methods for the Social Sciences* of Terre Blanche et al., *Qualitative Journey: Student and Mentor Experience with Research* of Minichiello and Kottler (2010), *The Practice of Qualitative Research* of Hesse-Biber and Leavy (2011), and *Learning in the Field: An Introduction to Qualitative Research* of Rossman and Rallis (2012) form the cornerstone of chapter 4 in which the methodological design of this study is explained.

Furthermore, selected documents have been used in order to engage in a dialogue between the results and existing literature as it appears in Chapters 5, 6, and 7. In this dialogue, literature such as *Beacons of Hope: HIV Competent Churches: A Framework for Action* of Parry (2008), journal articles, 'Gender Violence and HIV/AIDS: A Deadly Silence in the Church' of Haddad (2002) and 'A Call for Care: HIV/AIDS Challenges the Church' of Richardson (2006), as well as the book's chapter, 'Daughters and Sons of Africa: Seeking Life-Giving and Empowering Leadership in the Age of HIV/AIDS Pandemic' of Njoroge (2008) contributed to the identification of gaps of fulfilling the *missio Dei* in the FMSKZN's response to HIV and AIDS.

4.4.2 Individuals as Units of Analysis

In addition to the written documents, in-depth interviews with selected participants during the field research (empirical side) study were used. These participants form part of what researchers refer to as units of analysis of a phenomenon or focus/locus of investigation on which the study draws its conclusions (Durrheim, 2006; Rossman and Rallis, 2012). At this point, Babbie (1989) identifies four common units in social sciences, namely, individuals, groups, organisations and social artefacts. For Durrheim (2006), three properties of these units are described. These are 'conditions' or objective descriptions such as gender, age, or group structure; 'orientations' which are perspectives such as attitudes or policy; and 'actions' which are behaviours such as segregation or violence (:41). In an interconnected way, Gall, Borg, and Gall (1996) summarise these units and their properties into three points: individuals and their experiences and perceptions; groups and their culture(s); and languages and communication patterns (see also Rossman and Rallis, 2012:89). In the present study, one unit, that is, individuals, was focused on. Within this unit, two properties were investigated, namely, their orientation and actions as related to the HIV and AIDS pandemic[54]

In this regard, three categories of participants were involved in this study. One category was composed of church leaders. These are senior ministers, supply pastors, ministerial candidates, and board members at circuit level. This category also includes the directors of programmes such as Evangelisation and Mission, Youth, Women, and Men programmes, as well as other people who have recognised responsibilities in the Church and participate in leadership's decision making. The overseers of the Church are also included here. These are the Superintendent of the FMSKZN, the region in which the study was conducted, and the Bishop of the FMCSA.

[54] See Chapter 5 and 6 respectively.

The other category comprises caregivers. These are the church members who directly care for PLWHA. They are either family members or neighbours of PLWHA, members or staff of associations and non-governmental organisations or government services working in the area of HIV and AIDS where they meet the PLWHA.

The last category is composed of ordinary church members. In this group, adult people and youth who regularly attend the Church, benefits from its services, and identify themselves as church members regardless whether they are baptised or not were considered.

4.4.3 Research Techniques and Tools

In the fieldwork research, data was collected with methodically designed techniques. For Rossman and Rallis (2012:139), the selection of people to be involved in the study goes together with the decision on methods of data collection. They emphasise in-depth interviewing as the 'hallmark' of qualitative research (:176). They say this because of the meaningful role that they see in the 'talk' when the participant unfolds his/her worldview. They state,

> Often, deeper understandings develop through the dialogue of long, in-depth interviews, as interviewer and participants 'co-construct' meaning...Interviewing takes you into participants' world, at least as far as they can (or choose to) verbally relate what is in their minds (:176).

This means that with this method, the interviewee unveils his/her deep understanding and feeling about the phenomenon studied and the researcher acts as colleague, helper, or motivator in this process. Therefore, in the present study, in-depth interviews were used in order to capture the attitude of the FMSKZN, particularly of the participants, towards HIV and AIDS. The same method was used to collect information on a concrete response of this Church to the pandemic.

However, Rossman and Rallis (2012:177) also remark that in-depth interviews can be used alone or applied together with other methods (:177). Here, their idea of advocating various methods in the same study can be illustrated through the logic that Hesse-Biber and Leavy (2011) give to the mixing of qualitative and quantitative methodological approaches. They quote Greene and Caracelli (1997b:13) who defend that, "the whole is greater than the sum of its parts" (:278). With this insight, they also value Greene and Caracelli (1997)'s explanation that conversation between different methods from different paradigms provides more comprehensive results which could not be obtained through either paradigm used separately (Hesse-Biber and Leavy, 2011:278-279). Almost similar ideas were expressed by Phillips and Davidson (2010) and Lunn

and Smith (2010) in explaining the rationale of using FGD. They suggest that this method helps to ensure that due attention is paid to the subjective meaning of participants and to provide an opportunity for reflective interaction between participants which can unveil complementary or differing views (Phillips and Davidson, 2010:261-262; Lunn and Smith, 2010:212). Inspired by these authors, this study complements the in-depth interview method with FGD in order to have comprehensive information on the response of the FMSKZN to HIV and AIDS and to discern complementary and diverging views about this response.

In this regard, two interview guides have been used to collect empirical data, one adapted to church leaders and caregivers, and the other to ordinary church members. Some standards were followed during the construction of these tools. Minichiello and Kottler commenting in the chapter written by Gilchrist and Sullivan (2010) state that the interview guide "is often a loosely constructed list [of questions] that constantly evolves in the light of each research conversation" (:249). Because of this looseness and the possibility of constant edition it is called a 'guide' (:249). In emphasising this looseness, Hesse-Biber and Leavy (2011) highlight that questions in interview guides are open-ended and are structured according the specific agenda of the interviewer (:127).

In the light hereof, interview guides used in this study were mainly composed of open-ended questions exploring six themes related to the response of the FMSKZN to HIV and AIDS and the use of the WHCR as a resource. Table 2 shows the list of these themes and corresponding number of questions and sub-questions[55]

Table 2: Theme Covered by the Interview Guide and Corresponding Number of Questions and Sub-questions

Themes	Q	S/Q
I. Attitude of the Church towards HIV and AIDS and PLWHA, its Impact, and Initiatives to Improve this.	2	5
II. Response of the Church to HIV and AIDS	3	8
III. Other Church's Programmes Contributing to the Response to HIV and AIDS and Health Issues	3	0
IV. Partnership in Responding to HIV and AIDS	3	5
V. Successes and Weaknesses of the Church in Responding to HIV and AIDS	2	2
VI. Wesleyan Healthcare Response	3	3

Legend: Q = number of questions; S/Q = number of sub-questions

[55] Details of questions are given in the appendices 4 and 5.

According to Williams (2003), it is advised that members of the FGD have common social characteristics in order to avoid the domination or monopoly of the speech by one or few members, thus inhibiting the contribution of others (:67). In this regard, the three categories of participants were identified when forming focus groups. Because church leaders and caregivers are numerically less than ordinary church members,[56] they could not fulfil the conditions required for focus groups if each circuit is considered separately. Reference is made here to the observations of authors such as Rossman and Rallis (2012:189) according to whom focus groups ideally consist of 7 to 10 people, or in extreme cases, 4 to 12 and Lunn and Smith (2010:213), who estimate this number between 6 to 12. Therefore, these focus groups were formed for ordinary church members only and organised according to their age, that is, youth and adults separately. In this way, church leaders and caregivers were interviewed individually.

4.4.4 Sampling

This study has followed the standard process of choosing research participants. Nachmias and Nachmias (1982:294) warn that, "it is impractical to interview all possible respondents." This means that researchers have to select participants from the entire population. In order to respond to this requirement, quantitative researchers randomly choose a sample which is statistically representative of the whole population (:294-299). In forming such sample, their aim is to generalise results of the study on the whole population (Durrheim, 2006:49). In qualitative research, however, which is the case for the present study, a representative sample is not critical. According to Rossman and Rallis (2012:137), this is because qualitative researchers are interested in depth, unlike quantitative researchers who are interested in breadth. They rather ensure that they choose people whose characteristics are significant for the study (Williams, 2003:82), that they capture the process or meaning of people about the research phenomenon (Hesse-Biber and Leavy, 2011:45), and that research findings are transferable (Durrheim, 2006:49).

Therefore, in this study, not all the members of the FMCSA were interviewed. A few people were identified with the intention of seeking an in-depth understanding of their attitude and concrete response to HIV and AIDS. In this regard, discourses present a range of methods of selecting participants in qualitative research (Williams, 2003:73-86; Durrheim, 2006:49-51; Rossman and Rallis, 2012:138). But for this study, only three were used: purposive sampling, snowball sampling, and convenience sampling. As Durrheim (2006:50), William (2006), and Nachmias and Nachmias (1981:299) explain, participants in purposive sampling (or judgement

[56] See statistics in section 4.2.

sampling according to Hesse-Biber and Leavy, 2011:45) are determined before they are chosen and this choice is based on theoretical reasons. In this study purposive sampling in selecting geographical areas, church leaders, first circuits, and the gender of participants was employed.

With regard to geographical areas, decisions on two levels were taken. On the first level, the study was to be located in the FMSKZN. Four reasons guided this choice. One reason was the accessibility of the data, as the researcher was a full-time student at the University of KwaZulu-Natal, Pietermaritzburg Campus and member of the FMC's leadership in Pietermaritzburg. In conducting the study in the FMSKZN, there was the advantage of easy access to key people and written resources, and of reducing the cost for travel, accommodation and food during the fieldwork. The other reason for selecting the FMSKZN was the long presence of this Church in SKZN. In South Africa, the FMC started in SKZN in 1890 (Lamson, 1951:119-120) and is currently the strongest of the five Free Methodist regions (FMCSA, 2011). This region reflects the image of the FMCSA more effectively than others in which the Church expanded later. The third reason concerns the high rate of gender-based violence and HIV in the KZN Province. In some Christian communities in this Province, Phiri (2000:106; 2002:22) found that domestic violence was in 100% of the households which formed her sample.[57] Since gender-based violence is one of the factors of the spread of HIV and AIDS in South Africa (Onyejekwe, 2004), the research was located in the region where its impact was most deeply felt.

The second level of decision in choosing geographical areas was made in selecting research communities within the FMSKZN. This was to ensure that the study would include different communities of this region. The geographical area was thus divided into three communities, namely, Pietermaritzburg, Durban and Port Shepstone, which were included in the research.

In selecting church leaders, all levels of leadership were purposively included. There were two targets in each circuit, the senior minister or assistant pastor on the one hand, and the lay member counted among leadership such as board member or programme director on the other. At this level, the objective was to interview three leaders in each circuit. In addition, the Superintendent of the FMSKZN and the Bishop of the FMCSA were also included. The oldest circuits within each of the three communities were intentionally included to capture information from the context which reflects most of the features of the Church. In Port Shepstone community, it was Fairview where the first Free Methodist missionaries in South Africa started

[57] In Chapter 1, I have shown that there is high rate of HIV in this KwaZulu-Natal Province (see also Republic of South Africa, Statistic Service 2006:4)

their work in 1890 (Burritt, n.d.:44; Lamson, 1951:119). In the Durban Community, the oldest circuit is Umlazi. In the Pietermaritzburg community, there was no choice because it is composed of one circuit, the UFMC. With regard to selecting the gender of participants, both males and females in each category of participants from every circuit were included in order to hear both voices on HIV and AIDS and the response of the Church.

The other method used to select participants is snowball sampling. Hall and Hall (1996:113) and Williams (2003:81) explain that snowball sampling is used when it is impossible or difficult to identify beforehand all the people who fall into the categories required. The researcher starts with a few people available and gets them to refer him/her to others they think fall into these categories and may be approached. This method has been used to choose second circuits within Durban and Port Shepstone communities and the caregivers in all the circuits. In choosing these circuits, participants provided information from the first circuits purposively selected. Therefore, Hibberdene in Port Shepstone and Clermont (and KwaMashu) in Durban were included in the study. Three caregivers per circuit were selected based upon recommendation from the Church leaders.

The last method followed in selecting participants is convenience sampling. For Hall and Hall (1996:115) and Williams (2003:81), researchers who employ this method choose participants where it is possible to do so at the time of research. This method was used here to select ordinary church members. Therefore, in collaboration with church leaders, the study was announced during the Church services and people were invited to participate. Participants from those who met the required expectations of the study were selected.

Therefore, by means of these three sampling methods, 32 people were identified and interviewed individually, of whom 17 were church leaders and 15 were caregivers. Eight focus groups were organised, of which 4 were with adults and 4 with the youth. Table 3 provides the details of the coverage of the sample in each category of participants per community.

Table 3: The Sample Covered by the Study

Community	Structural Level	Interviews		FGD		Total Sessions
		Ch. Leader	Care Giver	Youth	Adult	
Port Shepstone/Fairview	Circuit	3	3	1 [8]	1 [8]	8
Port Shepstone/Hibberdene	Circuit	3	3	1 [6]	1 [10]	8
Durban/Umlazi	Circuit	3	3	1 [4]	1 [6]	8
Durban/Clermont+KwaMashu	Circuit	3	3		1 [6]	7

Community	Structural Level	Interviews		FGD		Total Sessions
		Ch. Leader	Care Giver	Youth	Adult	
Pietermaritzburg/UFMC	Circuit	3	3	1 [8]		7
Southern KwaZulu-Natal	Annual Conf.	1				1
Southern Africa	General Conf.	1				1
Total		17	15	4 [26]	4 [30]	40
Expected Sample		17	15	5	5	42
Coverage (%)		100	100	80	80	95.2

Legend: FGD: Focus Group Discussion; Ch. Leader: Church Leader; [Number in brackets]: Size of focus the group; Conf.: Conference

This table shows that the study reached only 95.2% of the expected sample. This was due to the challenge to organize focus groups with the youth from Clermont and KwaMashu and with adults from Pietermaritzburg. Concerning Clermont and KwaMashu, church members of these circuits advised that they did not have youth members. This information emerged from one FGD as follow:

Interviewer : *What do you think the Church is failing to do in the area of HIV and AIDS?*

Participants : *[Silence] Like in the youth we can't say anything because there are no youth in KwaMashu [and Clermont.].*

Interviewer : *Where are your children?*

Participants : *That is our weakness. Even if you want to talk they stay at home. They don't go to Church. It's only the old ladies. [Laughter] and we are young. You see us here, we are the youngest.*

This was a focus group for adults Clermont/KwaMashu. It was formed with women aged between 50 and 60 and they were claiming to be the youngest members. Their local church had no young men or women present at the time of this interview.[58]

Concerning Pietermaritzburg (UFMC) circuit, most of the adults were also church leaders and caregivers and were interviewed individually. This affected the required size of the focus group because there were no other members available. This void however, did not affect the results of the present study.

[58] The tendency of linking HIV and AIDS with the youth as if adult people are not concerned is also expressed in some other interviews. However, I did not analyse it because it was not falling in the lines of the main focus of this study.

4.4.5 Interviewing Process

The fifth point concerns the interviewing process. Rossman and Rallis (2012) advise that before starting the fieldwork, the researcher must seek "the opening or door through which he (sic) can discover the players and the operations of the world within" (146). According to their explanations, this entry means a person who is able to introduce the researcher to the research participants in order to build relationships and to facilitate research arrangements (:146). In this study, the entry was the Bishop of the FMCSA. The researcher's professional relationship with him over the years helped to facilitate the process of authorization. The research was explained to him and permission was requested to implement it. He accepted and introduced the researcher to the Superintendent of the FMSKZN, and requested him to assist him in all the steps of data collection. It is from this connection that he was able to contact other church leaders and to establish appointments and make arrangements for the whole fieldwork.

During the interviewing process, negotiation of trust, style of questioning, power relation dynamic, the timeframe, and the length of interviews were taken into account. Concerning the negotiation of trust, Hesse-Biber and Leavy (2011:127) remark that insider and outsider statuses can affect the interview. Here, insider status refers to the common characteristics between the researcher and the participant while outsider status refers to their differences (:127). According to Hesse-Biber and Leavy (2011), outsider status inhibits the trust and openness of the participant as well as the understanding of the researcher about the participant's world. However, insider status produces the opposite effect (:127). They advise that one of the strategies to reduce differences is to match to the participants some important characteristics such as race, gender, or age. Some differences were remarkable in this study. The most visible were those of citizenship and native language. The researcher is a Rwandan wanting to interview South Africans who spoke IsiZulu in which he was not proficient. However there were common characteristics that helped in building the trust. The researcher is a black African and FMC member that had close professional relationships with all of the pastors and most of other lay church leaders of the FMSKZN. As results, all the participants participated willingly and were able to freely express themselves.

Once trust has been established, the other task of the researcher is to maintain this during questioning. Hesse-Biber and Leavy (2011) suggest that when asking questions, the researcher should create a supportive environment in which the participant feels safe and comfortable (:127). During this period, the researcher focuses on the interviewee, does not interrupt or judge

him/her, and acknowledges and accepts their differences (:110-111). In the same vein, Minichiello and Kottler (2010b) tell of being courteous and open to make rich and deep exploration (:3). All these advices were followed during the data collection process, especially during the time of asking questions. The general structure of the interview session was similar to the one proposed by Rossman and Rallis (2012:177). This structure is divided into three steps. The first is the introduction where issues of the purpose of the study, informed consent, kinds of recording and ownership of the interview are negotiated. The second is the body of the interview in which themes are extensively explored through asking introductive and probing (follow-up) questions as the participant's world unfolds. The last step consists of the summary and closure in which the interviewee is also thanked (:178). The same process was followed during FGDs, bearing in mind that each group discussions session is a dynamic process based on interaction between people and which is unique (Hesse-Biber and Leavy, 2011:166). In this process, the researcher acts as facilitator instead of being the controller (Longwe, 2012:113). All the individual interviews and FGD were digitally recorded.

Another issue to consider during the interview is the power relation dynamic. Rossman and Rallis (2012) observe that research has been presented as a "western, masculine, and joyless enterprise that many cultures and people find alien and off-putting" (:157). Because of these stereotypes, the research creates a situation of imbalance in power relationship between the researcher and the participant, in which the researcher is given all the authority while the participant is made feel ignorant, impotent or of less value (:157). These differences are likely to smother the participant's trust and freedom of expression. For Hesse-Biber and Leavy (2011), the degree of division and hierarchy between the two collaborators should ideally be lowered (:94). One of the ways that they propose the researchers to reach this goal is to place themselves on the same level as the participant and cooperate with them in mutual respect while they construct social scientific knowledge (:105). As these authors estimate, this strategy allows participants to feel safe, comfortable and valued (:105).

In the light of these advices, situations which would create the image of hierarchy between researcher and participants were avoided. Church leaders presented the researcher not as a professional researcher, but as an ordinary student. They did not refer to him as church leader but as a church member like themselves (participants). The fact of being black and accompanied by a black South African research assistant speaking IsiZulu[59], their native language, also played a decisive role in reducing any blockage due to hierarchy. During the interview, the participants

[59] Details on this information will come later in this section.

were encouraged to speak while respecting their ideas and showing interest in what they said. Because of this process, participants were able to freely unfold their minds and share their feelings and thoughts.

Concerning the timeframe and the duration of the interview, data was collected in four main phases. In the Pietermaritzburg community (UFMC), data was collected on appointment in various places in Pietermaritzburg City during the month of May 2011. In the Port Shepstone community (Fairview and Hibberdene circuits), most people were interviewed during the Costal District Convention organised in Fairview from 13 to 15 May 2011. In the Durban community (Umlazi, Clermont, and KwaMashu circuits), most of the interviews were conducted during the Durban District Convention organised in Umlazi from 20 to 22 May 2011. The remaining participants were interviewed during the FMSKZN Annual Conference organised in KwaNyuswa (Mahlabathini) from 20 to 26 February 2012 and in different places on appointment between May 2011 and November 2012. The length of interviews varied according to the availability of the interviewee and the richness of the interview session. The extreme limits were 21 minutes and 2 hours 41 minutes. Four interviews lasted less than half an hour while two lasted more than two hours and five lasted between one hour and two hours. The mean time for all the interviews was 53 minutes.

After this overview of main features of data collection process, the other matter to highlight is the data analysis and interpretation process.

4.5 Data Analysis and Interpretation

According to Rossman and Rallis (2012), analysis and interpretation in research is a process of making sense or assigning meaning to the data (:140, 262). Hesse-Biber and Leavy (2011:301) specify that these two steps (analysis and interpretation) are interrelated. In explaining their point, they use the ethnographer Michael Agar (1980)'s quote,

> In ethnography…you learn something ('collect some data'), then you try to make sense out of it ('analysis'), then you go back and see if the interpretation makes sense in light of new experience ('collect more data'), then you refine your interpretation ('more analysis'), and so on. The process is dialectic, not linear (:301).

According to this quote, the interrelation makes analysis and interpretation an iterative or cyclical practice. This therefore leads to the distinction of two types of doing analysis and interpretation. For Rossman and Rallis (2012), the analysis can be done as the data are collected or at the end of

data gathering (:264). These authors recommend the former process as the one preferred by experienced fieldworkers (:264). But whatever type of process chosen, there are a number of tasks to successively accomplish during this work. Here, discourses suggest various numbers of tasks but seemingly describing similar figures. Table 4 displays the tasks suggested in four sources.

Table 4: Suggested Qualitative (Thematic) Analysis Processes

Rossman and Rallis (2012:273-287)	Marshall and Rossman (2006) (See Saranjira, 2009:160)	Braun and Clarke (2006) (See Saranjira, 2009:160)	Hesse-Biber and Leavy (2011:301-317).
1. Organizing data (inventory, clean up/edit, check dates, set criteria of coding & categorizing)	1. Organising the data		1. Data preparation (transcription + database)
2. Identifying categories 3. Familiarizing yourself with the data	2. Immersion in the data	1. Familiarising yourself with your data	2. Data exploration (get familiar, reads/highlights, think about, memos)
4. Coding the data 5. Generating themes	3. Coding the data 4. Generating categories and themes	2. Generating initial codes 3. Searching for themes 4. Reviewing themes	3. Specification/ Reduction of data (codes, memos, look for patterns in data)
6. Interpreting 7. Searching for alternative understanding	5. Offering interpretations through analytical memos 6. Searching for alternative understandings	5. Defining and naming themes	4. Interpretation
8. Writing the report	7. Writing the thesis	6. Producing the report	

As it appears in this table, the number of suggested tasks in the process of analysis depends on the perspectives of each author. However, there is no significant distinction between the model suggested by Rossman and Rallis (2012) and the one suggested by Marshall and Rossman (2006). Also, Saranjira (2009:160) observes that if 'familiarizing yourself with your data' in the Braun and Clarke (2006) model is taken to include 'organising data' and 'immersion in the data' in Marshall and Rossman (2006) both models are similar.

The 'on-going' analysis process was followed and the task of transcribing interviews, cleaning up texts, reading them from time to time, categorizing and coding information, and generating and interpreting themes were also accomplished.

During the analysis, two main categories were identified in the response of the FMSKZN to HIV and AIDS. The first concerned the attitude to the pandemic and PLWHA and the second focused on the concrete response of addressing HIV and AIDS.

In the first category, three themes were generated: (1) the attitude towards the necessity of the Church to respond to HIV and AIDS, (2) the attitude towards HIV and AIDS and its impact, and (3) the knowledge about gender and its influence on the spread of HIV and AIDS. These themes are described and critically interpreted in chapter 5.

Likewise, five themes were identified in the second category: (1) the response of the Church to the attitude of the community towards HIV and AIDS; (2) the response of the Church in terms of prevention, care and treatment; (3) the response to the gendered nature of HIV and AIDS; (4) health and social initiatives comprising the response to HIV and AIDS; and (5) partnership of the Church in addressing HIV and AIDS. Their analysis and interpretation are contained in chapter 6 of this thesis.

After this account of the process of analysis and interpretation of the data, the next section deals with ethical consideration.

4.6 Ethical Consideration

Wassenaaar (2006) contends that research ethics in social sciences should be a fundamental concern from the planning stage to the writing of the report, if the research concerns human participants (:61). Rossman and Rallis (2012) distinguish various ethical theories that they summarise under two headings, consequentialist and non-consequentialist (:69). As they explain, consequentialist ethical theories focus on the outcomes (:69). This means that the rightness or the wrongness of the action is determined on the basis of its consequences (:69). On the other hand, non-consequentialist ethical theories are based on "universal standards to guide all behaviour regardless of the consequences in a specific context" (:69). In this way, they attempt to avoid every wrong action considering that it can never yield any good outcome. Further, Rossman and Rallis (2012) specify that in this second type of ethical theories, qualitative researchers commonly consider two theories, the ethics of individual rights and responsibilities and the ethics of justice (:69). The former theory refers to the respect for the rights of the individual while the latter refers to equity, equality and fairness (:69-70).

In this study, both the consequentialist and non-consequentialist perspectives of research ethics were considered. With regard to the consequentialist perspective two aspects are considered. The first relates to what Wassenaaar (2006:67) terms Non-maleficence. This means that researchers have to ensure that participants are not harmed or wronged as a direct consequence of the research. This requirement was met in this study by not asking questions, carrying out acts or

creating a situation which is likely to harm the participants. If inadvertently, an ethical issue should emerge during the process, preparation was also made for counselling by competent professional counsellors or psychologists and specialists through an organisation which deals with psycho-social issues.

The consequentialist perspective was also valuable as it ensured privacy and confidentiality. As Rossman and Rallis (2012:72-73) explain, this requirement consists of "protecting the privacy of participants (identities, names, and specific roles) and holding in confidence what they share with you (not sharing it with others using their names)" (see also Hesse-Biber and Leavy, 2011:85). In order to meet this requirement, information was not shared in the research using the names of participants. In writing the report, the participants were identified using codes rather than by name. During the interview process, however, one participant agreed that his name may be revealed. In this case, the advice of Rossman and Rallis (2012:73) was followed, that of always masking identities unless under compelling reasons, because the written report can be used beyond the control of the researcher or the participant.

With regard to non-consequentialist ethical theories, the two theories preferred by qualitative researchers were considered. Two aspects relating to the theory of ethic of individual rights and responsibilities were focussed on. The first concerns the consent of participants. According to Hesse-Biber and Leavy (2011), the consent of research participants became mandatory because some researchers were threatening participants (:60). The most cited case is the Tuskegee syphilis study initiated by the United States Public Health Service in early 1932 in order to determine the natural causes of syphilis. Six hundred African-American men, 400 of whom were suffering from syphilis participated without being informed and were not given treatment, even after a suitable antibiotic became available in the 1940s (:60). However, as these authors explain the formal consideration of the participants' rights was informed by the realisation of atrocious medical experiments on Jews and other minority groups prisoners in Nazi concentration camps during World War II (:61). This resulted in the Nuremberg code of 1949 specifying that participation in research must be voluntary (:61).

In relation to this, Rossman and Rallis (2012) suggest four ethical principles fundamental to the participants' consent. Participants must be informed about the study's purpose and audience, understand the content and the meaning of their agreement, willingly give their consent, and understand that they may withdraw at any time without any negative consequences (:73-74). In order to meet these requirements, the participants were presented with an introductory letter that

outlined the principles that would govern the relationship during the data gathering.[60] After they declared their understanding of the context and process of the study, they were invited to fill in their names and to sign a consent form which was a summary of the letter and the specification that their identity will not be linked to the information they provide.[61] All of the participants approached willingly accepted to participate and filled in their names and gave their consent.

The second aspect focused on in the theory of ethics of individual rights and responsibilities, is the authorisation of church leaders. For Rossman and Rallis (2012), every field research has to be formally authorised even if it is about observing a public setting (:154). In this regard, the Bishop of the FMCSA was approached who gave formal permission to conduct the present research in the FMSKZN.[62] In addition to his agreement, he also introduced the researcher to the superintendent of the FMSKZN who, in turn, introduced him to the circuits' leaders.

As with the theory of ethics of justice, two aspects were taken into consideration. For Wassenaaar (2006), justice in research generally "requires that researchers treat research participants with fairness and equity during all stages of research" (:68). This requirement was met in two ways. One way concerned the choice of participants Sampling methods recommended in qualitative research were strictly adhered to and secondly, in every category of informants, participants answered the same questions.

The other aspect considered in the theory of ethic and justice is the beneficence. Rossman and Rallis (2012) state that there must be reciprocity between researchers and participants (:158). As they explain, while researchers obtain the data, participants need to "find something that makes their cooperation worthwhile, whether that something is a feeling of importance from being [studied], pleasure from interactions with the [researcher], or assistance in some task' (Patton, 2002, p. 312), or actual changes in life circumstances from action research" (:158). In this regards, the findings of this study have been shared with the church leaders and caregivers during the 108th Annual Conference of the FMSKZN held from 20 to 24 February 2013. During that Conference, they viewed their cooperation in the study as worthwhile in helping to improve the response of the Church to HIV and AIDS. Likewise, during the data collection one pastor expressed how the interviewing process had helped him:

[60] See appendix 2.
[61] See appendix 3.
[62] See appendix 8.

> *I just want to thank you for this interview and it is interesting. It helped me a lot to think why in the Church we have not to preach only but to do other things also. So, it encourages me to do more (CL20:10).*

Another added that,

> *The Church hasn't done anything really deliberate to encourage that [HIV status disclosure]. But I think it's a point that is noted that maybe we can discuss about this first in the leadership and then come to a point where we really make a decision to go forward and to encourage people (CL37:4).*

Therefore, it is expected that other church members, including PLWHA, will benefit from their involvement in addressing HIV and AIDS as one of the ways of caring for the community and living a Christian life.

Besides considering theories of research ethic as suggested by scholars, the policy defined by the UKZN as an institution was also taken into account. UKZN requires that students and staff undertaking research must have ethical clearance as proof that they have predefined the conditions of the research and are ready to respect all ethical prerequisites (UKZN, n.d). These conditions were therefore defined as part of this research's proposal and ethical clearance was granted.[63] The university's policy relating to plagiarism was also taken into account. According to the UKZN's Plagiarism Policy and Procedures approved in December 2009, all the academic documents and publications must avoid plagiarism which includes attempts to present others' ideas, words, and works without appropriate acknowledgement (UKZN, 2009:3-4). In order to meet this requirement, the motivation of the study and the methodology followed in collecting, analysing, and interpreting data were defined. In addition, all the sources of information, whether primary or secondary data were properly acknowledged

4.7 Methodological Limitations

Rossman and Rallis (2012) remark that limitations "derive from the design and methods and help contextualize the study" (:135). And in this contextualisation, limitations indicate weaknesses of the study so as the reader may consider them when using it (:135). Therefore, four limitations are identified in this study. The first relates to language. As mentioned above, the study was conducted in a predominantly IsiZulu-speaking community, which was foreign to the researcher. In such conditions, Rossman and Rallis (2012) advise that the researcher finds another person who is fluent in that language in order to assist in data analysis and interpretation (:53). In this case a competent IsiZulu indigenous speaker was engaged during the data collection to assist in

[63] See appendix 1.

translating for some participants who were not able to speak English or had chosen to be interviewed in their native language[64]. The results of this study were also presented on many occasions during the seminars organised by the School of Religion, Philosophy and Classics. Comments were received and considered from IsiZulu speaking researchers who attended the presentations. Despite these efforts, the persistence of language limitation is estimated in two ways. On the one hand, since translations and comments were done by a third person, it may have modified the participants' message. Since the use of English was not the native language of any participant in this sample, there is a possibility that even those who used this language may have inadvertently modified their original message. Therefore, the entire perception of the participants on this topic may not have been adequately or correctly captured.

The second limitation resides in the scope of the study. As indicated the section 4.3, this study is inspired by the research paradigms such as 'qualitative research' and 'Case Study.' But Minichiello and Kottler (2010a) warn that case studies "totally dependent on a single case that may be unique and not a common experience" (:29). However, this study is centred not only on a single case of the FMSKZN but also on the perceptions of selective persons from different circuits. This therefore brings the issue of the representativeness of the sample to the fore. Schofield (2006) argues that limitation of non-representative samples is acceptable because "the idea that a sample size should be related to the size of the population under study' is a fallacy." Even though it is crucial to consider, like Van der Riet and Durrheim (2006:92), that qualitative study does not inform contexts other than those studied. They rather "provide a framework with which to reflect on the arrangements of meaning and action that occur in these new contexts" (:92). Therefore, this study is not expected to provide a total picture of the response of the whole FMCSA to HIV and AIDS but a mere glimpse based upon the perception of those who were included in the sample.

