THE ROLE OF THE ANGLICAN CHURCH IN THE PREVENTION OF THE SPREAD OF HIV AND AIDS IN THE LIMPOPO PROVINCE

by

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DECLARATION

I declare that ***THE ROLE OF THE ANGLICAN CHURCH IN THE PREVENTION OF THE SPREAD OF HIV AND AIDS IN THE LIMPOPO PROVINCE*** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

ROSA ISEGBUYOTA USEH (MRS) **JUNE 2006**

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Abstract

This study examined the role of the Anglican Church in the prevention of the spread of HIV and AIDS in the Limpopo Province, South Africa, using a random sample of 51 members of the Zoutpansberg parish.

The study found that the Church currently contributes to the prevention of the spread of HIV among its congregation through HIV-related activities to reduce stigma, prejudice and discrimination against people living with HIV and AIDS (PLWHA). At the same time, however, much still needs to be done in the areas of cultural perception, sexual practices, and myths surrounding HIV and AIDS. Most of the respondents indicated that they would like to see the Church play an active role in voluntary counselling and testing (VCT), marital counselling, and encouraging openness with regard to HIV and AIDS.

It is recommended that the Church should extend its activities to include members of the community outside the congregation in the prevention of the spread of HIV and AIDS.

KEY CONCEPTS

Anglican Church; prevention of HIV and AIDS; role of the church; World Council of Churches

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LIST OF ABBREVIATION

AACC = All African Council of Churches
ACSA = Anglican Church of Southern Africa
AIDS = Acquired Immune-Deficiency Syndrome
ARC = AIDS related complex
AZT = Azidothymidine
CBOs = Community-based organisations
CC = Christian Church
CNS = Central nervous system
CPSA = Church of the Province of Southern Africa
DNA = Deoxyribonucleic acid
FGC = Female genital cutting
GPA = Global programme on AIDS
HIV = Human Immuno-Deficiency Virus
IEC = Independent electoral committee
IVDU = Intravenous drug use
MTCT = Mother-to-child transmission
NGOs = Non-Governmental organisations
PCP = Pneumocystis carinii pneumonia
PLWHIV/AIDS = People living with HIV/AIDS
RNA = Ribonucleic acid
SADC = Southern African Development community
SCT = Social cognitive theory
SPSS = Statistical package for social sciences
STDs = Sexually transmitted diseases
TB = Tuberculosis
TRA = Theory of reason action
TV = Television

UN = United Nations
USA = United States of America
WCC = World Council of Churches
WHO = World Health Organisation
ZDV = Zidovudine

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CHAPTER 1

Orientation

1.1 INTRODUCTION

HIV and AIDS have left a trail of destruction and affect all alike, knowing no boundaries. The virus does not discriminate between sex, race or creed, and has spread rapidly to every part of the globe (UNAID 2002:8). Globally, the epidemic is in the wider population, driven mainly by heterosexual intercourse and greatly associated with poverty, but it is also found among the rich in society (UNAID 2002:35-36). In Southern Africa, the HIV and AIDS epidemic has caused illness and death to millions, had a devastating social and economic impact, reduced productivity capacity in both private and public sectors, and derailed achievements in child survival and health (Zawaira 1999:25).

South Africa is one of the countries worst hit by the HIV and AIDS epidemic for reasons that are not clear. Some attribute it to the social devastation caused by migrant labour and the apartheid laws, which prevented families from settling as families near their places of work, and employment as well as engagement in mining, military or agriculture were often accompanied by prolonged spousal separation, thereby contributing to the spread of HIV (Zawaira 1999:26; Saayman & Kriel 1991:161). Gennrich (2004:7) blames secrecy, prejudice, ignorance, fear, denial, poverty, violence and abuse, particularly of children and women, as well as medical reasons because

“symptoms do not show for a few years, so people often do not know they are infected and therefore continue to spread it”.

The HIV/AIDS epidemic has provoked responses from national governments, United Nation (UN) bodies and non-governmental organisations (NGOs), including churches. Churches responded by joining hands with the worldwide efforts to provide care and support, reduce vulnerability to HIV and alleviate the impact of the epidemic through the implementation of the World Council of Churches (WCC) plan of action (Gennrich 2004:2).

In Africa, churches responded quickly to the HIV epidemic, leading the way in providing care to the sick and dying. They used their resources as well as their extensive and well-established networks, and mobilised communities to provide spiritual and practical support on a massive scale. In Uganda, the Order of St. Luke was created to help with the AIDS epidemic. The organisation trained community members, traditional healers and tribal leaders to render care and support to HIV and AIDS patients in the community. It also trained them to provide pastoral care and develop a loving and non-judgmental attitude towards people living with HIV and AIDS (Snidle 1997:7; Garvey 2003:1).

