THE PRACTICAL STRATEGIES USED BY RELIGIOUS ORGANISATIONS IN DEALING WITH ISSUES RELATED TO HIV/AIDS: BASED ON A SURVEY CONDUCTED IN GREATER PIETERMARITZBURG

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DEDICATION

This work is dedicated to all the people in Africa affected and infected by HIV/AIDS, especially the children who are orphaned and abused in many ways due to frustrations and misconceptions brought by this disease.

DECLARATION

This paper is my original work. I have compiled it without any assistance. It has not been submitted to any university for assessment or any other purpose. I therefore submit it for the first time in the School of Human Sciences at the University of Natal, Pietermaritzburg as a partial requirement for the Master of Social Science Degree in Sociology.

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ABSTRACT

This study seeks to investigate the practical strategies used by religious organisations in dealing with issues related to HIV/AIDS in Greater Pietermaritzburg. The study comes from the assumption that all religious organisations tend to structure and restructure themselves as a means of responding to and intervening in the problems of society. The study therefore argues that intervention in HIV/AIDS issues is one of the conditions through which restructuring of religious organisation in Greater Pietermaritzburg is currently evident.

By way of conclusion then, the study attempts to answer the question as to what extent such interventions are sustainable. The interventions are sustainable in that they are, by and large, undertaken by the grassroots people who are directly affected and infected by HIV/AIDS. However, the interventions are often very variable, ad hoc and haphazard. Thus the study concludes that questions about the sustainability of such interventions still give unclear answers.

ACKNOWLEDGEMENT

CHAPTER ONE

1.1. INTRODUTION

The theme of this study is the practical strategies used by religious organisations in dealing with issues related to HIV/AIDS in Greater Pietermaritzburg. The study falls within the field of the Sociology of Organisations which is concerned with

> The planned conscious structuring and restructuring of social groups, with the intention to achieve, ... a number of specified objectives (Thung, in Gill 1996: 342).

This study is an investigation of how religious organizations in Greater Pietermaritzburg[1] structure their social interventions in response to the problems of HIV/AIDS. We will investigate how the organisations utilise their knowledge of social intervention and engage other social resources to address the issues of HIV and AIDS.

In the study the term "religious organisations" is understood from two perspectives: spiritual and functional. The spiritual aspect denotes all communal institutions the operations of which are based on their adherence to the ultimate power, a power which in Christian circles is known as God. The functional facet was well described by Momen as what religion does. Functional thought conceptualises religion in terms of its roles and its response to human needs. (Momen 1999: 28).

While the spiritual definition is useful in identifying the key informants, the functional approach attempts to appreciate interventions undertaken by the organisations in the problems related to HIV/AIDS.

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[1]. Though Greater Pietermaritzburg was the main area where the study was carried out, interviews were also conducted in other areas within KwaZulu-Natal such as Durban. The study may then be seen as representing a large part of KwaZulu-Natal Province.

1.2. Aim, theoretical background, and hypothesis

We will investigate assumptions and practices that influence the organisations to take responsibility for HIV/AIDS interventions. This will bring us to an understanding of the theoretical motivating factors behind the interventions.

Our general theoretical assumption is that all religious organisations tend to structure and restructure themselves as a means of responding to and intervening in the problems of society. Social problems motivate needs for changes in organisations. (Dunkerley 1972: 50-53)

The study poses the hypothesis that interventions around HIV/AIDS issues by religious organisations in Greater Pietermaritzburg vary. These variations can be encountered in terms of both assumptions and practices. While the interventions seek to address the current scale and nature of the epidemic, a question will be asked as to whether they will stand the future growth of the problem.

1.3. Literature Review

The problem of HIV/AIDS has been the primary focus for much intellectual thinking and organizational response. Development agencies, including religious organisations, have also engaged in interventions at different levels to alleviate the problem.

Common to the involvement of religious organizations are interventions based on their traditions and the influence of their surrounding societies. Thus their interventions do not only fit in the customary religious practices but also in the wider context of common efforts from different role players. An understanding of the wider context of efforts made to alleviate the problem of HIV/AIDS and its theoretical assumptions and approaches are inevitable. In the next section, we will review the

concepts and theories used in interventions both in general and in the issues about HIV/AIDS[2].

1.3.2. The underlying concepts around interventions

> Interventions are based on assumptions which inform the
> decided-upon action. The way in which one intervenes in any
> given situation depends upon a conception of the nature of social
> reality and the nature of human beings. (Oellermann 1997: 62)

The claim which Oellermann makes here, informs us that interventions vary from situation to situation. This may depend upon the conceptualisation of the one who intervenes into the situation about the nature of the situation. However, this does not mean that we cannot theorise about intervention.

There are many social sectors that inform us about intervention. An example of these is the area of grassroots development issues[3]. Grassroots development embraces concepts such as grassroots empowerment, participatory development, sustainable development, leverage, and social analysis.

By empowerment these theories propose that the intended beneficiaries of an intervention should be helped to acquire capacities which can help them to deal with their situations on their own. (Thomas 1992: 118)

The practical approach to achieve this is to engage in participatory development. The World Bank Popular Participation Group understands participatory development as involving four stages namely:

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[2]. Apart from the readings which will be referred to in this paper, different books and articles have informed the critical thinking which was instrumental in analysing the interventions undertaken by religious organisations included in this study.

[3]. Intervention in HIV and AIDS issues by religious organisations is related to grassroots development paradigms in that members of religious organisations are primary beneficiaries of the activities taken by the organisations. These members are part of the grassroots communities.

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1. Information sharing: people are told about the development project and how it may affect them, and so can theoretically decide on their level of involvement in it.
2. Consultation: people are consulted on key issues, and may provide vital feedback to project managers.
3. Decision-making: people are involved in the design and implementation of a project, and thus influence its development at every stage.
4. Initiating action: people organise themselves to take action in the face of the shared problem or area of interest, rather than responding to the initiative of outside agencies. (World Bank, in Oxfam 1995: 15)

The rationale behind empowerment and participatory development is that interventions that involve these strategies are sustainable. Sustainability of initiatives in this sense means that initiatives continue to exist among the primary beneficiaries when the outside agent who initiates the intervention leaves. (World Commission of Environments and Development Report 1987).

In terms of leverage, the outside agent who intervenes plays an intermediary role between the primary beneficiaries and the higher authorities that may be perceived as having the power to support bringing change. This may take the form of demonstrations, public policy advocacy, political lobbying, monitoring compliance with public policies and laws, propagating new ideas and findings from studies, research, and public education. (Fowler 1997: 225)

Social analysis refers to activities done to understand the context in which one intervenes with the intention to find concrete issues related to one's conceptual framework.

In general these concepts inform interventions, but their concrete application vary from context to context. We will refer to the theories recorded by the UNAIDS (1999), the United Nations organisation co-coordinating the fight against AIDS across the globe. Our intention is to explore how these concepts are transformed into practical theories by interventionists specializing in HIV/AIDS.

1.3.3. Interventionist Theories

Interventions around HIV/AIDS vary according to context. What is common to them though, is that they are directly or indirectly based on theory. Some of these theories have focused on individual behaviour change, some on social forces promoting the spread of the disease and others on structural and environmental factors of society.

Theories emphasising individual behavioural change tend to define interventions with reference to people's health beliefs, social cognitive factors, significance of human reason, and stages of change of behaviour. These theories put emphasis on changing the individual's risky behavior.

1.3.3.1. Health beliefs theorists

Health beliefs theorists say that interventions should focus on change in health beliefs. These claim that some health belief patterns pose risks of contracting AIDS while others do not. For social cognitive theorists human behaviour is a continuous interaction between cognition, behaviour, and environment. Interventions should therefore educate people to recognize environmental barriers[4] which affect their lives.

1.3.3.2. Reasoned action theory

Reasoned action theory sees human beings as rational and able to make systematic use of information. Interventions should help people to rationally respond to norms, which can help in reducing risk behaviour.

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[4]. Environmental barriers could also be seen as social interactions which hinder people from taking or understanding proper initiatives to defend themselves against the conditions posing risk to contracting HI virus.

1.3.3.3. Stages of change theory

Stages of change theory proposes that change towards reducing risk behaviour is a process. The stages of change are: pre-contemplation, contemplation, preparation, action, maintenance and relapse. Interventions based on this theory should target the right stage of this process. Social change theories focus on change at a community level. They target subgroups and development initiatives, which can bring about change. Theories under this category include:

1. Diffusion of innovation theory, which influences opinion makers to adopt certain principles for change, endorse them and influence others to follow suit.

2. Social influence and social inoculation theory, which believes that interventions should help minimise the influence of peer groups on young people to engage in risky behaviour.

3. Social network theory, which seeks to find social networks which, pose risk to contracting the disease.

4. Theory of gender and power: gender and power theorists argue that risk is posed by the way power is distributed in heterosexual relationships. Interventions should "assess the impact of structurally determined gender differences on interpersonal sexual relationships."

1.3.3.4. Structural and environmental theories

Structural and environmental theories seek to change the civil and organisational components of society. They also study how economic realities influence people to engage in risky behaviours. The theories lead to the following models:

1. Individual and social change models: Individual and social change models aspire to promote dialogue among people. Through dialogue people are empowered to acquire problem-solving skills and overcome feelings of powerlessness. Interventions informed by this theory analyse belief systems and practices linked to interpersonal organisation and community change.

2. Social ecological models: In social ecological models interpersonal factors and processes are also considered. The theory looks at institutional, community and public policy factors, from which change can ensue. Interventions are therefore channelled through the mass media and skills development programmes and projects.

3. Socio-economic factors models: Models organised around socio-economic factors are influenced by the belief that poverty and underemployment force people into risky behaviours such as cohabitation, urban migration, seasonal work, truck driving, sex work, civil disturbances, and war. Initiatives at a societal level should therefore seek to overcome these problems and their results.

1.3.3.5. Constructs alone and transtheoretical model

Above all, people's constructs and reference to different models may influence them to avoid risky behaviours. This is called constructs alone or transtheoretical model.

1.3.3.6. The impact of theories in general

These theories have brought about different approaches to interventions focusing on behaviour change. Approaches aimed at changing the behaviour of the individuals have spread information about modes of transmission. They focus on components of prevention, teaching basic facts, promoting health behaviour, and minimising anxiety about casual transmission. These sometimes use the media as a means to reach people.

Small groups, sometimes in a form of peer groups, have also been used to sensitise people about the risks of AIDS. These look at the context of people with reference to their culture, gender, and developmental issues. Peer groups have been seen as ideal for influencing change. Members of peer groups find it easy to accept the opinions of their fellow members.

Interventions which have attempted to use counselling follow the principles of people's right to know about their HIV/AIDS status[5]. Such knowledge is seen as a means to influence people to take reasonable precautions. Testing and counselling approaches have also emphasised people's right to consent to receive psychological support.

There are also interventions at community level. These are important because social epidemiology is different among different social groups. Interventions at community level seek to change norms and sero-prevalence[6] by influencing social networks and subgroups. Sometimes subgroups are targeted through school campaigns based on classroom skills- building sessions and social norm change programmes.

Condom promotions have also been one of the greatest points of emphases in community level interventions. Here interventions have concentrated on distributing condoms and using marketing strategies to make condom use attractive through advertising.

Community based interventions have also sought to utilise participatory development strategies with the intention to achieve sustainable results. People are motivated to identify their problems, social historical roots, obstacles to achieving necessary goals. They are encouraged to envision a healthier society. Such initiatives attempt to improve people's self esteem, self-efficacy and promote behaviours that may help them to attain goals necessary to reduce risk to AIDS.

Above all, societies have sought to enact policies that ensure lasting and broad reductions of risk behavior among their members. The intention of influencing

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[5]. "HIV/AIDS status" means whether the person has contracted HI virus or not.

[6]. Sero-prevalence means the number of people in a particular social group or community who have contracted the disease.

society through policies has been to remove structural barriers that tend to hinder initiatives about promoting behaviour change.

1.3.4. The place of religious organizations in the context of civil society Interventions around HIV and AIDS

Intervention in the issues confronting society has always been one of the most important responsibilities that religious institutions have taken upon themselves. In Christian circles the story of social intervention starts from the mission of Jesus: healing the sick, challenging the bad behaviour of the political leaders of his time – that is, actively participating in overcoming social problems of the day.

As a fellow in the early days of the Church, St. Paul wrote to different communities advocating for the change of human behaviour, hence becoming an agent of social change. In the Middle Ages a story is told of St Francis of Assisi starting his mission by looking after people suffering from leprosy.

Influences of such leaders are echoed in every Christian organisation today. Lee-Anne Smith (2000) comments on the visibility of such interventions in the Salvation Army's HIV/AIDS intervention:

> With heart to God and hand to man, Salvationists combat
> suffering and despair around the world as they try to put God's
> love into action. The Salvation Army's mission to do God's work
> on earth has not faltered since its founder, General William
> Booth, first described his soldiers as "the servants of all". In South
> Africa ... the Salvation Army is actively involved in caring for
> those suffering from the HIV virus and AIDS through counselling,
> educational home-based care programmes, and "drop-in"
> centres.
> (WebPage: www.btimes.co.za/98/0524/survey4.htm)

Such is also the case with Moslem and other faith based organisations. Charity forms not only part of the doctrine, but also praxis. Where social intervention of

some form (e.g. in politics) is not part of the doctrine, changes and dynamics of society themselves challenge religious organisations to be involved in some indirect or direct way. For example, a survey of the Apostolic Faith Mission Church revealed that leaders of the church advocate the doctrine of non-involvement in politics. However, as a church believing in spiritual healing without discrimination, it has never avoided problems associated with politics by offering service to the victims of political oppression in its healing mission. (Oral History Project: 2000)

As this history is reflected in interventions about HIV/AIDS some of the activities are influenced by their religious value and doctrines. Some activities tend to respond to the influence of other social role players such as health experts, politicians and other civil society organizations. There are also activities, which try to balance their moral values and doctrines with what they learn from other social actors.

A typical issue, which seems to have readily been dealt with at all these levels is the relationship between HIV/AIDS and human sexual behaviour. The issue is explicitly visible around ideas concerning use of condoms as a preventive device for HIV/AIDS. A 1999 report on the response of the Nairobi Council of Churches in Kenya reveals that the church stood against the use of condoms. The council emphasized the "biblical model of a Christian family where children grow up with parents as role models"... (www.africanews.org).