The third limitation regards the physical location of the interview. Here, Hesse-Biber and Leavy (2011) suggest that interviews are conducted in the researcher's office, the participant's home or any other private place, provided that both parties feel comfortable (:99). Interviews in this study were conducted in various places such as unoccupied classrooms, church yards, arranged rooms, living rooms, the researcher's vehicle, and the researcher's bedroom. Although these places were selected by the participants and the researcher together, the comfort that they offered was not

[64] In the whole study, one person interviewed individually and some other people among five FGDs members have responded in IsiZulu.

the same. It is therefore estimated that the variability of these places has had effect on the variability of responses provided by the participants.

The last limitation concerns the availability of participants. Because most church leaders in the FMSKZN have other secular professions, they were very busy during week-days and week-ends. And although most of the interviews in the Durban and Port Shepstone communities were conducted during conferences and convention meetings, some leaders were not available due to their responsibilities in the Church. They regularly changed their appointments. For example, one participant postponed his appointment twice. When he was interviewed during the third appointment, the session was interrupted as he was needed at the Conference and could not resume the meeting that day.

However, in spite of these limitations, the impact of this study in the Church started showing signs as seen in the preceding section where pastors have taken cognisance of the issues and have decided to engage in addressing the pandemic (CL20:10; CL37:4).

4.8 Conclusion

In this chapter, the methodological design of the study was presented. The geographical location and the population of the study were specified, as were the theoretical paradigms which have informed the research design, the process of data collection and analysis, ethical consideration, and methodological limitations.

In trying to frame the design of the study within theoretical paradigms, it was determined that no clear-cut boundaries exist between assumption systems. Considering research approaches, this study is qualitative in nature. In view of ontology and epistemology, it is a critical humanist study. With regard to the goal of the research, it is a descriptive study. As to the use of research, it is applied study. Regarding the locus of the researcher's interest, it is a case study. When considering traditional research theories, it ranges from postmodernist to feminist theories. This implies that each one of these systems has its part in the design and the process of data collection and analysis.

The influence of these assumptions manifested in the use of primary and secondary written sources, in choosing individuals as units of analysis, and in using interview guides as research tools. They have likewise played a role in conducting both individual interviews and FGDs in the same study, in purposively dividing the field of the study into three communities, and the

participants into three categories. They were also referred to when asking questions during interviews in which participants were encouraged, respected and accepted. The inspiration of these assumptions was also extended to the analysis by categorising the results into themes in order to interpret them, as well as in the writing of the research report.

In addition to the assumption systems, the data collection and analysis were informed by research ethics as shaped by leading scholars and as required by UKZN. However, the chapter recognises methodological limitations, especially those based on language, the scope of the study and the availability of participants. This therefore shows that although the study has followed a systematic process required in research, it has its imperfection, which is accepted in the field of research.

More importantly, it has been shown in this chapter that the study was conducted within communities which are experiencing the effects of HIV and AIDS and where the FMCSA has been practicing its ministry and mission for a long time. This therefore raises questions of adequacy between the participants' perceptions and the actual phenomenon studied, namely, the FMSKZN's response to HIV and AIDS.

CHAPTER FIVE

ATTITUDES OF THE FMSKZN TOWARDS HIV AND AIDS AND ITS GENDERED NATURE

5.1 Introduction

In chapter 4, the methodology followed in developing the whole thesis was presented. The study is located geographically. The population of the study, the theoretical paradigms which have informed the research design, the methods used in data collection and analysis, as well as the ethical consideration and methodological limitations have been specified.

The focus of this chapter rests on the fieldwork results of this study. The attitude developed in the FMSKZN towards HIV and AIDS and its gendered nature will be analysed. The chapter is structured into three main sections. Firstly, the participants' attitude towards the necessity of the Church to respond to HIV and AIDS is considered. Secondly, the participants' attitude towards HIV and AIDS and its impact is examined. Lastly, the participants' knowledge and attitude towards gender and its influence on the spread of HIV and AIDS are scrutinised. This chapter is mainly resourced from the study's fieldwork results. Some literature is, however, used to integrate these results into existing discursive knowledge while assessing how they embody the *missio Dei*.

5.2 Attitude towards the Necessity of the Church to Respond to HIV and AIDS

In this section, the attitudes expressed by participants in this study on the necessity of the Church to respond to HIV and AIDS are explored. The content is based on their responses to the questions in the interview guides formulated in three segments as follows: a) Should the Church respond to HIV and AIDS? b) Why should the Church respond to HIV and AIDS? c) How should the Church respond? Responses to this question display the participants' approval for the Church's involvement but are poorly enlightened theologically and strategically.

5.2.1 Poorly Enlightened Approval

In response to segment a) of the above question, all the participants in individual interviews and FGDs agree that the Church should respond to the pandemic. Concerning the reason why the

Church should respond, five explanations were given. Firstly, participants understand that the Church should respond because HIV and AIDS is a threat to everybody, including church members. In expressing this view, one young person from FGD32:1[65] stated that,

> *Because as we know that we all are human beings, when we are in Church we are in this [physical] body [...]. It means that we are also being affected and infected with this HIV and AIDS [...] instead of just ignoring the fact that we can also be infected or affected by this HIV and AIDS. It means that we are deceiving ourselves if we say maybe that as we are Christians we do not have to talk about these things because back in our families, we do face with such issues and such diseases that attack us in our families [...]. So, that is why we have to tackle the issues that concern ourselves [...].*

This participant emphasises that because the Church itself is under attack it has to take a stand and defend itself.

Secondly, participants stated that the Church must respond to the pandemic because it is its duty and responsibility to do so. Some maintain that the Church has the responsibility to care for the sufferers. For others, caring and defending the weak and doing justice to them are God's commandments. Thirdly, participants think that the Church has to become involved simply because there are HIV positive people who seek its assistance and that therefore it has to answer to this demand. Other participants mentioned that some people still do not know how to face the disease and that the Church should orient them. Fourthly, participants stated that the Church should intervene because HIV and AIDS is similar to other diseases. They point out that this pandemic should not be seen as an isolated issue from other health challenges that the Church is concerned about. Lastly, the Church is expected to respond to HIV and AIDS because it is the right structure where good and trustworthy people are found. From this perspective, the Church is viewed as a second family.

In observing these responses from different categories of participants, it appears that the responses are almost equal among the church leaders, caregivers, ordinary adult members[66] and the youth[67] yet do not have the same popularity. Table 5 illustrates the frequency and related percentages of these responses in each group and in all sessions.

[65] This is the code of this particular FGD. In fact, in writing the results of the study, all the names of participants and most of the names of circuits and places are hidden for research ethics purpose. Where the names are hidden, only their codes are used.
[66] See FGDs with adults.
[67] See FGDs with the youth.

Table 5: Frequency and Percentages of Responses on Reasons for the Church to Respond to HIV and AIDS per Categories of Participants

Reasons for the Church to Respond to HIV and AIDS	Freq and % per Categories of Participants								Total [40]	
	CL [17]		CG [15]		FGD Y [4]		FGD Ad [4]			
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
1. Church is itself attacked	10	58.8	9	66.0	4	100.0	2	50.0	25	62.5
2. Church's responsibility	4	23.5	4	26.7	2	50.0	2	50.0	12	30.0
3. People seek the Church's support	2	12.5	2	13.3	2	50.0	0	0.0	6	15.4
4. HIV and AIDS is similar to other diseases	0	0.0	0	0.0	1	25.0	1	25.0	2	5.1
5. Church is the right place for support	0	0.0	1	6.7	1	25.0	0	0.0	2	5.1

Source: Field Research Results, 2011, 2012
Legend: CL=Church Leaders; CG=Caregivers; Y=Youth; Ad=Adults; Freq=Frequency

It emerges from this table that all categories of participants mostly understand that the Church has to respond to HIV and AIDS because it is also threatened. Likewise, HIV and AIDS viewed as any other diseases and the Church viewed as the right place for PLWHA's support were less frequent in all categories. It is noteworthy that each category has found at least three reasons why the Church should be involved in addressing HIV and AIDS.

Another point to notice is that in almost all sessions, participants referred to the social context when searching for reasons for the Church's involvement in addressing HIV and AIDS. Very few relate this action to theology, God or any form of spirituality. In this regard, only one participant, CG7:1, refers to the Bible in the Book of Isaiah 58 and to Jesus. His point is expressed in the following excerpt of his interview:

> CG7:1: *I think the Church should respond to the problem of HIV [...] because we are commanded in the Bible that we should stand in for those who are weak, and we should also serve justice where there is no justice. That's what – this is our call. Our God is calling us to do that. Even if you read the book of Isaiah 58, the proper fast that God is calling us to [...]*[68]

[68] The Chapter 58 of Book of Isaiah is about God challenging people about the fasting. Verses 1-5, expresses opposition to their efforts to seek God in fasting, bowing heads, and wearing sackcloth while during this same time they also exploit workers and end in quarrels and strife. From verse 6 to 14, God instructs them on the right fasting and advantages of such fasting. Here, God lists setting oppressed free, sharing food with the hungry, clothing the naked, and providing shelter to the poor wonderer among the component of true fasting (Revised Standard Version).

Interviewer: *Do you mean that the Church should combine the spiritual and the social?*

CG7:1: *Yes, because Jesus said we are the salt of the earth. And the people right now need salt.*

This is a young man who recognises the response to HIV and AIDS as God's calling and command. He was interviewed as caregiver. In this regard, it was realised that no church leader has linked the reason of the Church's involvement in responding to HIV and AIDS to religious belief.

Besides the reasons given for why the Church should become involved in addressing HIV and AIDS, participants expressed their views on how the Church should effect this. Observed together, these contributions display three kinds of insights. Firstly, they identify actions that can be conducted by the Church, especially for PLWHA, that include providing them with medical treatment or supporting them with transportation means to medical centres when they need medical care; organising awareness and VCT campaigns; providing material support such as food and clothes; providing them with care such as counselling and spiritual support; and empowering them economically. One church leader, CL4:1, mentioned some of these actions as follows:

> *Depending on the means, they know how care can vary. Some can show sympathy by giving some relief, some can take really care by being part of alleviating the pains or [...] if we have a medical centre, we can also give treatments. Some churches are even opening shelters or houses to host those who are ill; some are giving social help, or social workers, for those who are abandoned. So many [ways can be used]; there are various ways of the Church to show the sympathy and care towards people who are suffering.*

This church leader expects both palliative and medical treatments in the scope of intervention.

Secondly, participants identified strategies to be used in addressing HIV and AIDS. These comprise having proper structured comprehensive programmes instead of working with isolated cases, combining spiritual and social intervention, and starting with sensitizing church leaders. They also include intervention before HIV develops into AIDS, support of the most vulnerable persons, and the creation of safe spaces for expression on HIV related issues. Organisation of activities within different groups such as the youth, women, adults, children, non-church members; partnership with professionals or specialists who can address the people; and inclusion of attractive programmes such as sport, music, role play and sketches, and ballet were also identified as strategies to be used to address the pandemic.

Lastly, participants identified individuals who should participate and provide leadership to this health challenge on behalf of the Church. Three categories of people were suggested. These are the pastors who should introduce the programme in the Church, the parents who should talk

about HIV and AIDS as a way to create awareness amongst children, as well as the youth who should participate in organising events and other activities within and outside the Church. It appears that everybody in the Church is expected to be involved in responding to the pandemic. It is also noticeable that few of the comments focus on issues that relate to HIV prevention.

After this overview of the participants' responses as to whether, why and how the Church should respond to HIV and AIDS, it is important to interrogate the meaning of their comments within the existing knowledge of HIV and AIDS and the response of churches to the *missio Dei*.

5.2.2 Reflection on the Participants' Attitude towards the Necessity to Respond

5.2.2.1 Lack of Theological Rationale and Self-Centred Vision

Participants in this study understand that the Church should respond to HIV and AIDS but literature shows that they lack theological rationale and the concern of other people. Various theologian scholars also expect the church to respond to the pandemic (see for example Phiri, 2003a; Haddad, 2003; Parry, 2008). However, they identify two main reasons. Firstly, the church has to respond to HIV and AIDS because of what it is. In this regard, Richardson (2009:143), remarks that,

> The claim is that the first task of the church is neither to fight for justice nor to fight against HIV and AIDS but that the first task of the church is to be the church. Whatever action or inaction [that] follows must spring from this communal self awareness.

Here, Richardson understands that the ultimate reason for the church to become involved in addressing HIV and AIDS is that it is the church. He elucidates further that being the church implies being a Christian faith community that remembers and embodies the story of Jesus (:143-144). In particular, he insists on the church that is faithful to Jesus' instructions pronounced to his followers a few hours before his execution, that they should remember Him through the breaking of bread and drinking wine together, that is, through practicing the Eucharist (:145). In his understanding, the true follower of Jesus and true practitioner of the Eucharist is the one who, because of that instruction, follows in the ways of Jesus. In his other article, Richardson (2006:48-49) uses the term 'theological rationale' to name this framework of theological understanding that spurs the church into action. Therefore, he explains that because Jesus had compassion for those who were suffering during his days and that he touched them and engaged with them,

> Similarly, in this terrible time of HIV and AIDS, it seems right to say with Nicolson that the fight against AIDS has become a vital task of the church and that any church not prepared to engage in that fight will thereby 'compromise its essential nature' (Richardson, 2009:143; 2006:41-45).

Richardson's point is that the church which does not engage in HIV and AIDS during the present time loses or at least denies its identity as a Christian faith community.

Richardson shares this view with other scholars. Kimweli (2008) suggests that the distinctive and crucial role of the church in responding to HIV and AIDS is to represent Jesus Christ. In their explanation, Kimweli takes the church as God's people and a requisite to "provide a climate of life, acceptance and support for those who are infected or affected by HIV and AIDS" (:63). In the same way, Demissie (2008) refers to Jesus' ministry of healing to advocate that the major contribution of the church to the problem of HIV and AIDS is to be a community of healing and compassion. Quoting Howell, they agree that this contribution is never optional (:2-3). Moreover, according to the World Council of Churches (hereafter WCC) (2007:8), it is with reference to Jesus' ministry in which he unconditionally healed diseases, restored life to the lepers and aligned Himself with the marginalised that churches have realised their duty to witness love and compassion to people infected and affected with HIV and AIDS (see also Dube, 2003). Therefore, it becomes a common understanding that Jesus Christ and the church's identity as a Christian faith community are the ultimate references that compel the church to engage in responding to HIV and AIDS.

Secondly, literature informs that the church is expected to respond to the pandemic because of what it does. For Richardson (2006), the church has three intertwined functions: worship, the Eucharist and *diakonia*. In the context of HIV and AIDS, he insists on the importance of *diakonia* and repeatedly warns that the church, without this function "is not a church or at least seriously deficient," or "at least not fully" a church (:45, 47). As to the meaning of this function, he uses the definition from the Church of Norway explaining it as, "the care of fellow humans and the work to promote fellowship, especially the service which in a particular way is directed towards people in distress" (:46). To highlight its significance, he embraces the insight from Kjell Nordstokke that distinguishes it from other social initiatives of the church. He underlines that *diakonia* aims "to promote fellowship and is directed towards people in distress" (46). In this way, his argument is that the church has the obligation to care for people in desperate conditions, in suffering and in disadvantage, some being PLWHA (:48). In concluding his article, he clarifies that this function goes beyond individuals, families, and the church's boundaries to also include political and economic issues (:50). Therefore, with Richardson's view, it is clear that

the diaconal function is an important component of the church's ministry, and that through it the church is expected to care for people threatened by HIV and AIDS unselectively and unlimitedly.

Richardson's observation is echoed by Demissie (2008) who considers the practice of this function as living out *koinonia* in the true sense as opposed to simply engaging in routine good works (:11-12). In Demissie's view, PLWHA see the church's embrace as God's arms holding them and this allow them to rediscover human life as God's gift (:11).

These authors therefore allow realising that in addition to being a Christian faith community that bears witness to the life and the ministry of Jesus, the church is also assigned to fulfil the *diakonial* function which constitutes another reason to engage in addressing HIV and AIDS.

It is thus noteworthy that these scholars' reflections on reasons that engage the church into responding to HIV and AIDS agree with the understanding of Jesus' healing ministry as core component of the *missio Dei* as explained in chapter 3 of this thesis. However, they differ from the fieldwork results of this study on two points. Firstly, they find Jesus' life and ministry as motivation or theological rationale for the church's involvement in HIV and AIDS while most of participants in this study, including theologically trained pastors, find motivation in mere social life and human suffering. Therefore, taking the observation of Nordstokke and Demissie seriously, as discussed earlier, such social motivated involvement is likely to result in ordinary social actions or good works instead of being true *diakonia*.

Secondly, these scholars understand that the *diakonial* function of the church that comprises addressing HIV and AIDS is wider than individual, families and the church's boundaries. Conversely, since the majority in of participants think that the Church has to engage in addressing HIV and AIDS 'because it is also threatened,' they do not perceive the necessity to intervene beyond the Church's boundaries or to become involved when the threat remains outside the Church's membership. This implies that according to these results, the Church's main motivation is to protect its members instead of bearing witness of Jesus in the world. Therefore, this seemingly lack of a link between caring for human life and accountability to God and the neglect of concern about the community outside the Church's boundaries constitute obstacles to the participants' reflection of *missio Dei* in a time of HIV and AIDS.

5.2.2.2 Lack of Vision of Prevention and Long-Term Strategies

Participants also present various thoughts on how the Church should respond to HIV and AIDS. However, some challenging points can be raised from their suggestions. Therefore, it is remarkable that they generally propose responses related to the care and treatment of PLWHA. This means that HIV prevention does not feature clearly in their understanding of responding to HIV and AIDS. In chapter 2, it was shown that the neglect of prevention strategies is also an issue for the South African government's budgeting for HIV programme. As earlier specified, a big amount of money is allocated to care and treatment while an insignificant amount is allocated to prevention (See Fröhlich, 2011:11; Whiteside, 2010:418; Low, 2011:20; Stats SA, 2007:111-112). Neglecting the aspect of prevention while dealing with health, is missing the point because it does not guarantee any expectation that the problem will be resolved. But what do theological discourses say as to how the church should respond to this pandemic?

The response to this question may be found in chapter 3 where the 'SAVE' as a comprehensive strategy of addressing HIV and AIDS proposed to churches by the ANERELA (See Heath, 2009:71-72; PACSA, n.d.:12) was presented. Other theologian scholars provide insights that can be linked to this strategy. Referring to the theological rationale concept, Richardson (2006) suggests that inadequate understanding of the nature of the church renders its action impotent (:49). The idea embedded in his point is that any church that needs to respond to HIV and AIDS has first to define, understand and respect the theological rationale for this action.

In the same manner, WCC (2007) has conceived a HIV and AIDS curriculum for theological education institutions in Africa. Among the ten modules developed, three are dedicated to defining HIV and AIDS' theologies. These are: the theology of life (Dibeela, 2007; WCC, 2003; Ruele, 2003), theology of compassion (Dube, 2007), and the theology of healing (Hadebe, 2007).[69] It therefore appears that like Richardson, the WCC appreciates that any church that needs to address HIV and AIDS has to have a sound theological rationale for this action.

Still in learning from the WCC, another way of responding to HIV and AIDS is to develop programmes. Through all ten modules developed in the theological education institution curriculum, eight cross-cutting issues are covered. These are,

[69] Other seven modules focus on gender and religion (Phiri, 2007), sexuality (Ngure, 2007), the Bible (Old and New Testaments) (Nadar, 2007; Dube, 2007), indigenous religions (Chitando, 2007), pastoral care and counselling (Leshota, 2007), as well as preaching and liturgy (Leshota and Hadebe, 2007).

> Socio-economic (poverty); Gender (men and women's power relationships in society); Age (the impact of HIV&AIDS on children, youth and the elderly); People Living With HIV&AIDS (PLWHA) (prevention and care); Stigma (examining its impact and planning to minimise it); Cultural perspectives (the advantages and disadvantages of culture); Biblical and theological perspectives (to use the churches' resources); and Liturgical approaches (to speak to the heart and change attitudes) (Dube, 2003:215-216; WCC, 2007:12).

This means that according to the WCC, programmes relating to these eight issues are of great importance in the response to HIV and AIDS. In observing them, one can remark that they all can accommodate both prevention and care. In addition, they comprise short-term interventions such as care and treatment as well as long-term interventions such as poverty alleviation, gender equality and theological perspectives. From this observation, it is clear that in the view of the WCC, any programme of the church aiming at responding to HIV and AIDS should comprise both prevention and care strategies extended to short- and long-term periods. However, as observed in the fieldwork results of this study, not only is the theological rationale not defined, but also these dimensions of prevention and long-term strategies are not adequately considered by the participants, which is another obstacle in the fulfilment of the *missio Dei* in the context of HIV and AIDS.

Participants in this study unanimously agree that the Church should be involved in addressing HIV and AIDS. However, they lack a theological rationale for this engagement, are less concerned about the suffering of the general community and display inadequate perspectives about preventive and long-term strategies.

5.3 Attitude towards HIV and AIDS and People Living with HIV and Its Impact

In this section, responses of participants in the study on the Church's attitude towards HIV and AIDS and PLWHA and its impact are discussed. The reflection is based on data collected during the interviews using the questions formulated in the two segments: a) What is the attitude of the Church (ministers/leaders/members) towards HIV and AIDS and PLWHA? b) What impact does this attitude have on the behaviour of the Church members towards PLWHA and their lives? Responses to this question mostly display a negative attitude to the pandemic which indeed results in a negative impact.

5.3.1 Mixed Attitude

In response to segment a) of the question, three categories of attitudes are expressed. Firstly, some participants affirm that some people in the Church have a positive attitude towards PLWHA. This attitude is observed in the way PLWHA freely disclose their status, are accepted among other groups, and are not judged. This attitude is also seen in the way some people in the Church are involved in addressing HIV and AIDS. Still others recognize that in the past, there was stigma against PLWHA but today this stigma is no longer prominent. The following excerpt of an interview illustrates the positive attitude expressed by the caregiver, CG39:2:

CG39:2:	*At the moment – at the moment I cry. Because, I've got a lot of children I am doing feeding scheme for those children who have lost their parents through this AIDS. I've got a lot of children whom I am feeding, I am looking after, and I just feel sorry!*
Interviewer:	*How many about? [...]*
CG39:2:	*I've got 112 children that I am feeding every day. But I know the parents have died – most of them – not all of them. But I know – I have been to the funeral of their parents, being there and seeing the symptoms of their parents before they die. But I cannot stand here and confirm that – because in this country we can't just stand and say that, unless you have got certificate. But I'm not a child.*
Interviewer:	*But do you have among those children those who are HIV positive?*
CG39:2:	*Yes, I have got them. I don't have certificate but I know because the father or mother has died in this manner. I even know some children [that] are taking ARVs tablets. So, I feel like – I don't know – but I love them. I just pray that God [may help them].*

In this excerpt, this caregiver speaks about his own positive attitude towards PLWHA characterised by his compassion and support to vulnerable children, including those who are HIV positive. Like him, other participants also speak about their own positive attitude or the attitude of other church members and leaders. But not all are positive as is evident from the next point.

Secondly, participants in the study express a negative attitude towards PLWHA displayed by persons within or outside the Church. This attitude appears in certain names given to PLWHA; their rejection by church members, what participants call, 'out-stigma'; and in the isolation by PLWHA themselves, what they call, 'in-stigma'.[70] Other people in the Church associate HIV and AIDS with sexual immorality or sinfulness. The following excerpt illustrates how the caregiver, CG7:1, explains the negative attitude developed by church members.

[70] See for example CL20:3

CG7:1: *The attitude that we have as the Church, I would admit in a very sad way that it has been very secular. It has been very worldly and in previous times you will find that when people speak privately you hear them that [...] they give people who are living with virus certain names [...] Certain names; like we do not call AIDS, AIDS; we call it 'iqhoksi'*[71]*; [or] we call it 'The Three'*[72] *[...] We attach sigma to people who are living with that – with the disease. And always when it comes to Church, whenever somebody comes forward and says that they are living with HIV, there is thinking that the person has been immoral in a way. So [...] now we have associated HIV and AIDS with the devil. We see it as something that people have to be cleansed from. So that is what we have and it is a problem [...].*

Interviewer: *So, do these things happen here in Panele*[73] *[curcuit]?*

CG7:1: *It is a problem everywhere [...] I would not specifically say that people are like that but at the back of our minds* that's *how we are. So now as Panele, the attitude is like that. We share with everybody in our country that attitude towards HIV and AIDS.*

For this caregiver, the ridiculous naming of PLWHA and the association of HIV and AIDS with immorality and the devil are instigated by the community members, including church members. He therefore observes that the attitude of the Church towards HIV and AIDS and towards PLWHA is negative.

Thirdly, some participants display a mixed attitude, showing a partly negative attitude and a partly positive attitude. This is expressed in situations where they seem to show love and compassion to PLWHA while they consider that the conditions of these people result from the commission of sin. The other way in which this attitude is expressed is when church members do not have a negative or positive attitude towards HIV and AIDS but remain totally silent, seemingly neutral, while they are surrounded by PLWHA or are themselves infected and affected by HIV. In this case, no-one discloses their HIV status and no-one asks about it. In some interviews, participants understand that PLWHA's avoidance of this topic or of disclosure results from the fear that other people will stigmatise them if they know their status.[74] Participants also observe that the church members' avoidance to speak about this problem signifies that they do not feel concerned about it or that the sufferers are seen as the 'others'.[75]

In the following excerpt, the church leader, CL37:11, displays some elements of such an attitude while he was discussing how some church leaders call PLWHA sinners. He states that:

[71] *Iqhoksi* is a Zulu word which means, heel of a shoe. According to Ntokozo Zitha, a Zulu woman, fieldworker of Memory of HIV and AIDS Project of Sinamlando Centre, University of KwaZulu-Natal, this word is referred to in order to indicate that HIV infects loose women who wear shoes with narrow high heel and short skirt (I discussed this word with her on August 10, 2012, Pietermaritzburg).
[72] This word refers to the three letters: H-I-V (conversation with Zitha, 2012).
[73] This is not the true name of the circuit. The true name is hidden for ethical purpose.
[74] See for example CG8:1; CL23:3.
[75] See for example CL33:8.

> *As an evangelical Church, there is that dimension. I can't say that we say that HIV and AIDS is a sin. No, no, no [...]. But the mode of transmission of HIV and AIDS, by being sexual, it brings out the issue at some point how it's being – the infection is done. It brings the issue of immorality. If people are faithful to each other in the context of marriage, if they were abiding by the teaching of the Bible that someone should not fornicate [...] that you cannot have sexual relationship outside marriage [...] there is possibility of being able to control HIV and AIDS. And even coming to the issue of homosexuality [...], that also is propagating because some people who are doing same sex marriage – I mean not marriage but who are doing same sex cohabitation, and go with multiple partners, are also propagating this. So, I also believe that if people are abiding by the teaching of the Bible to not fornicate, to not commit adultery, and to abstain, it can be a good way of controlling the spread of HIV and AIDS. But is our Church focusing – taking that – to start telling people that if you are HIV positive you are sinner? I don't think so because we consider that it's not only sex that is the only sin. We sin in many ways [...]. So for us in the Church I believe – yes we tell people that [...] they should abstain, but at the same time we acknowledge the fact that those who have sinned be it because they committed sex before or outside marriage, that is as equal as those who have stolen money, or who have lied [...] So that's our own view [...]. So, there is no reason to take these ones to hang them publicly and those who stole to pamper them* (CL37:11).

Four concerns emerge from this excerpt. Firstly, this church leader restricts HIV infection to conditions that some conservative evangelical churches call sexual immorality such as fornication, adultery and homosexuality (Richison, 2008; Goldingay et al., 2011; Legge, 2004)[76], discounting that faithful monogamous heterosexual married people may also be infected with HIV through sexual activities (Byamugisha, 2007; Chitando, 2007:10).[77] Secondly, he looks at sex as the only way of HIV transmission, ignoring other modes.[78] Thirdly, he considers that abiding to the Bible's teachings is the only solution to HIV infection, overlooking other possible strategies (Heath, 2009:71-73). Lastly, he seems to insist that the Church does not associate HIV and AIDS with sin and that PLWHA are not seen as sinners, but he compromises his views by saying that they are not the only sinners. In other words, his views show that he regards them as sinners much like we regard thieves as sinners. Although this church leader appears to be sympathetic towards PLWHA, his attitude – as well as in all other similar cases – is totally negative as he considers their condition as the result of sin.

[76] However, the language about right and wrong sexuality is no longer the same among churches, including evangelicals. As an example, for Richison (2008), the regular (right) sex for evangelicals is done in heterosexual monogamous couples within a 'divine institution of marriage' while other forms of sexual relations are irregular or wrong. Conversely, Goldingay et al. (2011: 2-3) inform that at the August 2009 meeting of Evangelical Lutheran Church in America the two-third majority of voters accepted the ordination of homosexuals as clergy, the decision from which other churches such as Roman Catholic, Eastern Orthodox, Pentecostals and Methodists seem to distance themselves (:2-3). Moreover, we are informed that Anglican Communion in North America has integrated homosexuals among the ordained clergy and members of integrity while African provinces of the Communion such as Nigeria, Uganda, Kenya, and Rwanda have opposed that decision and, because of that, have tried to sever relationships with the Episcopal Church and the Anglican Church of Canada (Goldingay et al., 2011: 2-3. See also Legge, 2004 about the acceptance of homosexuals in the United Church of Canada). This therefore shows that all Christian churches are struggling to accommodate forms of sexuality that were traditionally seen as 'immoral.'

[77] See also Chapter 2.

[78] Other modes of HIV transmission include the transmission of the infected mother to the child during labour, delivery or breast feeding (Coovadia, 2010:201); transfusion of infected blood (Heyns and Swanevelder, 2010:226); and the sharing of needles and other sharpen materials (Leggett, 2010:240; Teklu, 2008:115).

In observing the attitude to HIV and AIDS and PLWHA within different categories of participants, it appears that these three kinds of attitude are common to all groups. Table 6 clearly illustrates this point.

Table 6: Frequency and Percentages of Responses on Attitudes of the Church to HIV and AIDS and PLWHA per Categories of Participants

Attitude towards HIV and AIDS and PLWHA	Freq and % per Categories of Participants								Total [40]	
	CL [17]		CG [15]		FGD Y [4]		FGD Ad [4]			
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
1. Mixed	12	75.0	13	81.3	3	75.0	3	75.0	31	79.5
2. Negative	11	68.8	6	40.0	3	75.0	2	50.0	22	56.4
3. Positive	10	58.8	3	20.0	1	25.0	1	25.0	15	37.5

Source: Field Research Results, 2011, 2012
Legend: CL=Church Leaders; CG=Caregivers; Y=Youth; Ad=Adults; Freq=Frequency

In responding to the question that led to the generating of this data, each participant expressed or reported at least one attitude towards HIV and AIDS and PLWHA displayed by church members within or outside the Church. In the above table therefore, it is evident that a mixed attitude is expressed in about 80% of all sessions. Likewise, the explicit negative attitude is expressed or witnessed more frequently than the positive attitude in all categories. When decoding the transcripts of all the interviews and FGDs, it emerges that every session points out at least one kind of negative or mixed attitude. In some sessions, the view is held that everything concerning HIV and AIDS and PLWHA in the Church is negative.

Drawing from these explanations, it therefore, seems that within the FMSKZN, the attitude towards HIV and AIDS and PLWHA is mostly negative[79] and that this attitude rests on the association of the pandemic with sinfulness, with special reference to sexual practices considered as sexual immorality. How do discourses explain the cause of this association?