In Southern Africa, the Church of the Province of Southern Africa (CPSA) developed a vision in their fight against HIV and AIDS, “*A generation without AIDS*”. The Anglican Archbishop of Cape Town, Njongonkulu Ndungane, gave this initiative the support it needed to get off the ground (CPSA 2002:28).

The Zoutpansberg Parish in the Limpopo Province established an HIV and AIDS parish task team, developed an HIV and AIDS plan, involved the Parish Council and received resources from the diocese. The leadership of the parish and interested members attend series of workshops on HIV and AIDS awareness, counselling, care of orphans and vulnerable children and wellness management organised by the Diocese. The purpose of this is to equip them with knowledge and skills on HIV and AIDS-related issues for the purpose of training others through workshops and personally being equipped with skills to minister to others both in the Church and the community infected with the HI virus thereby preventing the spread of HIV (Diocesan HIV/AIDS response .2002). The youth group adopted the policy of "*No sex before marriage*" and promotes faithfulness in marriage when they launched the parish's "Virgin Power, Virgin Pride" project (see appendix 7 for parish report and communiqué 2004).

With regard to African-American mothers, Morse, Morse, Klebba, Stock, Forehand and Panayotova (2000:261-276) found that the Church with its established network of churches and church organisations is ideally situated to make an impact both on the care of people who are HIV positive and in the prevention of the spread of the virus. The Church is the only institution that has the ability to mobilise the masses and disseminate information effectively because it still enjoys the respect and support of the people. Seele (1995:550) holds that the social mobilisation of the churches must be deeply rooted at the grassroots community level, taking advantage of the local churches, women's

and youth groups, as well as local chiefs, traditional healers, village health workers and other local groups where they exist.

According to Snidle and Yeoman (1997:7), equipping church members with basic knowledge about the HI virus and home care skills would assist in reducing stigmatisation, victimisation and discrimination suffered by people living with HIV and AIDS. It would also encourage safe sexual practices and assist in the prevention of transmission of this virus. Such grassroots community efforts would need to be co-ordinated and integrated into the existing health development packages and other bodies working in this field.

Despite church leaders' commitment to play an active role and the potential role of the Church in the prevention of the spread of HIV and AIDS, Garvey (2003:6) maintains that churches are less involved in HIV prevention, even though prevention can potentially save lives and prevent suffering. In addition, the researcher found little if any documentation regarding the role played by the Anglican Church at the grass-roots level to prevent the spread of HIV and AIDS. Therefore, this study wished to describe the extent to which the Anglican Church is involved in the prevention of the spread of HIV and AIDS in the Limpopo Province, more specifically in the Zoutpansberg parish, and explore the future role of the Church in the prevention of the spread of HIV and AIDS as perceived by church members.

1.2 BACKGROUND

Limpopo Province has a population of about five million people with 89% living in rural areas. It is the largest rural province nationally with the unemployment rate estimated at 46%. About 33% of those working earn less than R1000,00 per month (Diocesan response to HIV/AIDS 2002: 3). The Zoutpansberg parish is a cluster of chapels within the Zoutpansberg Mountain area of the Limpopo Province. It consists of St Mark's Anglican Church in Makhado (formerly Louis Trichardt), St Augustine's in Magau, Simon of Cyrene in Vleifontein, Peter Masiza in Waterval settlement and St John's Anglican Church in Musina (a sub-urban area) on the border of South Africa and Zimbabwe. The Zoutpansberg Parish has a membership of eighty-one (81) families on the Church roll and about one hundred and forty (140) worshippers, excluding children. The parish organises a number of HIV and AIDS-related activities, such as HIV and AIDS awareness, wellness management, and Youth and Sexuality programmes, weekly prayer for people living with HIV and AIDS, lighting of AIDS candles and care of AIDS orphans.

HIV/AIDS remains a major health problem, as the number of individuals suffering from the disease across the globe has increased since the early 1980s when the disease was first identified. At the end of 2002, 42 million people around the world were living with HIV and AIDS, with 5 million new HIV infections in 2002 alone (UNAIDS/WHO 2002:5). About 70% of the global HIV and AIDS-infected population can be found in sub-Saharan Africa. More than one-tenth of the adult population aged 15 to 49 years in sixteen countries is

infected with HIV; at least one adult in five is living with the virus in seven countries of the southern cone of the continent (UNAIDS 2002:23). In South Africa, about one in nine South Africans (or five million people) is living with HIV and AIDS. Between 1 500 and 2 000 new infections occur in South Africa every day.