But a Tanzanian report on the same issues points out that Catholics in the country base their interventions around HIV/AIDS issues on "three life boats"- abstinence, fidelity and condoms. The Church supposes, "that the stronger members of their community will climb into the first two boats, but the slightly weaker ones can shelter in the third." (Piot, in www.ips.org)

In some religious organisations what is important is that use of condoms solves the problem[7]. During one of the interviews made during this study a group of key informants from a Hindu religious group in Durban put it,

> If condoms are the solution to the problem of AIDS, it is the solution to the problem. We are more interested in solving the problem than complicating the matter. We are a practical and liberal religion – we listen to the doctors. (KI: 4)

At a practical level religious moral values of compassion and concern for others are influencing religious organizations to engage in interventions. These interventions are directed to caring for the sick and reducing risk behaviour through programmes such as home-based care, community education, spiritual and emotional support, group discussions and advocacy.

Some key individuals representing their organizations also engage in advocacy. A report on the Malawian Catholic Church reveals an example of attempts made by religious organizations in this area:

> The Catholic Church in Malawi claims a number of AIDS patients in the country have been healed of AIDS-related illnesses through the use of local herbs such as aloe vera, frangipani, guava leaves, sweet potatoes and okra. Sr. Lilia Conol of the AIDS Patients Home-Based Care Unit of the Church told reporters the use of a cocktail of the herbs have successfully healed AIDS-related ailments like shingles. ...Conol, therefore, called for concerted efforts between the government and other stakeholders to promote the use of herbal medicines instead of relying on "very expensive cocktails from the West." (Tenthani, in www.africanews.org/PANA/science/19981223/feat2)

Thus interventions carried out by religious organizations in social affairs are found in different forms. They are also a continuation of the history of religious organizations themselves and a fulfillment of their doctrinal and moral values. But above all, these moral and doctrinal values and their agents, as well as the interventions themselves represent the structural and functional characteristic of organizations in general.

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[7]. This does not mean that these religious organisations put their entire faith in the fight against AIDS in the use of condoms. Rather, they feel that it good to be flexible, allowing people to use the protective measures that work for them.

Thus it becomes important to explore some theories of what we mean by the term "organizations". Our next sections will explore theories about organizations from classic sociologists such as Michels, Max Weber, Robert Merton and others.

1.3.5. Social theories about organisations

This section will seek to answer the question: What do we mean by "organisations" from a sociological perspective? Understanding theoretic definition of organisations will facilitate our comprehension of the wider milieu in which the religious organisations in Greater Pietermaritzburg function.

1.3.5.1. Michels' Theory on Organisations

In Roberto Michels' view organisations are a means by which civil society and the state meet. Organisations are also a form of social grouping. Where they exist a need for leadership to emerge becomes indispensable.

Leaders, in small organisations are weak and informal. Their responsibility emerges naturally and spontaneously. The leaders participate in decision-making processes of the organisation.

Michels says in big organisations, leaders attain a positive function. Their power becomes personal. In big organizations leaders' authority and decisions may be delegated through other intermediary leaders. Conflict in big organisations may, however, emanate due to poor communication and ineffectual supervision. (Michels, in Dunkerley 1972)

1.3.5.2. Max Weber

Max Weber's theory of organisations points to how power manifests as domination. Domination is exhibited in three models of authority: charismatic, traditional, and legal rational authority. According to Weber, domination develops from power.

Weber defines power as "the possibility that one actor within the relationship will be in a position to carry out his own will despite resistance, regardless the basis on which this possibility lies." (Weber, in Dunkerley 1972: 18) When power becomes domination the ruler feels and believes that he has the right to exercise authority. This mostly happens when a small group evolves into a bigger one.

Levels of domination in the charismatic, traditional, and legal rational authorities are not the same. The lightest form of domination is found in charismatic authority followed by traditional and then the legal rational authority.

Traditional authority rights and duties are defined by the tradition of the organization. Traditions of organisations contain rules. Rules are followed by the members under the authority in question.

In legal rational authority the rulers impose their power as mandated by the legal systems in place.

In addition to these, there is collegial authority. Collegial authority is determined by one's profession and training.

Weber also says that modern organizations are functionally bureaucratic. They are characterised by a division of labour[8] and hierarchy[9]. Moreover,

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[8] This means that the total organisation is divided into small tasks.

organizations are governed by abstract rules and procedures. Leaders deal with people impersonally and responsibilities are based on qualifications and expertise. (Weber, in Dunkerley 1972: 18- 25)

1.3.5.3. Some Comments on Michels' and Weber's Theories

The theories above have been criticised by social scientists such as Robert Merton. For example, Merton points out that Weber's model does not reflect dysfunctionalities within organisations. Weber does not mention or analyse functional inadequacies and simple absence of functions in organisations.

In terms of the division of labour, Merton observes that the organisation may be split to such an extent that the individual has no idea of the basic goals of the organisations. In terms of hierarchical arrangements, all the power and control may be concentrated at the structural peak of the organisation. Impersonal rules may not be applicable to concrete situations. Finally Merton comments that too much concern with the organisation's rules can interfere with the objectives of the organisation. (Merton, in Dunkerley 1972: 29-30)

According to Dunkerley, dysfunctional and positive functions are likely to confront each other. There is need for theoretical solutions to this problem: create a secure environment within the organisation; balance principles and initiatives; create cohesive integrative workgroups; split the organisation into managerial authority; and make evaluations based on specified results. (1972: 29-32)

Further criticisms of these models have been made by a group of theorists called Natural Systems Theorists such as Gouldner (1959), Parsons and Selznick. These sociologists see the models as static. For example, Gouldner comments that organisations are composed of small entities which behave spontaneously and can be defined as natural independent variables. One should therefore

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[9]. This means that each office is supervised by another above it.

understand their spontaneous strategic nature and processes which link them together and facilitate their adjustment.

According to Parsons, an individual actor should be seen as finite and discrete unit of the organisation system. Roles are its dynamic parts. One should identify the parts of the whole system, which can generally be defined in terms of activities, interactions and sentiments of the individual actors. These are dynamic parts, which can be seen, relate to one another and make the whole organisation.

From these critiques Dunkerley comments that Systems Analysis recognises that individuals can bring their own characters into the organisation. Interests of individuals may not correspond with those of the organisation. The individual's values and principles may clash with the demands of the organisation.

The system can therefore be maintained by relating the security of the system to the environment, providing for stability of informal relations in the organisation, monitoring the continuity of policy and the sources of determination, and relating the homogeneity of its outlook to the meaning and the role of the organisation. (1972: 33-41)

There are also social psychological theories which appear to augment the thoughts of Michels and Weber. Prominent and relevant thinkers here include Simon (1957), Barnard (1938), Cyert and March (1963). Social psychological theory generally treats the individual as a rational being. Human beings are capable of making decisions and solving problems with reference to the options available to them. The individual foresees the consequences and makes preferences in seeking out what will be his/her best course of action.

Simon and Barnard see the study of organisations as the study of decision-making. Decisions involve factual and value elements. Members may join the

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organisations with motives which do not correspond with the principles of the organisation. Members may also be limited by their will. (Simon and Barnard, in Dunkerley 1972: 44-47)

Barnard adds to this view by pointing out that an organisation is a system of consciously coordinated activities. Its goals are refined and communicated by the hierarchy to the levels that act as the organisation's action elements.

According to Cyert, there is a potential internal conflict between diverse individuals and groups. This can be resolved by mechanisms such as division of labour and coordinating the individual's goals according to the needs of the organisation. (Cyert, in Dunkerley 1972: 47-50)

In all these processes there are uncertainties, which the organisation may avoid or predict and plan actions to be taken accordingly. There are also problems, which motivate needs for changes in the organisation. (Dunkerley 1972: 50-53)

1.3.5.4. How then to conceptualise organisations?

A distillation of the foregoing analyses leads to the conclusion that organisations can mainly be conceptualised at three levels: roles, structure, and institutional. Analysing roles is mainly significant when looking at key players and their interaction with others. Structural analysis involves analysing the main groups in the organisation. Institutional analysis is directed to understanding the characteristics. Characteristics here imply features which make the organisation to operate as a functioning whole. (Dunkerley 1972: 64-66)

Analysing organisations should also take into account the influence of the environment. Empirical studies have shown that organisations tend to respond to forces imposed on them by outside forces such as other organisations and technology. If an organisation is to remain identified and operating with its

traditional goals, it must be isolated as much as possible from environmental influences. (Dunkerley 1972: 71-72)

These theories allow us to approach religious organizations with a much more informed mind. Like any other type of organisation religious organizations have roles, structures, and an institutional aspect. Entities such as leadership, membership, moral values, and doctrines form the functioning mechanism of the whole. Following Weber, bureaucracy, hierarchy, division of labour[10], abstract rules[11] and above all the impersonality of the ultimate power claimed to be the utmost leader or God come into picture.

The systems and psychological theories help us to understand that the individual in the religious organizations has a significant place. As Dunkerley (1972: 71-72) observes we also conclude that religious organizations are effected by outside phenomena.

In this study such a systematic definition of organizations is useful as a tool to understand the social context and structure of the religious organizations in Greater Pietermaritzburg which we are going to look at in the next chapter.

1.4. Chapter outline

In this introduction the focus has been on the theoretical background of this research. This has included the assumptions which this research carries and sociological and interventionist theories which were informative to this study.

In chapter two our concern turns to the methodology which was used to conduct this study. We will look at the process which was followed to collect and analyse

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[10]. In terms of this study, this could mean tasks shared by members of religious organizations.

[11]. In terms of this study abstract rules imply doctrines and moral values imposed on the members of the organisations.

data. This will include research ethical guidelines which the researcher used; methods used to understand the social context of the key informants; and problems which the researcher encountered during the process.

Chapter three presents the findings from the research. Here we look at the views of the key informants about HIV/AIDS, particularly exploring how they, as religious leaders, conceptualise the problem.

Chapter four explores the availability of HIV/AIDS related policies and the interventions programmes in the religious organisations in Greater Pietermaritzburg. We will attempt to give an overall picture of variations in terms of the policies and interventions as explained by the key informants during the interviews.

In Chapter five we look at the concern of the religious leaders to utilise the resources available both within and outside their organisations to intervene in the HIV/AIDS issues. We analyse their willingness to undergo training and the areas they feel they need support on in order to begin or to improve interventions in their organisations.

Chapter six, by way of conclusion, critically considers analysis of what has been learnt from the study and how these findings relate to theory.

CHAPTER TWO

2.1. Research Methodology

2.1.1. Data collection through interviews with key informants

The study used a cluster, snowball sampling approach to collect data. In practice this was done through interviews[12]. The study saw religious organisations as social clusters composed of individuals who could be part of the sample. Religious leaders from these organisations were identified as key informants.

Identification of the leaders was done using a list of churches obtained from the KwaZulu-Natal Christian Council. The list contained names of representative leaders from Christian Churches. These names were used as first contact persons, who could either accept to be interviewed or provide names of the people to be interviewed.

However the list did not include all religious groups. For example Moslems, Hindus and some Christian Charismatic groups were not part of the list. Contacts with such religious groups were made through the assistance of academics in religious studies at the University of Natal. Further, a few informants were included in the study by searching for names of religious organisations in the Pietermaritzburg telephone directory.

Once key informants were identified contacts were made by telephone for appointments to conduct interviews. Interviews were conducted using a semi-

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[12]. We will see in the next page that a variety of forms of interviews were made. Some were one to one face to face while others were interviewed in groups. Few informants were sent questionnaires. Some informants were interviewed in Zulu, some in English and others in both Zulu and English. But whether the interviews were in Zulu or English, notes were taken in English.

structure questionnaire as a guide. Each question was discussed in-depth with the informants[13]. Through this process, 43 key informants were identified and interviewed during the months of September, October, and part of November 2000.

All key informants were religious leaders. However, their positions in the religious organisations were not the same. In rank they included bishops, parish priests and ministers, Hindu swamis, Moslem Imams, and leaders of Christian-based NGOs. Sometimes these religious leaders delegated church officials or members assigned by their organisations to handle HIV/AIDS issues.

Out of the 43 religious leaders, 25 were individually interviewed face to face, 9 were interviewed in four separate groups. Due to logistical reasons, two copies of the questionnaire were sent to one minister and an 8-member minister's fraternal group. The study used an interview guide that contained questions examining the following issues:

1. The common sense understanding of the key informants of the meaning of HIV/AIDS.
2. Challenges posed by the epidemic to the religious organizations.
3. Existence and ideas of HIV/AIDS intervention policies in the organizations.
4. Possible plans for future interventions.
5. The organizations' present plans for intervention programmes.
6. Whether the organizations have any intervention programmes to deal with opportunistic diseases.
7. Forces influential in helping the organizations involve themselves with HIV/AIDS and whether the organizations have devoted any financial and personnel resources to deal with the epidemic.
8. Effectiveness of policies and interventions that the organisations have in place.

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[13]. This means that once the informant gave an answer to the first question, further questions related to his/her answer were asked for clarification or expansion of the answer given.

9. Organisations and individuals working in partnership with the religious organizations.

10. Readiness of the organisations to be involved in any training to equip themselves with intervention skills. Their views about what kind of issues such training would have to address.

Table 1. **Distribution of cases included in the study and methods used to collect data**

NAME OF RELIGIOUS ORGANISATION	NUMBER OF KEY INFORMANTS INCLUDED IN THE SAMPLE	FACE TO FACE INTERVIEWS WITH INDIVIDUAL KEY INFORMANTS	PARTICIPANTS IN FACE TO FACE GROUP INTERVIEWS	NUMBER OF RESPONDENTS TO A MAILED QUESTIONNAIRE	PARTICIPANTS IN GROUP RESPONSE TO A MAILED QUESTIONNAIRE
Anglican Church	5	3	2	-	-
Methodists	3	1	2	-	-
Roman Catholics	4	3	-	-	1
Hindus	3	-	3	-	-
Seventh-day Adventists	2	2	-	-	-
Christian Charisma Groups	4	4	-	-	-
Full Gospel Church	1	1	-	-	-
Christian-based NGOs -cbos	2	2	-	-	-
Presbyterians	2	2	-	-	-
Salvation Army	2	-	2	-	-
Church of England	2	2	-	-	-
Lutherans	2	2	-	-	-
Baptist Church	1	1	-	-	-
Assemblies of God	2	1	-	-	1
Moslems	1	1	-	-	-
Church of Nazaren	1	-	-	1	-
Enige Kerk	1	-	-	-	1
ZCC	2	-	-	-	2
Weslyian Church	1	-	-	-	1
Unidentified from a mailed questionnai	2	-	-	-	2
TOTALS	43	25	9	1	8

Critically speaking, collection of data using different methods as indicated above can have effects on the reliability of the results obtained from the whole research. For example, respondents who were mailed the questionnaire tended to give short and brief answers. This is because the interviewer was not there to ask them to give clarifications or further explanations of their answers. These

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informants also sometimes seemed to misunderstand the questions. Those who were interviewed face to face tended to give detailed answers and provided sufficient time for the questionnaire to be administered. Those who were interviewed in groups were able to expand their point of views and deliver them from different angles.