5.3.2 Impact: Reserved Church Community

In addition to the attitude of the Church towards HIV and AIDS and PLWHA, participants expressed their views of the impact of this attitude on the behaviour of church members towards HIV and AIDS and PLWHA. Since the attitude manifested is mostly negative, participants also identify its negative impact. Seven notions of impact are identified here. Firstly, this negative

[79] See both negative and mixed.

attitude creates within PLWHA the fear of HIV, the fear of people and the fear to attend Church services. Secondly, this fear engenders the silence of PLWHA about their status within and outside the Church. Those who have developed AIDS attribute their poor health conditions to other causes such as being called by spirits to become *amadlozi* or *sangoma* (traditional spiritual leader or healer)[80]. Some of those who happen to attend Church services or who need the Church's support in prayer present their request as 'unspoken prayer requests'.[81] Thirdly, this negative attitude also promotes silence about HIV in the whole Church community. Fourthly, the silence of PLWHA prevents them from seeking assistance from people or approved centres of care. The silence of the church community also prevents it from providing primary assistance. Fifthly, this silence prevents the Church as an institution to formally engage in responding to HIV and AIDS (this point will be developed further in chapter 6). Sixthly, the negative attitude to HIV and AIDS creates tensions, incomprehension and divisions between PLWHA and those not infected.[82] Lastly, the negative attitude becomes cause for injustice and victimisation of PLWHA in their families, where they are chased away from home or are given their own rooms or plates simply because they are infected.[83] This negative impact can be seen in the two following excerpts. One excerpt is taken from the interview of the church leader, CL19:2, commenting on her HIV positive daughter.

Interviewer: *Did she know how she got infected?*

CL19:2: *She knows. She cannot not know because she had more than one boyfriend. She was going around and she got HIV. She is a teacher but she doesn't teach because she can make money without sweating. She is a pretty girl. You see. I am not pleased with her behaviour. She has accepted that she is sick; she knows she is going to die; she is worried about her son [that] she has got. That who will remain with this son? Sometimes she doesn't trust me, she even doesn't trust in her bothers. So now she wants to go out and build the house for this son so that he will stay himself rather than staying with us because we are bad.*

Interviewer: *What are you doing which makes her not having trust in you?*

CL19:2: *No, she knows I am a preacher; she knows I am a child of God. I don't like these things. I used to check on her when she was still young. But she got a baby though I was checking on her. So, she knows I don't like what she is doing. But with the sickness I have accepted her because there is nothing she can do now. It is late. The one thing she must do, she must stick to the treatments.*

This excerpt displays the impact of negative attitude to HIV and AIDS and PLWHA within a Christian family. This church leader and her sons do not show love and genuine acceptance

[80] See for example CL24:2.
[81] See for example CL37:3.
[82] See CL20:3; CL19:2.
[83] See CL28:2.

towards her HIV positive daughter. This family identify themselves as children of God, except their HIV positive daughter who is considered as living an immoral life and, consequently, as someone about to die. Because of this attitude of the family, the daughter is isolated together with her son. They do not trust family members and cannot seek any support from them. In other sections of the interview, this church leader also mentions that her daughter used to go to Church but that she left after she was infected. In addition, the Church as institution did not make any attempt to visit her or to invite her to return. It therefore appears that because of the negative attitude of her Christian family and her Christian church, this daughter has started to seek support from other people and is striving to make sure that her son will also be able to survive without depending on her family. Because of HIV infection, their survival becomes even more difficult.

The other excerpt is from an interview by the caregiver, CG39:4-5, speaking about his sister.

Interviewer: *Yes, I understand. But in the Church, is there anyone who has said openly, 'I am HIV positive, I am going through this problem?'*

CG39:4-5: *My sister told it openly in our convention [...]. My sister said it openly that she is HIV positive [...] in a way that after my sister has said that – that's a very painful experience when your sister is dying like that. Not even one person visited me, or not even one person has asked me, 'How is your sister doing?' and to ask, 'How do you cope when your sister is dying?' It was only, she said there and everybody has gone home, since from that day nobody has asked me a question, 'How is she doing, how is she coping?' So I think my Church – well that's very much [hurting] – it hurts me because I thought Superintendent or any person will just come to me and say, 'I am sorry for your sister who is dying of AIDS' because she came openly – openly. I remember I was MC [Master of Ceremony] that day, leading the church convention that includes about 300/400 people in that 'Tent Crusade'. But after that everybody said, 'sorry' – after the meeting, nobody has came to her or come to me as guardian for my sister. No, nothing happened.*

This excerpt demonstrates the impact of a negative attitude towards HIV and AIDS and PLWHA within the Church. It shows the silence of the Church in a clear case of HIV infected and affected persons who seek its support, be it material, emotional or spiritual. Because of this silence, this caregiver and his sister are no longer recognising the Church as trustworthy or helpful. This silence doesn't mean that the Church is unable to assist this household. Indeed other people do get helped or at least prayed for during such 'Tent Crusade' conventions.[84] During the fieldwork for this study, this was the only case in which mention is made of the public disclosure of the HIV status. This means that disclosure constitutes a hazardous admission because other PLWHA remain silent about their status in this Church.

[84] See for example FGD9:6.

After exploring the impact of the (negative) attitude of the Church to HIV and AIDS and PLWHA, it is also noteworthy how responses are distributed among the categories of participants. This is shown in the table 7.

Table 7: Frequency and Percentages of Responses on Impact of Negative Attitudes to HIV and AIDS and PLWHA per Categories of Participants

Impact of Negative Attitude towards HIV and AIDS and PLWHA	Freq and % per Categories of Participants								Total [40]	
	CL [17]		CG [15]		FGD Y [4]		FGD Ad [4]			
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
1. Fear and silence of the infected	12	75.0	12	80.0	1	25.0	4	100	29	74.4
2. Lack of/not seeking assistance	4	23.5	2	13.3	0	0.0	0	0.0	6	15.0
3. Inactivity of the Church community	2	12.5	2	13.3	0	0.0	1	25.0	5	12.8
4. Injustice and victimization	1	6.3	1	6.7	1	25.1	0	0.0	3	7.7
5. Tension between infected and non- infected	2	12.5	0	0.0	0	0.0	0	0.0	2	5.1

Source: Field Research Results, 2011, 2012
Legend: CL=Church Leaders; CG=Caregivers; Y=Youth; Ad=Adults; Freq=Frequency

The table indicates that the fear and the silence of the PLWHA are the most frequently quoted outcomes of a negative attitude to HIV and AIDS and PLWHA. It could be argued that this fear and silence may be contributing to limiting the knowledge of HIV and AIDS by Church members and may promote the spread of HIV and AIDS in the community. This is because the information does not circulate and PLWHA may continue to have sexual relations with uninfected people such as their spouses without protection as some of participants suggested.[85] Each category of participants identifies at least two aspects of impact of a negative attitude to HIV and AIDS within the Church or in the families of church members. Therefore it is important to engage in the views of scholars on the negative attitude towards HIV and AIDS and PLWHA, and the association of the pandemic with sexual immorality and/or sinfulness which drive this negative attitude.

[85] See CL19:5; CL38:2.

5.3.3 Critical Reflection on the Attitude to HIV and AIDS and PLWHA and Its Impact

Two possible sources seem to have contributed to the negative attitude towards HIV and AIDS, and these are the theology of retribution and the history of sexual ethics in Christian religion.

5.3.3.1 Retribution Theology

According to West and Zengele (2004), retribution theology was informed by a metaphor of ancient Israel's agricultural experience stipulating that people reap what they have sown (:114). They explain that initially, this metaphor meant that those who work hard reap plentiful crops and the lazy a handful. However, as they elucidate, its meaning gradually changed according to the socio-economic and political context of Israel. Therefore, it was later extended to all aspects of life in the community to mean that those who live a good life will reap the good while those who live a sinful life the bad. Later on, it was inverted to mean that what you reap indicates what you have sown (:114-115). With this new significance, prosperity – even by unjust means – was a sign of a just life before God and misery the sign of God's disapproval of one's life (:115; West, 2011:135).

Like this metaphor, the Bible is also considered as a source of the theology of retribution in the church. Nadar (2004) identifies this theology in Deuteronomy 28 where blessings for the obedient and curses for the disobedient are listed (:62). Quoting Crossan, Nadar also indicates that Deuteronomy interprets any fearsome circumstance like drought, infertility or war as God's punishment because of the people's sins (:63). According to Gill (2007), biblical dreaded diseases such as leprosy fall in this category. Here, Gill suggests a tenfold typology of perceptions of leprosy in the Jewish Bible (:102-105). This typology includes the view that leprosy is a result of sin or is inflicted by God[86], which are applicable in the context of HIV and AIDS, the modern day dreaded disease. In referring to this, Haddad (2008) speaks of the failure of the church leaders to deal with HIV and AIDS in Vulindlela, Pietermaritzburg. She notes:

> Clearly, leaders were in dilemma; pastorally they would not condemn people, but when pushed to preach prevention, they were extremely condemnatory. This contradiction, I came to realise, had much to do with their limited and uncritical theological training. [...] It [theology of retribution] has devastating effects on those living with HIV and has also rendered the Vulindlela church leaders impotent. They have no way of explaining what God is doing in the world, and

[86] According to Gill (2007:102-105), these perceptions suggest that leprosy (1) is shocking, (2) requires vigorous testing, (3) involves impurity, (4) renders other people/objects impure, (5) can result from sin, (6) is inflicted by God, (7) requires extensive reparation, (8) necessitates social exclusion, interdictions and stigmatization, (9) consumes flesh uncontrollably, and (10) can remain until (and even beyond) death.

> because of a lack of theological resources to deal with the magnitude of the crisis, they resort to what they know. Namely, if bad things happen to people, they must have done something wrong (:81-82).

This statement suggests that the only theological resource on HIV and AIDS the church leaders in Vulindlela have is the retribution theology which urges them to perceive that PLWHA must have done something wrong. She also refers to the mixed attitude (dilemma or contradiction) of these leaders who pastorally do not condemn PLWHA, while when preaching become harsh in condemning them. It is therefore likely that like these church leaders in Vulindlela, the negative and mixed attitudes towards HIV and AIDS and PLWHA among leaders and members of the FMSKZN are informed by the theology of retribution.

5.3.3.2 History of Sexual Ethics in Christian Religion

The association of HIV and AIDS with sexual immorality may have resulted from the ethics of sexuality developed during the history of Christian religion. Gruber (2010), Richison (2008), and Schmid (2005) suggest that current Christian sexual ethics were inherited from the attitudes of the church's forefathers about sex as shaped by ancient cultures such as the Greek, Roman, Persian, and Judaist teachings and traditions. Schmid (2005:2) specifies that Early Stoic teachings considered all passions as irrational and as leading to unreflected action and thus as deserving to be avoided. Under Pythagorean influence sexual relations were limited within marriage for the purpose of procreation only. Schmid also mentions that the influence of Judaism was the consideration of sexuality as God's first commandment on condition that it is performed with the intention to procreate in order to guarantee the survival of the nation.

Two tendencies already arise from these teachings, the tendency to take sexuality as a defiling matter and to reject it, and the tendency to accept sexuality under restrictions. Proponents of the tendency to reject sex were also said to have associated it with the curse of the human being through Adam and Eve (Gruber 2010). When exploring literature on the forefathers' attitudes towards sexuality, ramifications of both tendencies become evident. Gruber (2010) informs that John of Damascus said: "Adam and Eve were created sexless; their sin in Eden led to the horrors of sexual reproduction. If only our earliest progenitors had obeyed God, we would be procreating less sinfully now." Clement of Alexandria adds that: "… the first man of our race did not await the appropriate time, desiring the favour of marriage before the proper hour and he fell into sin by not waiting the time of God's will…". It seems here that though these forefathers were acknowledging the necessity of sexuality in human life (for reproduction) they were regarding it as the result of sin. According to Gruber (2010), it is this association of sex with sin

which led them to prefer celibacy as a sign of piety and motivated some of them such as Tertullian, Jerome and Augustine to promote teachings that viewed human sexuality as 'detestable and unholy.' For Richison (2008), those who did not go to that extreme, like Thomas Aquinas, have at least tolerated sex but for the reason of procreation only.

However, though these tendencies were visible among the forefathers, the church did not formally show any concern about sexuality until the Synod of Elvira AD 309 (Schmid, 2005). As Schmid (2005:3) recounts, when Christianity was officially accepted after the persecution, it received many new adherents from imperial religion who brought with them their former lifestyles. Schmid maintains that at the time the church was also influenced by the urbanism of former rural areas. Therefore, in order to re-establish the respectable image of the church, the Synod restricted sexuality to a heterosexual monogamous couple for reasons of reproduction only. Schmid specifies that it was not before the 15th century that the enjoyment of sex for romantic reasons among couples was accepted (:3). For Richison (2008) and Schmid (2005:3), it was only with the church Reformation that sex and marriage were deemed as worthy notions embedded in God's plan of creation. But here also sex was limited to heterosexual monogamous couples. When regarding the above-mentioned mixed attitudes to PLWHA displayed by the church leader in the FMSKZN, it becomes clear that this sexual restriction still prevails in this Church and causes leaders and members to consider that sexuality outside the heterosexual monogamous married couple paradigm is a sin and associated to the spread of HIV and AIDS.

Therefore the attitude of the FMSKZN towards HIV and AIDS and PLWHA is mostly negative and results in associating this pandemic with the sin of sexual immorality. Such attitude may have resulted from retribution theology developed from ancient Israel as well as the Bible. It may also have been nurtured by sexual ethics as developed in the history of Christian religion. This attitude prevents PLWHA from freely expressing their needs or standing in their dignity, and the Church from engaging in addressing the pandemic, thus becoming an obstacle to the church's fulfilment of the *missio Dei* in the context of HIV and AIDS. An effective response of the FMSKZN to HIV and AIDS will be explored in chapter 6. It is in chapter 7 that negative attitudes are reviewed to examine how the Wesleyan perspective of health and healing can serve as an inspiration for the emergence of an alternative to the contemporary dysfunctional model of care. In the next section, the knowledge and attitude of the FMSKZN towards gender and its influence on the spread of HIV and AIDS are explored.

5.4 Knowledge about Gender and Its Influence on the Spread of HIV and AIDS

In this section, the knowledge and attitudes of the participants on gender and its influence on the spread of HIV and AIDS are assessed. In this assessment the results of question 6 of the interview guides formulated as follows are used, a) What do you know about gender? b) How does gender contribute to the spread of HIV? c) How is this Church responding to the gendered nature of HIV? However, in the present section, only the responses to components a) and b) of this question are used while component c) is used in chapter 6. Therefore the section is structured in three points. Firstly the assessed knowledge of the participants on gender is presented. Secondly, it will be shown how they link gender to HIV and AIDS. Lastly, their views of the victims of this gender aspect of HIV and AIDS is considered.

5.4.1 Limited Knowledge of the Concept of Gender

Three categories of responses emerge from the participants' explanations of the gender concept. Firstly, some explanations link this concept with the notion of 'male' and 'female' and include other insights on power relations and gender role division. These are similar to those provided by the church leader, CL33:3, in the following excerpt:

> *To me, gender means becoming sensitive about issues that pertain to women and men differently and treat them equally sometimes. And, gender, be able to know and take cognisance of things that are more often needed to females and things that are more often needed to male. But also, being able to identify and come out clearly in terms of programme that addresses gender balance. You see, even in the Church when you nominate people that go to work in the Church, don't just concentrate mainly on men; also give portfolio to women to perform as well. And look at their skills as well. That's precisely the gender – how I understand gender.*

In this excerpt, the church leader mentions the notion of 'male' and 'female' and adds ideas of equality, gender role division, and some gender-based imbalances that are evident in the community and in the Church.

Secondly, other participants limit the explanations of gender to the notion of 'male' and 'female'. Here, they simply respond that gender implies 'male' and 'female'.

Lastly, other responses show that participants do not understand the meaning of this concept. Explanations in this category are similar to those given in the two following excerpts, one from the interview of a church leader and the other from that of a caregiver.

Excerpt from the interview of the church leader, CL11:2:

Interviewer: *There is also a problem of gender. Have you heard about gender?*

CL11:2: *No.*

Excerpt from the caregiver, CG6:4:

Interviewer: *Now let us come back to the issue of gender. What do you understand by gender?*

CG6:4: *What do you mean?*

Interviewer: *Gender.*

CG6:4: *[Silence].*

From these excerpts it appears that these participants have no idea about the concept of gender.

In viewing these responses through different categories of participants, it appears that they are not equally distributed. Table 8 illustrates their distribution.

Table 8: Frequency and Percentages of Responses Indicating the Knowledge about Gender per Categories of Participants

Knowledge about Gender	Freq and % per Categories of Participants								Total [40]	
	CL [17]		CG [15]		FGD Y [4]		FGD Ad [4]			
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
1. Male and female	8	50.0	10	66.7	4	100.0	4	100.0	26	66.7
2. Male and female and other insights	7	41.2	2	13.3	0	0.0	0	0.0	9	22.5
3. No clue	2	12.5	3	20.0	0	0.0	0	0.0	5	12.8

Source: Field Research Results, 2011, 2012
Legend: CL=Church Leaders; CG=Caregivers; Y=Youth; Ad=Adults; Freq=Frequency

Through this table, it is evident that the limitation of the concept of gender to the notion of 'male' and 'female' is the most frequent knowledge in all categories of participants. This was even the only knowledge about gender expressed during the FGDs with the youth and other ordinary adult church members. One also notes that there are people in the Church who are not conscious of the concept of gender. It also appears that the concept of gender is better known among church leaders than among other categories. The table also displays that about 80% of sessions exhibit a lack of gender awareness in the FMSKZN. However, in this study, the question on gender was a step to another question as explained in the next point.

5.4.2 Limited Consciousness of Gendered Nature of HIV and AIDS

During the interviews, the question on the understanding of gender was followed by a short discussion of aspects of gender.[87] This discussion was followed by the question about the link between gender and HIV and AIDS. In this thesis, this link is extensively explained in chapter 2. Therefore, participants have also given three kinds of responses to that question. Firstly, some participants directly acknowledge the link between gender issues and the spread of HIV and AIDS and gave additional explanations. The following excerpt from the interview of the church leader, CL38:2, serves as an example of such explanation:

> Interviewer: *Now there is a problem of HIV and AIDS and gender. Gender, I don't know whether you happened to connect this gender issue [...] and the infection of HIV?*
>
> CL38:2: *It is a problem, but within our circles, I haven't heard anything as far as that AIDS is concerned; but I know that there is a problem in communities because the husband will come and demand to have sexual relationships with the wife, and they don't even want to protect and perhaps, both of them are unaware that the other party is infected. You know, because perhaps the husband is a non-believer or a believer with the look-warm believer then plays around, goes around sleeping around then comes back home [and claims], 'Because I am the husband, you have got to do what I say – you must do [it].' I think that is what is meant by these power relations because 'I am a person of authority, you have to conform and obey me as your husband.'*

Without the intervention of the interviewer, this church leader finds an example to illustrate a gender issue that could likely result in HIV infection.

Secondly, other participants did not easily discover the link between gender and the spread of HIV and AIDS, but through further discussion with the interviewer on the matter, they acknowledged it and gave some examples. The pattern of such explanation is visible in the excerpt from the interview of the church leader, CL22:3. He said:

> *Yeah. Brother you were talking about the rape; there is a programme in the TV1 channel [...] [I]t is on Thursday at half past nine to ten. They were talking about rapes these two following Thursdays in the Eastern Cape. Ehee, Ayiii man! They are raping children, and kill them. And someone, a young makoti, young woman, three men raped this woman, and she killed herself because of this. And she was buried maybe last week or so, I don't remember but they came about this in this programme.*

[87] Three aspects of this notion were particularly mentioned in these discussions: (1) the power relations and (2) roles division between males and females and (3) the understanding of masculinity and femininity as defined by societies as well as their impact on the integration of males and females in the society (Momsen, 2004:2; Dube, 2003:87-90; Moyo 2004:72).

In this excerpt, the participant is referring to the link between rape as a gender issue and the spread of HIV and AIDS. However, this idea came after a short discussion with the interviewer on some aspects of gender that is likely to result in the spread of HIV and AIDS.

Lastly, other participants were not able to link gender and HIV and AIDS even after the interviewer's discussion with them about some aspects of this link. Two situations have been observed here. On the one hand, participants were trying to deny the link while they were raising cases where this link was visible. The following excerpt from the interview of the church leader, CL11:2, illustrates this case. He said:

> *I don't think there has been something which we can link the gender to the disease because this problem of rape it's been encouraged by the lack of punishment. By the power that has been – like the government, they take light of the habit of men raping women. They take light. They don't punish it strong enough that it can change the attitude of men towards the women because there is also false attitude like men saying that if a man[...]when he rapes a little child [or a virgin], yeah, they will be healed. That is a belief that has never been found. It's just confusion.*

In this excerpt, the participant gives examples that can explain the link between gender issues and the spread of HIV such as the rape of women, the government's light punishment of rapists, HIV positive men's rape of little children or virgins with the expectation to be healed (see examples of such cases in Ackermann, 2008:105-106) but in making his point, he denies this relationship.

On the other hand, some participants were unable to really have a clear view on the link between gender and HIV and AIDS. The following excerpt from the interview of the caregiver, CG5:3-4, serves as an example of such cases.

Interviewer:	[After discussion about some gender issues likely to result in HIV infection the interviewer asks again the question] *Now my question was this one, do you realise any relationship between HIV infection and gender issues?*
CG5:3-4:	*[Silence]*
Interviewer:	*This power relationship between men and women, do you see its influence on HIV infection?*
CG5:3-4:	*Gender, HIV infection!*
Interviewer:	*Yeah, we said that this relationship between man and women, this is what is gender issue. But has this relationship any influence…*
CG5:3-4:	*On HIV and AIDS?*
Interviewer:	*Yeah. HIV infection…*

CG5:3-4: *No.*

In spite of the interviewer's explanations, the excerpt shows that this participant does not see a relationship between gender and HIV and AIDS.

When these responses are observed through the four categories of participants, some differences come to light. These are visible in Table 9.

Table 9: Frequency and Percentages of Responses Indicating the Knowledge about the Link between Gender and HIV and AIDS per Categories of Participants

Knowledge about the Link between Gender and the Spread of HIV and AIDS	Freq and % per Categories of Participants								Total [40]	
	CL [17]		CG [15]		FGD Y [4]		FGD Ad [4]			
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
1. Find link after interviewer's intervention	8	50.0	6	40.0	2	50.0	3	75.0	19	48.7
2. Do not find the link after interviewer's intervention	4	25.0	5	33.3	2	50.0	1	25.0	12	30.8
3. Find the link without interviewer's intervention	5	29.4	4	26.7	0	0.0	0	0.0	9	22.5

Source: Field Research Results, 2011, 2012
Legend: CL=Church Leaders; CG=Caregivers; Y=Youth; Ad=Adults; Freq=Frequency.

In this table, it is evident that in about 80% of all sessions, people are not aware of the link between gender and the spread of HIV and AIDS. It is also clear that few sessions in which the link was identified (22.5%) were mostly composed of church leaders and caregivers, not the youth and ordinary adult church members. Likewise, the table shows that in 48.7% of all sessions, people were able to realise the link between gender and HIV and AIDS after the intervention of the interviewer. This means that church members can understand this link if any intervention is organised.

Therefore, these results reveal the gap in the awareness of the link between gender and the spread of HIV and AIDS in the FMSKZN.

5.4.3 Male and Female as Unequal Perpetrators and Victims

Explanations of participants who happened to identify the link between gender and the spread of HIV and AIDS, without or after the interviewer's intervention, display three scenarios describing

victims and cause agents of the HIV infection. Firstly, women are identified as victims. This view is linked to incidents of rape by men within and outside the family, sex control by men, men's rejection of using protection during sexual relationship, men's rejection of blood testing before marriage, economic and financial control by men or women's dependence, women's fear of being threatened in case of HIV status disclosure, and role division exposing women to HIV infection. In these conditions, men are mostly identified as the primary cause agents of the risk and spread of HIV and AIDS. However, in the case of men raping children in their homes, women also are said to keep silent in order to protect their partnership with men; and this is another way said to be condoning the spread of the disease.[88]

Secondly, in some settings, males are also identified as victims. The example of this suggestion is found in the excerpt of the FGD (FGD3:8-10) with the youth.

> Participant (a): *The men usually rape.*
>
> Interviewer: *Raping women?*
>
> Participant (b): *I think both of them do rape. Because sometimes you will find like women that force children to have sex with them; and then you will get men who have sex with the young girls. So I think it's both.*
>
> Interviewer: *Others what do you say? Are the women raping men?*
>
> All participants: *Yes.* [Laughter of all participants]
>
> Translator [for participant (c)]: *She is talking of a girl or probably unsatisfied prostitute to take in young children like fourteen and fifteen and force them to do unsafe sex on them without knowing that that is wrong. Even when that is wrong they [women] are taking care of them they [young boys] are in custody those women have power over them.*

This FGD was attended by girls only. They explain that not only women and girls are raped but also males, especially young boys, are undergoing the same experience. And in this case the perpetrators are women. Likewise, in the interview of the church leader, CL22:5, young boys are said to be raped by male homosexuals.

Thirdly, some participants acknowledge the existence of a link between gender and HIV and AIDS but place the responsibility on the victims, especially when it comes to rape. The two following excerpts illustrate the case. The first excerpt is from the interview of the church leader, CL11:3-4:

[88] See CG2:12-13.

CL11:3-4: *You see, as it is, these things, women who are not praying are helpless in their lives. They just believe anything. A man can entice them towards rape. Because if a man says 'I have somewhere where I can find you a job' they just agree. They agree just like that in their lives. They should be serious about that. Those are the killers but they still continue to follow them until they are raped and killed. Yeah. So, unless the women will be strong and reject those enticements.*

Interviewer: *And what do you think the Church can do just to empower those women?*

CL11:3-4: *To empower women is through the truth, gospel truth that the Bible has said or Jesus has Himself prophesised that towards the last days of this world, people will be lovers of money. Once there is something about money, they go without thinking. They are persuaded and they always accept it. Unless the person is strong spiritually and [goes on] praying and asking God's help; they will continue because it's not even for job seeking women. But they always like to sell their bodies. Yeah. They sell their bodies.*

This church leader emphasizes that women are raped because they need money and do not choose people whom they can trust. An almost similar view is suggested by young girls in the FGD, FGD3:8-10.

Translator: *She is saying that when women are raping men, it's not physically like men, but it's like visually the way they dress now is like they tempt a chance to draw men towards thinking and having the ideology that she is likely 'rapeable' or she is availing herself. The clothes they wear now and the way they present themselves these women tend to give the guys – to give men an idea of sex and now the [rape happens].*

Interviewer: *I want to understand well. What kind of dress could attract the [men]?*

Translator: *She said that the ladies let visible their thighs, they show that [they are ready]. She is discussing the way female youth's wears are because they are tight and they show outside their bodies and the shape and the legs and the bottom and that thing itself [sex]. And she is saying that males are always given the idea. They are weak in terms of sex when they see a female's body exposed [...]. And they [women] tend to walk around all over showing all of the parts of themselves. They don't care.*

Like the church leader, these young girls point out that though women and girls are raped, they are the ones who create the conditions for rape to take place.

In reviewing the participants' suggestions concerning victims and agents of gender issues likely to promote the spread of HIV and AIDS, it appears that some responses are frequent in all groups while others are rare. This is pictured in Table 10.

Table 10: Frequency and Percentages of Responses Indicating Victims and Agents of Gender Conditions Leading To the Spread of HIV and AIDS per Categories of Participants

Victims and cause agent	Freq and % per Categories of Participants								Total [27]	
	CL [12]		CG [10]		FGD Y [2]		FGD Ad [3]			
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
1. Female as victims ⇔ Male/female/culture as cause	8	66.7	10	100.0	2	100.0	2	66.7	22	81.5
2. Victim as responsible	5	41.7	1	10.0	1	50.0	0	0.0	7	25.9
3. Male as victims ⇔ Female/male/culture as cause	1	8.3	0	0.0	2	100.0	1	33.3	4	14.8

Source: Field Research Results, 2011, 2012
Legend: CL=Church Leaders; CG=Caregivers; Y=Youth; Ad=Adults; Freq=Frequency

The table indicates that in 81.5% of the 27 sessions in which gender happened to be linked to the spread of HIV and AIDS, women are identified as victims. In more than one fourth of the sessions, they emphasized that victims of rape are responsible for this incident. In about 15% of the sessions, they also acknowledged that males are victims of some gender conditions likely to result in the spread of HIV and AIDS. This data confirms that both males and females are victims and sufferers of HIV and AIDS as result of gender power relations and that females are the most frequent sufferers, as explained earlier in chapter 2 (Barnett and Whiteside, 2006:165; Lane et al., 2011:626). The data also added to the understanding that is likely to foster more suffering in the rape victims, especially when they (the victims) are held responsible for the act perpetrated against them.

We learn from this section that about 80% of the sessions display a gap in gender awareness in the FMSKZN and that this problem is especially among ordinary adult church members and the youth. The few who are clearly aware of this notion are mostly church leaders, followed by caregivers. We also realise that in about 80% of the sessions, participants do not realise the link between gender issues and the spread of HIV and AIDS. Again the few people who happen to perceive this link rapidly are among church leaders and caregivers. But it is clear from the results that people will recognise this link if any action is organised for that purpose. It is also noticeable that the Church already has people who can provide this information, namely, church leaders and caregivers.

Moreover, this section shows that in 81.5% of the sessions in which the link between gender and the spread of HIV and AIDS was identified, women are the most often reported as victims; however, men are also recognised as victims. This therefore confirms suggestions from other discourses that both men and women suffer in the pandemic while women are the leading sufferers as a result of the cultural gender worldview.[89] What this section did not explicitly mention is that South African men are victims of the culture of having sex everywhere at any time, where they are infected while believing that they are brave and manly (Hunter, 2008:567; Hadebe, 2010:40; Mills et al., 2009:7; Kenyon et al., 2010:35, 37). However, women's rape of young boys adds a new dimension not previously considered.

5.4.4 Critical Reflection: Victims as Responsible

The previous section identified some understandings of the life-denying link between gender and HIV and AIDS. Reference here is made to the notion of holding victims of rape responsible for the injustices done to them as seen earlier. With regard to this, Nadar (2009) finds that "I cannot but get emotional when survivors are accused of 'seducing' their rapists through, for example, wearing a 'kanga'" (:91). She refers here to her own experience of rape during her childhood and to many other similar cases in South Africa, to reject the idea of a colleague who was cautioning her against becoming too emotional about the 2006 Jacob Zuma rape trial case (:90-91). In this case, instead of justifying the victim, the prosecutor and the judge were persuaded to believe that she was mentally ill; the defence lawyer mocked her, suggesting that, "she should have learned how to defend herself against rape"; she was finally compelled to go into exile (:97). Nadar suggests a feminist missiological approach as a way to eradicate such erroneous interpretation of gender-based violence which is also nurtured by some biblical texts (:99-100). Like Nadar, Landman (2002) recounts stories of many women survivors of violence in South Africa, most of whom were accused of being responsible for the incidences that happened to them. Tracing similar cases in the Bible (Old Testament), Landman suggests other religious languages that would be used to liberate women's bodies. It is clear that both Nadar and Landman oppose the victimisation of the victims of rape. In chapter 7 of this study, Wesleyan perspective of gender is reviewed in order to find inspiration in *missio Dei*-led understanding of men-women relations.

[89] See Chapter 3.

5.5 Conclusion

In this chapter, attention was drawn to the attitude developed in this Church towards HIV and AIDS and its gendered nature. The attitude towards the necessity of the Church to respond to HIV and AIDS, attitude towards HIV and AIDS and PLWHA, as well as knowledge of and attitude about gender and its influence on the spread of HIV and AIDS were explored. In this endeavour, insights were drawn from the narratives of the participants. Their frequencies and percentages were observed and interpreted, using scholarly discourses. Finally, various features of attitude of this Church have been identified while most of them are likely to compromise adequate missional response to HIV and AIDS.

With regard to the necessity of the Church to respond to HIV and AIDS, participants understand that it should engage in the struggle. However, in their explanations, they display a lack of theological rationale and a concern about the suffering of people outside the Church. They also lack the vision of prevention and long-term strategies to address the pandemic.