In many large towns in Central, East and Southern Africa, the HIV prevalence rate among pregnant women currently exceeds 30%. About 8 000 babies are born to infected mothers every month. If nothing changes between now and 2010 in South Africa, it is estimated that 50% of all children now 15 years old will not live to see their twenty-fifth birthday. In 2002 approximately 150 000 children lost their mothers through AIDS. The number of deaths as a result of AIDS is expected to rise rapidly to reach up to 600 000 by 2010. Already one third of all adult deaths can be attributed to AIDS-related conditions. More than 600 people die from HIV and AIDS-related conditions every day (Gennrich 2004: 6).

The Minister of Health, Dr Manto Tshabalala-Msimang, emphasised the seriousness of the spread of HIV and Aids referring to it as “the biggest social and health care issue of our time” (Tulleken 2003:9). According to UNAIDS (2002:23), at the end of 2001, fewer than 30 000 people in Africa benefited from anti-retroviral drugs. The number of beds in health care institutions in most African countries cannot cope with the rate of admission. A shortage of beds means that people tend to be admitted only at the later stages of illness thus reducing their chances of recovery. The number of children orphaned by

AIDS in Africa will continue to grow, creating serious socio-economic challenges. Even with immediate exceptionally effective prevention, treatment and care programmes, the scale of the crisis means that the human and socio-economic toll will remain significant for many generations (UNAIDS 2002:23; Aventin & Huard 1999:350; Barnett, Whiteside & Desmond 2001:158). Young people are becoming more and more vulnerable to HIV and AIDS, with over 6 000 becoming infected every day (UNAIDS 2002:70). Finger (2002:224) found that the age of first sexual activity is dropping in many countries while the age of marriage is rising. Thus, there are more possible years of sexual activity with multiple partners. These figures indicate that young people are particularly vulnerable to HIV. Because of their vulnerability there is an urgent need to educate the youth in every society, particularly in the church, about sex and HIV. However, dealing with such issues is not easy. Garvey (2003:6) states that the churches experience difficulties in dealing with issues of sex and sexuality and this has weakened their response to the prevention of HIV. Furthermore, there is a reluctance to speak openly and frankly about HIV and sex, particularly among young people, fearing that this may lead to promiscuity. On the contrary, good quality sexual health and HIV education can lead to safer sexual practices amongst young people, lower rates of HIV and other sexually transmitted diseases, reduced teenage pregnancies, and more positive attitudes towards people living with HIV and AIDS. At a time when HIV is leading to 8 000 deaths every day, such reluctance has led to criticism of the churches, a criticism which many churches now accept as valid (Garvey 2003:3). This raises the question of when the appropriate time to give sex education to young people is. Many

advocate giving sex education before puberty, as many children start experimenting with sex earlier than their parents or teachers realise (Snidle & Yeoman1997:122). Garvey (2003:7) maintains that it is easier to influence young people's behaviour before behaviour patterns are established or they become sexually active. Sexual health and HIV education does not have a fixed syllabus, and the content as well as the quality of delivery vary according to cultural, social and economic context.

Research and evaluation has generally been conducted with projects that provide full, frank and supportive sex and HIV education, promoting a full range of safe sex strategies such as abstinence, faithfulness and safer sex practices, including condom use and fostering the development of relevant life skills, such as communication and negotiation (Garvey 2003:7). HIV education aims to be gender sensitive, to begin before young people are sexually active and to be sustained over a period of time. Participatory learning, helping young people to make their own decisions, is more effective than lectures. Small, confidential group decisions help people to explore their own feelings and values. Games, role-play, puppets, songs and drama can be very effective. Adolescents are more likely to relate to other young people than to authoritative figures (Snidle & Yeoman1997:122).

While sexual behaviour is the most important factor influencing the spread of HIV in Africa, behaviour also varies greatly across cultures, age groups, socio-economic class and gender (UNAIDS 2002: 25). According to Saayman and Kriel (1991:162), sexuality in humans originates mainly "in the mind" and

its expression and control are therefore completely dependent on psychological and socio-cultural mechanisms. In most traditional African cultures sexuality was both openly recognised and strictly controlled. This cultural control has been devastated by colonial rule and post-independent political and economic instability. Saayman and Kriel (1991:163) argue that many campaign strategies against HIV and AIDS focus on the issues of sexuality and the spread of HIV and AIDS, but unless the idolatrous view of sex and sexuality becomes the focus of the campaign against AIDS, the chances of success are slim. This does not mean that medical science should stop searching for a cure or vaccine; the search must continue, but within the wider framework of an extensive campaign focused on people's views on sex and sexuality (Saayman & Kriel 1991:163).