Any attempt to understand the findings of this research, therefore, needs to take into consideration these variations and their possible critical impact on the whole research.

2.1.2. Ethical Issues

Schaefer and Lamm give six ethical principles for conducting social research:
1. Maintain objectivity and integrity in research.
2. Respect the subject's rights to privacy and dignity.
3. Protect subjects from personal harm.
4. Preserve confidentiality.
5. Acknowledge research collaboration and assistance.
6. Disclose all sources of financial support.
   (1992:51)

And Newman comments:
> Given that most people who conduct social research are
> genuinely concerned about others, why would a researcher act
> in an ethically irresponsible manner? (1994: 428-429).

Several things were done with special consideration for the ethics of doing social research. Respect for the integrity and the wishes of the informants was paid in all pre-interview communications and in the interviews themselves. For both parties this was done in a way that would not jeopardise the research process and its results. For example, informants were given the opportunity to suggest time and place for interviews, and were also informed of the time limits of the interviewer.

During pre-interview contacts informants were briefed about the background of the research and the researcher himself. They were also informed about its goals

and objectives and what would be done with the findings compiled from the research.

Informants who were concerned about confidentiality were assured that their contributions would be used as part of the general results of the research and their names would not be used. They were also informed that if they were to be quoted directly their identities would be presented in the form of numbers assigned to key informants.[14]

2.1.3. The social context of the informants and the groups they represented

The study sought to understand the social contexts of the key informants and the organisations they represented by investigating the following:
1. The main roles players in the religious organisations.
2. The numbers of followers under each leader.
3. The racial composition of the members in each religious group represented by the informants.
4. The gender composition of the members in each religious group represented by the informants.
5. Other subgroups found in the religious communities represented by the informants.
6. Their working status in the religious organisations – i.e. whether they are volunteers or are employed.[15]

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[14]. When the researcher started analysing the results of the research he replaced each informant's name with a number. The term "key informant" was initialised as "KI". This means, as we shall see in the study that key informants were presented as KI: 1, meaning Key Informant 1, KI: 2, meaning Key Informant 2 and so on.

[15]. Employees were defined as people who solely depend on the organisations for their income and have signed contracts with the organisations based on labour relations laws and regulations. Volunteers refer to all the people taking certain roles in the organisations without any payment as a way of expressing their religious commitment.

Table 2. Estimated average number of members under the key informants, numbers of their employees, percentages of women and age profile of key informants and their assistants (*these figures apply to only the groups which were included in the sample, and not to all the churches of the organisations mentioned*)

NAME OF RELIGIOUS ORGANISATION	ESTIMATED AVERAGE NUMBER OF MEMBERS UNDER THE KEY INFORMANT	NUMBER OF EMPLOYEES IN THE ORGANISATION IN THE SAMPLE	PERCENTAGE OF WOMEN OUT OF THE TOTAL NUMBER OF MEMBERS	AGE PROFILE OF KEY INFORMANTS AND THEIR ASSISTANTS (Range of numbers of years of age – youngest to the oldest)
Anglican Church	600	34	60%	27-65
Methodists	946	3	65%	25-55
Roman Catholics	5500	1	78%	15-60
Hindus	500	0	50%	50-55
Seventh-Day Adventist	230	Occasional	61%	40-75
Christian Charismatic Groups	85	1	63%	30-40
Full Gospel Church	91	0	80%	25-70
Christian –based NGOs	256	12	85%	20-65
Presbyterians	910	2	64%	50-80
Salvation Army	150	0	60%	25-57
Church of England	500	5	55%	21-85
Lutherans	800	5	69%	20-75
Baptists	211	5	50%	40-70
Assemblies of God	300	Occasional	70%	35-60
Moslems		******	******	*****
Church of Nazarene	-	56	75%	No answer given
One ministers Fraternal group of leaders	129	0	80%	No answer given

It is evident from the table above that most of the religious groups studied did not employ people. Organisations containing many employees such as the Anglicans

came from the headquarters of the organisations where most of the administration work for larger regions of the organisation take place.

The table also reveals that women made up the majority in the following of almost all the key informants. In terms of age range the youngest person mentioned as part of the religious leadership was 15 years old, while the oldest was 85 years old.

Group divisions and racial compositions are not set out in the table. These aspects of social composition indicated a great deal of uniformity, hence it is easy to give a general description of their nature. With the exception of only one informant who indicated that the structure of his congregation is subdivided into couples, parents and youth organisations, all the informants indicated that their followers were divided into women's organisations, men's organisations and youth organisations.

In terms of racial composition, out of the 43 informants interviewed, 17 indicated that the groups they represented were composed of four racial groups (Africans, Indians, Coloureds and Whites), 22 indicated a composition of Africans only, three indicated composition of Indians, Coloureds and Whites and one indicated a composition of Whites only.

However, the religious groups comprised of all races were predominantly white. For example, St Alphegese Anglican Church was found to be an all-races religious group, yet statistics showed that 85% are whites, 10% Africans, 2½% Indians and 2½% Coloureds. Probably one would infer that such groups were historically white, and started to include Africans only recently. Those whose membership was a mixture of Indians, Coloureds and Africans were predominantly Indian and Coloured, but the percentage for Africans was larger than the ones in the predominantly white groups. Informants from Africans-only

groups indicated that they had other racial groups occasionally as visitors during functions or prayer services.

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CHAPTER THREE

3.1. Introduction

This chapter explores two questions: 1) knowledge and perceptions about HIV/AIDS, and 2) challenges posed by the epidemic to the religious organisations in Greater Pietermaritzburg.

Medical findings have played a great role in influencing knowledge about HIV/AIDS. For example, causality, prevention measures, and curative measures and methods of providing care for diseases form the common language of medicine. This language also entails questions accompanying the sadness of being sick. Society in general struggles with diseases around questions related to this language. However, different sectors of society reinterpret the language in their own way.

3.2. Perception and Challenges about HIV/AIDS

The Great Pietermaritzburg survey revealed different perceptions about aspects of HIV/AIDS which include: transmission of the disease, provision of treatment and care to the sufferers, prevention mechanisms, requirement for interventions to alleviate the problem, and symptoms of the disease. All the categories show the influence of medical knowledge. But they also reveal the influence of religious morals and values.

Our respondents generally perceived that the HI virus is transmitted through sexual intercourse. This perception is also packed with moral judgments about sexual behaviour, as sexual relationships outside marriage are perceived to be normatively depraved. Perceptions about the disease's transmission led the respondents to blame those who have the disease for being sexually immoral. They volunteered moral judgements that contracting the disease is a result of

human moral weakness. They also stated that those who contract the disease without engaging in promiscuous behaviour themselves are involved in a sexual relationship with unfaithful partners.

> It is a sexually transmitted disease which affects promiscuous people. Some innocent people are affected because of their unfaithful partners. (KI:20)

Moral judgements also form the basis for frustrations. There is a tendency to believe that in order to stop the spread of the disease people must live according to moral values proposed by their religions. The difficulty of dealing with the disease is conceptualised around this judgment. It is perceived that the sexual drive has dominated human conscious to the extent that people are oblivious of the fact that the disease is a serious problem of our society.

The informants commented that instead of respecting moral values which may minimise risk of contracting the disease, people dwell on defensive arguments questioning how the disease started.

Sometimes questioning about the origin of the disease is coupled with suspicions influenced by people's historical experiences of oppression, e.g., believing that the disease was inflicted on the African people by Whites as a means of oppression and a plot to eliminate the African race. (KI: 14 and KI: 25) Thus those who have the disease sometimes refuse to accept the reality.

In some cases the defensive arguments are strengthened by traditional beliefs such as those of witchcraft.

> People take it lightly – probably because they are sexually too active. Young people do not seem to be threatened; they do not accept that it exists. ... When you talk about it they just laugh. They tend to politicize about how it came. (KI: 9)

> Some, even if they have it, refuse to accept that they have AIDS. They would say that they have been bewitched. People refuse to admit that this disease exists. (KI: 8)

People's lack of acceptance of the disease creates frustration among religious leaders. The informants saw the fact that people did not take the disease seriously and refused to listen to moral advice as an obstacle to their efforts to help people alter their behaviour and to stop or minimize the spread of the disease.

Moral judgements on sexual behaviour were sometimes related to the oppression of women. According to this view men are seen as more sexually active than women and so they tend to impose their will upon women. The most extreme form of this behaviour is rape. In this view men's dominance was understood to complement the tendency of women to seek acceptance from men. This only increases the dominance of men.

Some informants' views proposed to counter the spread of the disease by advocating behaviour which empowers women so that they can challenge men's dominance in sexual relations without feeling rejected by men. That is, women should seek "to change the broken morality of young people ... especially those engaged in bad behaviours such as rape". (KI: 20)

Another area in which medical influence seemed to meet with religious values was that of care giving for the sufferers. Concepts about care giving were borrowed from community based health care systems and were reinterpreted according to religio-ethical values of compassion and care for others. According to the informants, this trend seemed to go through five steps.

First an intervention agent accepts the medical claim that AIDS is caused by a virus (HI virus), which finds its habitat in and develops in human blood. Touching the blood is therefore taken as dangerous. (KI: 3) Second, was knowledge about what one should do to avoid contracting the disease through the blood of an infected person.

The use of gloves and/or avoiding touching the infected person when bleeding were given as examples here. Third, this knowledge was seen as a basis for overcoming the fear of being infected when one is directly in contact with an HIV-positive person. Fourth, overcoming the fear opens the way for intervention based on care giving to the sufferers. When the fourth step is reached religious moral values of compassion and concern for others become easy to apply[16].

However, the informants commented that individuals in religious organisations can make their own decisions contrary to the ideas imposed on them by their leaders or the doctrines and moral values of their religions. Individuals' interests, perceptions and concern about the sufferers of the disease may not correspond with those of the organisation's leaders.[17]

A typical example is one from a White congregation in the Seventh Day Adventist Church, where a key informant reveals the influence of prejudices against African people on the individuals' response to epidemic:

> There is lack of understanding about the disease ... The perception of my congregation which is pre-dominantly White is that it is a disease for only Black people. Moreover, people have distanced themselves from the awareness programme. At the back of their minds they tell themselves that it is a Black sort of a problem. I think that is not correct. (KI: 14)

This poses a challenge to religious organisations as to how they can mobilise their members to participate in intervention programmes that accept AIDS sufferers as normal people in need of care. It is a challenge to the moral whims of compassion and concern for others. Thus while indicating the awareness of

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[16]. Note that this point is supported by the fact that all the key informants who commented on care giving (such as home-based care) emphasised that it is important to use gloves when touching AIDS sufferers or avoid touching them altogether.

[17]. This point corresponds with what we have learnt in Chapter 1 that individuals have the capacity to challenge the demands of their organisations. (Dunkerley 1972: 33-41) This may happen because of forces from the secular world which create in the individual a certain callousness toward the needs of others. Or it may happen because of the individual's preconceived perceptions about the meaning of the disease at a social level.

the need for interventions based on home based care, some informants also mentioned this very difficulty:

> To persuade people to accept those with AIDS as normal people
> and to provide care for survivors and those rejected by the family.
> (KI:1)

> [To make people] ... look at HIV-positive people without judging
> them. (KI: 23)

This finding suggests that understanding medical strategies to avoid contracting the disease when engaging in care giving is not enough to influence participation of church members. Factors related to individuals' own decisions do always interfere with moral values of compassion and care for others.

Individual decisions and perceptions about HIV/AIDS affect the sufferers themselves. In the dynamics of social interactions being HIV-positive is considered a shame upon the sufferers and their families (KI: 10). Despite campaigns which encourage people to speak out about the disease, the feeling of shame still keeps the affected and infected people silent about it. The informants said that this happens even though the affected and infected people are aware that symptoms of the disease are commonly known.

> Mostly it is difficult to know [the infected and affected people]
> because people do not like to reveal when they are HIV-positive,
> but one can also see symptoms. At some funerals of people who
> died of AIDS relatives refuse to open the coffin for people to see
> the corpse for the last time. (KI: 8)

In religious organisations this perception is deepened by the moral judgments about the association between HIV/AIDS and sexual behaviour, which religious leaders themselves make.

> Sometimes people do not reveal to us, ministers, because
> they know that we also teach them moral values and they do
> not want to expose themselves as having done something
> wrong. They are afraid that we will accuse them of being
> immoral. (KI: 12)

Feelings of stigma were therefore perceived as posing a challenge at three levels. First, leaders of religious organisations found themselves confronting the difficulty of convincing their members to reveal when they are affected and infected by the disease.

> People do not say anything when they are HIV positive. We never had any funeral we know to have resulted from AIDS. (KIs: 4)

> It is difficult to remove the stigma from the people with the disease. It is not easy to know who is suffering from the disease. (KI: 10)

> Some disclose, some just complain that they catch cold, they have rushes and that they suspect that they have it. The problem is how they can disclose. They only mention symptoms. (KI: 30)

Second, if infected and affected people fear being accused of being immoral, how could religious leaders intervene with the moral teachings which might help reduce sexually risky behaviour? Thus in some cases it became a challenge "to proclaim good news without moralising ...for all social groups." (KI: 23)

Third, the silence makes it difficult for religious leaders to identify those infected and affected by the disease in order to support them to cope with the difficulties at hand.

> It is difficult for ministers to help people with AIDS because people are shy to talk about it. Ministers are not able to identify them. (KI:12)

For some informants knowledge of HIV/AIDS symptoms did not seem to provide an adequate basis for identifying those infected. Somewhat perversely, the fact that the symptoms[18] which appear in the diseased are those of common opportunistic diseases[19] provides a means of hiding the truth of being infected and affected. People choose to mention that they are suffering from the opportunistic disease for which symptoms are seen rather than divulging the fact that they are HIV-positive.

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[18]. Symptoms identified by key informants as they explained their understanding about HIV/AIDS are: stomach-ache, headache, and pneumonia (KI: 8); swollen legs and feet, diarrhoea and vomiting (KI: 15), skin rashes, loss of weight, and loss of memory. (KI: 31)

[19]. Apart from TB, other opportunistic diseases which were identified by the key informants are pneumonia and leukaemia.