As to HIV and AIDS and PLWHA, the participants express a mixture of negative and positive attitudes which mostly weight on the negative side. As result, PLWHA and the Church have not found common ground to accept, integrate and support each other. According to the literature, this negative attitude may have resulted from the theology of retribution and the restrictive sexual ethics developed during the history of Christian religion.

Concerning gender and its influence on the spread of HIV and AIDS, the majority of participants are not aware of these notions, while the few who have witnessed that consciousness are among church leaders and caregivers. It was also found that although both men and women are recognized as suffering from the pandemic with females being the most vulnerable, there are participants who hold the victims of rape responsible for this act.

All these features are likely to constitute obstacles for the Church in its endeavour to fulfil *missio Dei* in time of HIV and AIDS. In chapter 7, the Wesleyan perspective of health is revisited to see how it can be referred to as resource to reshape such attitude, thus as resource for fulfilling *missio Dei* in a time of HIV and AIDS in the South African context. The current impact of this attitude is observed in chapter 6, which explores the concrete responses of the FMSKZN to HIV and AIDS.

CHAPTER SIX

THE SEARCH FOR A CONCRETE RESPONSE TO HIV AND AIDS IN THE FMSKZN

6.1 Introduction

In the preceding chapter, the attitude of the FMSKZN towards HIV and AIDS was examined in three sections. The attitude towards the necessity of the Church to respond to HIV and AIDS, the attitude towards HIV and AIDS and PLWHA and the knowledge and attitude about gender and its influence on the spread of HIV and AIDS were explored. An analysis of the results of the study and re-visitation of the literature allowed for the unveiling of some features of the FMSKZN's attitude which were likely to betray the *missio Dei.*

Chapter 6 will focus on the concrete response by tracing the study's results to identify practical initiatives of the FMSKZN that envisage responding to HIV and AIDS. The chapter is structured as follows: Firstly, responses developed in order to improve the attitude of church members and the whole community towards HIV and AIDS and PLWHA will be searched for. Secondly, other concrete responses to HIV and AIDS in terms of prevention, care, and treatment will be considered. Thirdly, emphasis will be placed on responses to the gendered nature of HIV and AIDS. Fourthly, the FMSKZN's health and social actions initiated with the vision to include HIV and Aid will be explored. Lastly, attention will be drawn to the partnerships undertaken with the intention to respond to HIV and AIDS.

In this chapter, less emphasis is placed on the frequencies and percentages of sessions which generated responses compared to chapter 5, where the focus was mainly on people's attitudes. Here, attention is placed on the facts which illustrate what happened in responding to HIV and AIDS. The content of this chapter is mainly resourced from the fieldwork results. In addition, literature is used in order to explain some facts and to confront results with other existing literature to enhance understanding.

6.2 Response to the Attitude towards HIV and AIDS and PLWHA

This section explores the contribution made by the FMSKZN to improve the attitude of the community and/or church members towards HIV and AIDS and PLWHA. Responses of

participants to questions 3 and 5 of the interview guides are used. Questions are formulated as follows: Question 3: What is the Church currently doing to challenge or improve the attitude, behaviour and response of the community (community, church members, government's structures or leaders) pertaining to HIV and AIDS and PLWHA? Question 5: (a) What have you learnt about HIV and AIDS from this Church/circuit? (b) When did this happen? (c) In what context?[90]

According to the fieldwork results, the common view held by the participants is that the FMSKZN is silent on the pandemic. However, some participants try to address the subject but their perspectives are less than convincing.

6.2.1 Silence in the Church

Commenting on the general silence of the Church, some participants articulate their disappointment and shame. The following excerpt from the interview of caregiver, CG39:5, is a reflection of their emotions.

> Interviewer: *According to what we said it means that the Church is not doing anything about HIV and AIDS?*
>
> CG39:5: *I am afraid to say that [...] because I might sit here maybe at town in Durban they are doing something. But if they do it it's not much; it's not visible to me. I have never heard it in report – all the reports, you were here today; you did not hear [even] one report. This is a conference centre; you did not hear [even] one report, not one. We finished our reports today, but not even one person who reported about that.*
>
> Interviewer: *What is your impression?*
>
> CG39:5: *I think – I think – I think it's terrible. I think it's terrible. And yet KwaZulu-Natal we are the highest in South Africa [...] Yeah but we don't see [any initiative] and I think – it's a shame to me. It's a shame. It's a shame and I don't know – I don't know about other conferences; that's why I said I don't want to be sitting here and say, 'nothing happens, nobody says [anything] nobody says [anything]', I don't know what happens in Eastern Cape; I don't know Northern KwaZulu[-Natal], Gauteng [...] So, maybe in other conferences they do mention. But unfortunately here I now would be lying. There is not even statistics; there is not even one person who said, 'I have heard somebody [saying this]', so it's sad. It is very much disappointing [...].*

This caregiver was interviewed during the Annual Conference of the FMSKZN in 2012 where church leaders from the 10 circuits of this region presented annual reports on the activities. He was disappointed that not a single reporter mentioned HIV and AIDS when they operate in KZN, a province most affected by HIV (Gouws and Karim, 2010:62-64). He is not sure whether

[90] See appendices 4 and 5.

this silence is due to the failure of the reporters to mention all that was happening and wonders whether this silence on HIV is peculiar to the FMSKZN only or whether it includes all the other regions of the FMCSA.

Likewise, the observation of the overseer of the FMCSA does not eliminate this caregiver's doubts. He states:

> *The pastors within the congregations, some of them are doing that, others are scared because we discussed in the pastors' retreat also that the pastors have got to address these issues with the children, so that they may know how they are supposed to behave as children. But you find [...] some pastors who are scared of talking about sex issues; because even the parents at homes they are being encouraged to speak about these issues but some of them are not doing that. It's a cultural thing. Talking about sex is taboo in some of our cultures as blacks here in South Africa (CL38:2-3).*

In his excerpt, this overseer is disappointed that (some) pastors keep silent about HIV and AIDS because they are afraid to engage on the topic of sex, especially with the youth and children.

Although pastors also acknowledge the silence of the Church on HIV and AIDS, their views on the seriousness of this concern vary. Some recognise this failure and understand that they should engage in raising awareness and should encourage church members to talk about the pandemic. The following excerpt serves as an example of this category:

> *I think the Church hasn't done anything as a deliberate strategy. We haven't discussed about this and the Church hasn't done anything really deliberate to encourage that. But I think it's a point that is noted that maybe we can discuss about this first in the leadership and then come to a point where we really make decision to go forward and to encourage people. Like I said, maybe one of the ways can be within the leadership or within the board of the Church to encourage every person to do their own test and to bring out their own results and to break the silence, yeah, so that it becomes an opportunity (CL37:4).*

This pastor noted that the Church is failing in its mission and purpose. In his understanding, church leaders should be the first people to get tested and to disclose their status and use this disclosure as a starting point to discuss the disease in the church community.

However, other pastors did not recognise the need to discourse on HIV and AIDS. The following excerpt of the interview of the pastor, CL22:1, illustrates this point:

> *Brother, I think everybody knows about HIV and AIDS. Because [...] the Department of Health they have done some workshops. There are others – because we have Phlila*[91] *[organisation] in Snburg*[92] *[town]. Phlila they are busy helping those people who are HIV positive; so I think brother the Church or people know about this problem (*CL22:1).

[91] The real name of the organisation is hidden for ethical purpose.
[92] The real name of the town is hidden for ethical purpose.

This pastor, like others, believes that that HIV and AIDS is currently well-known and therefore awareness programmes are no longer necessary. This view seems to be a form escaping from their responsibilities. Indeed this view contrasts with the concern of a young girl of lack of information about this pandemic. The translator reported her intervention during the FGD as follows:

> *She is saying that parents and adults within the Church should really try and speak to young people and then announce to all the church community about sexual issues around and HIV and AIDS and maybe make people aware of it. She is emphasizing that they should really raise the idea of fearing the children and come out because the experience is that some of them are scared to talk about sex to their children and that's where it happens that the children contract AIDS because they do not know what the parents are hiding. [They think that] 'maybe my mum and dad or my uncles are hiding something nice.' And then they go and want to explore men because it happens in the young men (*FGD3:13).

This girl insists on the necessity of parental involvement in discussions on HIV and AIDS and of assisting the youth in getting to know how to deal with it. Her claim therefore confirms the idea of fear and avoidance of talking about HIV and AIDS in the Church and contradicts the view of church leaders who argue that the initiative for HIV and AIDS awareness is no longer necessary.

The last point which highlights the silence on HIV and AIDS in the Church is mentioned by the pastor, CL13:8, who simply understands that the Church is a holy place in which the [unholy] topic of HIV and AIDS cannot take place. He states:

> *Whatever question you ask about HIV and AIDS you link it to the Church [...]. It becomes a problem because it's a Church. You see. A Church, when people think about the Church they think about the Church where you go and praise God. A holy place; [...] we need to address certain issues in the Church. But because I went there for church services, let's look at the issues that pertain to the Church and address them, you see, and forget about other issues [...]. Like I am saying to you I don't want to talk about people fearing to talk about HIV and AIDS [...] I cannot say 'people are afraid' or 'people are not afraid' because we don't have enough time in the Church. Because you get there at nine o'clock, by eleven you are out, [laughter] two hours. You don't have time to talk about these things. You see! All we talk about, you think about the leaking roof. You think about the closet water [water closet] that – the tape that is not working because the municipality officers cut off water. Then we start thinking about how to generate funds to be able to pay the debts. You see! Less we think about HIV and AIDS* (CL13:8).

Four concerns are evident in this excerpt. Firstly, for this pastor the Church is a holy place in which the 'unholy topic' like HIV and AIDS cannot be discussed. Secondly, the Church has other more important issues than HIV and AIDS ('issues that pertain to the Church') to address. Thirdly, there is not enough time to discuss the pandemic. Lastly, people are not afraid to talk about HIV and AIDS in the Church; it is only because of these above mentioned reasons that it is not discussed. This pastor is very confident in what he says and by repeating the expression, 'you see,' he seems to be convinced that HIV and AIDS has no place in the Church. It may be

said that because of this attitude, it is difficult to expect any initiative involving discussions on HIV and AIDS in his circuit.

Therefore, through this overview on the reactions of the participants, there are many stories which point out the failure of the FMSKZN in promoting HIV and AIDS awareness. The failure is compounded by the Church's conspicuous silence on HIV and AIDS because: (1) 'HIV and AIDS is already known everywhere by everyone' (although the youth proves this view wrong), and (2) '(unholy) HIV and AIDS cannot find a place in a holy Church.' However, in contemplating the complaints of the caregiver and the youth, the disappointment displayed by the overseer and the arguments of the pastors, it can be argued that although there is this silence, people are aware of what the Church should be doing.

6.2.2 Speculation about the Church's Action on HIV and AIDS

Some participants identified activities in which the Church has been involved. A few pastors argued that when they are preaching, they sometimes speak about HIV and AIDS although this has never been the main theme of the sermon. For others, topics on HIV and AIDS have been developed during the yearly Conventions or HIV and AIDS awareness campaigns organised for the youth. In his statement, the church leader, CL14:3, touches on these three points in this way,

> *The youth leader used to call people from outside to teach the youth about HIV. It's because actually we as Church, we have seen that the youth are the people which are very fast. We are trying to caution them that they mustn't sleep around, just let's say 'AIDS awareness.' We use actually to teach the youth [...]. And then also in our Conventions, previously the formal president, Mpr3, used to organize a nurse to teach about HIV. This has been actually happening [during] Conventions and also inside the Church* (CL14:3).

This church leader claims the involvement of the Church in promoting HIV and AIDS awareness through Conventions, the Church's normal programme and addresses by external guests. However, he also mentions that as a Church they try to caution the youth about sleeping around. For other people, especially the youth, such spiritual and moralistic teaching has been the only topic developed during the rare occasions in which sex or HIV was thought about rather than choosing a theme related to HIV and AIDS. In the following excerpt caregiver CG39:5 raises this issue.

> *No, I don't think they have any plan. I have never heard that there is any plan, no strategy of whatever [like] 'we need to fight AIDS in this manner and to fight this one' except that young people must repent and accept Jesus Christ; the answer is only in Christ Jesus. That's the only solution [...]. Well, that's true. That's very true but I don't think that's the only way.*

For this caregiver the only contribution the Church has made regarding HIV and AIDS is to ask the youth to repent, instead of teaching them about it. He does not deny the importance of moral and spiritual salvation teachings but contends that they are not enough.

Three cases cited by participants in which HIV and AIDS has been spoken about are acknowledged here. In the first case, an external person sought the permission to carry out an HIV and AIDS awareness campaign in one circuit on behalf of his organisation.[93] In the second case, a person from the Department of Health was once invited during a Youth Convention to address them on the pandemic. But this resulted in conflict between the youth leaders and the church leaders, since the speaker encouraged the youth to use condoms while this is contrary to the sexual ethics of the Church.[94] In the third case, one church member was once given a short time slot to address people about HIV and AIDS during the yearly Convention. Many participants spoke about these three cases but no one could remember when this happened, which can be assumed to have happened a long time ago, as it made very little impact, and hence is of no significance. Therefore, there is no convincing evidence that proves that the FMSKZN has initiated any form of significant action for HIV and AIDS awareness or has improved the attitude of church members or the community towards this pandemic.

Although there have been some rare cases in which issues about HIV and AIDS were discussed, their potential and effective role in improving the attitude towards HIV and AIDS and PLWHA is negligible. The Church is more comfortable in promoting moralistic teachings to the youth without clear directives on the pandemic.

6.2.3 Reflection on the Results: Deadly Silence, Hypocrisy, and Inadequate Attempt

The Church's noticeable silence on HIV and AIDS has been the concern of Haddad (2002:97; 2003:155). In the context of the high rate of gender-based violence and its relationship with HIV and AIDS in South Africa, in which women and girls are the most vulnerable, she observes that the silence on these matters is deadly and she holds the Church accountable. It is argued here that her observation on silence can also apply to the FMSKZN since this Church has not effectively listened or responded to the real challenges and threats to people's lives.

This silence on HIV and AIDS may be the result of the association of the pandemic with sin as explained by West and Zengele (2004:114) and West (2011:135). In this way, some church

[93] See CL4:11.
[94] See CG8:8.

leaders have considered the Church as a holy place where 'sin' (HIV and AIDS) must not be welcomed and this has prevented the pandemic from being discussed and addressed. The attitude of these church leaders reminds one of the negative reactions of Jesus' opponents to his healing of a crippled woman on the Sabbath as highlighted in Luke 13:10-17 (Folk, 1990:105). According to Folk (1990), such acts of healing on the Sabbath always provoked attacks. In this particular case, Jesus responds harshly and calls his opponents hypocrites because they cared for their oxen and donkeys on the Sabbath but attacked Him for having untied the 'daughter of Abraham' whom Satan held bound for eighteen years (:105). It could be argued that church leaders who believe that talking about taps, leaking roofs and water closets (WC) in the Church is holier than talking about HIV which is threatening people display a similar attitude to the critics of Jesus.

With regard to the moralistic teachings instead of real education regarding HIV and AIDS, Ryan (2007:66) holds that, "Merely to repeat that sexual activity outside marriage is sinful will simply not work" because early attempts at such strategies have been found unsuccessful.

Therefore, from this exploration, it is debatable that the FMSKZN's silence about HIV and AIDS and its few attempts to raise awareness convey a positive influence of the attitude of the church members or the general community towards the pandemic. In the next section, programmes or actions developed by the FMSKZN for HIV prevention and /or care and treatment of people infected and affected by the virus will be examined.

6.3 Prevention, Care and Treatment

The contents of this section is drawn from results obtained using question 4 of interview guides formulated in the following two points, a) Does this Church have programmes to address HIV and AIDS? b) If yes, mention these programmes, target groups, frequency and their content.[95] Responses to this question contain reference to the Church's inaction, some individual initiatives and the existence of unfunded project proposals.

6.3.1 Inaction of the Church

Participants explain that no programme was developed in the Church with the intention to respond to HIV and AIDS. The caregiver CG26:2 was embarrassed to admit to this reality. The excerpt from his interview reads as follows:

[95] See appendix 4 and 5.

CG26:2: *To be honest with you we do not have a formal structure that is set up to cater for these people affected with HIV and AIDS. To my knowledge, we don't have formal structure. We do have some people that have got the required training, for doing that. And maybe in certain circuits or conferences they might be used for this purpose. And maybe, in fact, that's why I am saying that we do not have a formal structure because our conference has not put it in place. But that particular circuit should have the particular person who is trained in that field. Maybe they can use him or her.*

Interviewer: *Can we turn* now *and go to the positive things and try to find whatever the Church has done in issues of HIV and AIDS, and identify it just to acknowledge that the Church has done something?*

CG26:2: *[Silence] Ehhh!! Not really. [Laughter] You know, I am ashamed because I am also a member but I can't; you know, I like to say 'this is what we have done! This is what we have done!' But I can't [now].*

This caregiver is surprised that he cannot find any single action that his circuit has done on issues relating to HIV and AIDS while he is ordinarily proud to enumerate the Church's achievements. In his narrative, he places responsibility on the Superintendent who is the overseer of the FMSKZN.

Such response denying the Church's engagement in addressing HIV and AIDS is found in all the circuits covered by the study, though not necessarily by all the participants. However, the participants' views of the reasons for this failure differ. Some of them think that it is because the government is doing everything, including addressing HIV and AIDS and that therefore, the Church does not feel obliged. This view is expressed by the caregiver, CG7:12 as follows:

You see! Now the problem today is that the government is doing so much. And people have that mentality that everything should be done by the government. The government is becoming God likely. People are all depending on the government, government this and government that, the government this, we need toilet you go to complain to the government, why just can't you dig your hole what are you doing? You know, really! [...]. I think the very same mentality is within the Church. We are so depending on what the government is doing that we do not gona take an initiative to start our own programmes [...]. We are just okay of what the government is doing (CG7:12).

For this caregiver, inactivity exists not only in the Church or in the lack of a response to HIV and AIDS. It is also in the larger community and in all domains because the government is caring for the population thus preventing them from taking their own initiative.

But other participants believe that the church leaders do not make HIV and AIDS a priority because 'their own' people, from their families or circuit are not affected. The excerpt from the interview of the church leader, CL13:7-8, can serve as an example of this statement:

Interviewer: *Why are people so silent about this HIV?*

> CL13:7-8: *No I don't want to address that issue. I don't want to address it; because I might lose focus in saying [that at] CLZ3 [circuit] [it] might not be our priority. It's not that people are silent about it. [It is] because they see no need to go to programmes like HIV and AIDS. There are quite a lot of other things that we need to achieve as a Church before we go to HIV. We need to get our priority straight. But if we say maybe over a period of three years, we are hurt by more than – maybe four people died of HIV and AIDS, it becomes an issue. Then the Church must say 'what do we do?' Can you see? That's why when you ask these questions, you will find a lot of people being evasive, not giving you direct answers.*

This church leader does not see HIV and AIDS as the Church's priority because none in their small circle has died of this pandemic. And like him, many other participants claim that the Church is inactive on issues of HIV and AIDS because there are no PLWHA in their midst. This view raises two concerns. Firstly, it is a confirmation that the Church is less concerned about the suffering of people outside the Church, which is sign of selfishness. Secondly, people think that there are no PLWHA in the Church while this inconspicuousness may be due to the non-disclosure of their status or their withdrawal from the Church, since the environment there does not accommodate them.[96] Therefore all the suggestions similar to this one become illusionary and deceptive.

However, the central idea contained in the responses of the participants is that the Church has not initiated programmes responding to the challenges raised by HIV and AIDS.

6.3.2 Some Individual Initiatives

Besides the general denial of the Church's involvement in addressing HIV and AIDS, the second response asserts the involvement of some individuals based on their own initiatives. Three categories of persons are described here. The first category consists of some nurses who work in clinics or hospitals. In a few isolated cases, they provide general advice to people on issues of health.[97] The second category is composed of some church leaders employed as staff in hospitals or clinics (three in the sample) and who, as part of their daily work, deal with HIV and AIDS.[98] The last group comprises people (two in the sample) who, through their own initiatives went to hospitals or clinics to assist the sick spiritually but who finally were recognised by these institutions and given authorization to assist in all the wards and were granted a monthly financial incentive.[99]

[96] See Section 5.3.2
[97] See CL38:2; FGD17:9.
[98] See CL20:1-11; CL21:10; CG27:1-11.
[99] See CL21:6-7; CG39:6.

Two observations can be made with regard to these groups. Firstly, church leaders in the second and third groups do not organise activities to address HIV and AIDS within the Church as an institution. They prefer to remain in health institutions while church members are reclaiming their service in the Church.[100] Secondly, no coordination, monitoring, recording or reporting of all these initiatives within the Church is taking place. This can therefore be interpreted that the Church as an institution does not have a plan or a vision for this missional constraint, which is a sign of its incompetence in matters relating to HIV and AIDS. The paradox is that there are competent professionals within the Church who could provide the necessary resources to respond to the challenge if the Church developed a strategic plan that included HIV and AIDS.

6.3.3 Unfunded Project Proposal

The investigation into the involvement of the Church in addressing HIV and AIDS realised the existence of a project proposal for responding to the pandemic in four district municipalities of the KZN Province. This was established in 2005 for a period of two years. Activities planned include workshops and trips for church leaders; training and conferences for various church groups (men, women and the youth) at different hierarchical levels; income generating activities for PLWHA; support and care for PLWHA and orphans; as well as vocational training for the youth. Its budget was estimated at US$1,290,110 (FMCSA, 2005). According to the overseer of the Church in the Southern Africa, this is the only formal HIV programme ever planned in the FMCSA, yet it is neither funded nor implemented.

The clarification of this proposal raises two questions. Firstly, does this mean that without huge amount of money, the Church is unable to afford or take steps to respond to HIV and AIDS? Secondly, does this mean that without external funders, the Church cannot take the initiative to address HIV and AIDS? Another observation is that the proposal document does not acknowledge any link between this initiative and the mission of the Church or at least its theological motivation. Without a theological rationale, the church's initiative in the community is reduced into mere social actions or good works instead of reflecting true *diakonia,* as expected in Christian churches.[101]

The next area of enquiry concerns what selective literature evinces about the meaning of these results.

[100] See Section 6.2.1.
[101] See Section 5.5.2.1.

6.3.4 Reflection on the Absence of Action to Address HIV and AIDS in the FMSKZN

6.3.4.1 Denial of PLWHA in the Church and Lack of Compassion for Others' Suffering

The denial of PLWHA within the Church can be explained through the model of behavioural change developed by the BEAD group (Van Houten, 2006). This model comprises four gradual sequences: invisible epidemic, awareness, acceptance and behaviour change (:167-168).[102] Therefore, the FMSKZN's behaviour can be classified according to stages two and three characterised by denial because inadequate results prove that it has not yet arrived at stage four of developing strategies to address the pandemic. It therefore has a long way to go in order to be able to achieve this objective.

Connected to this denial is the lack of compassion for 'others' since in some settings the inaction is justified by the absence of PLWHA within the Church. However, some scholars disagree with such behaviour. In chapter 5, it was pointed out that for Richardson (2006) the church, which practices true *diakonia* in a time of HIV and AIDS, is expected not to be discriminatory. Like him, Parry (2008:79) understands that as a church "We need to be compassionate in what we do and to accompany, in solidarity, those amongst us who suffer from the effect of HIV." She explains here that compassion reclaimed means to engage in responding to the pandemic and to make sure that the afflicted people are served in the best way. The question posed by Njoroge (2008) also fits into this context. She asks, "What kind of leadership do we have in the church and in society that rolls merrily along as the children of God perish? Are these not the 'stiff-necked people, uncircumcised in heart and ears' that Stephen preached about in Acts 7:51?" (:180).

These three authors advocate not only for church members but for all those who suffer in the community. Materu (2010) also suggests that "each Christian [...] is admonished to play his/her role to ensure that the afflicted are getting the required care as long as they live. To fail to provide care to the needy is to fail Christ because he identifies himself with individuals in difficult situations" (:51-52). For Materu, a Christian who does not engage to assist those in need does not qualify to be called Christian. It is perceptible that not one of these scholars supports the Church's silence about HIV and AIDS under any pretext.

[102] See Section 2.3.3..

6.3.4.2 Isolation and Suffocation of Internal Potential Initiatives

Not engaging in addressing HIV and AIDS because the government is involved clashes with the views of some scholars and South African's current perspective on healthcare. Here, Parry (2008:76) observes that faith communities are not islands which stand alone. They need to collaborate with other key role players for a better service delivery and the use of maximum efforts and resources. Furthermore, the South African Government has sought partnership with churches in taking care of the sick, especially those admitted to the hospitals (Mkhize, 2011). It is therefore evident that the FMSKZN is not responding to these calls, thus isolating itself.

The lack of the Church's coordination, monitoring, and reporting of internal initiatives for addressing HIV and AIDS also challenges the response of the FMSKZN as an institution, to the pandemic. This distancing of the church's senior leadership can have a negative effect on the motivation and involvement of church members, especially when HIV and AIDS is linked to the notion of sin as it is currently the case in the FMSKZN.[103] According to Moore (2007:85), when HIV and AIDS is associated with sinning, even those church leaders and members who are willing to become involved are unable to do so because of the fear of being accused of condoning that sin. It therefore appears that people in the FMSKZN may refrain from engaging in addressing HIV and AIDS because the Church's overseers do not show much interest in this action. Another consequence is that efforts of the few who try to respond are not recorded in the missional response of the Church as institution to the pandemic. Therefore, the notion held by Njoroge (2008) who understands that the church has "to nurture and empower its lay and ordained leadership to guide its members towards actively participating in the eradication of HIV/AIDS and all other pressing social injustice" (:193) is supported.

6.3.4.3 Dependency on External Donors and Neglect of Local Resources

Literature also contributes to the realisation that the FMCSA's expensive unfunded project proposal is a sign of dependency on missionaries and a hindrance to the Church's engagement in addressing the pandemic. To explain this, Le Roux (2011:80) uses the comment from Roland Allen in which he argues that indigenous leaders were developed in such a way that they depend on missionaries and cannot take any initiative without the missionary's guidance, and this resulted in them being unable to design and implement their own plan. Chitando (2007:34-35) maintains that, unlike African Initiated Churches and African Pentecostal Churches, mainline

[103] See Sections 5.3.1 and 5.3.2.1.

churches generally depend on resources from the western countries for their projects. He warns that depending on external countries prevents them from maximising local resources in responding to HIV and AIDS. He also observes that HIV and AIDS successful projects are not necessarily those using 'big money' but that a modest sum of money can help achieving important objectives.

This latter idea of Chitando also resonates with the development strategy 'Asset-Based Community Development' (ABCD) proposed by Kretzmann and McNight (1993). This strategy is an alternative to the Needs-Based Development Approach (NBDA) which communities use to define their project proposals on the basis of what is lacking. In order to attract substantial amounts of money from donors, they try their best to define the community in a negative way. Kretzmann and McNight (1993) therefore argue that one cannot build a community on what people do not have. They further demonstrate that communities have all the required assets for their own development. These may include human resources, infrastructures; land, water and climate (see also de Gruchy, 2003:21; Kajumulo, 2003:2; Mathie and Cunningham, 200:1-2). The results of this study confirm that the FMCSA (thus the FMSKZN) was not wise to evaluate its existing assets in order to respond to HIV and AIDS but relied on external donors who are not even responding.

In concluding this section, it is noteworthy that the FMSKZN has not initiated programmes that support the prevention of HIV infection or the care for people infected or affected of HIV. The justifications offered by participants that there are no PLWHA in the Church and that the government is already involved in this action do not find support in the literature and South African perspectives of health. Likewise, the lack of monitoring of potential initiatives in the Church marks its incompetence in responding to the challenge of HIV and AIDS. Furthermore, it was found that this Church has fallen into the trap of depending on external donors and therefore undermining the harnessing of local resources. Since the initiation of the study was motivated by the context of gender-based violence and its link with the spread of HIV and AIDS, the question to explore is, how has the FMSKZN responded to the gendered nature of this pandemic? The next section responds to this question.

6.4 Response to the Gendered Nature of HIV and AIDS

In this section the Church's response to the gendered nature of HIV and AIDS is explored. The content of this section is based on the responses to questions 6(c) and 17 of the interview guides used in the study and formulated as follows. Question 6(c): How is this Church responding to

the gendered nature of HIV? Question 17: How can the Wesleyan Healthcare ministry be a gender-sensitive resource of this Church in responding to HIV and AIDS?[104] Responses to these questions contain two ideas. Firstly, the Church has not responded to the gendered nature of HIV and AIDS. Here, the main reason for this failure is the domination of an oppressive patriarchal culture. Secondly, the Church has a project designed to address gender issues but does not extend this to addressing HIV and AIDS.

6.4.1 Domination of Oppressive Patriarchal Culture

Participants do not see what the Church is doing or has done in addressing the gendered nature of HIV and AIDS. Some are desperate because they think that the Church cannot do anything. The excerpt from the interview of one young female caregiver, CG8:3-4, displays this despair:

> CG8:3-4: *It is very difficult for the Church to assist in terms of gender. Because what I have observed is that [...] our church leaders are scared of women. They are scared of women's power. They do not want to empower women. You know when a woman is in leadership position, she is intimidated.*
>
> Interviewer: *Even in our Church?*
>
> CG8:3-4: *Yes. They are always reminded – you know when you go to the pulpit and then you remind the women that Jesus didn't have female followers, among the twelve apostles it was only men, no women nor children. You know that feeling that you are reminding that 'okay as much as you are given this opportunity but [silence] – you understand. So, the problem is that, I am [sure] this is my belief. From what I have experienced within the Church, our leaders are intimidated by women. And I think it will be difficult for them to make women understand that they have a say even in relationship for that matter. Because they will feel that okay, if they [women] realize that they have a say in relationship and then they realize that they have a say in the Church, and then they will not succumb to whatever is being said. So, I am not sure if the Church is at that stage of [addressing the problem of gender and HIV].*

This young woman does not expect church leaders to address the gendered nature of HIV and AIDS because they are not willing to empower women. Other participants' views are categorical and support the status quo. Such view is, for example, expressed by the male caregiver, CG15:4 in the following excerpt of his interview,

> Interviewer: *I think in my mind that maybe we can empower these women to be able to decide; even to have money.*
>
> CG15:4: *How do you empower them now?*
>
> Interviewer: *I don't know; this is what I want to ask you; but to make them able to have a say when maybe it is time to do sex, or it is time to decide what to do, things like that.*

[104] See appendices 4 and 5.

CG15:4: *[Laughter] You see brother these things – in this there is a culture thing that a man will always be a man. You see. So, no matter what; and then my wife will have to respect me, whether I am wrong or right. Yeah. Culture is culture, you can't deny that. You see that's why they will always be vulnerable. That's what I can say because cultural thing goes there. [The woman will say] "No I am respecting my husband. He is buying food, he is buying everything, he is giving me this," so [it's not easy].*

This man is surprised to hear that women should be empowered. For him, issues related to gender are not only difficult to address but they cannot be addressed, because "women will always be vulnerable," therefore, the Church cannot change this order.

Some participants do not understand why the Church should enter into a debate on male and female relationships. They think that it has no role to play here. This thinking is evident in the excerpt of the FGD12-5.

Interviewer: *What do you think the Church can do to respond to those issues of power relation between men and women?*

FGD12:5: *Sorry, do you think the Church can interfere to the family matters? [...] [Laughter] I think it's not easy.*

Interviewer: *Why do you say that it is not easy?*

FGD12:5: *How can you talk about somebody's family matters? Those are family matters. He or she must talk with the family [...] [She] must report to the eldest. That's all [...] [It is reported] in the family, not in the Church [...] I think we must not interfere to that family matters. So, if the family has got this problem, they must talk to the family and tell the eldest to discuss. They must sit down and discuss [...]. At Church you put your problem that if I have a problem like that so we must pray for this problem. But you can't discuss the family matters [in the Church]. You must discuss it at home in the family.*

This FGD comprised eight women and two men. But in this excerpt only women voice their opinions. According to them, not only does the Church not do anything about relationship between men and women, but it is not even supposed to become involved as these are family matters.