This formed the basis for the circumstance that religious leaders sometimes blamed both non-sufferers for not accepting or for judging those who are infected as being immoral and also the infected people themselves. It is as though the whole problem of responding to the challenge of the epidemic was trapped in a web of blames. On the one hand, the assumption was that if people started to accept those who are infected interventions would be possible by encouraging members to take care of one another. On the other hand, the belief is that infected and affected people themselves posed an impediment to interventions by being silent or by lying and saying they are not infected by the disease. Some informants drew these conclusions from their own concrete experiences:

> I remember a case of woman and her family. The woman
> suffered from AIDS, but they kept saying that it was
> witchcraft. My wife talked to the woman secretly and advised
> her to admit that she was HIV-positive. When she admitted it
> my wife and I prayed for the woman – and she became better
> – the woman was a member of the girls association in the
> church. (KI: 12)

Last, the informants indicated that medical assertions that the disease is incurable and that death inevitably accompanies it posed an institutional[20] threat to the religious organisations. Medical knowledge that the disease is incurable was not excluded from the perceptions that religious leaders had about the disease.

> It is an incurable and killing disease (KI: 18); it is an incurable
> disease transmitted in many ways (KI: 3); It is incurable. (KI: 2)

However there were also perceptions which contended that being HIV-positive does not mean an automatic way to death. In this case death of the people infected was not the issue. Rather, the issue was the danger posed by the HIV-positive people who do not know about their status. Such people were perceived as vectors who may transmit the disease to others unknowingly.

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[20]. The term "institution" here borrows the idea of Dunkerley that organisational analysis is directed to understanding the characteristics or features that make an organisation operate as a functioning whole. (1972: 64-66). The primary organisational problem posed by HIV/AIDS's quality of being a certain, deadly disease is simply that members who make a religious organization function are dying of the sickness and so are the organisations themselves.

> Being HIV-positive does not mean immediate death. An infected
> person can live up to 10 years. If one is not aware that s/he is
> HIV-positive s/he may infect other people. (KI: 15)

For this, the challenge for the informants was to encourage people to take necessary precautions and go for periodic medical testing for the disease. (KI: 23)

The institutional challenge of being an incurable disease leading to death was also based on the fact that the informants had a general perception that the disease mostly targets young people who constitute the potential membership for future religious congregations and their leadership. Moreover, as people die the organisations' financial security suffers. This is crucial because the financial security of most religious organisations rests overwhelmingly upon the contributions of their members.

Some informants also commented that deaths and sicknesses impose financial challenges upon families as they spend money, which they should have contributed to their religious organisations, for caring for their relatives infected by the disease or for paying for funeral expenses. Sometimes the psychological strain that family members encounter makes them withdraw from religious functions.

> The church is loosing the people especially the youth who build
> its future- the manpower of the church. The church will have no
> replacement. (KI: 22)

> It is a big challenge. A church is a church because of people
> coming to church. If they die, there is no church. Those who die
> are the ones who contribute a lot [financially]. (KI: 27)

> It leaves the family perilous because of medical and funeral
> expenses. It affects the family members and friends mentally and
> psychologically. (KI: 31)

According to some informants, on top of these challenges there is a sense of helplessness that church leaders felt when members die. This came from moral convictions that HIV/AIDS is associated with promiscuity. There is a belief that it is the responsibility of the religious leader to make sure that moral values are followed. If this does not happen failure is attributed not only to the person

neglecting the values, but also to the religious leader him or herself. Thus promiscuity is seen as coming from the failure of the religious leaders to change people's immoral sexual behaviour. This belief resulted in the conclusion that the church leaders do contribute in the death resulting from AIDS.

> A [church] minister feels guilty when someone is sick or dies of the disease. S/he may feel that s/he did not do enough to teach the person good morals. It is touching when you hear parents worrying that their people are dying. When I give them opportunity to pray I hear them praying saying "please God protect our children [from this disease]". I have a lay preacher who is a victim of the disease. He always helps me – a high-spirited man. When he is praying you will hear him praying silently at some point and I know that he is talking to God about his sickness, but he does not want us to hear. (KI: 27)

Frustration from this challenge was also mixed with confusion. According to the informants, information spread every day by medical experts, social workers and all other main role player did not bring any answer to the problem. The message of Jesus did not bring any answer to the problem. Hence,

> The main problem is how to prevent it. There is a lot of information that has been spread about HIV/AIDS, but the main problem, which remains, is how to prevent it. (KI: 25)

Some informants commented that the problem of HIV/AIDS is not an immediate challenge to their religious communities. Failure to see HIV/AIDS as a challenge was coupled with the fact that these informants had never seen anyone suffering from the disease in their religious communities. However, there was a feeling to take precautions to prepare for the possibility of being affected in future.

> If the disease gets out of hand, it could pose a serious problem. We presently have no statistics of our members who are HIV-positive. So we do not know how it affects our Hindu community. We never had any funeral we know to have resulted from AIDS. People do not say anything when they are HIV positive. (KI: 4)

> We have no immediate challenge. I have never buried a person who died of AIDS to my knowledge and there is no person I know to have the disease in my church. But in time we could have people with the problem. So we need to prepare for that time. (KI: 7)

Failure to see HIV/AIDS as an immediate problem was also influenced by the confidence which the religious leaders had in their members. For some, confidence in their members was brought by the fact that members understand issues about HIV/AIDS very well. This means that they are able to understand ways of protecting themselves against it. This was coupled by the fact that their members were often not economically challenged. That is, they were not prone to engage in economic activities which posed a high risk of contracting the disease.

> HIV/AIDS is not a high-profile topic in our church. Most of our members are middle class. They are not impinged by the problem. They understand the social systems and issues about AIDS. So the problem does not affect the members of the church directly. I have not heard of any member who is HIV-positive. But what worries people is the stories about economic effects of AIDS. They are aware that the state and health services are not coping with the problem. But they also fear that family members may be infected. (KI: 13)

For others the confidence in members of their organisations was based on their conviction that the members were able to follow religious values which the leaders preached to them.

> It is not a challenge as a congregation. People of the church observe its morality. In the congregation there is no one known to have the disease. There is no evidence for the disease among the congregants. (KI: 21)

All in all, it is clear that respondent perceptions of the epidemic influence their responses to those who are infected or affected by HIV-AIDS. Also the fact that religious practice intertwines with moral constructs serves as a barrier to effectively ministering to people's needs, where these are recognised. In such a context, the question that arises is the extent to which they are supported by policy to carry out their work.

CHAPTER FOUR

4.1. Variations in policies and interventions about HIV/AIDS

Investigating the interventional responses of the religious leaders to the epidemic was first done by finding out whether the organisations had policies, which dealt with HIV/AIDS. The study then went further to investigate the practical activities which the organisations took in their responses to the epidemic.

4.1.1. Variations in policies

As the previous chapter showed, religious leaders are influenced to a considerable extent by bio-medical information about HIV/AIDS. Such knowledge is re-interpreted through the lenses of religious moral and doctrinal values. Such re-interpretation provides a way to explain the context of HIV/AIDS policies adopted by religious organisations in Greater Pietermaritzburg.

Knowledge of policy is very mixed. Some respondents said that their organisations have policies, while others said that they have no policies at all. Some mentioned that their organisations have documents in the form of pastoral letters which advocate intervention in HIV/AIDS issues. These pastoral letters put emphasis on religio-ethical values which provide guides for action. An example of such a document is the joint pastoral letter of 30 KwaZulu-Natal Christian Church leaders published by the KwaZulu-Natal Christian Council. The letter was written to mark the July 9 – 14, 2000 World AIDS Conference in Durban. It was distributed to local Christian religious communities.[21]

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[21]. We will include the letter in this section, as part of our analysis for the policy related issues of the religious organizations. This document reveals briefly what are the values of these organizations.

Some informants indicated that they know of policies, or documents of some kind, which were published by their head offices while others said that they do not have local level policies and do not know of any document from their head offices.

> We have no policy... I do not know any document from the
> headquarters of my church which talks about what the church
> must do about the problem of AIDS. (KI: 2)

The informants also revealed that in most cases head offices make rules without being directly in touch with their local religious communities. In such situations, leaders do not create strategies to apply the rules to all their branches at a local level. Among the respondents who indicated that they knew about policies kept[22] at head offices, there were those who said that the policies had not been distributed to the local congregations. Others said that the policies had been distributed, but they had not been used at all.

> There is a national policy in the church directed to supporting the
> affected people and people living with AIDS. But there is no
> written policy at the local level. The policy has not been applied at
> any level. The document has not even been distributed to
> different parishes. (KI: 10)

In some cases head offices were in the process of drafting their policies, which could be used at a regional level.

> There is no specific policy at the moment. But the Lutheran
> Church of the Southern Africa is working on a document which
> will say what the Lutheran Church should do in response to the
> epidemic. Some countries involved are South Africa, Namibia,
> Angola, Zambia, Mozambique, Botswana and Swaziland. (KI: 17)

An examination of issues addressed in these policies tended to acknowledge the existence of the disease. They also stressed the need for action in the local religious communities. From their moral point of view these policies also attacked liberal views about drug abuse and human sexual behaviour propagated by the media and entertainment sectors. The policies pointed out that the liberal views did not consider

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[22]. Here the word "kept" should be seen in terms of policies which have not been issued to the branches of the head office.

the negative consequences of sexual behaviour. There was also emphasis that the individual must take responsibility for his or her sexual behaviour. Proper and acceptable sex was only seen as necessary where it is legitimated by marriage as marriage functions not only as a milieu for sexual practices but also can provide a home where children can be nurtured.

Thus, actions and views articulated in the policies were driven by religious ethical values, especially values about consolidating one-partner-marriages.

> Promiscuity and drug abuse are keys for the spread of the virus. Our prophetic ministry is to focus on exposing and overcoming the hedonistic assumption, powerfully propagated by advertising and entertainment industries, that every individual is entitled to the immediate and total satisfaction of all his/her whims and desires, regardless of the consequences for him/herself, others and society at large. Freedom must be matched with responsibility; otherwise it is destructive, in this case even fatal. We must regain a sense of the deeper meaning and purpose of sex as the celebration of the mature love in a committed relationship, which provides a "nest" for the young generation. (Southern Africa Lutheran and Moravian Church Draft Programme for HIV and AIDS 2000: 1)

Hope in the power of God and in the ability of the people's goodwill to deliver society from the problem of HIV/AIDS were also seen as important messages in the documents. The difficulty in finding remedies for the problem of HIV/AIDS was neutralised by the belief and hope that there is nothing impossible with God and that there are people worldwide who are making efforts to contain the problem. The documents also argue that there is no need to give up the struggle against AIDS because the unfailing love of God shows that He will not simply leave people alone to die.

The documents then emphasize that such hope should be a motivating factor for taking actions to change the immoral sexual behaviour of people. The hope should also motivate society to overcome the socio-economic problems which influence people to be involved in risky sexual behaviour. This hope should encourage key

role players in the issues of HIV/AIDS to commit themselves to a solution to the problem.

> We believe that we are not alone in the struggle with AIDS. We are surrounded by the love of God and the love of many good people. This gives us hope.... We can change our way of life: we hope and believe that lifestyles and behaviour can change. We know that the major reason for the rapid spread of HIV/AIDS is sexual activity with a variety of partners. We hope and believe that a vaccine for HIV will soon be developed together with cheaper treatment. We can influence research into and the development of treatment for HIV/AIDS by constantly keeping the public focus on the dire straits of people living with HIV/AIDS and reminding the government of its responsibility to encourage and fund those engaged in such research. (A join pastoral letter of the KwaZulu-Natal Christian Church Leaders' Group and the KwaZulu-Natal Christian Council: June 2000)

At a practical level, the policies recommend that local committees composed of both professional and non-professional personnel be established, although there was no indication of how the professionals are to be attracted to serve on committees. Inclusion of youth in committees is also expressly mentioned.

> The proposed programme for practical involvement focuses on the establishment of AIDS Committee in each parish, ideally composed of the pastor, doctor or nurse, a social worker, a representative of the youth and a person who is HIV positive. (Southern Africa Lutheran and Moravian Church Draft Programme for HIV and AIDS 2000: 1)

Some of the organisations suggested choosing only one person in a local religious community who would be responsible for liaisons between the local religious community and the other sectors and individuals who might help in strategic planning for intervention. The department of health in the local government in this case was seen as the primary potential partner reinforcing the link with medical based knowledge.

Individuals with reputations in the area of health issues (e.g. doctors) were mentioned as people whose assistance might be sought. Religious leaders expected that these professionals would provide advice on the material needs for the

strategies planned by the local religious communities. Religious authorities were also identified as key role players whose moral opinion might be sought by the local officials responsible for HIV/AIDS issues.

> [We] have voted that each church elect a person who can run programmes on AIDS and for AIDS patients in our country. This person will work in close conjunction with the health and temperance department of the church. ...[and] will approach Mrs Thyssen to advise the conference on approaches to take and to help with the preparation of resource materials for the local church. (Minutes of Seventh Day Adventist Kwazulu-Natal Conference: 2 September 2000)

The policies tended to be cautious about spending financial resources[23]. There was also a tendency to look negatively at the term bureaucracy without realising that their proposal for committees composed of different people with different skills automatically drives their strategy into a bureaucratic mode.

> Due to the immensity of the problem, costs must be kept to an absolute minimum and the development of an AIDS bureaucracy must be avoided. (Southern Africa Lutheran and Moravian Church Draft Programme for HIV and AIDS 2000: 1)

In some cases, instead of proposing only local community mechanisms, documents preparing for policies and plans of action mentioned co-ordinated systems. These systems required a co-ordinator who would have an advisory committee. This committee would help him/her to facilitate, monitor, and provide support in strategic planning and policy-making for HIV/AIDS programmes in local religious communities of the particular religious organisation.

> This meeting of the Diocesan Council of the Diocese of Natal ... affirms the appointment of the diocesan HIV/Aids co-ordinator. (Resolution of the Diocesan Council of the Anglican Diocese of Natal: 9 September 2000)

> The Diocesan Aids Committee, meeting on Thursday 14 September 2000 agreed that a support group needs to be set up around the Diocesan Aids Co-ordinator. ... It is envisaged that the

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[23]. A critical argument here is that securing professional people to help in religious communities is not easy for every organisation and, if found, his/her assistance could be expensive.

primary function of the group will be to provide support and
advice to the Diocesan Aids Co-ordinator. The group will be
meeting in Durban from time-to-time, as and when the need
arises. (Letter of invitation to prospective AIDS advisory
committee members for the Anglican Diocese of   Natal)

From the documents it is clear that the impersonal authority of God was seen as
putting a stamp on the proposed rules. The documents suggest that actions taken
by people to respond to the proposals made by the organisations are sanctioned by
and deserving of rewards from the ultimate authority – God. This was because
actions taken to deal with the disease were also seen as demanded by God.
Messages from historically sacred figures, such as Jesus, were featured as God's
tools to direct people in HIV/AIDS intervention.

This was evidently true in Christian circles where God was seen as Master of
everything and his followers were seen as helpers committed to make the world a
good place to live in. The documents showed God's law as requiring that humans
must live in healthy conditions. Through that law God is seen as endowing humans
with the gift of the ability to fight against diseases, which tend to negate God's
omnipotence.