With regard to this, no-one amongst the church leaders and lay members who participated in the study realised that although men dominate, they are also exposed to the risk of HIV infection.[105] And none was sure whether gender inequality can be addressed through the Church, especially when it comes to allowing women to decide on their sexuality.

[105] See Chapter 2.

6.4.2 The Haven Shelter Project

This study has found that throughout Southern Africa, the FMCSA has one formal gender-related programme which indirectly touches on HIV and AIDS. This is the Haven Shelter Project registered as a non-profit organisation (NPO) and based in Pietermaritzburg, KwaZulu-Natal Province This project was established in 1996 as an emergency shelter for women and children survivors of domestic violence (The Haven, 2008). The overall objective of this project as stipulated in its Constitution is, "to provide a secure, short term crisis shelter for women and their children who are victims of violence and sexual assault and who can no longer live safely in their own environment" (:3). In its nine secondary objectives, one relates to HIV and AIDS. It reads, "To provide education regarding HIV/AIDS prevention and treatment, as well as emotional support for those infected and affected" (:3).

One acknowledges the importance of this project in addressing gender challenges since it assists survivors of gender-based violence. Nevertheless, in spite of its objective on HIV and AIDS, practical actions addressing the pandemic are not in evidence. One church leader in Pietermaritzburg, CL37:7, seeks some response to HIV and AIDS in this project but does not find any evidence thereof. He states:

> *The [...] way in which I can say that we, as a Church at Ubunye particularly, we are doing that is that we have a centre which is a shelter, specifically for women and their children [...].Which actually raises also our sensitivity to realize that these women are not only victims of violence, but [also of HIV]. Even when you look at the objectives of The Haven, HIV and AIDS is one of the objectives that are raised there as our concern. So, it's our own way so far to try to deal with that issue by bringing these women in the shelter, and although we don't provide full counselling in terms of HIV and AIDS but we are related to other social organizations like FAMSA, Life Line, and so on that are providing those kinds of counselling. So that's our own way also of dealing with the issue of HIV and AIDS and particularly, trying to support those who are the most vulnerable in the society who are women and the children (CL37:7).*

The explanation of this church leader does not clearly show how HIV and AIDS is addressed. He only affirms that they respond to it by relating to other social organisations such as FAMSA (Family and Marriage Society of South Africa) and Life Line. He does not say whether the Church knows what these organisations do about these women in terms of addressing HIV and AIDS issues or whether it follows up to make sure that they address it.

Therefore, participants in this study observe that the FMSKZN is not responding to the gendered nature of HIV and AIDS and is not in a position to address it. Only one action was initiated to address this matter but failed to achieve this objective. What, therefore, do these results indicate?

6.4.3 Reflection on the FMSKZN's Response to the Gendered Nature of HIV and AIDS

6.4.3.1 Influence of *Imago Dei* and Mind-Body Dualism

According to the literature, the church leader's tolerance or support of women's subordination or violence may result from the doctrines of *imago Dei* and mind-body dualism as developed in the religious field. For Bongmba (2007:44) the *imago Dei* doctrine is mostly based on the first two chapters of the Book of Genesis where human beings are said to be created in God's image. Rakoczi (2004:33) specifies here that with this doctrine, men appropriate unto themselves the image of God, a behaviour that she qualifies as 'arrogant.' She finds source of the church fathers' attitude inherited from Greek philosophers such as Western Augustine of Hippo (430) (:34). As to mind-body dualism, Rakoczi (2004) explains that it was also influenced by Greek philosophy which considered the spiritual reality as good while associating the matter with evil and danger. Within this dualism, men are identified with the spirit and women with the matter (:32-33). Considering both doctrines, Rakoczi elucidates that, "The divine archetype refers only to the spirit, and humanity's bodily nature is not in God's image" (:33). This combination removes the woman from the likeness of God and from any form of worthiness.

The danger of these doctrines is that they continue to guide the church, especially in encouraging women's exclusion and negation of their rights. In highlighting this, African women theologians such as Phiri (2000; 2002a; 2002b; 2011) and Nadar (2002; 2005) show how these doctrines hinder the partnership between women and men in church leadership and the Christian women's family well-being in South Africa. In the context of HIV and AIDS, these doctrines manifest themselves in the church's insensitivity towards women's oppression and vulnerability to HIV infection (Haddad, 2003:155). It is therefore not surprising to learn that FMSKZN pastors may have embraced the same life-denying behaviour.

6.4.3.2 Influence of the Free Methodist Church's Doctrine on Marriage and Family

Another factor which may lead the FMSKZN's leaders to condone or remain silent about domestic abuses is the doctrine of marriage and family as defined in the *Book of Discipline* of the FMCNA (FMCNA, 2000) which is also that used by the FMCSA. In this document, the only recognised form of marriage is the heterosexual monogamous union solemnised by both church and State rites (:53-54). Therefore, this understanding may lead church leaders not to assist couples who do not respect this order, and there are many of such cases in South Africa (Stats

SA 2007:1[106]). Another issue addressed in this *Book of Discipline* is that of the divorce. Here, "the deserted partner is no longer bound by the marriage" (FMCNA 2000:54-55). But also, "a member of the Church divorced from adulterous spouse or deserted by unbelieving mate, after attempts at forgiveness and reconciliation have been rejected, may remarry (FMCNA, 2000:55). The problem here concerns the deserter who may be a victim of abuse or the church member divorced from abuser (not adulterous) spouse or deserted by a believing mate. The doctrine of the Church does not give these people the freedom to remarry. This doctrine therefore may prevent church leaders from demanding justice for these persons and therefore condone domestic abuse and the risk of HIV infection, the victims being mostly women.

6.4.3.3 Influence of 'Unholy Trinity'

Beside the church's history and doctrine, another source of the Church's silence on domestic abuse may be its partnership with the culture and gender socialisation, what Maluleke and Nadar (2002) call the covenant of death of the unholy trinity. Using examples from African and Indian South African cultures, these authors demonstrate that these three partners conclude and reinforce a covenant of silence about violence of men against women (:7, 14-15; Nadar, 2005). For this reason, some participants in this study think that the Church cannot change culture.[107]

It is therefore clear that the FMSKZN is embedded in a context which can easily guide its leaders and members into tolerating or promoting a gender imbalance, thus promoting the spread of HIV and AIDS.

In a nutshell, participants in this study observe that the FMSKZN is not responding to the gendered nature of HIV and AIDS. Some believe that the Church cannot change the *status quo* either because church leaders are not willing to empower women or because it cannot change the cultures which oppress them - thus exposing them to HIV infection - or that relationships are a family matter which excludes the clerical interference. The Haven shelter project of Pietermaritzburg was initially supposed to respond to this need but does not show how it is putting this objective into practice. According to the literature, the source of this failure may include the doctrines of *imago Dei* and mind-body dualism, the doctrine of marriage and family in the FMC and the partnership between religion, culture and gender socialisation. The next section

[106] "In 2006, 93 530 (50,6%) of the 184 860 marriages were solemnised by civil rites and 61 230 (33,1%) by religious rites" (Stats SA, 2007:1). Many other couples cohabitate without any of these forms of marriage (:28).
[107] See CG15:4; CG8:3-4.

will attempt to establish whether there are health or social programmes in the FMSKZN conceived with the vision to include HIV and AIDS.

6.5 Health and Social Initiatives Comprising the Response to HIV and AIDS

The section is structured into three areas of concern, namely health, social and empowerment initiatives.

6.5.1 Health-related Initiatives

In this section health-related initiatives are examined that deal with various kinds of afflictions and sicknesses which, in the context of South Africa include HIV and AIDS related conditions. In this regards, Maartens (2010:479) informs that "mortality and morbidity in HIV is largely a consequence of opportunistic infections [...] but even when antiretroviral therapy is used, these infections still occur." Here, opportunistic infections include tuberculosis, malaria, herpes, and meningitis. Likewise, in the South African *National Development Plan 2030,* the component of health includes HIV and AIDS and opportunistic diseases (Republic of South Africa, 2011:295-324). It was an expectation that if the FMCSA has health programmes, issues of HIV and AIDS are directly or indirectly addressed.

The content of this section was obtained from the responses to question 7 of the interview guides formulated as follows: What are the (other) health-related initiatives of this Church for the community apart from HIV and AIDS? The study found that the FMCSA has no nationally or locally organised health-related initiatives. However, in the past, there was a hospital built and run by Free Methodist missionaries. According to Fear (1979), this hospital started in 1955 in Greenville, Transkei, the current Eastern Cape. In 1964, the hospital received financial support for extension of services from the South African government which was unable to supply its own health institutions with the necessary health professionals. When the South African government created the Transkei homeland, the health policy in the new nation changed. All health institutions were now to be under the control of the state and their staff Africanised. In this way, missionaries were no longer able to manage the hospital though they could be employed there (:70-71). Fear (1979:71) informs that by 1978, total Africanization had taken place. Until the time of this study, no other attempt was done to establish health institutions or health services as part of the FMCSA (thus, the FMSKZN)'s ministry (Msweli, 2012; Shembe, 2012).

6.5.2 Social-related Initiatives

This section focuses on social initiatives. HIV and AIDS is not only a health problem but also a social problem and therefore addressing it includes social strategies. Wittenberg (2007) identifies three dimensions of HIV and AIDS, these being the physical, the social and the psychic and expects that the response to this pandemic must be equally comprehensive (:152). Also, Karim and Baxter (2010b:268), Fröhlich (2011:10), and Whiteside (2012:2) assert that there is no unique strategy to address HIV and AIDS. Among others, they quote scientific strategies such as vaccines, microbicides, ART and social and economic strategies such as gender equality, poverty alleviation, political intervention, behavioural change, and education. It was therefore hoped that HIV and AIDS may be addressed through similar strategies. Hence, during the field research question 8 of the interview guides was formulated as follows: What are the other social initiatives of this Church which support the health of the people (apart from health-related activities)? The content of this section is based on the responses to this question.

The results of this study show both formal and informal social initiatives of the FMCSA which involve the FMSKZN.

6.5.2.1 Formal Initiatives: Housing, Domestic Abuse Projects, Pastoral Ministry

Three formal social initiatives have been identified. These are the housing and domestic abuse projects as well as pastoral ministry.

6.5.2.1.1 Housing Project

One initiative is the Ubunye Cooperative Housing. It was established in 1995 in Pietermaritzburg, KZN Province, as a non-profit organisation. Its objective was to provide cheap accommodation to the low income urban dwellers (Sheffield and Sheffield, 1998:4; Ntakirutimana, 2004; Capp, 2006:62). Initially, residents and the Church managed the project together. But later, their joint management of the project was acrimoniously ended. At the time of this study they were no longer working together. Officially, the premises belonged to the Church, but it was no longer receiving the minimal payments from the tenants and had problems with the municipality because of arrears in the payment of water and electricity bills. The Church was not able to evict the tenants since it had no other place to send them to, which was a requirement according to South African law (CHRE, n.d.:11). The residents, on the other hand, no longer received services from the owner of the property, such as maintenance and repairs.

Because of this crisis and related problems, The Haven shelter, which was initially based in the UCH compound, was relocated in 2011 to a nearby protected building formerly used by the Church as a place of worship (UFMC, 2011)[108].

Addressing HIV and AIDS was not identified as an objective of the UCH project (Sheffield and Sheffield, 1998). Nevertheless, it could contribute to addressing this pandemic since it was meant to receive low income urban dwellers, and economic imbalance is one of the factors of the spread of HIV and AIDS in South Africa (Warren and Hajiyiannis, 2008:8; Gouws and Karim, 2010:65-66). It is claimed that some underprivileged women resort to unprotected sex as a way of economic survival, thus exposing themselves to a high risk of HIV infection (Karim, Karim and Baxter, 2010:50; Iyakaremye, 2010b:101). Therefore, it is likely that with affordable shelter, residents can reasonably manage their small income and live independently. However, because of the break-down in the partnership, the tenants are placed at a higher risk of exposure to HIV infection. Some of them live in dwellings with no electricity and lack of security, and children do not have a safe space to play. These factors contribute to weakening this project's capacity to address HIV and AIDS.

6.5.2.1.2 Domestic Violence Survivors' Shelter

Like the UCH, The Haven shelter should be able to contribute to addressing HIV and AIDS since it assists survivors of abuse in which HIV infection is possible. However, although addressing HIV and AIDS appears in the objectives of this project, the way the project is managed does not show how HIV and AIDS is dealt with.[109] Secondly, the study conducted in 2010 (Iyakaremye, 2010b) shows that this shelter mostly acts as an emergency refuge. After six weeks, women are sent back to their homes without the protection of the organisation (:101). Therefore the Haven does not qualify as an institution that positively addresses HIV and AIDS.

6.5.2.1.3 Pastoral Ministry

In the analysis of the fieldwork results, services of the minister such as evangelism and pastoral counselling are also dealt with as social initiatives. These services have been said to be a way to address HIV and AIDS, especially when sacred text are used in a redemptive way (West, 2011:138-158). During data collection, some church leaders mentioned these services as ways to

[108] I provide some details here as eyewitness and one of the church leaders at the UFMC where this project was based.
[109] See section 6.4.2.

address HIV and AIDS while others were of the opinion that they do not talk about it. The two following excerpts from the pastors' interviews illustrate these two viewpoints. One pastor stated:

> *I think the only thing that I can say that the Church is doing is probably at two levels. The first level, as a Church, [we] provide teachings, biblical teaching, evangelical teaching; we have been touching these issues of HIV and AIDS very often. And I think that even though we don't do it formally, but informally we really touch the issue of HIV and AIDS often time in our discussions [...] (CL37:7).*

Another pastor stated:

> *To be honest with you I don't quite remember the time where we had a prayer meetings and talk about these things, talk about HIV and AIDS. And we have never had a time where we preach specifically about these things: HIV and AIDS. But in your sermon, you touch these things. You know, you just touch about it and you pass. But we have never had a situation whereby the whole sermon focuses on HIV and AIDS (CL33-2).*

In these excerpts, the first pastor insists that HIV and AIDS is preached on and discussed while the latter denies this. However, it appears that both pastors agree on one issue - that they do not plan to speak about the pandemic in the church ministry. What they say about is arbitrary and without in-depth reflection and preparation. During the interview no pastor or lay member mentioned having heard a sermon or a discussion intentionally prepared to address HIV and AIDS in the church service. When they do mention the topic, it is dealt with in an immature way by asking the youth to repent instead of discussing HIV and AIDS in an informed and intelligent way. Therefore, the pastoral ministry that constitutes a primary resource to address HIV and AIDS is not effectively used in the circuits of the FMSKZN covered in this study.

6.5.2.2 Informal Initiatives: Visiting and Social Support

Besides the formal initiatives, there are some informal actions which have been mentioned by the participants but still without evidence that these address HIV and AIDS. Each circuit has found a participant who acknowledges informal action(s). In this regard, four ways are used to assist people who experience social challenges. Firstly, they are provided with money or in-kind donations collected in the Church. Secondly, the women's ministry, *Malihambe,* visits people, especially the sick, to pray with them and to assist them materially. Thirdly, pastors visit families to attend to their spiritual needs. Lastly, assistance is organised in response to individual initiative and needs.

However, although these actions are reported in all circuits, the numbers of sessions in which they are mentioned differ. Table 11 shows the frequencies and percentages of acknowledgements of such informal social actions in the circuits covered in this study.

Table 11: Frequency and Percentages of Acknowledgement of Informal Social Action per Circuit

Structure	Total Sessions	Frequency	Percentage
Hibberdene circuit	8	2	25.0
UFMC circuit	7	2	28.6
Clermont/KwaMashu circuit	7	3	42.9
Fairview circuit	8	4	50.0
Overseers	2	1	50.0
Umlazi circuit	8	6	75.0
Total	**40**	**18**	**45.0**

Source: Field Research Results, 2011, 2012

This table illustrates that informal social actions are more acknowledged in some circuits than in others. Their acknowledgement varies from 25% of sessions in Hibberdene to 75% in Umlazi. During interview sessions and with focus groups tangible examples of such actions were stated by people from only three circuits. Others affirmed that informal action took place without identifying specific cases. This means that the few informal social actions initiated in this Church are not equally expanded to all circuits. And within the circuits where they occurred they are not unanimously recognised.

Nevertheless, as seen in Chapters 2 and 3, the SAVE strategy of dealing with HIV and AIDS, confirmed that such visits and assistance to the needy are part of required strategies to respond to HIV and AIDS. Since PLWHA are not able to disclose their status in the FMSKZN as seen earlier, it is not likely that these support initiatives adequately address the needs of PLWHA.

6.5.3 Attempts at Empowerment

This section considers the empowerment of people as a way to address HIV and AIDS. According to the SAVE strategy, empowerment plays a very important role in responding to HIV and AIDS since it deals with factors which promote HIV infection or may hinder adequate response (Heath, 2009:71-73; PACSA, n.d.:12)[110]. Therefore, this point was developed with the intention to see whether the FMSKZN has initiated any action in this regard. The content of the

[110] See Chapters 2 and 3.

section is based on responses given to question 9 of the interview guides formulated as follows: What does this Church do to equip people for their self-help in preventing HIV infection or caring for the sick?

Four areas of empowerment initiated in the FMSKZN are found in the results of the study: gender equality, poverty alleviation, education and spiritual empowerment.

6.5.3.1 Gender Equality

There is evidence of empowerment in gender equality in The Haven shelter. This shelter empowers survivors of domestic violence in many ways. It restores their self-esteem through counselling and other ministerial services. It assists women to obtain employment by informing them about job advertisements, helping them to compile their curriculum vitae, and giving them priority when job offers become available in the shelter.[111] The researcher's study of 2010 (Iyakaremye, 2010b:95-96) has found that the management of the shelter organises workshops in which professionals address women on their rights. The same study also found that these women are assisted with obtaining administrative documents from the Department of Home Affairs and registering their children for support grants if these services are needed. Moreover, Sheffield and Sheffield (1998:1) describe a case of a female teacher who was abused by her husband but because of the intervention of The Haven, was able to obtain the assistance of the police and the court to recover her belongings, to separate from the abuser, and to settle in accommodation provided by the UCH Project.

All these services reported here can contribute to the restoration of women's dignity, self-esteem, right of citizenship and financial empowerment which are likely to promote women's freedom and self-sufficiency. Therefore, although HIV and AIDS is not openly addressed in this project, to a certain extent, services provided are likely to play a positive role in addressing HIV and AIDS. However, no evidence has been found in this regard. Thus, since the Church or shelter does not make HIV and AIDS an intentionally monitored component of services to these women, The Haven's response to the pandemic remains invisible.

[111] See CL37:10.

6.5.3.2 Poverty Alleviation

During interviews, two church leaders, CL37:10 and CL16:8-9, declared having helped people to initiate small businesses of selling sweets and chips. In total, three persons were reported being supported in this way. At the time of this study, however, only two were still working.

Financial empowerment can result in empowering people towards self-sufficiency and a healthy lifestyle which are part of the strategies to address HIV and AIDS (Barnett and Whiteside, 2006; Visser, 2010). However, three aspects deter from ascertaining that these attempts in the FMSKZN play a role in addressing HIV and AIDS. Firstly, they are insignificant and limited to a small number of people, if one considers the size of the sample here (five circuits). Secondly, they are not as a result of the Church's policy or engagement but of some individuals' informal commitment. Thirdly, the intention of initiating these actions does not comprise addressing HIV and AIDS. This shows therefore that the FMSKZN does not have any record of participating in poverty alleviation as a way of addressing HIV and AIDS.

6.5.3.3 Education

Concerning education, the FMCSA has a bursary fund known as the Wesley Association of Theological Education (WATE). This fund provides financial support to the church members for pastoral education. In this regard, most of the ministers in this Church have been sponsored by this fund during their theological education. The interview with the overseer has also revealed that the committee of this fund has recently decided to include students following other fields of study such as medicine, economy and technology as beneficiaries.[112] According to the UNAIDS the promotion of education can also contribute to addressing HIV and AIDS (UNAIDS, 2010b:12, 76, 114, 130). However, the FMCSA has not yet done this with a conscious intention of responding to the pandemic.[113] This means that the choice of beneficiaries and decisions about the amount of bursary have never taken into account the challenge of HIV and AIDS. It is thus very difficult to include this fund as a strategy of the FMCSA/FMSKZN to address the pandemic.

[112] See CL38-10.
[113] See CL38-10.

6.5.3.4 Spiritual Empowerment

It was briefly stated earlier in the chapter that women in The Haven shelter are empowered through counselling and other ministerial service[114]. In fact, church members in all circuits receive such services through sermons, prayer meetings and Bible study. Through these services, people are emotionally and spiritually strengthened by the belief in God's love, God's protection and the future heavenly life. This belief helps them nurture a positive view of life and live with hope. According to the results of this study, these are the services the most provided in the FMSKZN. However, in Chapters 5, the Church still has a negative attitude towards HIV and AIDS and PLWHA which results in silence on the pandemic or in inadequate ways of addressing it. It instead settles for mere moralistic teachings on sexuality[115] without offering any ministerial service initiated with the intention to (adequately) address HIV and AIDS.

From this overview on the health and social initiatives in the FMSKZN, it is noticeable that only one project, The Haven shelter, has HIV and AIDS in its conception. Although all of these initiatives can be used as a way of addressing HIV and AIDS, none is fulfilling that purpose.

6.6 Partnership in Addressing HIV and AIDS

This section examines how the FMSKZN has developed partnerships with other key players with the intention to respond to HIV and AIDS. In the previous section, it is explained that no single strategy is enough to address HIV and AIDS. This being the case, it is not likely that one single institution or individual can respond to all aspects of the pandemic. This means that the intervention of others partners and networking are essential (Parry, 2008:76). Hence, from the field research, question 10 was used, formulated as follows, (a) How does this Church collaborate with other partners in responding to HIV? (b) What do you know about the EHAIA[116]? c) How is this Church involved with the programme of the EHAIA? The content of this section is drawn from responses to this question. However, it is difficult discourse on partnership in addressing HIV and AIDS in the FMSKZN while all the previous sections have found no evidence that this Church is responding to the pandemic. However, it is still important to reveal the reactions of the participants to this question. The section is structured as follows: absence of collaboration and rejection of the EHAIA.

[114] See CL37:10.
[115] See Sections 6.2.2 and 6.2.3.
[116] EHAIA means, Ecumenical HIV and AIDS Initiative in Africa.

6.6.1 Absence of Collaboration

The common view resulting from this study is that the FMSKZN has not developed any strategic and systematic partnership as a way to respond to HIV and AIDS. One example of developing a partnership was found in one circuit, where the youth invited officials from the Health Department to address the community on HIV and AIDS. This initiative drew objections from church leaders since the use of condoms was encouraged which is against the teachings of the Church.[117] In Pietermaritzburg, The Haven shelter collaborates with other organisations in caring for women survivors of domestic abuse, especially in counselling. But the way this partnership relates to HIV and AIDS is not very visible.[118]

In addition, the Church has sometimes responded to the invitations or suggestions of other institutions in the context of HIV and AIDS or gender. These institutions include ECAP (ESSA Christian AIDS Programme) which was welcomed in UFMC in Pietermaritzburg, for the HIV and AIDS awareness campaign.[119] This same circuit has also responded to some invitations of PACSA (Pietermaritzburg Agency for Christian Social Awareness) for workshops on gender and HIV and AIDS.[120] In Fairview, they have twice received donations from the Anglican Church and another Non-Governmental organisation (NGO) based in Port Shepstone.[121] This circuit has also welcomed people from the municipality for gender awareness campaign on Women's Day.[122]

It seems that these potential partners include government departments, NGOs, and faith-based organisations. These organisations that have been partnered could become an important network in addressing the pandemic. However, the Church neither initiates such partnerships nor maintains those initiated by others. Therefore, for some participants, such unacknowledged and non-reciprocal partnerships do not yield fruits. In the following excerpt, the caregiver, CG8:6, expresses this thought:

> Interviewer: *Now, has the Church developed any relationship with other institutions or other structures like NGOs as a way to deal with HIV?*
>
> CG8:6: *[...] But as a said to you whenever we invite people, they talk on the topic, and then they go. And there is no follow-up on the topic to see whether there is anything [that] you can do within, you see. We just invite people, they talk, open discussions and people just sit there and look at the person, there is no discussion, and then the*

[117] See CG8:8.
[118] See CL37:7.
[119] See CL4:3-4.
[120] See CG1:16-17.
[121] See CG27:4; CL22:6-7.
[122] See FGD9:7.

> *person steps down from the podium and it ends there. But the previous convention, just I was working I was not there but [they invited people]. But no other than that that happened.*

From these insights therefore, it is clear that the FMSKZN has not developed substantial partnerships which can bear fruit in addressing the pandemic.

6.6.2 Rejection of the EHAIA

The EHAIA is an ecumenical network created in 2002 by the Health and Healing Programme of the WCC in collaboration with the All Africa Conference of Churches with the objective to empower churches and theological institutions to be HIV and AIDS competent (Weinreich and Benn, 2004:99; EHAIA, 2011:6). The EHAIA facilitates churches and faith-based organisations in Africa to have access to information, training, resources and contacts with other churches and bodies working in the field of HIV and AIDS (EHAIA, 2011:6). Since 2002, the EHAIA has recorded important successes. As an example, until 2008, it organised and facilitated 222 training events attended by 12,082 people (EHAIA, 2011:11). Training themes include awareness in HIV and AIDS, stigma and discrimination, gender and advocacy; development of skills in counselling, communication, strategic planning, fund and resource mobilisation, ecumenical approaches and the integration of HIV and AIDS in theological curricula; specified group such as church leaders, youth and women in relation to HIV; sexuality and gender-based violence; as well as responses to HIV which include prevention, treatment care and contextual Bible study (EHAIA, 2011:15). Until 2011, the EHAIA worked with 81 faith-based organisations and developed a partnership with 41 governments and international institutions (EHAIA, 2011:45-49).

Therefore, in asking the question on the EHAIA, it was hoped that since it is an ecumenical network helping churches to be competent in HIV and AIDS, the FMSKZN would have taken this opportunity to use it in order to address the pandemic. However, the results of the study show that this network is unknown in this Church. Only three church leaders out of seventeen have heard about it and none have interacted with it. It is also noteworthy that while almost all the participants who had heard about the EHAIA during this study recognised it as a worthy resource that the Church can liaise with, two influential pastors[123] remain sceptical simply because it is initiated by the WCC. The excerpt of the interview of one of the pastors CL11:4, reads as follows.

[123] I abstain myself from describing how they are influential for ethical discretion purpose.

CL11:4: *In fact the [World] Council of Churches has weakness of people with dubious characters. Yeah. Some may say something, and practice something else. So, it's like this politics, which means, politics can influence people to say things which they don't practice. Many times, we find people in the World Council of Churches, who have dubious characters.*

Interviewer: *Like what? Can you describe those dubious characters?*

CL11:4: *They say something in public and they practice something else [...] Yeah. So, I cannot take it from the World Council of Churches because I don't trust them, yeah, completely because unless somebody is genuinely saved and lives a green life. So, to me it doesn't need [World] Council of Churches [...]. It needs the person who is spiritually strong.*

For this pastor, the WCC is not trustworthy in terms of holiness, and therefore, there is no need to connect with it.

For the other pastor, CL37:14, there is still doubt of how the FMSKZN can collaborate with the WCC due to the difference in doctrine. He views are as follows:

CL37:14: *No we don't have any connection with them. Basically one of the reasons is because EHAIA is a project under WCC [...] and in terms of denominational biases.*

Interviewer: *Biases?*

CL37:14: *Yes, I can say that we are known as evangelicals. So we don't have any close collaboration. It's in the same sense when you talk about the KZN [KwaZulu-Natal] Council of Churches, which is actually a good organization that deals with issues of HIV and AIDS also but it is also under WCC where it receives a lot of funding. The major issue that I can raise there is because some of the approaches of handling the Bible [...] when they are addressing issues of HIV and AIDS sometimes contradicts or go into conflicts with our own belief. So [...] I don't see our Church at the level where it is to be able to engage in that context. So, those are some of the reasons.* [...] *There is the whole issue of how we address some issues, ethically, doctrinally, which varies.*

Unlike the former pastor who rejects the WCC because its people are 'liars' and 'unsaved,' this pastor argues that they have different ethics and doctrines. What is not plausible is, if these pastors do not like the partnership with the WCC, why do they not seek to liaise with World Evangelical Alliance, which also deals with HIV and AIDS (http://www.worldevangelicals.org/commissions/list/?com=wc)?

However, the views of these pastors are different to that of the overseer of the FMCSA who believes that this Church can collaborate with the EHAIA although they have not yet started[124].

[124] The researcher affirms that the bishop of the FMCSA is willing to collaborate with EHAIA/WCC because in 2011 he accepted his [researcher] proposition of inviting consultants of EHAIA for a workshop in the FMSKZN in

In addition, their views are different from those in other countries like Rwanda. The FMC in this context is a member of the Protestant Council of Rwanda (CPR) which is a collective of Protestant churches and a full member of the WCC. CPR was led by a Free Methodist pastor some years ago until 2009, and through it, the WCC has sponsored the studies of one Rwandan Free Methodist bishop who graduated with a Master's degree from the University of KwaZulu-Natal in April 2008[125].

This therefore means that although the views of these pastors may disturb the partnership of the Church with institutions such as the WCC, this is not the norm in the FMCSA and elsewhere. But one then needs to ask, what is the reason for these conflicting views in the same Church? Literature shows numerous controversies among Christian churches, including the evangelical churches, around sexuality. The Baylor Religion Survey of 2005 has shown that 81% of evangelical Protestants, 57% of Catholics, and 54% of mainline Protestants in America are of the opinion that same sex relationships are wrong (Scheitle and Hahn, 2011:2). The ordination of homosexuals in the Evangelical Lutheran Church and Anglican Communion in America has found opposition, especially from Africa (Goldingay et al., 2011: 2-3; Legge, 2011). Therefore, although these two pastors in the FMSKZN did not specify exactly what is wrong in the WCC, issues of sexual orientation may be one of their points of reference. This is because the WCC believes that people infected or affected by HIV are to be loved and assisted regardless of their sexual orientation (Ngure, 2007:122) while homosexuality was raised in this study by one of these two church leaders as a source of spreading HIV and AIDS.[126]

To conclude this section, the FMSKZN has not developed any consistent partnership in addressing HIV and AIDS. Even the EHAIA, which could assist this Church to be HIV and AIDS competent, is looked down upon by some church leaders. However, their position is not the norm.

6.7 Conclusion

In this chapter the concrete responses of the FMSKZN to HIV and AIDS were explored. These included responses to the negative attitude of the community towards HIV and AIDS and PLWHA; responses in terms of prevention, care and treatment; responses to the gendered

order to empower church leaders in competency of addressing HIV and AIDS. Unfortunately the workshop did not take place because of some structural reasons in the FMSKZN.

[125] The researcher testifies this as an active member of the Free Methodist Church of Rwanda involved in services of high level of country leadership.

[126] See Section 5.3.1.

nature of HIV and AIDS; health and social initiatives integrating the response to the pandemic, and partnerships initiated with the intention to address HIV and AIDS.

All of the steps taken show that the FMSKZN has failed to act positively in dealing with HIV and AIDS. Firstly, results display no influence of the FMSKZN on the improvement of the community's attitude towards HIV and AIDS and PLWHA. Church leaders are silent because they are afraid to discuss sex-related matters. Other participants suggested that the pandemic is already known while others tried to justify their inaction by suggesting that HIV is a (an unholy) subject which cannot find place in the holy Church. Some attempts of the Church's initiatives are also suggested but are rather seen in this study as merely moralistic rather than a concrete response to the pandemic.

Secondly, nothing constructively or demonstratively has been done in the HIV prevention and care of PLWHA. Reasons advanced include that the government is already responding to the pandemic in such a way that the Church is left with nothing to contribute. This study interprets this as the Church's tendency to isolate itself from other potential partners and hence the demonstration of missional incompetence in dealing with HIV and AIDS. Similar incompetence was observed in the lack of monitoring of potential internal initiatives. Participants also submitted that the Church is inactive because there are no PLWHA in the Church. However, it may be argued that some church members may be in a state of denial of the pandemic or that they lack compassion for the suffering of others. Moreover, the Church's unfunded project proposal, based upon unhealthy dependency on external donors and neglect of local resources, demonstrated its missional short-sightedness.