The policies then assert that the power of God is transformative to the society. God
changes the suffering nature of society to a happy one. This happens through the
actions of those who follow his teaching about loving the suffering people. That
means that followers of God's teaching are required to act with the intention to fulfil
the transformative aspect of the Gospel.

> Our understanding of the Mastery of God over everything that
> exists and happens in this world makes us bold to "struggle with
> God" for ways out of the predicament. Our understanding of the
> law of God as a formulation of the preconditions for a healthy
> human existence, rather than an authoritarian code of oppressive
> laws, allows us to use God's Gifts of observation and reason to
> see what must be done to contain the pandemic.

> Our understanding of the Gospel of Christ as God's
> unconditional, suffering acceptance of the unacceptable makes
> us ready to bear the cross with those who are infected and
> affected, whether their condition is due to their own moral failure
> or whether they are victims of the failure of others.
>
> Our understanding of the fruits of the gospel invites us to become
> part of the process of transformation, not only of the lives of
> infected and affected persons and families, but also of the
> Christian congregation and the wider community. (Southern
> Africa Lutheran and Moravian Church Draft Programme for HIV
> and AIDS 2000: 1)

There are also cases in which policies concerning HIV/AIDS are not the subject of a special focus but are rather simply part of general instructions in handbooks or guidebooks regularly published by the organisation's head offices.

> In the 2000-year book [for the Methodist Church at a National
> level], HIV/AIDS has been specifically identified as an important
> area of social concern. (KI: 19)

Respondents suggested that some policies made at local religious community level emphasise the importance of community support in local congregations. They proposed methods of how the communities could help to find proper solutions to the problem of HIV/AIDS. That was discussed in council meetings without being put into written form.

> Our policy is that if people come and declare that that they
> are HIV-positive they are to be part of the community – then
> we may refer them to societies that can help – no one has
> ever come and declared him/herself HIV-positive. The policy
> is not written. It is just discussed by the church council. Last
> time we had a meeting in which we talked about AIDS was in
> 1998. (KI: 1)

Some respondents indicated that they had no policies at all. However HIV/AIDS issues were reflected in their council meetings. Such discussions were part of searching for means of dealing with the problem. They were also milieux in which information about HIV/AIDS was shared. Common to the decisions made in these meetings was the need to integrate HIV/AIDS issues in preaching.

> We have talked about AIDS in one of our meetings. We have also brought it to the attention of the congregation in sermons. (KI: 4)

Among the respondents who indicated that they have no policies there was a general belief that policies are not important for religious organisations. Biblical passages, morals and doctrinal values were taken as ready-made policies. Thus what was required was not to sit down and set up policies but to engage in action. One way of doing this was to relate issues about HIV/AIDS to the Scriptures.

> The church has no policy. But [AIDS] is theoretically talked about through scriptures. (KI: 9)

Reference to the Bible was made with special recognition of the values and principles laid down by key biblical figures such as Jesus. Specifically, Jesus' concern and caring for the sick were seen as keystones to how AIDS/HIV victims deserve to be treated. Actions were governed by the moral religious values of the organisations. They tended to conform to the impersonal authorities and moral abstract rules and values embedded in religious traditions. This approach undermined the need to prepare appropriate policies which might respond to concrete situations in the way demanded of them.

> We have no policy. But I would relate what we are supposed to do from the Biblical perspective. Before Jesus' time in the Jewish Tradition, it was forbidden to touch lepers. But Jesus reached out to those suffering all kinds of sicknesses. That is the platform we can assume. We cannot distance ourselves from whatever social problems people are experiencing in our society. We are intimately involved in other diseases: we make visitations, lay hands and do everything from the Biblical perspective, our mandate is Biblical. (KI: 14)

These respondents saw that the Bible not only provided the mandate for action but also for moral values. They asserted that advocating and following moral values were final solutions to the problem of HIV/AIDS.

> There is no specific policy. But the answer is the Gospel. If people believed what the Bible says in 7 years there would be no AIDS. (KI: 21)

Some respondents perceived moral values as useful to changing the behaviour of young people.

> There is no direct policy. ...The church focuses on teaching moral
> values to the youth. (KI: 20)

For some respondents reference to the biblical values was re-interpreted in terms of the general mission of religious organisations. These people assumed that by being part of a religious organisation, one has automatically been given a mission to respond to the problems of society. When social problems such as those of HIV/AIDS are encountered reference must be made to one's own mission to the society. Preparing policies is for those who have not been given a prior mission to respond to social problems.

> We have no policy – one does not need to form a church
> policy for AIDS. Everything needs to be done in the form of
> the church mission. (KI: 24)

Another group of respondents who talked about having no policies believed that the issue of HIV/AIDS is adequately being addressed by the other social organizations. These saw their role as simply a supplement to the initiatives taken by institutions such as governments and NGOs which give specific focus to the issues of HIV/AIDS. They believed that if they engaged in addressing the issue with total seriousness they might be duplicating other institutional initiatives. But these respondents also felt that their facilities could be used for conducting trainings for those who were involved.

> We have no policy. But the disease is adequately being
> addressed by other sectors of society. So there is no need to
> duplicate such initiatives. The church has facilities which can
> be used for workshops and training of any kind. So anyone is
> welcome to use those facilities, but the church itself does not
> do anything. (KI: 5)

For others the need to let other sectors handle the issues of HIV/AIDS was based on the fact that some members of religious organisations did not respect the views of their leaders. These also commented that the medical/social nature of HIV/AIDS did not correspond with the people's perceptions about the role of

religious organisations in society. They said members of religious organisations see their leaders as only responsible for spiritual issues rather than social problems such as HIV/AIDS. People are used to seeing the issue of HIV/AIDS being addressed by politicians and not by religious leaders. They said that there were people who tended to view HI/AIDS as part of the struggle against apartheid, believing that the disease was brought by whites with the intention of eliminating Africans.

> It is better when people from outside talk about it than when the ministers themselves talk about it. Politicians have always addressed the problem. The people who started talking about it were the politicians, the people who are not trusted in the society. This has made people develop a prejudice against it. That is why even if ministers are talking about it now, people do not like to listen. Some people dwell on the critical assumption that the disease was brought by the whites to the blacks in order to eliminate blacks; some say that it came from outside South Africa. So people are busy taking it as part of the struggle as they ask the question: Who brought it into the country? (KI: 9)

4.1.2. Variation in Interventions[24]

Although by and large respondents said their organisations did not have policy on HIV/AIDS they did engage in activities which were influenced by their moral values, doctrines and ideas taken from other social sectors. Respondents indicated that there were few activities taken as institutional intervention.[25] A majority of the activities were integrated into the general religious activities undertaken by the organisations.

These activities varied from one organisation to another, but what was common in the way they were explained by the respondents was that they focused on

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[24]. In general information from the respondents indicated that intervention initiatives were already complementing some of the proposals made in the policies above and other related documents.

[25]. By institutional intervention, I mean situations in which a religious organisation forms a specific intervention programme/project to intervene in HIV/AIDS issues. To qualify as an institutional intervention the programme/project must be separate from the daily spiritual activities of the organisation. (cf. Catholic Weekly, The Southern Cross, July 4 to July 10, 2001)

developing knowledge around issues about HIV/AIDS[26]. They also created groups which might be supportive to the infected and affected people and care givers. This was done by the members of the organisations.

One way in which information about AIDS was spread among local religious community members was by participating in formal training. Training in local religious communities, was not only for those who were affected, but was generally broader, treated as a way of preparing for the future. These activities were driven by the assumption that time would come when religious communities would be highly affected due to the ominous growth of the epidemic.

> We have sent four people to do some AIDS training at the [Anglican] Cathedral. They are doing home-based care training. They are given two, twelve weeks courses which started this year. This is done to make our people ready for the time when the epidemic will reach a serious level in our parish. The courses are given free of charge to Anglican members. (KI: 1)

Besides having some people formally trained, another activity is to run AIDS concern groups, also called AIDS committees. These evidently symbolised the influence of bio-medical knowledge as they sought help from individuals and non-religious organisations which dealt with public health or scientific methods of dealing with psychological problems related to HIV/AIDS, e.g. counselling.

Respondents stated that after being trained, these committees announced themselves to the local religious community or even to the larger community as people who might be called upon for help whenever need arose. Sometimes such groups embarked on training programmes for their fellow members to become volunteers for the HIV/AIDS programmes. A religious community which reached this level could also employ people who provided technical support for

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[26]. Developing knowledge around HIV/AIDS issues is sometimes done through publications of the religious organisations. Only one informant mentioned that her organisation was involved in publications related to HIV/AIDS. In general, in South Africa as a whole there are publications issued by religious organisations which include HIV/AIDS issues. The Southern Cross, a Southern Africa Catholic newspaper, occasionally publishes articles on HIV/AIDS issues. Such articles usually bring comments from religious leaders on the subject.

the operations of the trained group. This could sometimes develop into a bureaucratic HIV/AIDS programme. There would develop specialization and a division of duties, e.g. those who dealt with training, home-based care, and counselling.

A typical example of this process is what occurred at the Holy Nativity Anglican Cathedral in Pietermaritzburg[27]. Key informants from the church commented on their efforts to deal with the disease in this way:

> We formed an AIDS committee, which was trained by ATTIC. ATTIC deals with HIVS/AIDS counselling especially pre- and post- test counselling. They run their trainings free-of charge. They also do HIV testing. We then run our own training for volunteers from the church who will do AIDS counselling. For two months we gave sixteen lessons of 2.5 hours each. We taught them basics and what it means to be HIV-positive. We also do home-based care training to family members to take care of the sick people (AIDS sufferers) e.g. bathing them when they have diarrhoea. Embalehle Clinic in Edendale often calls us to do this. People also phone us to look after their sick people when they have gone to work. They say, "My daughter is dying. Come and help us!" (KIs: 15)

In some cases developments of this nature were turned into separate institutional operations. An analysis of such projects showed that they sometimes became programmes completely detached from the power of the hierarchical religious leadership, though they retained their position as part of a specific religious organisation. In other words, their religious status was maintained by any of the following aspects:

1. Some parts of their written statements, (e.g. mission statements)

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[27]. Note that when we reflected about issues addressed in the policies above we indicated that when the research was made the Anglican Diocese of Durban was in the process of creating a co-ordinated AIDS programme in the whole diocese. It would have a co-ordinator, supported by an advisory committee for the whole diocese. The programme at the Holy Nativity Cathedral should not be taken as a product of the diocesan programme as it started long before the diocesan plan was suggested. However, it is possible that when the diocesan programme was well established, the Holy Nativity Cathedral became part of it, since the diocesan programme sought to support local initiatives such as those of the Holy Nativity Cathedral.

2. Their background (e.g. if the initiative was began by a religious person or organisation)
3. Receiving sponsorship from the religious organisation from which they emerged
4. The fact that the person leading the initiative is a religious leader or
5. A combination of all or some of these aspects

Their foci in the areas of involvement might be: counselling, training, home-based care, providing information about AIDS to the public and religious communities, and looking after AIDS orphans and patients.

Because they were detached from the hierarchical religious leadership such initiatives tended to collaborate with other organisations (both religious and non-religious). Initiatives such as these were mainly started by religious leaders who were competent in the area of HIV/AIDS or experts in some religion-related fields (e.g. theology). Those were sometimes people who had retired from their main careers.

Growth of such initiatives often widened the geographical area of services for the organisation, extending from being a local initiative to an organisation which serves the whole region or province. Operations were carried out on non-profit principles, depending very much on the funds which were sought from both religious and non-religious funding agencies. Thus assuming that funds were properly used, limitation of funds could be a contributing factor to the scope of operations.

> There is a project in Pietermaritzburg, which focuses on AIDS at Kenosis. A retired professor, Gunther Wittenberg, from the university of Natal – School of Theology initiated and leads the project. The project has two houses for AIDS orphans. The project also writes newsletters, which spread information about HIV/AIDS. (KI: 17)

According to some respondents lay members of the organisations sometimes started these initiatives. Yet their skills, donors, partners and practical knowledge were drawn from social actors other than the religious organisations themselves.[28]

> In Hammarsdale there is a station – home for mothers with AIDS. There is also a pre-school for children to live in. This project is for only HIV-positive people, especially those with fully blown AIDS. The project is for the whole of KwaZulu-Natal. The home is called Lilly of the Valley Home. A family called Keyser started the project. These people came with the idea of the project and used their money to start and run it. They also get funds from overseas. They were inspired by Gospel values to demonstrate the love of Jesus. They are early pensioners. The church provides personnel for the project, but not money. The personnel are paid by the organization, Lilly of the Valley Home, they are not a group of volunteers. (KI: 16)

Some respondents said that information was also spread to the members through religious community subgroups. These groups were created with the purpose of educating people about AIDS. They used electronic media such as videos or they invited people from outside the religious communities, such as social workers and doctors, to speak to them about HIV/AIDS. In this case members were encouraged to come to one place, commonly a church building, either at regular intervals or just at any time when decision makers of the organisations decide to do so.

Sometimes those that operated on a regular basis, e.g., every weekend, took the shape of informal gatherings. There were no specific people who were selected to take part in them, except for those who might be present for technical support. Religious leaders themselves sometimes gave technical support.[29]

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[28]. See Chapter 5, section on external resources influencing the religious organisations.

[29]. For example, if they were watching a video at a church a leader of the local religious community would be available to provide videos and open doors for rooms where the videos were shown.

Invitations to the communities were made by simply encouraging those who were interested to attend the gatherings. People were also encouraged to come with friends who might not be part of the religious community. Because attendance at these gatherings was entirely voluntary, attendance could be easily avoided.

> We once started a programme in Imbali, but people did not come. In the programme we were showing videos, which explained what HIV and AIDS are and how they can be prevented. The videos were shown on Saturdays and we were inviting everyone interested to watch, not only the Catholics. (KI: 8)

Inviting experts to talk to the religious organisations was done without a specific long-term plan on how, when, and where people will be meeting to discuss or hear about AIDS. Respondents revealed that those experts were sometimes members of the religious communities themselves. These were frequently people who were also employed by secular organisations such as the sections of government's Department of Health which dealt with the problems related to HIV/AIDS.[30]

In situations where a specific religious community did not have a member proficient in the issues about HIV/AIDS, speakers were invited from elsewhere. Experts from the government's Department of Health were commonly mentioned as speakers. The people who spoke to the communities also distributed pamphlets which gave some basic knowledge about HIV/AIDS.