Thirdly, results do not show any response to the gendered nature of HIV and AIDS. Both clergy and laity were sceptical about the Church's possibility or right to address gender-based violence in families because they claimed that family and cultural matters are immutable. They also failed to realise that the male's risk of HIV infection may be as a result of negative masculinities. The analysis has traced the possible origin of this perception to the mind-body dualism and *imago Dei* doctrines; Free Methodist's doctrine of marriage and family life as well as the interrelation between religion, culture and gender socialisation. Nevertheless, one project, The Haven, was conceived to address both gender and HIV issues but the objective relating to HIV and AIDS was not implemented.

Fourthly, the study has found no current health initiative in the FMCSA, thus, in the FMSKZN. Some social initiatives such as housing projects, The Haven shelter, pastoral services as well as

assistance to the sick and the poor were found in the Church but with no discernible link to HIV and AIDS. The same situation was observed in the empowerment initiatives in gender equality, poverty alleviation, education and spiritual life.

Lastly, no partnership has been initiated by the FMCSA/FMSKZN in the context of responding to the pandemic. The Church did not even attempt to nurture relationships with organisations which attempted to initiate such partnerships. Even the network initiated to help churches being competent in HIV and AIDS, the EHAIA, was poorly known and sometimes contested on the basis of the understanding of holiness and doctrine.

All of these five points were initially understood as ways of addressing the pandemic. However, the FMSKZN did not use them or undertake any other alternative. This inaction seemingly reflects its attitude of silence towards HIV and AIDS as observed in chapter 5. It is therefore submitted that as long as this Church remains silent, indifferent and inactive in the face of this pandemic, it is not likely to produce a substantial response in order to address it. However, in the theoretical framework of this study,[127] it was demonstrated that WHCR, which is part of the Free Methodist foundation can be reclaimed as a valuable resource for the fulfilment of the *missio Dei* in the time of HIV and AIDS. It was therefore the intention in this study to examine the extent to which this resource was valued by the FMSKZN and how it can inspire the closing of exposed gaps. This is the objective of chapter 7.

[127] See Chapter 3.

CHAPTER SEVEN

RELEVANCE OF THE WHCR IN THE FMCSA'S RESPONSE TO HIV AND AIDS

7.1 Introduction

In the three preceding chapters, it was shown how the FMCSA has responded to the HIV and AIDS pandemic in SKZN. Chapter 4 presented the process used to collect, analyse and interpret the data. In Chapters 5 and 6, the various features of attitudes and concrete response of the FMCSA to HIV and AIDS were delineated. These chapters confirm the Church's failure to bear witness in fulfilling the *missio Dei* in a time of HIV and AIDS. In this regard, participants displayed a lack of theological and missional rationale that could motivate the Church to respond to HIV and AIDS. This gap seemingly has had a negative impact on the Church's perception of the pandemic and the people affected, characterised by its lack of concern about people's suffering and the inadequate engagement in addressing the pandemic.

Since WHCR is embodied in the foundations of the FMCSA as explained in Chapters 1 and 3, it has been argued that it can be a valuable resource for the fulfilment of *missio Dei* in a time of HIV and AIDS. Therefore it is important to consider the extent to which this resource was identified as a strategic asset by this Church in its response to the pandemic. Hence, the intention of the present chapter is to assess the significance of WHCR as a missional asset that can be used by the FMCSA as a resource for addressing HIV and AIDS within the South African context. In order to achieve this goal, features of the response of the FMCSA to HIV and AIDS are revisited and the way this response could be better informed by the WHCR examined.

The chapter embodies an appraisal of the relevance of the WHCR in the FMCSA's response to HIV and AIDS for a better fulfilment of the *missio Dei* as exemplified in the ministry of Jesus. Missional insights from the WHCR that could empower the Church to fulfil its obedience to the *missio Dei* in a time of HIV and AIDS in the South African context are also identified. Relevant literature is identified to highlight the usefulness of Wesley's attitude and theology towards health, his initiative of healthcare, and his gender sensitivity, all of which could better facilitate a positive and wholesome response to HIV and AIDS within the current context of South Africa.

7.2 Relevance of WHCR in the FMCSA's Response to HIV and AIDS

Wesleyan Healthcare Response in the FMCSA was unknown to many of the participants. Only a few of the church leaders interviewed had heard about Wesley's social ethics, especially his commitment to helping the poor, opposing slavery and alleviating poverty. However, none of the participants were aware of his engagement in healthcare. Therefore, the objective of this section is to identify the gap caused by this unawareness in the FMCSA's response to HIV and AIDS in order to highlight how this Church could be empowered by embracing the WHCR as its missional inheritance.

7.2.1 Relevance of WHCR in the FMCSA's Attitude to HIV and AIDS

Five features of the attitude of the FMCSA towards HIV and AIDS are explored here. The first feature regards the participants' agreement that the Church should respond to HIV and AIDS. As highlighted in chapter 5, all the participants agreed that the Church should respond to HIV and AIDS because it is a threat to everybody within and outside the church membership. This understanding accurately reflects the example of Jesus through his engagement with and fulfilment of the *missio Dei.* Jesus did not hesitate to heal the sick even if this required breaking the religious law of observing the Sabbath day (Folk, 1990:105). In the same way, this thinking embraces that of Wesley about the community's health crisis. In this regard, chapter 3 describes Wesley's solidarity with people in England, mostly the poor who were threatened by disease and poverty and had difficulties to access medical services (Hill 1958; Marquardt, 1992). Therefore the views of participants in this study with regard to the necessity of the Church to respond to HIV and AIDS are consistent with Wesley's perception of fulfilling the *missio Dei* in time of a health crisis. However, this similarity is betrayed when it comes to why and how the Church should respond.

The second feature concerns the lack of theological rationale. The results of the study have shown that mostly social reasons are given by the participants as to why the Church should respond to HIV and AIDS. Participants expressed that the Church is also affected by the pandemic, and therefore, has the responsibility to assist people, and to be approached by people who need help. They also mentioned that PWLHA should not be isolated from other life crises in which the Church intervenes. It was also found that no church leader referred to healthcare as God's will or commandment.

While the social crisis and injustices of PLWHA are relevant reasons for the Church's engagement, they are not the only ones as far as the Church is concerned. Others factors must be taken into account (Richardson, 2006; 2009; Demissie, 2008). In this regard, chapter 3 articulates that Jesus declared Himself as sent by God to build God's kingdom on earth and that healthcare was part of the core components of his agenda (Maddocks, 1981:45-48). Jesus healed sick people not only because they were suffering and were in need of support but also because healing was part of the *missio Dei*. Like Jesus, Wesley also engaged in healthcare for social and theological reasons. Chapter 3 demonstrates that he initiated this care, not only because there were many diseases and the poor's inaccessibility to healthcare in England, but also because he embraced the understanding that God is involved in healing (Wesley, 2004:i-ii). However, most of the participants in this study were not able to appreciate this reference to God when explaining the reasons of the Church's engagement in addressing health issues.

The third feature regards the lack of concern about the suffering of others. The data confirmed that the majority of participants (61.5%) agreed that the Church should engage in responding to HIV and AIDS because the Church is also threatened. This suggests that they were more concerned about their personal health interests and less about the suffering of the people outside the Church. This view clashes with that of Richardson (2006:50) who understands that *diakonia* should reach out beyond the church's boundaries. It also differs from that of Jesus who healed all people regardless their holiness, religious membership or nationality (Dube, 2007:93).

Wesley extended his healthcare ministry to church members and non-church members, Methodists and non-Methodists alike. He helped without applying any faith-based criterion in selecting beneficiaries (Marquardt, 1992:23-24). He used his own savings to serve everybody in his clinics (Hill, 1958:1, 12-13). All categories of community members were eligible to receive his cost-free/reduced book, *Primitive Physic* on easy ways of curing diseases (Maddox, 2007:27). Therefore, the perspectives of these participants run contrary to that of Wesley that the suffering of the general community is also the missional concern of the church.

The fourth feature is the lack of vision in prevention and long-term strategies to address HIV and AIDS. In expressing how the Church should respond to HIV and AIDS, participants' suggestions mainly envisioned the care and treatment of PLWHA while HIV prevention and long-term solutions were not explicitly mentioned. It was found that this gap went contrary to the views of the WCC and some scholars who advocate that programmes should include preventive, curative, short and long-term strategies to address the pandemic (Dube, 2003:215-

216; WCC, 2007:12; Heath, 2009:71-72). In addition to healing people, which is a curative and short-term solution, Jesus, our model of fulfilling the *missio Dei*, also developed preventive and long-term solutions for the sick and other marginalised people that included the forgiveness of their sins, challenging life-denying social structures and scriptures (Dube, 2007:91-95).

In Wesley's healthcare strategy, curative and short-term strategies are found in his use of natural and pharmaceutical medicine to cure various diseases (Wesley, 2004). Likewise, preventive and long-term strategies can be traced in his advice to people for a better management of the six 'non-natural' factors in order to maintain a healthy lifestyle (Gadsby, 1998; Wesley, 2004:v-vi; Health and Healing, 2001:6-7). As an example, Newton (1988) writes:

> He [Wesley] often expresses concern for the physical, as well as spiritual, health of his women friends. To Lady Maxwell (23 February 1767) he urges: 'Exercise, especially as the spring comes on, will be of greater service to your health than an hundred medicines; and I know not whether it will not be restored in a larger measure than for many years when the peace of God fixes in your heart...' (:136).

This quote shows how Wesley was placing great value on preventing sicknesses rather than curing them. But also, preventive and long-term measures are comprised in Wesley's distribution of his book, *Primitive Physic,* in the community (Maddox, 2007:27), and in his support of the poor for income generation through financial loans and job creation (Marquardt, 1992:29). It is therefore clear here that the perception of participants in the present study lack understanding of the value of preventive and long-term solutions to the disease.

The last feature relates to the explicit negative attitude towards HIV and AIDS. The results of the study confirmed that in some settings, the Free Methodists in South Africa stigmatize PLWHA with abusive names such as *iqhoksi* (loose woman wearing shoes with high heel and short skirt) or 'the three' (meaning the three letters, H-I-V) (see CG7:1). It was also found that the pandemic is mostly associated with 'sin' of 'sexual immorality' (CL37:11; CL19:2). As a result, PLWHA and the Church's community do not find a way to accept, integrate or support each other.

This attitude is different to that of Jesus who sympathised with and advocated for the sick (Dube, 2007:90, 93), did not associate sickness with sin (Kgalemang, 2004:156-159) and forgave sinners, including prostitutes (Dube, 2007:92, 96). It is likewise different from that of Wesley, who, according to Maddocks (1988:139), tried to imitate 'his master' Jesus in his ministry of holistic salvation. In this regard, in explaining the factors which have caused miserable conditions for the poor of England, which are part of Wesley's motivation to engage in a health ministry,

Marquardt (1992) elucidates how a life of poverty was understood as an indication of God's punishment. He states:

> Partial responsibility also belongs to the traditional English attitude that poverty itself is a fault, to be borne as a stigma of divine punishment. A fixed scale of religiously grounded values supported the static character of a segmented society. The property owners' egoism was so great that their charitable activities and humanitarian gifts were frequently exercises of religious obligation rather than actual help directed toward bringing about change for the needy. Because criminal acts resulting from poverty were better known than the misery of the poor, indignation tended to replace sympathy (:21).

Their negative attitude of the poor was preventing them from finding adequate solution to that wretchedness. However, Wesley's attitude was different as Marquardt continues to highlight:

> According to Wesley, poverty's actual basis lies neither in an inscrutable decree nor in unworthiness of those affected by it. ... In the majority of cases, unemployment was simply undeserved. Those affected should not be blamed for something that had its cause in other factors. For this reasons, others must provide help for them... Wesley and the Methodists felt themselves ethically obligated to render such assistance (:31).

Wesley abstained from accusing the poor of a situation caused by other factors and his position gave him reason and strength to engage in assisting them, including in medical care. It is this encouraging attitude that the FMCSA has failed to grasp, which has resulted in its silence about HIV and AIDS as will be shown later.

To conclude this section, it is noteworthy that the participants agreed that the Church should respond to HIV and AIDS but their perception of why and how compromises the way exemplified by Jesus in fulfilling the *missio Dei*. Wesley's perception of human health and the importance of healthcare comprises insights that support the *missio Dei*. However, the FMCSA has failed to adopt Wesley's methodology of missional healthcare for the poor. The next section will examine how a concrete response from the FMCSA to the pandemic embodies insights from the WHCR.

7.2.2 Relevance of WHCR in the FMCSA's Concrete Response to HIV and AIDS

This section assesses the relevance of the WHCR in the FMCSA's response to HIV and AIDS and the extent to which they have been informed by Wesley's way of fulfilling the *missio Dei* through healthcare.

Six elements are observed in this section. The first element is the lack of adequate initiative to improve the attitude of the community towards HIV and AIDS. The assumption in this study was that the attitude of the community would improve through positive awareness of HIV and AIDS. However, the general observation of the participants (chapter 6) is that the Church did not take part in this cause. Suggested reasons for this inaction included the conviction that the pandemic is already known to the community and that there is no new information to bring to the people (though this was proven wrong by the youth). Also that HIV and AIDS is a profane topic which cannot be accommodated in the holy Church. Others believe that the silence is caused by the fear of church leaders to develop sex-related topics such as HIV and AIDS because of the cultural taboos of black South Africans. Nonetheless, the study has also shown some attempts of HIV awareness organised by the youth but contested by church leaders because the promotion of condom was part of the message which conflicted with the Church's understanding of the youth's sexuality. Other rare attempts were initiated by church leaders but developed into a moralistic diatribe instead of offering real HIV and AIDS awareness.

Whatever reason has caused this failure, it seems that the response of the FMCSA as expressed by participants in this study departs from Jesus' way of accomplishing the *missio Dei* in the community in a time of a negative sickness-driven attitude. In this regard, Kgalemang (2004:156-159) shows that in the Gospel of John 9:1-5, Jesus explains why the man he had healed was born blind, thus helping them not to associate his disability with sin. Folk (1990:105) also explains how Jesus, after healing a crippled woman on the Sabbath (Luke 13:10-17) defended this acts before his opponents, underlining that she had much more value than their oxen and donkeys which are also freed and watered on the Sabbath and called her 'daughter of Abraham', a title of honour which normally was only given to males (See Chapters 3 and 6).

Wesley also challenged the negative attitude towards the sick and advocated for them. For example, in his sermon, 'On Visiting the Sick' he admonished his audience to visit the sick. He stated:

> Many are so circumstanced, that they cannot attend the sick in person; and where this is the real case, it is undoubtedly sufficient for them to send help, being the only expedient they can use. But this is not properly visiting the sick; it is another thing [...]. To send them assistance is, therefore, entirely a different thing from visiting them (Wesley, n.d.:119).

According to him, sick people are to be approached, visited and cared for. Sending money or other assistance to them cannot be recognised as a visit but as a pretext for distancing

themselves physically. In the FMCSA therefore, the influence of this worthy example of drawing the attention of the community to their duties for the good of the sick is non-existent in this time of HIV and AIDS.

The second element is the lack of monitoring internal potential initiatives. The study has shown that within the FMCSA there are nurses, caregivers, pastors and other people who have tried to organise a few activities through which HIV and AIDS can be addressed. These activities include visiting the sick, helping the poor, providing counselling in hospitals and addressing the people on health issues. However, since these initiatives are not recorded or monitored among the Church's activities, they remain unacknowledged and unknown and the motivation of the initiators does not grow.

This ignorance of the Church's potential human resources is dissimilar to Jesus' example of the *missio Dei*. According to Engelbrecht (1986:43-44) and Maddocks (1981: 52-57), although Jesus was able to heal all diseases, He also encouraged and involved his disciples and other people in this action. He gave power and authority to drive out demons and to heal diseases, firstly to the twelve disciples (Maddocks, 1981:52-55), then to seventy disciples (Luc 10:1) (:55-56), and finally to all believers (:56-57).

Wesley likewise encouraged his people to become involved in healthcare. According to Maddox (2007:8-9), Wesley urged Methodist preachers to read and to always carry with them books on spiritual and physical health and to leave some in the parishes so that parishioners may use them too. He also gave advice to all the people on how to remain healthy and clean (Guy, 1988:122-123). By distributing his book *Primitive Physic* on easy ways of curing various diseases as mentioned earlier (:27), Wesley also involved the whole community. Therefore, this insight of encouraging the people to involve themselves in healthcare has wholly escaped the FMCSA in responding to HIV and AIDS.

The third element concerns the lack of love shown to people outside the Church. Many participants believed that there are no HIV positive people in the Church. This conviction was presented as one of the reasons of the Church's non-engagement in addressing HIV and AIDS (CL13:7-8). The interpretation of this behaviour seems to signify that there was a lack of love and compassion for 'the neighbour'.

Under these conditions, this conduct diverges from that of Jesus' understanding of how to respond to the suffering of others. According to Maddocks (1981:59), Jesus' healing and caring

ministry is part of his teaching of how to care and have compassion for one's neighbour. In explaining his point, Maddocks uses Jesus' parable of the Good Samaritan who took care of the Israelite injured by robbers on the way from Jerusalem to Jericho, thus becoming his true neighbour (Luke 10.25-37). Maddocks explains that many people see in this Samaritan "the person of Jesus Himself, who *comes where we are* and ministers to our many wounds" (:59). He goes on to emphasise that such is the caring that people need and that Jesus came to give, an expression of God's limitless love (:59).

Like Jesus, Wesley manifested love and compassion to all, near and far. According to Hulley (1988:69, 77) and Wesley (n.d.:495), Wesley's engagement in healthcare is an expression of respect to God's commandment of love. Marquardt (1992) concurs and specifies that for Wesley, "failing to fulfil this obligation blocks the way to happiness" (:26). Moreover, Wesley encouraged other people to have the same compassion. In the sermon 'On visiting the sick,' he scolds the rich for having little sympathy for the poor. For Wesley, the rich do not know the poor because they do not care to know them and they preserve the way of ignoring them making it a pretext of their hardness of heart. He also encourages them to get involved into caring for the sick (Wesley, n.d.:119). Like these rich, the participants in the present study did not approve of having to love 'others.'

The fourth element comprises the FMCSA's dependency on external donors and the neglect of local resources. From 2005, this Church had an HIV and AIDS project proposal whose budget was estimated at 1,290,110 American dollars. The proposal was submitted to external donors but was not funded. Within the seven years between that proposal's development and the present study, the Church had not tried to find alternatives within its own resources to respond to the pandemic.

If the FMCSA were committed to following the example of Jesus and Wesley then it would not remain inactive to the challenge of HIV and AIDS simply because it did not receive a huge sum of money from external sources. As mentioned in chapter 3, Jesus used simple, local and accessible means such as the word, touch, oil, saliva, mud poultice, individual's faith, prayer, food, and water (Maddocks, 1981:40-41; 60-61; Schmidt, 2007:13-15) to heal the sick.

In the same way, though Wesley used pharmaceutical products in his healthcare, he also valued local resources. He assisted the poor who were not financially and socially privileged to have access to health care of quality (Hill, 1958:2-4; Gadsby, 1998). Wesley developed natural, affordable and easily accessible recipes which included water, air, milk, physical exercise, honey,

whey, treacle, herbs, common medicine, healthy nutrition, visits, counselling and prayer (Wesley, 2004:v-vii; Maddox, 2007:17-23). In term of finance, Wesley mostly used his own savings (Maddox, 2007:27). The Church has not captured the value of using simple and accessible means such as visits, prayer, food, advice, and counselling as some of the ways in which to address the pandemic.

The fifth element concerns the lack of health and social initiatives as means to address HIV and AIDS. Although the FMCSA has no comprehensive health initiative through which HIV and AIDS-related issues may be addressed, there are a few social projects or services such as the UCH and The Haven shelter in Pietermaritzburg, KZN, and some isolated cases of support to the poor and the sick, as well as pastoral services in all circuits which could have been a useful medium for generating awareness of HIV and AIDS and care for PLWHA. But the current use of these initiatives lack strategic purpose.

However, Jesus linked physical healing with social, emotional, and spiritual healing. As shown in chapter 3, Schmidt (2007:5) observes that the leper in Matthew 8:1-4 was physically, relationally, emotionally and spiritually healed. Dube (2007:91-95) also specifies that Jesus performed economic, racism, and social injustice healing as part of the ministry of salvation. Maddocks (1981:30-52, 58) echoes that Jesus ministry as holistic.

Wesley followed Jesus' example in this holistic ministry. Both Wesley (2004:vi) and Maddox (1994:147) show that Wesley believed in the interconnectivity of different kinds of diseases these being physical, emotional and spiritual. Maddox (1994:146-147; 2007:6-7), Health and Healing (2001:8), and Wesley (n.d.:120) maintains that Wesley found that holistic remedy was required in addressing diseases. Therefore, by not having any health or social initiative used as a means to address HIV and AIDS, the FMCSA does not value these insights into holistic remedy.

The last element focuses on the lack of partnership in response to HIV and AIDS. The study has found that some of the reasons why the FMCSA is not responding to HIV and AIDS are based on the claim that the government is already involved in addressing the health challenge. However this is an invalid argument because the South African government encourages churches to partner with it in caring for the sick admitted in hospitals (Mkhize, 2011) but that the FMCSA has ignored this call. The study has moreover shown that the FMCSA has not developed any other collaboration with other organisations or individuals or nurtured collaborations initiated by other institutions in the context of HIV and AIDS. The EHAIA which was initiated by the WCC in order to help churches be competent in HIV and AIDS has also been neglected by the

FMCSA. Because of the prejudices of its leaders, it is dismissing the work of the WCC as liberal and not evangelical enough to be treated as partners in caring for PLWHA.

Jesus did not disregard the importance of partnership in his ministry. Maddocks (1981) and Engelbrecht (1986) show that he was collaborating not only with his disciples, but also with God the Father. For Maddocks (1981:17), Jesus did not come to proclaim Himself but to do the will of the One who sent Him. Thus, he considered God's kingdom as the source of human's health (:20). For this reason, Jesus consulted the Father in everything, including healing. As for Maddocks (1981), the Lord's Prayer "is a prayer for the health and healing of creation and the establishment of the Kingdom, an urgent prayer for it asks for fulfilment, both corporate (all the house of Israel) and personal (in your lifetime and in your days), in the present generation" (:27). In affirming this partnership with the Father in his healing ministry, Jesus told his disciples that the case of being healed from evil spirits as described in Mark 9:14-34 requires being in prayer (Engelbrecht, 1986:43).

Wesley also valued the importance of partnership in his healthcare initiative. He was referring complicated and critical cases to specialist physicians (Hill, 1958:1, 13; Marquardt, 1992:28). In curing most diseases, he used books and expertise from other physicians such as Dr Tissot (Hill, 1958:54-82) and Dr Cheyne (Wesley, 2004:v-vi). He was drawing on the experience borrowed from herbalists (Gadsby, 1998 and Health and Healing, 2001:4-5). As seen above, he also collaborated with his co-preachers and involved them in the ministry. It seems therefore that by not developing any partnership to respond to HIV and AIDS, the FMCSA does not value this insight.

To end this section, it is noteworthy that the WHCR has many insights to fulfil the *missio Dei* in the current context of HIV and AIDS which have been overlooked by the FMCSA during this pandemic. The next section focuses on the relevance of Wesleyan gender sensitivity.

7.2.3 Relevance of Wesleyan Gender Sensitivity in the FMCSA's Response to the Gendered Nature of HIV and AIDS

In this section the relevance of Wesley's gender sensitivity in informing the FMCSA's response to the gendered nature of HIV and AIDS is examined. To what extent do the insights offered by John Wesley's view and behaviour about gender inform and influence the FMCSA's view and response to the gendered nature of HIV and AIDS?.

Chapters 5 and 6 show how the majority of participants were not informed about the significance of the gender concept and its influence on the spread of HIV and AIDS. They are already aware of gender inequality in the community but do not think that this structure can change. They do not even believe that the Church can or has the right to play a role in changing this order which prevents women from enjoying their rights. Moreover, some participant's ignorance held the victims of rape responsible for this act. No participant proves to realise that in this inequality, men, who mostly appear as abusers of women, are also at risk of being infected with HIV. Furthermore, the study found that even the project initiated to combine issues of gender and HIV and AIDS in Pietermaritzburg does not address the HIV and AIDS component.

Jesus challenged gender-based oppression and honoured both men and women (Folk, 1990:104-106; Rackoczy, 2004:104-106). He appointed both male and female disciples (Rackoczy, 2004:104), he cured men and women equally (Howard, 2001; Schmidt, 2007) and defended women when they were unjustly threatened (Folk, 1990:105). This means that Jesus was aware of the dangers of oppression meted out to women as a result of social structures and tried to break this structure.

Literature reveals that Wesley was also conscious of the socially constructed relationships between men and women and its impact on women's oppression and also tried to subvert this structure, as can be seen from the following discussion. Firstly, Wesley criticized women's abuse by men. In his sermon 'On Family Religion,' he stated, "I cannot find in the Bible that a husband has authority to strike his wife on any account, even suppose she struck him first, unless his life were in imminent danger" (Wesley, 1872). Likewise, his diary shows that on Thursday 28 April 1757, he rebuked a man who, advised by his pastor, had deliberately and assertively beaten his wife with a large stick and her whole body changed colour because of the wounds (Wesley, 1837:626). It is visible in this case that although pastors and laymen sustained the oppression of women, Wesley was not on their side.

Secondly, Wesley encouraged women to seek their liberation from being viewed and treated as sexual objects by men and to participate in all activities as skilled individuals. In his sermon, 'On Visiting the Sick,' he stated:

> '[T]here is neither male nor female in Christ Jesus.' Indeed it has long passed for a maxim with many, that 'women are only to be seen, not heard.' And accordingly many of them are brought up in such a manner as if they were only designed for agreeable playthings! But is this doing honour to the sex? Or is it a

> real kindness to them? No; it is the deepest unkindness; it is horrid cruelty; it is mere Turkish barbarity. [...] Let all you [women] that have in your power assert the right which the God of nature has given you. Yield not to that vile bondage any longer! You as well as men, are rational creatures. You, like them, were made in the image of God; you are equally candidates for immortality [...] And every one of *you* likewise 'shall receive *your* own reward, *according to your* own labour' (Wesley, n.d.:125-126).

This sermon applies to men who prevent women from decision-making in sexual relationships, especially in this time of HIV and AIDS.

Thirdly, connected to this preceding point is Wesley's challenge to men to love their wives. In the sermon, 'On Family Religion,' he reminded men that they have to love their wives as Christ has loved the Church and died for it in order to purify it unto Himself and to prevent it from being blemished. He then exhorts them, "The same end is every husband to pursue, in all his intercourse with his wife; to use every possible means that she may be freed from every spot, and may walk unblamable in love" (Wesley, 1872). Similarly, in his sermon, 'Upon our Lord's Sermon on the Mount,' Wesley reproved men for giving free rein to their sexual desires through adultery and polygamy (Wesley, 1810a). These teachings also challenge men who, after having unprotected sex with other people, return home and infect their wives and pretend to love them.

Lastly, Wesley gave women positions of genuine responsibility, thus acknowledging their dignity, rights and abilities. Here, Newton (1988:134) informs that Grace Murray was in charge of the orphanage, Hannah Ball of the Sunday School work and Nancy Bolton of pastoral care and leadership in the society. Wesley treated his female co-workers with respect, advised them as he did for men and admired their work (:135-136).

Through these points Wesley challenged those views which supported the denigration of women and promoted women's oppression. It is also noteworthy that Wesley was born and grew up within a patriarchal culture with all the gender inequality that it entailed during his time. He lived before the advent of movements which challenged oppressive patriarchy such as feminism and womanism (Rakoczy, 2004:11-15). However, although he was a male and was within his rights to benefit from this structure, he categorically opposed it. Conversely, it is evident that most of the participants in this study are insensitive to gender equality even while they are exposed to structures which uphold gender equality such as feminism, the African women theologians' Circle (Phiri and Nadar, 2006:3-6) and the South African constitution (Republic of South Africa, 1996). This means that the FMCSA does not use insights from

Wesley to overcome the current gender inequality which contributes to the spreading of HIV and AIDS.

This section has explored the FMCSA's Response to HIV and AIDS. It has shown that the attitude expressed by participants towards HIV and AIDS and the response developed by this Church to the pandemic and its gendered nature has not taken into account insights from the WHCR which seemingly constitute a sound approach of responding to the pandemic. How then can the WHCR be used to recover gaps unveiled by the present study in the FMCSA's response to HIV and AIDS? The next section responds to this question.

7.3 WHCR as Resource to Address HIV and AIDS within the South African Context

In this section, insights of rendering the WHCR a major a resource to respond to HIV and AIDS within the South African context are presented. The systematic analysis of the response of the FMCSA to the pandemic has shown that various useful insights from the WHCR are not being valued. It would be absurd to expect that the WHCR as developed in the 18th century can automatically be applied to the 21st century. For this reason, the insights that are proposed serve as a source of inspiration, leaving the debate open to any other interpretations and analyses. To this end, eight insights are presented below.

7.3.1 Definition of Theological Rationale

The first insight is the definition of theological rationale. The study has revealed that participants in this study, including church leaders, do not associate the necessity of the Church to respond to HIV and AIDS with God's priorities. However, Le Roux (2011:106) underlines that, "the missional church points to the reign of God, depending on God's action in the past, present and future." This means that being at God's work, the church has always to abide by God's will in any action and initiative. It is here that Richardson (2006; 2009) and Demissie (2008) insist that Christian churches are to remain faithful to the meaning of the Eucharist which engages them to do as Jesus did on the earth, otherwise their initiatives fall into the category of mere social actions or good works instead of being true *diakonia* (see chapter 5).

Therefore having a theological rationale is profitable and obligatory in every faith-based initiative. In the present context of HIV and AIDS studied within a faith-based organisation, a theological rationale is of great importance. Dube (2007) developed a theology of compassion to be used in counteracting the stigma and discrimination attached to HIV and AIDS. Chitando

(2007) complements her by providing a warning for the use of this theology. He observes that compassion is not to be understood as feeling pity or sorry for PLWHA, which could be deemed patronising, but as standing in solidarity with them (:51). Similarly, Dibeela (2007) has proposed a theology of life which can be used to encourage the appreciation of life in the time of HIV and AIDS. The other theology in the context of HIV and AIDS is that of healing suggested by Hadebe (2007) which can be used to address social and structural injustices and the needs of people infected or affected by HIV and AIDS. Gill (2007:3-4) proposes that a theology of sexuality is also needed in order to acknowledge its goodness and its role in human development and happiness. It seems that all these various theologies can be useful in the present South Africa since they are meant to address situations which are evident in this country, as seen earlier.

Therefore, since these scholars also support the definition of a theological rationale in the context of HIV and AIDS, the WHCR gives clarity to what constitutes its theological rationale which can be helpful in this time of the HIV and AIDS pandemic.

7.3.2 Extension of Love and Care to All People

The second insight regards the extension of love and care to all people. Through the analysis of the WHCR, it was found that Wesley was concerned about the suffering of all people, regardless of their church membership, Methodist membership, wealth, social position and citizenship. In practicing his conviction of the love of God and the neighbour he was ready to receive and to serve everybody. According to Marquardt (1992), Wesley understood that faith and love are inseparable and neither is a substitute for the other (:104). With this theological ethics, differences based on nationality, race, religion or philosophy does not make any person unworthy of love (:107). Wesley's perception of acceptance, concern, and love of other people can also be discerned in his sermon 'A Caution against Bigotry' (Wesley, 1810c). This sermon is based on the Gospel of Mark 9.38-39 where Jesus disapproves of his disciples' action of forbidding someone to cast out demons simply because he does not follow them. Similarly, Wesley disapproves of exclusion or rejection of people simply because they do not connect with us, do not adhere to our politics, have dissimilar religious opinions, have adopted different practices, seem to be anti-scriptural or anti-Christians or do not show affection to us. Because of this openness and love to everybody, Wesley was able to indiscriminately serve all the people using his own resources and urging others to do the same (see chapter 3 and preceding section).