> There are days when AIDS is given special focus: We invite people from outside dealing with AIDS issues to talk to our congregations and issue pamphlets about AIDS to the congregation. (KI: 18)

However, respondents indicated that the issuing of condoms by outside experts was always a sensitive issue. They said that they would not allow the outsiders to come and advocate for the use of condoms, let alone allow them to issue

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[30]. This could be another factor leading to the bio-medical knowledge about AIDS among religious organisations.

packets of condoms or leave a box of condoms at the entrance of the worship building (church, temple or mosque).

> When we invite nurses to talk to the congregation we do not allow them to distribute condoms. One time nurses came to our church to talk and they distributed condoms. People did not like it. (KI: 26)

> It is very difficult to talk about condoms in the church. It is as if we are encouraging people to sleep around. (KI: 22)

Respondents indicated also that there were times that they, themselves, talked to their members. They said that they shared their knowledge with their members about HIV/AIDS. They also encouraged them to join initiatives in their communities to alleviate the problems related to HIV/AIDS. They also occasionally facilitated sessions in which HIV/AIDS issues were discussed. This was sometimes done through discussions in sub-groups within the local religious communities such as the women's organisations or the youth organisations.

> Most of our intervention so far has been in terms of education. We have information sessions – information evenings where we talk about HIV/AIDS issues through different church organisations, e.g. mothers' organisations and youth organisations. (KI: 23)

> I motivated people in my church to get involved in associations dealing with HIV/AIDS issues. (KI: 24)

Some informants indicated that religious leaders also talked to each other to share ideas about HIV/AIDS, usually in councils of religious leaders. Their discussions focused on finding out what to do and encouraging each other to talk about the problem to their followers. The intention was to strengthen confidence in each other. They also discussed means to encourage their followers to join activities related to HIV/AIDS.

> We started with ministers around Pietermaritzburg to encourage them to speak about it [HIV and AIDS] in their parishes. AIDS is among the items on the agenda for the

whole Assemblies of God Church – to talk openly about it. We
think that ministers can be trusted to do this work[31]. (KI: 22)

Whether it was experts invited from outside, experts who were part of the
religious communities, or the religious leaders themselves doing the talks or
sharing information, the question of follow-up was critical for some informants,
with several pointing out that this did not occur. These informants said that they
had not had recent meetings concerning HIV/AIDS.

> We had someone who talked about HIV and AIDS last year
> [1999] to our church members – that was one of our
> ministers. But since then there has never been any follow-up.
> (KI: 14)

Meetings among the leaders to specifically address HIV/AIDS issues were very
rare. However, HIV/AIDS issues were included in regular gatherings such as
worship services. For example, integration of HIV/AIDS issues into religious
functions was sometimes done through preaching and prayers. This did not
mean that there were special sermons devoted only to HIV/AIDS. HIV/AIDS
issues were simply included when they illustrated a subject with which the
preacher was dealing, such as promiscuity.

> Last time we had a meeting in which we talked about AIDS was in
> 1998. But now and again we share information about AIDS in the
> church, either during sermons or at the end of the service. (KI: 1)
>
> AIDS is mentioned in sermons, church prayers and general
> meetings. There is an acute awareness of the situation in the
> church. (KI: 17)

In such sermons, strong emphasis was made on changing the "irresponsible"
sexual behaviour of the members of the religious community.

> People should be educated about it. This can be done
> through platform ministry (preaching and teaching)–

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[31]. Despite this fact some respondents did not believe that religious leaders should talk about
HIV/AIDS to their local communities. These believed that HIV/AIDS issues are packed with
politics and therefore should not be handled by religious leaders. There were also respondents
who believed that talking to the members should be taken as simply an attempt to change their
sexual behaviour which poses the risk of contracting the disease.

encourage people not to have [sexual] intercourse before
marriage – we believe that abstinence is the solution. Wait
until you get the right partner. Talk about sex to the family,
especially to the children. (KI: 26)

Another area in which HIV/AIDS issues were integrated into the general practices
of the religious organisations was one of catechesis.[32] Some respondents
indicated that they included HIV/AIDS issues in their religious educations –
especially during Sunday Schools.

The problem of HIV/AIDS has been incorporated in other tasks
such as the Sunday school and youth education. (KI: 24)

Even those that did not have any intervention programme saw teaching about
sexual behaviour as important in their religious education. The background
religious theory which was found to be useful in this case was one of
conversion.[33] These respondents said that young people should be taught to
follow moral values laid down by historical religious figures such as Jesus.

However, they indicated that experience had taught them that no one could force
people to be converted. For some, in issues such as those of condom-use, the
idea of not forcing people to be converted became of primary significance. They
said that there were two different types of people: those who could easily be
converted and those who were difficult to convert. Those who could easily be
converted should be convinced to abstain from sex before and outside marriage.
Those who were difficult to convert should be encouraged to use condoms.[34]

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[32]. Catechesis refers to the department which deals with religious education. Members, especially
new ones, of the organisations are taught about the doctrines and moral values they are
supposed to follow.

[33]. In religious circles conversion means a process in which a person is turned from non-religious
behaviour to a religious one. Here one is expected to follow the religious doctrines, principles and
values taught by the particular religion.

[34]. This matter has been one of great confusion to some religious organisations. During mid-July
2001 media coverage on the Catholic Church's response to AIDS indicated that the church was
considering making condom use optional in the church. Later during the same month South Africa
newspapers and televisions reported of the Catholic Bishops criticising the government "for its
widespread and indiscriminate distribution and promotion of condoms as a means of fighting
HIV/AIDS. The bishops said they regarded condoms as an immoral and misguided weapon

Moreover, they said that AIDS is a reality which absolutely demands that people should use every means possible to protect themselves from the disease.

The informants said that religious organisations should therefore not be complacent in thinking that they can change people's dangerous sexual behaviour.

> Our intervention does not go beyond just encouraging church elders to talk about AIDS to their [religious] communities. If there were anything more to be done, it would be conversion of young people. They [young people] must accept Jesus and abstain from sex before marriage. But one must be aware that we cannot force people to be converted. AIDS is a reality. Those who cannot be converted can use condoms. No one can force them to be converted. The church is preaching everyday. But sexual sin remains a reality. There are people the church suspends all the time from the church because of this sin. Such people are the ones who do not want to be converted and one cannot say that such people could abstain from sex if the ministers asked them to do so. (KI: 12)

In some organisations, issues about HIV/AIDS are not only integrated into the religious functions but are also part of other religious social intervention activities such as poverty alleviation, spiritual counselling, and visitations to sick people in both hospitals and homes. Respondents indicated that this kind of intervention was common when they dealt with opportunistic diseases. In other words opportunistic diseases were dealt with in the way the organisations had dealt with any kind of disease in the history of their social interventions.

The primary force behind such activities was the moral concern for others. There was a religio-moral tendency to believe that people must identify themselves with the problems of others. In some cases such responsibilities resulted in the formation of sub-groups within the organisational structure. The groups were formed with a specific mission in mind and were enacted through a well-defined membership which agreed on rules of behaviour. Thus, a member was

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contributing to the breakdown of the moral fibre of the nation" (Pretoria News, Tuesday July 31 2001).

registered, required to attend meetings, to do his/her duty properly and to follow certain rules on which the group based its activities.[35]

> We have a scheme called the "League of Mercy." Both men
> and women go to hospitals to visit the sick. They go to
> anyone who is sick including people suffering from AIDS as
> long as they discover them. The procedure to be a member of
> the group is: applying for membership, getting a certificate
> (meaning that you are accepted), and going to visit the sick.
> When you come back you sign a form showing how many
> people you have visited and describe what you did for them.
> The League of Mercy was there even before AIDS. It is there
> for the sick people, the bereaved, the unemployed, and to
> help with food and whatever one can give. (KI: 26)

Apart from traditional moral concern for others there was also a clear indication that the organizations were drawn to experts specializing in home-based care and the search for remedies. Respondents said that the officials from the government such as nurses informed their interventions.

> Our members who are working in hospitals are asked to
> advise the church on things, which can boost the lives of HIV-
> positive people. The government does not supply things for
> boosting life – the church can only help up to the level of
> home-based care interventions. (KI: 22)

For some respondents the issue was not only about home-based care. Counselling and paying for medical expenses was also of primary importance when dealing with opportunistic diseases. Medical expenses could be paid for as long as that was seen as part of the traditional responsibilities of social intervention, which the specific organisation had taken upon itself. In most critical situations paying for medical expenses would be supplemented by provision of shelter, food, and counselling.

> The church can pay for medical care as part of its programme
> to take care of the poor in the parish. The church can also
> provide shelter, food, and counselling. I have already
> counselled six HIV-positive people who are members of my
> church. (KI: 5)

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[35]. These sub-groups might take an institutional form, but their operating base was within the church premises and building.

There were also individuals from the religious organisation who engaged in intervention through participating in activities which were carried out by secular organisations in local communities. These interventions were based on the individual interest to alleviate the problems related to HIV/AIDS. These might have little effect within the religious organisations themselves but they might contribute a great deal to the general society. Their knowledge about HIV/AIDS was infused with secular methods rather than religious methods of dealing with the problem. A good example was one of our respondents, a Catholic nun. She had worked with ATICC, a secular organisation which counselled people on issues of HIV/AIDS. She explained her knowledge about intervention in HIV/AIDS issues and what she did in this way:

> There is no disease called AIDS, but it comes through other sickness such as TB, diarrhoea and sores. These are treated through direct observation treatment method. When this is done for sometime without any change I advise my clients to go for HIV testing. I give counselling before and after the test. If the person is found to be positive, I give continuous counselling. In counselling I help people to make informed decisions. (KI: 3)

CHAPTER FIVE

5.1. Forces influencing religious organisations to engage in HIV/AIDS issues

For any intervention to be effective an organisation needs resources. Resources can be obtained from outside or within the organisation.

This chapter looks at the way that religious organisations have learned to make use of the external forces available in their communities. These forces include both religious and secular organisations as well as individuals who have developed strategies to respond to the issues of HIV/AIDS. They use those strategies for their own operations and also share them with other organisations and individuals.

5.1.1. External resources[36] influencing religious organisations

As seen above, perceptions and interventions about HIV/AIDS among religious organisations cannot only be attributed to religious, moral, spiritual and doctrinal values dominating their daily actions. There are also forces outside the organisations which influence these perceptions and interventions.

In general the study found that religious organisations in Greater Pietermaritzburg encountered external forces at two levels. First there is a direct encounter. In direct encounters religious organisations are influenced directly by the non-religious organisations dealing with the issues of HIV/AIDS without going through another religious organisation. This phenomenon has two dimensions. Either religious leaders themselves get involved in other social activities and

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[36]. External resources here, means non-religious and religious organisations and individuals who have advanced knowledge, strategies, activities and resources for intervention in the issues of HIV and AIDS.

through such activities they encounter issues related to HIV/AIDS. They then go back to their organisations and shared these ideas with the members of their organisations.

> I take part in hospice work in Edendale. I provide spiritual counselling. That motivated me. So I also motivated people in my church to get involved in activities dealing with HIV and AIDS. (KI: 24)

Or, direct encounters occur through the lay members of the religious organisations. These were the members who, in their daily lives, encounter HIV/AIDS through formal or informal social interactions. As a result of these interactions people shared ideas and this in turn, leads to these members mobilising their fellow members to alleviate the problem. Sometimes the people mobilising the congregations were sufferers themselves.

> Our members in the church have addressed the issues of HIV and AIDS, but so far there is nothing that has come from the top. We have had a visit about a month ago from a doctor from Edendale Hospital. He came to talk to the whole congregation. The initiative to invite the doctor was taken by our members, with the leadership of one woman, Susan Moletsane. (KI: 6)

> Our HIV/AIDS concern groups are formed by HIV-positive people, experts in the issue, non-experts – interested people who feel concerned with the problem. They run workshops to their fellow members of the congregation every Sunday. (KI: 25)

Informants mentioned the following secular sectors as having direct influence on their HIV/AIDS related activities and knowledge: ATICC; Boom Street STI Clinic; people from the local community; a traditional healer in Howick; the Department of Health; Thandanani Children's Project; Communicable Disease Unit (Edendale Hospital); University of Natal; Children in Distress (CINDI); South Africa Opportunities Industrial Centre (SA-IOC) and Edendale Government Hospital.[37]

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[37]. See appendix. For details of HIV/AIDS related activities taken by these organisations as viewed by the informants.

Secondly, there are indirect encounters. In indirect encounters there are special religious organisations which act as agents of influence to other religious organisations. Religious organisations which had developed authority in their ability to intervene in social issues were taken as role models by other religious organisations and sometimes even by secular organisations. These religious organisations were either approached by other religious organisations for advice, or took initiatives themselves to influence their counterparts who had less knowledge or interest on the issue.

Religious organisations influencing others had individuals with specialised knowledge of HIV/AIDS. They gained this knowledge either through their daily work within the organisation, through studies, or as a result of participation in activities outside their own organisations. Sometimes developing knowledge around HIV/AIDS issues was a by-product of dealing with other social problems with which they had been dealing over years. Through such activities they became trusted by both the general society and other religious organisations. Thus they developed capacity and reputation sufficient to advise or lead activities related to social needs. Respondents mentioned the following organisations which came to deal with HIV/AIDS by this route: Pietermaritzburg Agency for Christian and Social Awareness (PACSA); Youth for Christ; Anglican Cathedral; Evangelical Seminary of Southern Africa (ESSA); Gateway Project; KwaZulu-Natal Christian Council; Sinosizo Catholic Organisation; Diakonia; and Lilly of the Valley Organisation.[38]

All in all informants depended upon secular organisations and other influential religious organisations to understand issues related to HIV/AIDS and methods of intervention to deal with the problem. However, given their religious background they tended to re-interpret this information to harmonize them with the ethical paradigms which command their daily activities.

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[38]. See appendix. For details of HIV/AIDS related activities taken by these organisations as vied by the informants.

5.1.2. Availability of personnel and financial resources

Personnel and financial resources are important for the operation of any organisation. However, an organisation can only make the right decisions about these if it has a well defined strategic plan for intervention. As we have already noted, policy responses of religious organisations in Greater Pietermaritzburg ranged from being silent about HIV/AIDS to those which established specific programmes to deal with the problem, with most responding in an ad hoc or partial way. These variations are reflected in the extent to which resources (both people and funding) are allocated to HIV/AIDS in every organisation.

For those religious organizations with few members or a limited economic base there were myriad reasons that accounted for their lack of resource commitment. Generally, they lacked:
1. skills to obtain such resources;
2. knowledge of where resources might exist; and
3. understanding the relationship between resources and their chosen intervention strategies.

For the purposes here we will confine our reflection to the availability of these resources in the religious organisations in Greater Pietermaritzburg and how these relate to respondents' account of resource access.

Some respondents indicated that they have the personnel, some that they are in the process of training them, while others said that they do not have the personnel at all. Those who said they had personnel for HIV/AIDS were characterised by two features. The first is that their organizations actually had individuals who volunteered their time and knowledge to help their fellow members deal with the problem.[39] These individuals formed HIV/AIDS concern

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[39]. This refers to the individuals we have seen above as being in touch with HIV/AIDS resources outside the organisations they belong, either through direct or indirect encounters. Both the

subgroups within the organisations. They developed a plan with tasks and timetables and agreed a set of rules of practice on the basis of common interests and available resources. They shared tasks according to their skills and needs. In some instances these subgroups were functioning long before HIV/AIDS issues became a concern. They were groups which had always volunteered their time, money, and skills to support the sick within the organisations. Involvement in the HIV/AIDS issues became either a supplement to their other activities or an entirely new focus.

> We have active people who voluntarily help those suffering
> from the disease. (KI: 8)[40]

The study found that there were only a few organizations that had sufficient financial resources to employ personnel for HIV/AIDS work. Only two informants indicated that their organisations had employed professionals to help mobilize and train volunteers and community members interested in HIV/AIDS initiatives. (KI: 11 and KI: 15). One informant indicated that his organisation was in the process of hiring a professional who would manage an HIV/AIDS concern desk. (KI: 19)[41]

Generally, there were three responses to the allocation of monetary resources for HIV/AIDS intervention. Some organisations said that they had not allocated any money at all. Some said that the money was allocated for other purposes, but that it could be used for intervention in HIV/AIDS. While others said that they had not made any monetary allocation to HIV/AIDS, but they were in the process of doing so.

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previous chapter and the beginning of this chapter have indicated that when these individuals go back to their religious organisations, they mobilise their fellow members to participate in the HIV/AIDS intervention initiatives.

[40]. Cf. Chapter four on HIV/AIDS activities included in other traditional activities of religious organisations ((KI: 26)

[41]. KI: 11 represents a denominational organisation while KI: 15 and KI: 19 represent Christian non-denominational organisations. In general denominational Christian organisations tend to use the skills of their members offered voluntarily. Christian non-denominational organisations tend to operate with employed personnel – volunteers may be used only as a supplement for the employed staff.

Most of the informants said that the main reason for not budgetting for HIV/IDS was lack of money, although none reported having encouraged their members to make any contributions towards the problem. The common view was that the money which is supposed to be used for HIV/AIDS was controlled by the South African government.

> We have no money and resources. The government has the resources and money. (KI: 4)

Some felt that overseas donors would be the source for money for intervention in HIV/AIDS issues.

> Assistance may come from donors, especially overseas. (KI: 17)

Some respondents said that they were aware that there was a budget at the diocesan level which was put aside for HIV/AIDS intervention in the local communities. Some pointed out that this money was contributed by people belonging to the organisation from different local communities and sent to the diocesan office.

> There is a budget at a diocesan level for training ministers in the issues of HIV and AIDS intervention. (KI: 18)

> There is money collected for HIV and AIDS each Sunday from the parish, but it is collected in contribution to the project run at the diocesan level – the money is sent to the diocesan office in Durban. (KI: 25)

Some found making budgets unnecessary because their daily operations depended on contributions from their members who themselves were living in poverty. They held that they would mobilise their members to make HIV/AIDS intervention contributions only when the need becomes severe:

> If an occasion comes for us to help an AIDS sufferer we would announce and take an offering[42] from the people. We have no

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[42]. Some prefer to call this "church contributions".

budget – we will respond as need arises, we depend on the
assistance of poor people. (KI: 7)

Some commented that asking for contributions from poor people for such
projects would not work in any case.

We may ask members to contribute, but that may not be easy.
We tried to involve members to collect relief fund from them,
but that did not work. (KI: 22)

Informants who integrated their organization's HIV/AIDS intervention budgets into
other budgets mentioned poverty alleviation, funds for general sicknesses and
general pastoral care as areas through which funds could be drawn for HIV/AIDS
interventions.

We would depend on contributions people in our congregation
make every month for the needy. (KI: 7)

We have funds for general sicknesses. Church members
donate. This year we have 4 – 5000 Rands. We have also a
trust fund which was donated by one of our church members in
1969. We use this money in critical cases. The money could be
used in critical situations of HIV and AIDS. (KI: 13)

We have what we call "care and compassionate fund". With
that fund we help people who have a need of any sort. We
could use that in case of AIDS if there is a need. (KI: 14)

5.1.3. Expanding Intervention by Training

The study attempted to ascertain the willingness of the informants to develop
their knowledge and interventions through training. Responses were mixed.
While some saw the need for training, others felt it was unnecessary and some
were uncertain whether members would even be interested.

For those who saw the need for traininig responses varied as to who must give
the training, how it would be presented, why it is necessary to have such training,
and who would be the recipients of such training.

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In terms of who gives the course the informants mentioned two possibilities. First were the people who had already shown initiative in dealing with HIV/AIDS within the religious communities.

> Some people who are members of the church could offer a
> course of that nature. (KI: 5)

Second, the informants indicated that they would open their doors for anyone coming from outside to train them about HIV/AIDS, but that the invitation of such people would depend on the willingness of the members and other leaders of the organisation to welcome and attend the course.

> [I would welcome the training]. But there might be a need to
> consult other ministers first. (KI: 22)

The informants made two suggestions as to how they thought such training ought to be presented. First there were those who felt that the training design and presentation ought to involve concrete life testimonies and demonstrations about people living with AIDS.

> The course is necessary because AIDS is a real problem. The
> course must be well organised. For example, it must include
> someone living with AIDS to give testimonies about the way
> s/he is coping with the disease. It must include a drama which
> captures people's attention. Since people hear about AIDS
> everyday, they need something that captures their attention.
> (KI:2)

Second, there were those who commented that though the training might largely concern issues informed by disciplines such as sociology and medicine, they would have to consider the need to include religious values.

> We would like the course dealt with in the context of Religious
> Faith which integrates other disciplines such as sociology,
> ethics, and medical problems. (KIs: 4)

> We may greatly wish that whatever the course brings must not
> be out of Biblical values (KI: 19)

The insistence of including religious values was a veiled appeal by some that such training should not advocate the use of condoms.

> I would not give specific conditions for the course. But I would not be in favour of a course that come to my parish and advocate for condoms. (KI: 8)

> I would expect the course to respect the fact that we preach abstinence, not condom use. (KI:7)

As to why training was necessary, informants said that they would like to gain additional knowledge on the subject especially as some lacked confidence about their level of expertise in the field.

> There is always something we need [to know]. I need more training. If there was a chance, I could attend more courses, because experts are still researching to understand more about the disease. (KI: 3)

> Since HIV and AIDS is a new field in the society, people dealing with the problem in our localities need to learn special approaches. They need skills about the special care required. They need to learn the sensitivities about the disease. (KI: 10)

> The course is necessary since it may bring something that we do not know. (KI: 11)

> The course can be necessary to tap the knowledge about HIV and AIDS which the members of the church have. (KI:24)

Some commented that the course is necessary because "the initiatives that the church has carried out so far are not enough". (KI:20) While others remarked that the training would be useful as a preparation for the future-increasing incidence of the disease within religious communities.

> I realise that the course would be helpful for the future due to rumours [about the expansion of AIDS] I hear. I would accept the course on the basis of preparing for the future when the problem becomes worse than it is now. (KI: 7)

Lastly, the general response to who should be given training was that such courses should be offered to anyone. Some qualified their viewpoint by saying that it would depend on the type of course: some courses might be necessary only for religious leaders; some for only women, while other trainings would be offered to the organization's whole congregation.

> The course would be offered to the [church] elders. But
> depending on the type of the course, one would also include
> other [subgroups of the organisation], e.g. the youth, women,
> and so on. (KI: 12)

> The course would be given to the whole church: members,
> leaders and administrative staff (KI: 6)

Informants who thought there was no need for training, gave essentially two
reasons. One was a claim that people are not interested in HIV/AIDS because
they are scared to be involved in HIV/AIDS initiatives.

> No. I would not welcome any course at this stage. The
> manpower is not forthcoming. People are scared to get
> involved. (KI: 14)

The other was a claim that people were fatigued by HIV/AIDS. They were tired of
hearing about it daily and that they would only be interested if they felt that they
would learn something new.

> People seem to be fed-up with AIDS issues. It is difficult to
> know what is lacking. It is difficult to know what they do not
> know. The training should bring something new about the
> disease. (KI:18)

5.1.4. Issues to be address in training

As we have seen above, religious organisations in Greater Pietermaritzburg had
not been completely quiet about HIV/AIDS, and there was already a knowledge
base on the subject.

The response to the issues they would want addressed through training varied.
First there were those whose main concern was about the future of the disease.
These saw that any training at the current stage should bring projections about
the progress of the disease and how it will affect their religious mission in future.

> The training should bring information about progress of the
> problem and the attitudes it will bring to people as they interact
> with each other in society. (KI:1)

> We would like a training which shows how AIDS will affect the
> church's mission in future (KI: 6)

There were also those who saw issues of HIV/AIDS as related to its impact on the future economic needs of families and the society as a whole. These commented that any training given at this stage should not undermine this fact.

> The training should address the question of the impact of the
> disease on the future economic situations to the families and
> society as whole. (KI: 13)

Others were particularly concerned about the future burdens to the society of caring for AIDS orphans.

> Any course coming at this stage should tell us what we should
> do to help the orphans left everyday by their parents dying of
> AIDS. (KI: 23)

Second, there were those whose main concern was about the need to clarify current confusions about HIV/AIDS. These informants commented that any course given to their communities should attempt to clarify the misconceptions which result in the stigma, prejudices against those infected and affected, and lack of participation in attempts to alleviate the problem. Such clarification should include means to provide care to those affected and infected.

> The course would have to give real facts about HIV and AIDS
> to overcome misconceptions about it. [For example], the course
> would have to emphasise that AIDS is not a problem of black
> people alone. It would have also to include persuasion of
> people to participate physically and not only to send money for
> assistance in programmes concerning the problem. (KI: 5)

For some overcoming misconceptions about HIV/AIDS is also important to help society overcome prejudices against the infected and affected people – "acceptance of HIV-positive people, not condemning them" (KI: 7, KI: 9 and KI:13)

Several emphasised the value of training to facilitate religious leaders to start talking about HIV/AIDS to their members.

> The training must show how to make people to open up – to
> stop shyness. People need to accept that AIDS is just one of
> the sicknesses; there is no need to be shy about it. (KI: 12)

> It should facilitate church people to speak out about the disease
> and their needs to alleviate the situation. (KI: 9)

The informants also indicated that there are a lot of misconceptions concerning the medical aspect of the disease. Thus any training offered to religious organisations should attempt to dispel misconceptions related to the medical aspects of HIV/AIDS. (KI: 13) The training touching medical aspects "should also indicate the primary targets of the disease"[43]. (KI: 9)

Third, there was the view that any training offered to congregations should touch the moral aspects related HIV/AIDS. These saw morality related to HIV/AIDS as embedded in sexual behaviour and relationships of young people and how men treat women in their social interactions.

> The training must touch on the issue of sexual relationships.
> (KI: 8)

> [The training] should encourage young people to follow the
> advices they are given and that should not give up. (KI: 9)

> The course must teach strategies of men talking to men about
> how they must treat women – there must be a facilitation of
> workshops of men challenging other men. (KI: 20)

The informants also saw the moral values in terms of spiritual needs.
> The course may look at the social aspects and include the
> spiritual aspect of the problem too. (KI: 24)

Some informants warned against advocacy for condoms in any training.

> The question of condoms may have to be touched carefully.
> Condoms should not be taken as a solution to the problem, but
> a mechanism that creates more problems – they open a door
> for young people to do sex anytime. One must be aware that
> sex is beautiful, but for married people only. Condoms are only
> to be used as the last resort theory e.g. if a married person
> does not trust her partner. When teaching, AIDS should not be
> taken as a point of departure. Start with the person – change

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[43]. That is, social groups which are regularly infected by the disease.

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his/her behaviour and then let him/her know the pros and cons of AIDS and allow them to ask themselves what they can do. (KI: 25)

Fourth, there are those who felt that if some training comes to their religious communities, it should address issues about prevention. These saw hygiene and understanding how the disease is spread as crucial factors to prevention of the disease.

We need to learn hygienic factors – how to touch people who are injured as a way of preventing ourselves from contacting it when caring for them. (KI: 8, KI: 19, KI: 22)

The training should include details about how the disease is spread e.g. that it is not only spread by sexual intercourse. (KI: 9)

Fifth, it was felt that any course given to them must address the question of caring for infected and affected people. Some of them mentioned empathy for infected and affected people as one of the things that should be addressed.

The course must tell us about Empathy – to feel with people who are suffering from AIDS. (KI: 8)

Others saw that the question of care as being related to opportunistic diseases, especially where home-based care is given primary consideration.

I would want a course that talks about provision of home-based care -especially for opportunistic diseases. (KI: 23)

Lastly there those who were undecided about what they would benefit from such training. Comments ranged from saying that it should be up to the experts to decide what to teach, to those who believed that there is almost nothing that is not known about HIV/AIDS.

We would leave it to the doctors to decide. It was going to be more helpful if we had 3 – 4 doctors who could help in the matter. (KIs: 4)

I am not sure what remains to be known about HIV/AIDS. (KI: 18)

CHAPTER SIX

Concluding Remarks

This study points to some important findings about faith based organisational responses to HIV/AIDS in the province where the epidemic is at its most extreme. Generally, while religious organisations have responded to and have changed in response to the pandemic, these changes are very variable, often ad hoc and haphazard. It is clear that there is a great need to restructure social interventions among the religious organisations in Greater Pietermaritzburg.

In general, some organisations integrate HIV/AIDS into their already existing intervention mechanisms. Others opt to start new programmes altogether, while others have still to begin to deal with the issue in any coherent and systematic way.

But the study has also helped us to understand these variations in considerable depth. For example, those integrating interventions into more traditional activities take different approaches. Some integrate HIV/AIDS issues into other social intervention such as a general ministry to the sick. Some integrate their interventions into their religious educations. And for others HIV/AIDS is only found in core spiritual activities such as prayers and sermons.

Those who opted to engage in separate interventions that are designed specifically for HIV/AIDS also generate variations on the theme. Some chose to remain attached to the religious organisations from which they emerge, while others operate as separate entities with considerable autonomy from their original religious organisations.

Variations are also evident in terms of the policies that inform the interventions. Some have no policies at all. Others develop policies in the local communities of the organisations, while others have officials generate policies in the organisations' head offices. Some policies are distributed to different branches of the organisations concerned, while others are not. Some policies are in written form while the leaders and members of the organisations verbally share others in meetings. Some propose to use expertise from medical professionals outside and inside the organisations, while others simply talk about encouraging the general membership of the organisations to be involved in the initiatives about HIV/AIDS.