However, the results of this study have shown a dissimilar attitude and behaviour in the FMCSA. Most of participants were of the opinion that the Church should address HIV and AIDS simply

because of self-interest which seems to mean that if the disease impacts only on the wider community and not within the Church, the Church would keep quiet and inactive. Other participants said that the Church is not responding to the pandemic because there are no PLWHA among its members, which can be interpreted that if the Church is safe, the suffering of the general community can safely be ignored.

However, scholars emphasise and support the notion of goodness and the necessity of love to all in the context of HIV and AIDS. According to Richardson (2006), it would be a contradiction if people, joined by a common allegiance to Jesus, do not care or embody compassion for people in need. He also states later that not responding to HIV and AIDS is itself a failure to love (:42). Like him, Demissies (2008) understands that the Christians' adequate response to the pandemic requires that they are guided by the divine solidarity with Jesus, "towards genuine solidarity, in co-suffering and compassion, with those living with HIV and AIDS" (:7). Here, these authors do not confine compassion and solidarity within the church but extend it to all those infected and affected.

Extending love and care to all the people like Wesley did, constitute a missional mandate of the church. In the context of South Africa, the idea of such love can also be sustained by the wisdom of *ubuntu* which, according to Shutte (2001:31), comprises a fundamental attitude towards others which sees them as 'another self,' and considers everyone, no matter how foreign, as 'one of us' and as "having a claim on one's time and energy."[128]

7.3.3 The Fight against Stigma

The third insight concerns the fight against the stigma attached to HIV and AIDS. In chapter 3 it was mentioned that during Wesley's life time, poverty was seen as a burden and linked to the notion of punishment from God. For this reason, the rich and the political authorities were not concerned about the poor and all their problems, including those related to health (Marquardt, 1992:21-23). However, Wesley did not agree with this attitude. He urged the rich to change this attitude, to visit the sick and to help the poor since they [the poor] were not accountable of any wrong doing (Marquardt, 1992:31; Wesley, n.d.:119). In his sermon 'On Love,' he also admonishes his audience not to condemn others without evidence (Wesley, 1771:959).

[128] However, in the context of gender, *ubuntu* has been criticised. These critics and proposed alternatives are discussed in another section below dealing with the negative impact of oppressive patriarchy.

However, in this study, some attitudes towards HIV and AIDS and PLWHA diverged from Wesley's attitude towards the poor, the sick and sickness. Divergences were discerned in the abusive naming of HIV and AIDS and PLWHA, the association of the pandemic with the sin of sexual immorality and the belief that the Church is a holy place in which HIV and AIDS cannot be spoken about. In the Church, this negative attitude was accompanied by silence and inaction with regard to HIV and AIDS. PLWHA likewise did not find a platform to express their concerns and to obtain adequate assistance.

When regarding the literature, one finds that retribution theology causes regrettable damages. West and Zengele (2006:51-52) realise that because of the stigma and discrimination which accompany this theology, some people who had disclosed their HIV status have been obliged to leave the church and to find alternative sites to construct their own life-giving theology, one of which being the Siyaphila network of support groups in Pietermaritzburg. According to Vitillo (2007:36), some priests and ministers refuse church care and services to PLWHA (:36) while others forced them to confess to the sin which has caused the infection (:38). He also observed that in The Ivory Coast and in South Africa, some women refused to test for their HIV status or did not return for their results for fear of being stigmatised (:36).

However, while PLWHA are being asked to confess, scholars such as Demissie (2008:7) and McDonagh (2007:44) observe that not all HIV infection or human suffering result from sin or are God's punishment. For Gillespie, Niehof, and Rugalema (2010:25), stigma is far more sinful than what PLWHA are often blamed for. It is therefore clear that avoiding and fighting stigma, like Wesley did, can be a way of avoiding such damages which are likely to occur in the FMCSA. Some practical ideas have already been suggested. West and Zengele (2006:60, 61) and West (2011) speak of the redemptive use of the Bible. Chitando (2007:46, 47) proposes the replacement of the theology of death and lament with the theology of life and joy. Ackermann (2008:114) suggests ethics of resisting retribution theology, morbidity and death; affirming the worth and dignity of PLWHA, and having hope where there is little cause for it. Gill (2007:28) states that we need to break the silence on HIV, tell the truth of it and acknowledge its meaning. Manda (2011:201) maintains that there are life-promoting and life-affirming values focusing on relationality, inclusivity, love, care and compassion, and religious contextual relevance. The list is long but the important aspect here is to adapt practices to local context.

7.3.4 Development of both Preventive and Restorative Strategies

The fourth insight involves the development of both preventive and restorative strategies. In chapter 3 Wesley addressed health-related issues using preventive, curative, short-term and long-term strategies. According to Marquardt (1992:27-30), the mixture of both strategies was very encouraging, especially for the poor.

However, in the FMCSA, although there is no noticeable initiative to address HIV and AIDS, even the thoughts of the participants on how the Church should respond are mostly limited to care and treatment and short-term strategies, with less emphasis on preventive and long-term strategies (chapter 5).

Unlike the FMCSA, Barnett and Whiteside (2006:348-349) remarked that the committed people's intervention in HIV and AIDS includes prevention, care and response to the impact. Like them, Gillespie et al. (2010:6-7) distinguish three sequential phases of vulnerabilities related to HIV and AIDS that interventions should take in account. These are the *upstream* phase relating to the individuals' risk of being exposed to HIV infection; the *midstream* phase regarding the risk of HIV positive people to develop opportunistic infection; the *downstream* phase regarding the risk of the serious impact of HIV infection. For them, these phases can be identified at individual, household or community levels. They propose that prevention measures are appropriate in the *upstream* phase, care and treatment at the *midstream* phase, and mitigation at the *downstream* phase. If preventive and mitigating strategies are not utilised then the response to the pandemic would be inadequate.

Wesley's ways of responding to diseases represent a template that the FMCSA could adapt and adopt. Preventive, long-term and restorative (care, treatment, and mitigation) may include developing theologies related to HIV and AIDS, strategies for behavioural change among infected and non-infected people, promotion of gender equality, and poverty alleviation.

7.3.5 Development of Holistic Response

The fifth insight is the development of a holistic response and is centred on the variety of strategies that have been adopted. Wesley utilized a variety of healthcare strategies for the poor that include a medical response through medicines; an emotional response through counselling; a spiritual response through prayer and sermons; and a social response through poverty alleviation, advice on nutrition, material assistance, opposition against slavery, and assistance to prisoners.

However, the FMCSA's strategy towards HIV and AIDS failed to respond in a holistic way towards this pandemic. Wittenberg (2007:152), argues for a three-dimensional approach that involves the physical, the psychic, the mental or spiritual, as well as the social. Dube (2004:vi) presents these dimensions in two points which render the pandemic not an individual health issue but a social issue. She mentions firstly that it works through social injustice, and secondly, that it affects all aspects of life. Carton (2006:97-98), Buvé (2006:55), and Vitillo (2007:34) also link the pandemic to unemployment and poverty. At the same time, scholars suggest that because of its multidimensional form, the response is to be multidimensional too. Among others, Gillespie (2010:5) and Manda (2011:208) inform that scholars recognise that a sustainable response to HIV and AIDS needs to move beyond the biomedical, narrow behavioural change and mere pitiful compassion to PLWHA. These views are echoed by McDonagh (2007:57-58) who states that medical treatment is not enough to deal with all aspects of the pandemic. Shutte (2001:130-131) observes that health is part of the goal of total life but not its end.

Therefore, since all these discourses sustain holistic approaches to HIV and AIDS, Wesley's use of various strategies to care for health can serve as an example and inspiration to anyone intending to address the pandemic. Such a response may be similar to the decision of World Methodist Council during its twentieth Conference held in Durban in 2011, where they repented of having allowed fatigue and complacency to weaken the response to HIV and AIDS, and vowed "to promote holistic prevention of HIV and to collaborate ecumenically to respond to the challenge" (World Methodist Council, 2011:260). Based on the results of this study, a holistic approach to HIV and AIDS in the context of South Africa may include the following: an enhanced HIV and AIDS awareness; spiritual, social and financial empowerment; nutrition, treatment and care; human rights and advocacy.

7.3.6 Use of Available and Low-Cost Resources

The sixth insight is the use of available and low-cost resources. In chapter 3, it was argued that Wesley used simple and less expensive means of prevention and treatment of diseases. His recipe was composed of mostly natural and local products such as water, whey and physical exercise. Wesley did not omit to collaborate with local preachers, parishioners, local physicians and herbalists in his ministry. He likewise used the Word of God as an instrument to restore people's lives. These arrangements enabled him to use his limited financial resources to accomplish great achievements which included the establishment of dispensaries/clinics and the cure of a multitude of people.

However, the FMCSA's arrangements in response to HIV and AIDS seem to be the opposite because it opted for a reliance on large sums of money that was unrealistic and unachievable for their ill-budgeted project proposal. They neglected to consider and utilise the low-cost resources already existing within Church environment. They did not value the possible partnership with institutions and individuals in order to respond to the pandemic. As result they did not achieve any successful response to HIV and AIDS.

Literature disagrees with this Church's reaction to the pandemic. For Demissie (2008:5), the church should not rely only on external support and expect to change the situation of HIV and AIDS, even if it receives sufficient money. Njoroge (2008:192) and Kimweli (2008:63) point respectively to church leaders and general church members as potential human resources to be empowered and managed efficiently. Literature also suggests useful low-cost strategies in responding to the pandemic. Ackermann (2007:118), Gillespie et al. (2010:25-26), West and Zengele (2004:119-120), and West (2008:202) include here the use of Bible study and laments in a redemptive way whereas Kraft (1986:198-200), Ackermann (2008:120-122) and Manda (2011:207) engage the churches' rituals such as the Sacraments. Other strategies involve the use of small groups of church members (Demissie, 2008:9), involvement of the whole church (Richardson, 2006:49-50), and the acknowledgement of the possible role of PLWHA in this process of responding to the pandemic (Gill, 2007:1).

Flohlich (2010:381-382) underlines the importance of networking with families and communities when caring for PLWHA. Gennrich (2007:174-176) points to the importance of networking with nature. Like other authors such as CAMI (2007), Kaya (2007), and Thinwa (2004), she identifies plants which have recorded good results in mitigating the impact of HIV and AIDS in South Africa. Particularly in KZN, she mentions plants such as *Carpobrotus edulis [sour fig] [ibohlololo lasolwandle/umgongni]* and *Bulbine frutescens [ibhucu]* which have successfully been used in the treatment of throat infections, thrush, sores of the skin, itchy spots and mouth ulcers (Gennrich, 2007:174-175).

If Wesley's examples of using available and low-cost resources were taken seriously by the FMCSA, it would offer a better response to HIV and AIDS, especially in the context of South Africa. The church's holistic approach is not meant to deny the importance of modern medicine but to emphasise that there is no need to wait for the unavailability of external help while there are already possible local solutions that can be harnessed.

7.3.7 Breaking the Silence on Sexuality

The seventh insight is the breaking of the silence on sexuality. In the literature on the WHCR, it appears that Wesley treated various diseases, including those related to sex and sexuality. In his book *Primitive Physic,* the very first advice is about the prevention of abortions (Wesley, 2004:1). He also includes advices about delivery (:18), collapsed wombs (:24), fistula (:26), flooding accompanying delivery (:27), inflammation or swelling of the scrotum (:43), pains or inflammation in testicles (:51), ulcers in the urethra (:53) and problems in urinating (:54). He was also naming parts of the body such as breasts, women's nipples, the nose as well as functions and malfunctions of the body such as bleeding, swelling and convulsion of the bowels (:7-8, 15). He encouraged women to seek freedom from being used as sexual 'playthings' (Wesley, n.d.:125-126) and rebuked men for their promiscuous sexual desires (Wesley, 1810a). This shows that he did not restrain himself from naming the problem directly as long as he could save the lives of people.

Sexuality is one of the important issues to deal with when addressing HIV and AIDS (Njoroge, 2008:181-182). This study has found that church leaders in the FMCSA are afraid to discuss this topic and this silence is preventing them from initiating adequate preventative measures in response to the HIV and AIDS pandemic, thus contributing to the pandemic's spread. Literature indeed shows that many church leaders do not want to speak about sex and sexuality. According to Byamugisha et al. (2002:92), Khathide (2003:2-3), and Schmid (2005:4), this is due to the cultural taboos surrounding this issue. Weinreich and Christoph (2004:13) observe that pastors argue that talking about sexuality, especially when promoting the use of condoms increases sexual promiscuity, whilst research has proven the contrary (Schmid, 2005:6).

It was also found that this silence has a damaging impact. Stiebert (2004:81) and Schmid (2005:4) observe that the silence about HIV and AIDS enhances the stigma of people infected or affected by the virus. Denis (2011:64-65), argues that it also weakens the effectiveness in sexual behaviour changes, especially for the youth. With regard to this, Ryan (2007:66-67) understands that the church which does not communicate with its members about the role of chastity is accountable of their sexual immorality done in ignorance. This means that according to him, the church should openly speak about sexuality.

Ryan's postulation is echoed by many other scholars who also try to provide some reasons. For Schmid (2005:4) and Blake (2011) the twentieth century has bequeathed freedom, forms and availability of sexuality and contraceptives. Therefore, the church should not respond by merely

condemning pre-marital or extra-marital sexual relations. Njoroge (2008:181-182) also understands that the church should gather courage to speak about sex since it is a creative gift meant to be enjoyed.

These authors seem to be in support of what Wesley has done, by openly naming elements involved in the search for a solution to the problems of human existence, including issues related to sex and sexuality. Thus this makes his healthcare response a viable asset that the FMCSA can use and a significant tool to improve its response to HIV and AIDS in South Africa, namely, in breaking the silence around sexuality. The practicability is however, to be discussed further since issues of culture are involved.

7.3.8 Recognition of and Response to Gender Inequality

The last insight is the recognition of and response to gender inequality. Wesley was sensitive to the impact of gender-based inequality which oppresses women. He also tried to address it by encouraging women to seek their liberation and rebuking men for their gendered life-denying behaviours, such as sexual promiscuity.

Conversely, results of the study point to a low proportion of participants who are aware of the impact of gender inequality on the spread of HIV and AIDS. In addition to this deficiency, they do not perceive that the oppressive patriarchal structure which already exists in their community can be changed through the Church's involvement.

But their view differs from perspectives provided by literature. Khathide (2003:7) observes that men's sexual behaviour has a long history and is based on cultural and spiritual licence. Maluleke and Nadar (2002) also find that culture, religion and gender socialisation work together to make women's oppression an accepted norm in social life. In addition, HIV and AIDS is seen to have been fuelled by such culturally and religiously established structures. In this regard, Van Klinken (2011:281-280) presents analyses by various scholars who, for example, explain that in Africa, men are possessed with virility, or that patriarchal masculinities are characterised by power, potency and fertility, which make the prevention of HIV infection through sexual abstinence unsuccessful.

Since culture and religion are involved in establishing gendered structures which contribute to the spread of the pandemic, scholars have tried to reflect on them as sources to address the issue. For Le Roux (2011:201), a missional church has to engage with but not conform to

surrounding (oppressive) cultures. As for Maluleke and Nadar (2002:7, 14-16), there is a need to find strategies to destroy oppressive structures from within, what Nadar (2005:20) calls using the master's tool to break down the master's house. From this perspective, Dube (2003:97-99) proposes capitalizing on life-giving insights from culture, human rights and school education.

From within the culture, Shutte (2001:31) suggests the use of *ubuntu* ethics, as introduced earlier. However, in the context of gender, *ubuntu* ethics has been criticised. Fulata Moyo (2005:130, 135-137) argues that it cannot adequately address the health problems that African women face. As she explains, *ubuntu*'s weakness resides in the fact that it reinforces women's subordination since it is inherently hierarchical (Manda, 2011:207). She rather proposes biblical *agape* which promotes mutuality and companionship in marriage (Van Klinken, 2011:284). Like Moyo, Chitando (2007) also views *ubuntu* philosophy as connected to the oppressive patriarchal definition of the community. He proposes 'solidarity' which, according to him, means "standing for, and with, the other" and prevents men from engaging in multiple sexual partners (Van Klinken, 2011:284-285). Chitando (2011:246) argues that *ubuntu* ethics was practically helpful only in caring for vulnerable children.

With regard to religion as a source to oppose gender inequality in the context of HIV and AIDS, Van Klinken (2011:284) draws from his experience in the Zambian Christian churches to indicate the success in using patriarchal masculinities to insist on men's responsibilities in sexuality, relationships and marriage. Likewise, Ackermann (2004) and Nadar (2004) propose a re-reading of the Bible from a gender-sensitive perspective. These scholars also support the involvement of religious people and the use of religious resources to address gender inequality. Therefore, Wesley's stance with regard to gender issues constitutes a FMCSA's source of inspiration and encouragement to recognise the impact of gender inequality, particularly on the spread of HIV and AIDS and to contribute to addressing the issue.

To conclude this section, the various insights from the WHCR can constitute resources to fill the gaps identified in the response to HIV and AIDS within the South Africa context. They represent a signpost of hope. It is also noteworthy that the use of these insights requires meticulous adaptation to local conditions. Nonetheless, this section corroborates the idea of this study, that of reclaiming the WHCR as a strategic resource in the FMCSA's response to HIV and AIDS and its gendered nature.

7.6 Conclusion

This chapter was developed as a means to assess the extent to which the WHCR has been used by the FMCSA as a resource for addressing HIV and AIDS. Features of the response of the FMCSA (Chapters 5 and 6), obtained through fieldwork research (chapter 4) were revisited to assess how they were informed by Wesley's method of fulfilling the *missio Dei* in the midst of a health crisis (chapter 3). This meticulous work has allowed for the identification of insights from Wesley's healthcare that the FMCSA has failed to consider in responding to HIV and AIDS (chapter 2). Based on this failure, the chapter has used literature to highlight how these insights are credible for a better fulfilment of the *missio Dei* in a time of HIV and AIDS in the context of South Africa.

Therefore, the chapter has presented eleven points which identified the failure of the FMCSA to making the WHCR a positive and viable resource to respond to HIV and AIDS. These are the lack of a theological rationale, the lack of concern about others' suffering, lack of vision for prevention and long-term strategies, lack of adequate initiative to improve the attitude of the community towards HIV and AIDS, lack of love to people outside the Church, lack of health and social initiatives as a means to address HIV and AIDS, lack of partnerships as response to HIV and AIDS and a lack of a response to the gendered dimension of HIV and AIDS. Likewise, results have displayed a serious lack of monitoring of internal potential initiatives, the dependency on external donors and neglect of local resources, and explicit negative attitude towards HIV and AIDS.

Furthermore, eight insights from the WHCR were identified to be useful in addressing HIV and AIDS, especially in filling gaps found in the FMCSA's response to the pandemic. These are the definition of a theological rationale, the extension of love and care to all people, the fight against stigma, the development of both preventive and restorative strategies, the development of a holistic response, the use of available and less costly resources, the breaking of the silence on sexuality and the recognition of and response to the impact of gender inequality on the spread of HIV and AIDS.

Based on this analysis, this chapter has confirmed the hypothesis of the study, that the FMCSA is not using valuable insights gained from the WHCR to respond to HIV and AIDS. If these contributions are ever used, it is not done in a gender-sensitive manner. The analysis has also supported the idea of this study of reclaiming the WHCR in the FMCSA's response to HIV and AIDS and its gendered nature.

CHAPTER EIGHT

CONCLUSION

8.1 Introduction

This study investigated the response of the FMCSA to the challenge of HIV and AIDS and postulated the ways in which a Wesleyan Healthcare model could be used as an inspiration to empower and equip the Church's response to HIV and AIDS from a gender-sensitive perspective. In this concluding chapter a summary is made of the entire study and demonstrates the extent to which this goal has been achieved. This is presented in the following six sections. Firstly, a general overview of the study's design is given. Secondly, a review of the objectives of the study and the extent to which they have been achieved is provided. Thirdly, an assessment of the quality of the present study is included. Fourthly, the contribution of the present study to new knowledge is evaluated. Fifth, future research is suggested in order to cover the gaps identified in this study. Lastly, the conclusions are summarised and the final statement is presented.

8.2 General Overview of the Study Design

Personal and academic motivations inspired the initiative of this study. Therefore, the researcher's membership of the FMCSA and its leadership team afforded him a privileged view on how to respond to the real needs of the community that the Church is serving, namely, the need of living a healthy lifestyle. The motivation was also influenced by an in-depth reflection on how to accomplish the mission of the church in a time of HIV and AIDS and how the FMCSA can identify and harness the use of available resources for the good of the community.

The noticeable feeble response of the FMCSA to HIV and AIDS and its gendered nature triggered the academic motivation. This inadequate and lacking response was recognised within the Church and in the literature. A direct link between gender-based relationship issues and HIV and AIDS is recognised in academic literature and confirmed in case studies of women survivors of domestic violence assisted by this Church in Pietermaritzburg. Therefore, the response of the Church to such problems could serve as a signpost for other researchers that wish to examine issues regarding HIV and AIDS and its link to gender issues.

In addition to the Church's silence on its response to the pandemic, there was also a silence on the use of some important resources embedded in the essence of this Church to address HIV and AIDS. In this regard, the healthcare response initiated by John Wesley, the founder of Methodism, and that the founders of the FMC promised to embrace was grossly neglected as a resource that could empower its response to the pandemic. The thesis argued that through effective appropriation of the WHCR, the FMCSA can offer an effective response to HIV and AIDs from a gender-sensitive perspective.

In order to discover how the WHCR can inspire the FMCSA to respond to the HIV and AIDS pandemic from a gender-sensitive perspective it was important to examine the response of the FMCSA to the HIV and AIDS pandemic and the extent to which the WHCR has been used by this Church as a resource to respond to the pandemic. The core question was: how can the WHCR be utilised as a major resource for addressing HIV and AIDS and its gendered nature in the context of South Africa?

In order to respond to the question five objectives for the study were identified. The first objective explored a discursive account of HIV and AIDS and its gendered nature in South Africa and the FMCSA's response. The second objective critically reflected on the WHCR as a FMCSA's potential resource for the *missio Dei*'s fulfilment in a time of HIV and AIDS. The third objective examined the attitudes and concrete responses to the HIV and AIDS pandemic in the Free Methodist Southern KwaZulu-Natal. With the fourth objective an assessment was made of the extent to which the WHCR has been used as resource for addressing HIV and AIDS in the Free Methodist Southern KwaZulu-Natal. The last objective suggested insights of making the WHCR a resource to respond to HIV and AIDS within the South African context.

To this end a mixture of empirical and non-empirical qualitative research methods were utilised. This included diverse academic documentation and fieldwork research. In the field research five circuits were selected in three communities of the FMSKZN. The study involved church leaders and caregivers interviewed individually and ordinary church members gathered in FGD. These participants were chosen using purposive, snowball, and convenience sampling methods. Based on the fieldwork results, a meticulous reflection led to a demonstration of how the WHCR can inform the response of the FMCSA in fulfilling the *missio Dei* in a time of HIV and AIDS from a gender-sensitive perspective.

8.3 Review of Objectives and their Achievement

Each chapter in this study was developed according to particular objectives pursued. Chapter 2 dealt with achieving the first objective of exploring a discursive account of HIV and AIDS and its gendered nature in South Africa and the FMCSA's response to this. The chapter served as background of the study by exploring the literature on HIV and AIDS in South Africa, the gendered nature of this pandemic in South Africa, and the FMCSA. Key themes emerging from this chapter emphasised that since the first diagnosis on AIDS in South Africa in 1982, the rate of HIV continued to increase although some decrease was observed among women attending ANCs. This disease in its early stages was deemed to be a problem for males. However, this feature has changed to the point where currently females are the most affected. Since factors related to gender inequality and abuse have played a substantial role in this shift, it was argued that addressing gender issues should always be a constitutive element in addressing HIV and AIDS in South Africa. It is through the development of this chapter that the gap in literature on the response of the FMCSA to the gendered nature of HIV and AIDS was exposed.

Likewise, the second objective aimed at critically reflecting on the WHCR as a potential resource for the *missio Dei*'s fulfilment in a time of HIV and AIDS for the FMCSA. This objective was explored in chapter 3. The chapter therefore served to delineate the theoretical/theological framework of this study. It explored the *missio Dei* paradigm and its significance in addressing HIV and AIDS and shed light on the WHCR as fulfilment of the *missio Dei* in a time of HIV and AIDS. The link between the WHCR and the FMCSA and the reasons why this Church should use this ministry as a resource were also highlighted. Throughout this chapter it was consistently argued that responding to HIV and AIDS is in line with fulfilling the *missio Dei* and also that the WHCR is an accomplishment of the *missio Dei* and serves as a tool to address HIV and AIDS and its gendered nature. The second gap identified that the WHCR was not academically researched to assess its relevance within the context of HIV and AIDS in South Africa. It was argued that since the founders of the Free Methodism have committed to preserving the way of life as taught and lived by John Wesley and that his healthcare response constitutes an important health asset that can be used to address HIV and AIDS, the FMCSA should utilise this resources in fulfilling the *missio Dei* in a time of HIV and AIDS.

The third objective concerned the examination of the attitude and concrete response of the FMCSA to the HIV and AIDS pandemic. Chapters 4, 5, and 6 have been used to achieve this objective. In chapter 4 the theoretical design was elucidated. The geographical location and the

population were identified, the theoretical paradigm of the study was framed and methods of data collection and the analysis and interpretation were explained. Ethical considerations and methodological limitations were identified. The study has embraced characteristics of qualitative, critical humanist and descriptive research designed as a case study within the perspectives of postmodernist and feminist theories. These characteristics have therefore informed the data collection and analysis.

Chapter 5 moved away from the analysis and interpretation of the field work results to describe the attitude of the FMCSA towards HIV and AIDS and its gendered nature. The principal focus was on the necessity of the Church to respond to HIV and AIDS and its attitude towards HIV and AIDS and its impact. The other theme explored in this chapter concerns the knowledge of the participants about gender and its influence on the spread of HIV and AIDS. It was therefore found that although the participants understood that the Church should respond to the pandemic, their understanding was not underpinned by an informed theological rationale. Research data also displayed a lack of concern about the suffering of the 'other' and the lack of a long-term vision and strategies to address the pandemic. The study also confirmed that the attitudes of the participants were informed by a theology of retribution and ethics of sexuality developed by religions. Participants were also found less informed about gender and its influence on the spread of HIV and AIDS. Within this gender issue, victims of rape were also held responsible for their traumatic experience especially with reference to the clothing that they wear. This attitude is likely to compromise an adequate response to HIV and AIDS by the Church.

The last step for achieving the third objective was explored through the issues raised in chapter 6. Through an analysis and interpretation of the field work data, an assessment of the concrete response of the FMCSA to the pandemic was made. This gave primary focus to the response to the attitude of the community towards HIV and AIDS, the response in prevention, care and treatment, and the response to the gendered nature to HIV and AIDS. The assessment also included the response of this Church to HIV and AIDS through its health and social initiatives and partnership with other institutions that promote a healthy lifestyle. In this regard, data does not confirm any significant influence of the FMCSA's perspective and practice in promoting an improvement in the attitude of the community towards the pandemic. In addition, there was no concrete action taken by the Church in terms of the prevention of HIV, care or treatment of people infected or affected by HIV and AIDS. Similarly, there was no concrete response to the gendered nature of HIV and AIDS. Apart from a few social services, there is no health service in this Church. These services are not practically linked to the response to HIV and AIDS although

some of them, namely The Haven shelter, were designed with the objective to address problems linked with gender issues and HIV and AIDS. The study has not found any partnership initiated by this Church as a way to respond to the pandemic.

The fourth and fifth objectives were achieved through chapter 7 that is dedicated to the assessment of the relevance of the WHCR in the FMCSA's response to HIV and AIDS. An assessment of the extent to which the WHCR has been used by the FMCSA as a resource for addressing HIV and AIDS was shared using the theory of the *missio Dei* as the framework. Therefore, it was found that the FMCSA failed to make the WHCR a resource for addressing HIV and AIDS. This failure was manifested in the lack of a theological rationale on issues of HIV and AIDS, a lack of concern about the suffering of others, a lack of a vision for the prevention and long-term strategies, a lack of adequate initiatives to improve the attitude of the community towards HIV and AIDS, and a lack of love to people outside the Church. The lack of health and social initiatives as a means to address HIV and AIDS, a lack of partnership as a response to HIV and AIDS and a lack of response to the gendered dimension of HIV and AIDS also constitute deficiencies in the FMCSA. The deficiency is further complicated by its lack of monitoring internal potential initiatives, the dependency on external donors, neglect of local resources and an explicit negative attitude towards HIV and AIDS. It is on the basis of this missional inadequacy that the hypothesis of this study, that the FMCSA has failed to learn from and use valuable insights from the WHCR to respond to HIV and AIDS in a gender-sensitive way, has been postulated.

The fifth objective proposed the WHCR as a resource to respond to HIV and AIDS within the South African context. Eight insights were suggested in this regard. These are the definition of a theological rationale regarding health issues, including HIV and AIDS; the extension of love and care to all the people; and the fight against the stigma placed on HIV and AIDS. It was also suggested that the development of preventive and restorative strategies, the development of holistic response, the use of available and less costly resources, the breaking of the silence on sexuality and the recognition and the response gender inequality constitute viable missional responses that the Church should embrace.

8.4 Assessment of the Quality of the Study

In assessing the quality of the present study, concepts of validity/credibility, reliability/dependability, generalizability/transferability and reflexivity /positionality have been used as recommended by selective researchers.

8.4.1 Validity/Credibility

Van der Riet and Durrheim (2006) suggest that the concept of validity refers to "the degree to which the research conclusions are sound" (:90). While this is a broad explanation, Hesse-Biber and Leavy (2011) specifically link this concept with the response to the question which asks how the researchers know whether their findings are plausible and will be received as a credible explanation or interpretation of the phenomenon they are studying (:48). In this clarification, they relate the validity to the acceptability by the reader – including the researcher – of the research findings as a genuine reflection of the phenomenon studied. But whereas this way of assessing the quality of the research is upheld by positivist researchers using a quantitative research approach (Williams (2003:11-17), Van der Riet and Durrheim (2006) inform that social constructionists reject the possibility of having findings accurately reflecting the reality (:90). As qualitative researchers, constructionists rather understand that "social phenomena do not exist as natural events or objects in the world, but are brought into existence by human social activities that have important implications for how they should be studied" (Searle, 1995). In saying this, they assert that social phenomena are dynamic and depend on how they have been given the meaning within their own context (:23). Therefore, in rejecting research validity, constructionists alternatively propose its credibility (Van der Riet and Durrheim, 2006:90). According to them, research is credible when it produces convincing and believable findings (:90). They go on saying that research credibility is established along with the research practice by continually looking for different evidences to the hypotheses of the study (91).

With this constructionists' perspective in mind, various ways of ensuring research credibility are recommended, the most prominent being the 'triangulation.' To Van der Riet and Durrheim (2006:91) and Rossman and Rallis (2012:65), triangulation is a way of employing various methodologies and strategies while observing whether they provide discrepant findings. In this regard, Van der Riet and Durrheim (2006) provide the example of using quantitative and qualitative approaches in the same study (:91). Likewise, Rossman and Rallis (2012) advocate for a variety of sources of data, of points in time and of methods (:65). Apart from triangulation, Rossman and Rallis (2012:65) advise four more methods. These are spending a prolonged time with participants in their environment; seeking the participants' feed-back/validation on the findings; having a peer debriefer or a critical person serving as an intellectual watchdog on the manner the research is being conducted and sometimes modified; as well as having a critical discussion with valued colleagues.

Therefore, in conducting the study, a qualitative approach of research was used that ensured quality by monitoring its credibility instead of its validity. Using the Rossman and Rallis (2012:65) model to illustrate this, a practice of triangulation was employed by purposively ensuring the inclusion of three categories of church members in the study, namely, the church leaders, caregivers and ordinary church members. Interviewing methods were triangulated by using both individual interviews and FGD and the collection of data was made in the three communities of SKZN identified as namely: Pietermaritzburg, Durban and Port Shepstone. Other triangulations concern gender where both males and females were purposively included in the study as well as the age at which both adults and the youth were interviewed.