One factor which is obvious is that these policies and interventions have their own roots –they are driven by forces influencing the organisations to engage in the interventions at different levels. We have seen that faith based organisations utilize both internal and external resources to engage in the interventions. For example, we have seen in chapter four that some interventions were initiated and implemented by individuals and groups that had been involved in other social issues either within or outside the organisations. The absence of such individuals and groups sometimes prevented the interventions from taking place. One of the study's key informants said:

> There is no programme in place. When I encouraged the people to attend the course at the Evangelical Seminary of Southern Africa (ESSA) there was no response. I tried to approach individuals, but this did not work either. This is happening because the church has not been involved in social intervention affairs all along – so it is difficult for the people to suddenly start. (KI: 2)

Despite these variations what the organisations share is the tendency to reinterpret what they draw from the internal and external forces in terms of their religious moral and traditional values. At this level there is a powerful focus on issues related to people's sexual behaviour. Condemnation of promiscuity is paradoxically countered by values of forgiveness and compassion.

Hence, intervention in HIV/AIDS issues is not seen as a contradiction to condemning people who are infected because of their sexual misconduct. Rather it is a way of joining God's forgiveness and compassion for sinners. Practically this means joining the redemptive service of God for the physical nature of human beings. The power dynamics in this set up can be seen in terms of the descending order of God, His moral commands and the implementation of those moral commands orchestrated by the concerned members[44] of the organisations and their leaders.[45]

As long as the study reveals that individual members have made significant inputs and played innovative roles in the HIV/AIDS activities, we can confirm Dunkerley's contention in Sociological Systems Analysis. Individuals stamp organisations with their own characters. This view is also confirmed by the fact that we found cases in which religious leaders claimed to have tried to encourage their members to engage in HIV/AIDS intervention activities, but had received a negative response from them. Individuals' interests may not correspond with those of the organisation and/or of their leaders. Individuals may challenge the demands of the organisation.[46] (1972: 33-41)

Difference in the readiness to intervene in HIV/AIDS issues also demonstrates that religious organisations are entities that cannot avoid social conflict. HIV/AIDS has sometimes become a milieu through which social conflict in religious organisations manifests. Thus issues of whether to intervene or not,

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[44]. These members join their views with other members and form concern groups. Thus Barnard (in Dunkerley: 1972) adds that an organisation is a system of consciously co-ordinated activities.

[45]. In reference to Weber's view of domination through authority, God's authority and moral authority could be defined as traditional while the authority of concerned members can be rated as charismatic. Religious leaders' authority could be seen as legal rational. However, the study reveals that the control exercised by religious leaders over HIV/AIDS issues has been minimal except in organisations which were just in the process of establishing their policies and intervention projects. Religious leaders' control is mostly dependent upon the good will of the members of the organisations. (cf. Chapter 1)

[46]. Cf Chapter 1

what kind of intervention to embark upon, who should be involved in the interventions, and so on are always accompanied by conflicting views.[47]

At this level three conclusions can be established. First, the interventions differ because of the differences in the forces that influence them and because of differences in the way they respond to the forces. Differences based on the forces external and internal to the organisations depend on the nature of the forces themselves. Differences based on the way the organisations respond can be attributed to the nature of the traditions and social composition of the organisations.

Second, social interactions between and beyond faith-based organisations are crucial for interventions. This means that an interest in engaging in HIV and AIDS interventions must be coupled with a willingness to interact with other social role players.[48]

Third, the study indicates that in most organisations there are always individuals who can force certain courses of action. Organisations must learn to tap the skills of their own members when faced with the need to intervene in issues challenging their environment.[49]

Fourth, lack of financial resources is not reason enough to explain why interventions have not been developed. But there is also an indication that

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[47]. According to Cyert, (in Dunkerley 1972) in every organisation there is a potential internal conflict between diverse individuals and groups. (33-41) (Cf. Chapter 1)

[48]. Note that this point corresponds with what Dunkerley says in chapter 1. Dunkerley says that empirical studies have shown that organisations tend to respond to forces imposed on them by the outside world such as other organisations and technology.

[49]. Here the study touches on perspectives from social psychological theory. As we have seen in Chapter One, according to Dunkerley Simon (1957), Barnard (1938), Cyert and March (1963) are authors of social psychological theory. The theory says that the individual foresees the consequences of a variety of options open to him/her and makes preferences in seeking the best possible utility.

organisations have always managed to use the human resources they have with very little or without any money at all. This is probably an indication that organisations which do not have money to support their intervention can always find alternative ways of being involved in alleviating the problem. They have to approach HIV/AIDS like any other intervention activity – to budget and plan for it. They also have to become more familiar with the resource environment as there are organisations that have the potential to render substantial support to their initiatives. Equally, it has to be recognised that with such support, they may be well placed to deliver much needed support and care to people in need.

Above all, the study reveals that our beliefs about how religious organisations can respond to issues such as those of HIV/AIDS must be accompanied by a closer understanding of how the organisations operate, how they are confronted by external forces, and the dynamics of the individuals and groups which form their daily meaning and existence.

In Chapter one we also proposed that the study would attempt to investigate the potential for sustainability of the interventions taken by the organisations in question. We have discovered that there are interventions taken by the organisations at different levels. But common to the interventions is the fact they are ethically based on religious interpretations of HIV/AIDS.

This reveals that the organisations have managed to integrate the interventions to their traditional lifestyles. They see the interventions as a continuation of how they have been engaged in alleviating the social problems that threaten their communities.

Theories about sustainability often propose empowerment through participation of the people on the ground in issues that concern them. In general this assumes that the beneficiaries of the intervention must also take initiatives. We have learnt

that there are interventions that are initiated by the members of the organisations themselves both the HIV/AIDS affected/infected and uninfected/affected.

We therefore could conclude that these interventions have the potential for sustainability, as they automatically involve the people in the organisations and integrate the traditional operations and lifestyles of the organisations.

Comments from some informants also showed that the organisations had ideas about what they might do in future when the pandemic becomes worse.

> The church may work with medical professionals – looking at the need by hearing what the professionals say. Counselling may also be used - one may deal with the question of supporting the families dealing with questions of how the disease was contracted. (KI: 17)

> Our intervention will include provision of sacraments (holy communion), encouragement of family responsibility and seeing the sufferers as part of the church community. In other illnesses we do the same e.g. alcoholism and mental illness. AIDS will be taken as one disease among other diseases. If a person working with us happens to take an early retirement due to AIDS sickness, s/he will be given his/her package as it is the case with all other people who take early retirement. (KIs: 15)

But, others showed that they were not sure about what their future position might take if the pandemic becomes worse. For examples some informants had this to say:

> I have never thought about the question before. There is no policy on what will happen or what to do in such a situation. But I still feel that there will be a need to support such people – offering general support that all people are given when they are sick. (KI: 10)

> The fact that people do not want to talk about it makes it difficult for ministers to know what to do if most members happened to suffer from the disease. (KI: 12)

Thus the study established that there are religious organisations with ideas about what they might do about the pandemic in the future. But there are also those who are not sure about what they might do in the future.

Whether an organisation has ideas about what they will do in the future or not the growth of the HIV/AIDS epidemic is progressing daily. It is highly unlikely that the efforts made by faith-based organisations will halt the epidemic or sufficiently relieve its impacts. This issue is critical, especially considering the fact that most of the interventions taken by the organisations are not largely guided by strategic and policy framework which means that ideas about what the organisations might do in the future were poorly thought through.

More often than not, they have nothing written that can act as a guide for future changes in the intervention and a guide to monitor current activities and whether they are following changes in the pandemic. Where written policies and plans of action are found, they are in their infancy. Hence, from the perspective of strategic planning, at the time of the study it was difficult to predict the potential for future sustainability of the activities taken by the organisations. This brings us to an overall finale that the study was not able to establish enough evidence to make a substantial conclusion about the future sustainability of the interventions.

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Appendix

External organisations mentioned by informants as influencing their HIV/AIDS activities

INFORMANT	INFLUENCING INDIVIDUAL OR ORGANISATION	RELIGIOUS STATUS OF ORGANISATION OR INDIVIDUAL	WHAT THE ORGANISATION OR INDIVIDUAL DOES ON HIV/AIDS
KI: 1	Pietermaritzburg Agency for Christian and Social Awareness (PACSA)	Non-denominational[50] Christian NGO	Publishes and issues pamphlets which include issues related to HIV and AIDS
	ATTIC	Secular NGO	Pre-test and post-test counselling and involved in general AIDS awareness campaigns
	Youth for Christ	Non-denominational Christian organisation	Has no specific programme on HIV and AIDS, but plans to do so soon. They provide shelter and education to the youth.
	Anglican Cathedral	Denominational[51] Religious organisation	They have HIV/AIDS counselling and Home-based care services
KI: 2	Evangelical Seminary of Southern Africa (ESSA)	Ecumenical[52] organisation	They offer their students and Church ministers courses on HIV and AIDS
	Pietermaritzburg Agency for Christian and Social Awareness (PACSA)	Non-denominational Christian NGO	Publishes and issues pamphlets which include issues related to HIV and AIDS
KI: 3	Gateway Project	Non-denominational Christian local NGO	They distribute parcels to the needy which include blankets. They could sometimes be used for home-based care

[50]. This means that the organisation's operations may be based on general Christian principles and values, not doctrinal beliefs and values of a specific religious organisation/denomination.

[51]. Denominational organisations are those bound to be attached to a specific denomination. Its operations may be based on the doctrinal values and beliefs of that denomination.

[52]. Ecumenical organisations are those that are formed by a formal coalition of different denominations.

	Boom Street Clinic	Government facility	The informant used to provide counselling service at the clinic
	People from the local community	Concerned individuals	Help to organise workshops
	A traditional healer in Howick	Traditional healer with special concern in HIV/AIDS issues	Collaborated with the informant to teach his nurses about HIV and AIDS
KI: 4	The Department of health	Governmental organisation	Could called upon for any HIV and AIDS service need at any time and distribute AIDS awareness pamphlets
KI: 5	Evangelical Seminary of Southern Africa (ESSA)	Ecumenical organisation	They offer their students and Church ministers courses on HIV and AIDS
KI: 6	ATTIC	Secular NGO	Pre-test and post-test counselling and involved in general AIDS awareness campaigns
	Thandanani	Secular	Involved in child development projects – especially for orphans
	Communicable Disease Unit (Edendale Hospital)	Governmental organisation	
	University of Natal	Educational secular organisation	Has academic courses and projects which are helpful to the communities to deal with HIV and AIDS problems
KI: 7	Gateway Project	Non-denominational	They distribute parcels to

		Christian local NGO	the needy which include blankets. They could sometimes be used for home-based care
KI: 8	The Department of health	Governmental organisation	Could called upon for any HIV and AIDS service need at any time and distribute AIDS awareness pamphlets
KI: 10	ATTIC	Secular NGO	Pre-test and post-test counselling and involved in general AIDS awareness campaigns
	Children in Distress (CINDI)	Local Community based network of NGOs, groups and individuals interested in the issues of HIV and AIDS	Through sharing of ideas and resources find means of providing care to the infected and affected peoples
	South Africa Opportunities Industrial Centre (SA-IOC)	Non-denominational Christian local NGO	Plans to engage in HIV/AIDS awareness campaigns
	Thandanani	Secular NGO	Involved in child development projects (e.g. providing crèche service) – especially to the orphans
	Red Cross	International NGO	Could help on temporary basis during the time of crisis

KI: 11	Youth for Christ	Non-denominational Christian organisation	Has no specific programme on HIV and AIDS, but plans to do so soon. They provide shelter and education to the youth.
	Rape Crisis	Local secular NGO	Offers short term shelter for abused women
	Midlands Women's Group	Regional Women's Group	————————
KI: 12	Hospices	Secular voluntary organisations	Committed to providing care to the chronically ill people at home and in care centres
	Evangelical Seminar of Southern Africa	Ecumenical organisation	They offer their students and Church ministers courses on HIV and AIDS
KI: 13	Youth for Christ	Non-denominational Christian organisation	Has no specific programme on HIV and AIDS, but plans to do so soon. They provide shelter and education to the youth.
KI: 14	Hospices	Secular voluntary organisations	Committed to providing care to the chronically ill people at home and in care centres
KI: 16	Lilly of the Valley	Non-denominational Christian organisation	Care centre for AIDS orphans and sufferers
KI: 17	KwaZulu-Natal Christian Council	Ecumenical Provincial Christian organisation	In the process of starting a province-wide HIV/AIDS programme
KI: 18	Edendale Government Hospital	Government organisation	Involved in awareness campaign
KI: 19	KwaZulu-Natal Christian Council	Ecumenical Provincial Christian organisation	In the process of starting a province-wide HIV/AIDS programme
KI: 20	Department of Health	Governmental organisation	Could called upon for any

			HIV and AIDS service need at any time and distribute AIDS awareness pamphlets
KI: 21	Department of Health	Governmental organisation	Could called upon for any HIV and AIDS service need at any time and distribute AIDS awareness pamphlets
KI: 22	Department of Health	Governmental organisation	Could called upon for any HIV and AIDS service need at any time and distribute AIDS awareness pamphlets
	ATTIC	Secular NGO	Pre-test and post-test counselling and involved in general AIDS awareness campaigns
KI: 23	Department of Health	Governmental Organisation	Could called upon for any HIV and AIDS service need at any time and distribute AIDS awareness pamphlets
	Sinosizo Catholic Organisation	Denominational Religious organisation	Runs HIV and AIDS home-based programme
	Diakonia	Ecumenical NGO	Has HIV and AIDS programmes and church leaders involved learn from those programmes
KI: 24	Hospices	Secular voluntary organisations	Committed to providing care to the chronically ill people at home and in care centres
	People living with AIDS	Community individuals	Give workshops to church members
KI: 25	Pietermaritzburg Agency for Christian and Social Awareness (PACSA)	Non-denominational Christian NGO	Publishes and issues pamphlets which include issues related to HIV and AIDS

	KwaZulu-Natal Christian Council	Ecumenical Provincial Christian organisation	In the process of starting a province-wide HIV/AIDS programme
	Hospices	Secular voluntary organisations	Committed to providing care to the chronically ill people at home and in care centres
KI: 26	Children in Distress (CINDI)	Local Community based network of NGOs, groups and individuals interested in the issues of HIV and AIDS	Through sharing of ideas and resources find means of providing care to the infected and affected peoples
KI: 27	Secular NGO	Involved in child development projects (e.g. providing crèche service) – especially to the orphans	