Likewise, another way that secured the credibility of the study involved staying with the participants for at least three days and sometimes longer. This was eased by conducting interviews most of the time during the Church's conventions and conferences where participants were staying together for three to five days. This strategy has allowed the researcher to build trust with participants that facilitated openness during the interviews.

Moreover, the academic integrity and credibility of the study was also facilitated through the comments from, not a peer debriefer but the supervisor, Professor Phiri, and co-supervisor, Dr. Hewitt. They monitored and critiqued every step of this study from the conception of the proposal until the final submission of the thesis. Their rich experience, comments and advices have shaped this entire study.

Furthermore, regular presentation of the research project was made during the seminars organised by the School through the Programme of Gender and Religion and the CHART. Five presentations of the research findings were also shared during seminars organised by the Circle of Concerned African Women Theologians in 2011 and 2012. Another presentation was organised during the 108th FMSKZN annual conference in February 2013. Feedback, comments and advice received during these presentations have strengthened the credibility of the study.

8.4.2 Reliability/Dependability

Van der Riet and Durrheim (2006:92-93) explain reliability as "the degree to which the results are repeatable" (:92). This repetition of results is observed in both the measurement and outcomes, and in all occasions that these measurements are applied under similar conditions (see also Durrheim, 2006:51). Hesse-Biber and Leavy, 2011:52) discuss two types of reliabilities when gathering data through observation. He mentions 'internal consistency' in field observation

where the researcher responds to questions whether the observations are reasonable, fit together, or are consistent "over time and in different contexts." He also speaks about external consistency where verification is done by cross-checking observations with other divergent sources (:52). But whatever way used to verify reliability, qualitative researchers reject this kind of assessment. Their argument is that social phenomena depend on context and on the situation the research participant is in at the moment of research (Durrheim, 2006:51). Rather than reliability, they opt for dependability in which instead of "using a measurement scale as an instrument of observation, the researcher is the instrument of observation." This means that observations are not consistent by themselves, but the researcher gives them the order.

Three ways are proposed to assess dependability. Firstly, for Van der Riet and Durrheim (2006:93), the researcher describes in details the methods used to collect and analyse data (:93). Secondly, Van der Riet and Durrheim (2006:93) also suggest that the researcher makes rich and detailed description showing "how certain actions and opinions are rooted in, and develop out of, contextualisation." The last method of assessing dependability is proposed by Durrheim (2006:51) who stipulates that during analysis, observations registered as a result of study are "categorised into themes and a more general picture of the phenomenon under investigation built up from particulars." In these ways therefore, the researcher makes observation consistent.

This study was conducted following the model of qualitative researchers that ensured dependability by using valid methods to collect and analyse the data[129].

8.4.3 Generalisability/Transferability

Generalisability is explained as "the extent to which it is possible to generalise from the data and context of the research study to broader populations and settings" (Van der Riet and Durrheim, 2006:91). In this way, it is a level by which a sample of the study reflects the whole population. According to Van der Riet and Durrheim (2006), generalisability is important in two instances. Firstly, it is useful when the researchers want to part from experimental findings or findings from small natural setting in order to make universal theoretical claims. Secondly, it is also helpful when the researchers aim to part from a representative sample of the population in order to describe the whole population (:91). In research, generalisation is mainly used by positivists although some interpretivists also employ it to explain and describe common and wide categories of human experience (:91; Rossman and Rallis, 2012:64).

[129] See Chapter 4.

However, generalisability has been questioned by constructionist researchers who realise that instead of this probability logic, the best way is to proceed through 'analytic generalizability' (Hesse-Biber and Leavy, 2011) or 'reasoning by analogy' (Rossman and Rallis, 2012:104). Their argument is that "meanings are highly variable across contexts of human interaction and do not seek generalisable findings" (Van der Riet and Durrheim, 2006:91). With this other way of reasoning, they rather propose 'transferability' (:91). According to Lodico et al. (2006), transferability "refers to the degree of similarity between the research site and other sites as judged by the reader." This means that the findings from one setting can constitute a framework for other studies occurring in similar settings, thus being a useful tool to understand the findings in those other settings (Van der Riet and Durrheim, 2006:91, 92).

A number of ways of ensuring transferability are proposed. In the view of Van der Riet and Durrheim, (2006:91-92), the researcher produces a detailed and rich description of the context of the study. In agreement with them, Rossman and Rallis (2012) propose a much more detailed orientation. For Rossman and Rallis (2012), researchers have to provide a thorough description of their theoretical and methodological orientation and research process, and a rich description of lessons learned (:64). They also explain that this description should include details about the context. It is therefore on the basis of these details that other researchers can determine whether the findings can be used in their own similar research context/setting (:64-65).

Following these orientations, chapter 2 was used to richly define the context of the present study. During the data analysis, conditions in which particular responses were given by participants were also described. As an example, in section 6.2.1, one caregiver stipulated that the silence of the Church about HIV and AIDS was disappointing. It was pointed out that this participant was referring to the 2012 Annual Conference of the FMSKZN in which HIV and AIDS was not mentioned while it is a serious problem in KZN.

In addition to the context of the study, chapter 3 provides a description of the theoretical orientation and framework. The methodological orientation and research process in chapter 4 presented the design and practice. Lessons learned during the analysis and interpretations of findings are presented in Chapters 5 and 6. Chapters 7 and 8 present the findings using perspectives from the theoretical and theological framework of the WHCR and the conclusion of the study. All these details indicate the efforts deployed to make this study transferable.

8.4.4 Reflexivity/Positionality

8.4.4.1 Mechanism of Reflexivity/Positionality

The concept of reflexivity has two levels of meaning. Rossman and Rallis (2012:46-47) differentiate these levels using this concept's etymological origin, the Latin word, *reflexus* which means, 'bending back,' and its derivative English world, *reflex* which means, 'automatic response' or 'unexamined reaction.' Therefore, the first level of meaning relates to this automatic response. According to Hesse-Biber and Leavy (2011:120), researchers come into the field with their backgrounds and assumptions based on their various attributes such as gender, class, ethnicity/race, and education which may intervene during the research process. These authors refer to these as the researchers' 'positionality.' Minichiello and Kottler (2010b:7) and Leary et al. (2010:52) extend their meaning to the concept of personality, that is, the researcher's motives, interests, values, and goals (:7). In agreement with them, Rossman and Rallis (2012) emphasise that these assumptions and backgrounds are carried not only by the researcher, but also by the participants (:46). As Rossman and Rallis (2012) specify further, researchers with their outsider (*etic*)'s perspective and participants with their insider(*emic*)'s perspective reciprocally and iteratively react and influence each other during their interactions (:47). Therefore, each side draws from its theoretical knowledge to generate constructs or identity patterns of the other. And these constructs may change in the time researchers and participants spend together (:47). It is here that reflexivity takes the meaning of automatic response.

The second level of the meaning of reflexivity relates to its etymological sense of 'bending back.' This is what Foley (2002) terms 'radical reflexivity' or the capacity of 'language and thought – of any system of signification – to turn or bend back upon itself, thus becoming an object to itself'. In qualitative research, this 'radical reflexivity' means the capacity to be aware of emotional and relational complexity between the researchers and the participants and their potential impact on the research (Leary et al., 2010:52-53). In other words, it is the capacity to be aware of your positionality (Hesse-Biber and Leavy, 2011:120).

In this regard, positivist researchers seek the high quality research by trying to minimise effects of the positionality, using objectivity (Hesse-Biber and Leavy, 2011:111-112). But qualitative researchers deny the possibility to label, to frame, to control, or to eliminate it (see also Rossman and Rallis, 2012:48). As Leary et al. (2010) illustrate, qualitative researchers rather opt for systematic and critical reflection on their own experience, assumptions, and knowledge (:59). This means researchers' inductive reasoning on the research and their consent "to see things

differently, even when these alternative viewpoints may contradict with what you already think you know and understand" (:59).

In this regard, there were features of the researcher's positionality which could affect the study. Instead of identifying all of them, the following section presents a sample of four, the effects of which is likely to have a negative impact on the research.

8.4.4.2 Features of the Researcher's Positionality

The first feature emanates from the researcher's status as theologian scholar at the School of Religion, Philosophy and Classic. In the School, the researcher was exposed to the readings of various journal articles and books and attendance to various seminars, especially those organised by the 'Theology café' programme, the CHART, and postgraduate seminars programme. Theology café is a programme of the School of Religion, Philosophy and Classics in which many scholars around the world are invited to present their papers from various disciplines but with a common denominator of the church. The CHART is a Collaborative for HIV and AIDS, Religion and Theology which is a programme of this School. Through this programme, scholars conduct research on the church and HIV and AIDS and PhD students doing their research in the same field receive fieldwork fellowship. All these researchers therefore present their findings within the School under the sponsorship of this programme. Likewise, during postgraduate seminars, all the student doing Honours, Masters and PhD programmes regularly present their research projects and findings. Therefore, from these readings and seminars, the church is criticised and its weaknesses exposed in many ways following the field of research. In the context of HIV and AIDS, the church was many times accused of being judgemental in associating HIV and AIDS with sin and to promote stigma (as example, Joshua, 2010; Materu, 2010). Therefore, because of the exposure to these sources and knowledge, the tendency during the research was to assume that the FMCSA has been judgmental about HIV and AIDS and has associated the pandemic with the sin. However, the results of the field data confirmed that these assumptions were not based on bias but on the reality of the church.

The second feature relates to the researcher's status as student and researcher in the field of gender and religion. The dominant references in the programme of Gender and Religion at the University of KwaZulu-Natal are the publications of members of the Circle of Concerned African Women Theologians emphasising on gender and religion. This Circle comprises indigenous African and African women from Indian and European origins who are engaged in theological dialogue with all the components of African context which define the identity of women [and men] such as

culture, religion and sacred writings (Kanyoro, 2006:20). In this endeavour, they write and publish from the experiences of African women in their religious and cultural environment (Phiri, 2003a:4). As their contribution in addressing the HIV and AIDS pandemic, the Circle educates African societies and advocates for justice using theological and religious resources. They also empower women by helping them to better understand the foundation of the Bible-based faith (Kanyoro (2004:viii). In addition to accessing this rich resource advocating for justice in gender issues, especially in the context of HIV and AIDS, the researcher was encouraged by the School to publish a journal article in this field. This article was about the *missio Dei* in the context of gender-based violence and the high risk of HIV infection. It highlighted how women and children survivors of domestic violence assisted by The Haven shelter project of the FMCSA in Pietermaritzburg were often exposed to HIV infection (Iyakaremye, 2010b). Therefore, this background has exposed him to some deplorable realities that influenced this study to include the gendered nature of HIV and AIDS as an important issue which necessarily should appear among the priorities of the Church.

The third feature is connected to the researcher's status as a member of the Free Methodist Church of Rwanda. His responsibility involved leadership activities at national level such as leading commissions and advising the Church in writing proposals for developmental and social projects.[130] These positions have allowed him to visit and being in touch with various social initiatives of this Church such as educational institutions such as schools, from nursery school to the university, hospitals/health centres, retreat centres and other projects. However, when he relocated to South Africa for his postgraduate studies, he realised that only one social project, The Haven shelter for women and children victims of domestic violence, was successfully developed by the FMCSA. This has influenced his inclination to believe that the FMCSA had weaknesses in its leadership structure.

The last feature concerns the researcher's status as active church leader and member in the FMCSA. During the time of fieldwork, the researcher was active member and leader in the FMCSA, Pietermaritzburg where he occupied the positions of assistant pastor and Board member of The Haven project for women and children survivors of domestic violence. Though he was not known by ordinary church members in other four circuits of the FMSKZN that participated in the study and that church leaders in these circuits presented him as simple student, his status may have influenced the dynamic of the FGD with the youth in Pietermaritzburg.

[130] See Section 1.4.

Therefore, the study has attempted to be credible, dependable, transferable, but is not perfect. In the next section the contribution of the present study to new knowledge is highlighted.

8.5 Contribution to New Knowledge

The contribution of the study to new knowledge is three-fold. On the one hand, Sections 1.3, 1.4, 2.3 and 2.5 demonstrated that the limited academic literature available on the FMCSA informs on the social aspects of its ministry in one particular city, this being Pietermaritzburg in KwaZulu-Natal. Within the limits of the literature review there was no documented information about the ministry of this Church in other areas of South Africa. On the other hand, there was no literature on the response of this Church to HIV and AIDS and its gendered nature. Therefore, by conducting the present study in the FMSKZN, and highlighting the response of this Church to HIV and AIDS from a gender-sensitive perspective (see Chapters 5 and 6), the present study has contributed to the filling of these gaps.

The third component of this contribution resides in the reflection on the WHCR in the context of HIV and AIDS in South Africa. As mentioned in Sections 1.3, 14, and 3.3, only medical, social and religious aspects of this ministry were documented without any mention about its application in the context of HIV and AIDS. Therefore, by demonstrating that this ministry can contribute to the application of the SAVE strategy (see section 3.3.4), and to improve the response of the FMCSA to HIV and AIDS (see chapter 7), the present study has raised an awareness for future researchers in respect of this new and valuable area.

However, it must be acknowledged that the study has left a number of other gaps that have not been examined and which should be taken in account by further research.

8.6 Identifying the Gaps and Suggestions for Future Research

In concluding her PhD thesis, Longwe (2012:226) stated that "no study can exhaust all that can be known about the experience of pastors' wives". The same holds true for the study on the FMCSA and its response to HIV and AIDS and its gendered nature. In this regard, there are still gaps left by the present study. Therefore, the following questions emerging from the results of the present study can be of worth for future researchers:

- Why do some church leaders in the FMSKZN engage in HIV and AIDS in the community (hospitals, clinics) but not in the context of the family of the Church?
- What is the essence of the controversies between church leaders and the youth about addressing HIV and AIDS and how could one reconcile the two parties?
- How does the FMCSA understand and respond to the question of sexuality among the youth?
- Why is the FMCSA keen to address domestic violence (at UFMC) but not HIV and AIDS?
- What is the basis for denial of the Church's capacity and right to address gender-based abuse happening in families by some church members?
- What is the situation on domestic violence within the FMCSA church leaders' families?
- What is the attitude and response to HIV and AIDS in other regions of the FMCSA compared to that of the FMSKZN?

In addition to responding to these questions researchers in the future should examine the voice of PLWHA in-depth when reflecting on the Church's response to the pandemic.

8.7 Summary of Conclusions and Final Statement

In this concluding chapter, the design of the study was reviewed and the achievement of the study's objectives was identified. Furthermore the quality of this study was assessed and its contribution highlighted in order to identify any new knowledge and gaps to be filled by future researchers. It was therefore realised through various conclusions in different parts of this study that the FMCSA did not adequately respond to HIV and AIDS and its gendered nature and that the WHCR remains an inspirational potential resource to improve its response to the pandemic.

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APPENDICES

Appendix 1: Ethical Clearance from the University of KwaZulu-Natal

UNIVERSITY OF
KWAZULU-NATAL
University of KwaZulu-Natal
Research Office, Govan Mbeki Centre
Westville Campus
Private Bag x54001
DURBAN
4000
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24 November 2010

Mr. I Iyakaremye (208506280)
School of Religion and Theology

Dear Mr. Iyakaremye

PROTOCOL REFERENCE NUMBER: HSS/1322/010D
PROJECT TITLE: The Free Methodist Church of Southern Africa and HIV and AIDS: Reclaiming the Wesleyan Health Care Ministry from a Gender Perspective.

EXPEDITED APPROVAL

I wish to inform you that your application has been granted Full Approval through an expedited review process:

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....
Professor Steven Collings (Chair)
HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE

cc. Supervisor – Prof. I A Phiri
cc. Mrs. B Jacobsen

Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

Appendix 2: Letter of Introduction

Dear Participant,

I am **Innocent Iyakaremye**, a student at the University of KwaZulu-Natal (UKZN), studying for a PhD in Theology in the Gender and Religion Programme. The accomplishment of this programme requires conducting a study the results of which will be used for the improvement of the well-being in the community. Therefore, in agreement with my School, I chose to conduct a study on the response of the Free Methodist Church of Southern Africa to HIV and AIDS, hoping that the results of this study will contribute to the improvement of the efforts of this Church to respond to the people's needs which include needs for health and wellbeing.

The title of my study is *'The Free Methodist Church of Southern Africa and HIV and AIDS: Reclaiming the Wesleyan Healthcare Ministry from a Gender Perspective.'* The aim of the study is to explore how the Free Methodist Church of Southern Africa has responded to HIV and AIDS and how the Wesleyan Healthcare Ministry can be used as a resource for this response from a gender perspective.

I have chosen you as [bishop / superintendent / minister / board member / programme director / caregiver / church member] to participate in this study. I hope to learn more about the Church's way of addressing HIV and AIDS, and this will help me to make useful suggestions for improvement.

Please understand that your participation is voluntary and that you are not being forced to take part in this study. The choice of whether to participate or not is yours alone. If you agree to participate, you may stop at any time and discontinue your participation. If you refuse to participate or withdraw, you will not be affected in any way whatsoever. However, I would really appreciate it if you share your thoughts with me.

I will not record your name anywhere on the questionnaire, and none will be able to link you to the answers you give, unless you specifically give me permission to use your name. Only myself as the researcher will have access to the unlinked information. All individual information will remain confidential and will be destroyed within three months after the submission of this study..

The interview will last approximately one hour. I will be asking you a few questions and request that you be as open and honest as possible in answering these questions. Some questions may be of a personal and/or sensitive nature. You may choose not to answer these questions. I will also be asking some questions that you may not have thought about before, and which will also involve thinking about the past or the future. I know that you cannot be absolutely certain about the answers to these questions, but I ask you to try to think about them. When it comes to answering these questions, there are no right and wrong answers.

If I ask you a question which makes you feel sad or upset, we can stop and talk about it. I am in contact with the counsellors who are willing and available to assist you with issues that upset you if you need any assistance later.

If possible, I intend to share the results of the study with the staff and church leaders without revealing your identity. If you have a complaint about any aspect of this study, you may also contact my supervisors at **+27 33 260 6132**.

Details of the Researcher

Innocent Iyakaremye;
Student: PhD in Theology Degree; Gender and Religion Programme;
School of Religion and Theology; University of KwaZulu-Natal
P.O.Box 3209 Pietermaritzburg; South Africa
Tel. +27720741892; E-mail: iyakin2@gmail.com

Details of the Project Supervisor

Professor Isabel Apawo Phiri;
Coordinator: African Theology programme;
School of Religion and Theology; University of KwaZulu-Natal
Private Bag X01; Scottsville; 3209; Pietermaritzburg; South Africa
Tel: 27 33 260 6132 (w); 27 33 3462920 (h); 27 724239134(c);
Fax 27 33 260 5858; E-mail: phirii@ukzn.ac.za

Appendix 3: Informed Consent Form

Consent

I hereby agree to participate in the research on *'The Free Methodist Church of Southern Africa and HIV and AIDS: Reclaiming the Wesleyan Healthcare Ministry from a gender perspective.'* I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop this interview at any point should I not want to continue and that this decision will not in any way affect me negatively. The purpose of the study has been explained to me, and I understand what is expected of my participation.

I know the person to contact should I need to speak about any issues that may arise in this interview.

I understand that this consent form will not be linked to the questionnaire, and that my answers will remain confidential, unless I specifically give permission to use my name.

_____	_____	_____
Name of participant	Signature of participant	Date

Appendix 4: Individual Interview Guide for Church Leaders and Caregivers

THEMES AND QUESTIONS EXPLORED

I. Attitude of the Church towards HIV and AIDS **and People Living with HIV and** AIDS**, its Impact, and Initiatives to Improve It**

1. a) Should the Church respond to HIV and AIDS? b) Why should the Church respond to HIV and AIDS? c) How should the Church respond?
2. a) What is the attitude of the Church (minister/leaders/members) towards HIV and AIDS and People Living with HIV and AIDS? b) What impact does this attitude have on the behaviour of the church members (and the community) towards People Living with HIV and AIDS and the life of People Living with HIV and AIDS?
3. What is the Church currently doing to challenge or improve the attitude, behaviour and response of the community (community, church members, government's structures or leaders) pertaining to HIV and AIDS and People Living with HIV and AIDS?

II. Response of the Church to HIV and AIDS

4. a) Does this Church have programmes to address HIV and AIDS? b) If yes, mention the programmes, target groups, frequency, content of the programmes
5. a) What do you know about gender? b) How does gender contribute to the spread of HIV? c) How is this Church responding to the gendered nature of HIV?

III. Other Church's Programmes Contributing to the Response to HIV and AIDS **and Health Issues**

6. What are the other health related initiatives of this Church for the community apart from HIV and AIDS?[135]
7. What are the other social initiatives of this Church to support the health of the people apart from health related activities?[136]
8. What does this Church do to equip people for their self-help in preventing HIV infection or caring for the sick?

[135] For example healthcare centre or hospital, vaccination campaign…
[136] For example, poverty alleviation, schooling, hygiene, nutrition, housing…

IV. Partnership in Responding to HIV and AIDS

9. a) How does this Church collaborate with other partners/networks in responding to HIV? b) What do you know about the EHAIA? c) How is this Church involved with the programme of the EHAIA?
10. How can this Church improve its collaboration with other partners in responding to HIV and AIDS?
11. a) What are the other resources available in the community that this Church can use to better respond to HIV and AIDS? B) How can this Church better use these community resources [and other resources available] to respond to HIV and AIDS [e.g. EHAIA]?

V. Successes and Weaknesses of the Church in Responding to HIV and AIDS

12. What are the successes stories of this Church in responding to HIV and AIDS?
13. a) What are the weaknesses of this Church in responding to HIV and AIDS? B) How should this Church improve in its response to HIV?

VI. Wesleyan Healthcare Ministry

14. a) What do you know about the Wesleyan Healthcare Ministry? B) Has the Wesleyan Healthcare Ministry influenced this Church in responding to HIV and AIDS? C) If yes, how?
15. How can Wesleyan Healthcare Ministry better be involved in this Church's response to HIV and AIDS?
16. How can Wesleyan Healthcare Ministry be made gender-sensitive resource of this Church in responding to HIV and AIDS?

Appendix 5: Focus Group Discussion Guide for Ordinary Church Members [Youth and Adults]

THEMES AND QUESTIONS EXPLORED

I. Attitude of the Church towards HIV and AIDS **and People Living with HIV and** AIDS**, its Impact, and Initiatives to Improve It**

1. a) Should the Church respond to HIV and AIDS? b) Why should the Church respond to HIV and AIDS? c) How should the Church respond?
2. a) What is the attitude of the Church (minister/leaders/members) towards HIV and AIDS and People Living with HIV and AIDS? b) What impact does this attitude have on the behaviour of the church members (and the community) towards People Living with HIV and AIDS and the life of People Living with HIV and AIDS?
3. What is the Church currently doing to challenge or to improve the attitude, behaviour and response of the community (community, church members, government's structures or leaders) pertaining to HIV and AIDS and People Living with HIV and AIDS?

II. Response of the Church to HIV and AIDS

4. a) Does this Church have programmes to address HIV and AIDS? b) If yes, mention the programmes, target groups, frequency, content of the programmes
5. a) What have you learnt about HIV and AIDS from this Church/circuit? b) When did this happen? c) In what context?
6. a) What do you know about gender? b) How does gender contribute to the spread of HIV? c) How is this Church responding to the gendered nature of HIV?

III. Other Church's Programmes Contributing to the Response to HIV and AIDS **and Health Issues**

7. What are the other health related initiatives of this Church for the community apart from HIV and AIDS?[137]
8. What are the other social initiatives of this Church to support the health of the people apart from health related activities?[138]

[137] For example healthcare centre or hospital, vaccination campaign…

9. What does this Church do to equip people for their self-help in preventing HIV infection or caring for the sick?

IV. Partnership in Responding to HIV and AIDS

10. a) How does this Church collaborate with other partners/networks in responding to HIV? b) What do you know about the EHAIA? c) How is this Church involved with the programme of the EHAIA?
11. How can this Church improve its collaboration with other partners in responding to HIV and AIDS?
12. a) What are the other resources available in the community that this Church can use to better respond to HIV and AIDS? B) How can this Church better use these community resources [and other resources available] to respond to HIV and AIDS [e.g. EHAIA]?

V. Successes and Weaknesses of the Church in Responding to HIV and AIDS

13. What are the successes stories of this Church in responding to HIV and AIDS?
14. a) What are the weaknesses of this Church in responding to HIV and AIDS? B) How should this Church improve in its response to HIV?

VI. Wesleyan Healthcare Ministry

15. a) What do you know about the Wesleyan Healthcare Ministry? B) Has the Wesleyan Healthcare Ministry influenced this Church in responding to HIV and AIDS? C) If yes, how?
16. How can Wesleyan Healthcare Ministry better be involved in this Church's response to HIV and AIDS?
17. How can Wesleyan Healthcare Ministry be made gender-sensitive resource of this Church in responding to HIV and AIDS?

[138] For example, poverty alleviation, schooling, hygiene, nutrition, housing…

Appendix 6: List of interviewees per circuit

NO	NAMES/CIRCUITS	CATEGORY OF INTERVIEWEES	DATE OF INTERVIEW
	CLERMONT/KWAMASHU CIRCUIT, DURBAN		
1	Mr. Khumalo, Ernest	Church Leader	21/05/2017
2	Mrs. Mkhize Girlie	Care giver	22/05/2022
3	Mr. Ngcobo, Moffat	Church Leader	21/05/2015
4	Ms. Ntombela, Trizzah	Church Leader	21/05/2016
5	Mrs. Shinga, Nonhlanhla	Care giver	22/05/2021
6	Rev. Thango, M I	Church Leader	21/05/2020
	FAIRVIEW CIRCUIT, PORT SHEPSTONE		
7	Rev. Cele, E Dumisani	Church Leader	15/5/2011
8	Mr. Cele Thamsanqa	Church Leader	14/5/2011
9	Ms. Hlope, Gugu	Care giver	14/5/2011
10	Ms. Ndwalane, Smangele	Care giver	14/5/2011
11	Ms. Mpume, Blose	Care giver	14/5/2011
12	Mrs. Zona	Church Leader	14/5/2011
	HIBBERDENE CIRCUIT, PORT SHEPSTONE		
13	Mrs. Luthuli, Nondumiso	Care giver	15/5/2011
14	Mrs. Madlala, Pearl Sibongile	Church Leader	15/5/2011
15	Rev. Msweli	Church Leader	14/5/2011
16	Rev. Msweli [Follow up]	Church Leader	25/02/2012
17	Mr. Mzameko, Dumisane	Care giver	24/02/2012
18	Mr. Ndlovu, M.F.	Care giver	15/5/2011
19	Mrs. Ngwane, ZH	Church Leader	15/5/2011
	UBUNYE CIRCUIT, PIETERMARITZBURG (UFMC)		
20	Mrs. Kankindi, Edith	Church Leader	30/11/2012

NO	NAMES/CIRCUITS	CATEGORY OF INTERVIEWEES	DATE OF INTERVIEW
21	Rev. Emedi, Philippe	Church Leader	18/07/2011
22	Rev. Dr. Lubunga, Venance	Church Leader	2011/11/05
23	Mr. Madlala, Sfiso	Caregiver	14/5/2011
24	Ms. Mukwanazi, Ntokhozo	Care giver	2011/04/05
25	Mrs. Nxumalo, Goodness	Care giver	2011/05/05
	UMLAZI CIRCUIT, DURBAN		
26	Mr. Cele, Mphatheploa	Church Leader	21/05/2011
27	Rev. Juta, Erasmus	Church Leader	21/05/2011
28	Mrs. Khanyisile, Christina Juta	Care giver	21/05/2014
29	Mr. Ncayiyana, Christopher	Church Leader	21/05/2011
30	Mr. Shembe, L.W.	Care giver	21/05/2013
31	Mrs. Thembie	Care giver	21/05/2012
	OVERSEERS		
32	Rev. Ndlovu, Ntokozo	Church Leader/ FMSKZN	21/05/2011
33	Bishop Shembe, Zwelisha	Church Leader/ FMCSA	25/02/2012

Appendix 7: List of participants in FGDs per circuit

Circuit: UFMC, Pietermaritzburg
Age group: Youth
Date of interview: 07/05/2011

Names	Age (year)
1. Ms Chocholo, Queen	21
2. Ms Kisten, Nikita	15
3. Ms Kisten, Reanntha	14
4. Ms Magubane, Thulile	24
5. Ms Mthembu, Nokwanda	19
6. Ms Shabane, Sthembile	19
7. Ms Sithole, Zinhle	16
8. Ms Winda, Nomfundo	23

Circuit: Fairview, Port Shepstone
Age group: Youth
Date of interview: 14/05/2011

Names	Age (year)
1. Ms Khawula, Mabongie	25
2. Ms Khumalo, Khanyo	16
3. Mr Mqadi, Simiso	16
4. Ms Madlala, Sinovuyo	17
5. Ms Mbhele, Nomfundo	21
6. Ms Mbhele, Sthembile	24
7. Mr Mqadi, Mduduzi	18

Circuit: Hibberdene, Port Shepstone
Age group: Youth
Date of interview: 14/05/2011

Names	Age (year)
1. Mr Alfred	16
2. Mr Cebo	18
3. Mr Lindo	15
4. Mr Nkosinathi	20
5. Ms Nothando	16
6. Ms Pinky	20

Circuit: Umlazi, Durban
Age group: Youth
Date of interview: 21/05/2011

Names	Age (year)
1. Ms Makhanya Magerly	39
2. Ms Msweli, Naomi	40
3. Ms Mkhize, Zodwa	34
4. Ms Nyawose, Phumzile	38

Circuit: Fairview, Port Shepstone
Age group: Adult
Date of interview: 15/05/2011

Names	Gender
1. Blose, Constance	Female
2. Cele, Beauty	Female
3. Cele, N G.	Female
4. Cele, Nomkhosi	Female
5. Madlala, Sibongile	Female
6. Madlala, Z Hazel	Female
7. Malaphane, Betty	Female
8. Memela, Beauty	Female

Circuit: Hibberdene, Port Shepstone
Age group: Adult
Date of interview: 14/05/2011

Names	Gender
1. Dlamini, R.	Female
2. Jama, C.	Female
3. Mbhele, B.	Female
4. Mbhele, V:	Male
5. Mqadi, E Z.	Female
6. Ndlovu, T.	Female
7. Phehlukwayo, S.	Female
8. Phehlukwayo, V.	Male
9. Shabane, P T.	Female
10. Slozi, C.	Female

Circuit: Umlazi, Durban
Age group: Adult
Date of interview: 22/05/2011

Names	Gender
1. Dlamini, Thembekhihe	Female
2. Hadebe, Ntombifuthi	Female
3. Mathebuki, Nontokozo	Female
4. Mhlongo, Themba	Female
5. Mkize, Sindisiwe	Female
6. Ngeme, Nqobile	Male

Circuit: Clermont/KwaMashu, Durban
Age group: Adult
Date of interview: 21/05/2011

Names	Gender
1. Dlamini, Nomthamsanqa	Female
2. Mkhize Girlie	Female
3. Mthembu, June-Rose	Female
4. Sibuya, Zandile	Female
5. Zulu, Thandazile	Female
6. Zuma, Zakhona	Female

Appendix 8: Letter of Approval from the Free Methodist Church of Southern Africa

FREE METHODIST CHURCH OF SOUTHERN AFRICA

(Association incorporated under Section 21)
Registration Number: 2005/007411/08

30 April, 2011

TO WHOM IT MAY CONCERN

I, Zwelisha Lincoln Shembe, as presiding bishop of the Free Methodist Church of Southern Africa, hereby grant permission and authorise Innocent Iyakaremye, to do his fieldwork research within our Southern KwaZulu Natal Annual Conference.

His topic: The Free Methodist Church of Southern Africa and HIV and Aids: Reclaiming Wesleyan Health Care Ministry from a Gender Perspective, is of interest to us as a church and we hope that this will contribute immensely to the way we as a church approach this subject.

Sincerely,

Bishop Zwelisha L. Shembe