The Christian Church is the body of Jesus Christ and one of its roles is to bring Christ to a world that is increasingly being forced to recognise its brokenness and need for God (Snidle & Yeoman 1997:125). The primary role of the Church is to proclaim the gospel of Jesus Christ and equip individual Christians in the Church to show Christian values and service (Acts 6:1-4). Individuals in the Church are encouraged to follow the example of the early Church when "seven reputable men, filled with the Spirit and wisdom" were appointed the task of feeding the widows while the Twelve devoted themselves "to prayer and to the ministry of the word" (Acts 6:3, 4). Snidle and Yeoman (1997:125) emphasise that "the Church has a mandate to console, reconcile, love and minister in unconditional acceptance even to AIDS sufferers. It should provide a climate of love, acceptance and support for

those who are vulnerable to or affected by HIV and AIDS. It should also make a crucial contribution to the ethical discernment that leaves no room for judgements and participates in the discussion in society at large on ethical issues".

According to Snidle and Yeoman (1997:31-32), Christians "should respond to AIDS sufferers with compassion, having the insight that Jesus responded compassionately to all who were broken by life and accepted those who were unacceptable to society". They (ibid 1997:32) go further to say that "the Church teaches faithfulness within marriage and abstinence outside marriage as a positive ideal for true human fulfilment, rather as a bulwark against chaos or as an overtly pragmatic means of achieving safe sex. Primarily, the Church promotes abstinence and fidelity, also advocates the use of condom and promotes safe sex in specific circumstances." Morse et al (2000:261-276) state that sexual health, sexuality, abstinence and related topics must therefore be openly discussed in the Church to prevent the spread of HIV. Catholic and Protestant Churches organise various services for congregants, such as Bible discussion groups, marriage counselling, and youth groups. They teach their followers to meet some of the needs of the community through prayer, counselling, caring for the sick, the aged and the needy, and providing spiritual support for the downcast, marriage counselling, baptism and burial. Some members visit hospitals and orphanages to pray with the sick and give spiritual support to the children orphaned. With the HIV and AIDS pandemic, the Church has continued to care for the sick and give support to the families of the infected and those affected by HIV/AIDS.

The World Council of Churches (WCC) (1997:104-108) points out that society expects more from the Church, however, because society sees the Church as a place to obtain spiritual healing, to share their stories and testimonies. With the HIV and AIDS pandemic, society expects the Church to

- address the issues of stigma and discrimination, human rights related to HIV and AIDS, abuse of young and poor children for prostitution or to escape infection, violence against children, men and women who are denied their fundamental human rights on the grounds of social status, sexual orientation or drug addiction
- lobby the government to provide anti-retroviral medication and
- educate the congregation by creating HIV and AIDS awareness in the Church.

Seele (1995:550) points out that society also expects sexual health, sexuality, abstinence and related topics to be openly discussed in the Church in order to prevent the spread of HIV as the Church, by the virtue of its position, still enjoys the respect and support of the people. The WCC (1997:2) recommends reflecting together on ethical issues raised by the HIV pandemic. Furthermore, the WCC (1997:2) mandated the formation of a consultative group to conduct a study on HIV and AIDS that would help the ecumenical movement to shape its response in the three areas of theology and ethics, namely pastoral care, the Church as a healing community, and justice and human rights. The study was meant to challenge the churches to be honest, faithful and better informed, and become communities that are safe places for people living with HIV and AIDS.

1.3 AIM AND OBJECTIVES OF THE STUDY

The aim of this study was to describe the current and future roles of the Anglican Church in the prevention of the spread of HIV and AIDS in the Limpopo Province as perceived by the congregants of the Zoutpansberg parish.

The objectives of this study were to describe:

- the current role of the Anglican Church in the prevention of the spread of HIV and AIDS as perceived by the congregants
- the extent to which HIV and AIDS-related messages are included or discussed in the main church activities
- the extent to which HIV and AIDS prevention issues are addressed in the main activities organised
- the extent to which HIV and AIDS activities are organised and/or addressed in the Church
- the congregants' beliefs on the spread of HIV and AIDS
- the future steps or actions the congregants consider the Anglican Church should take to prevent the spread of HIV and AIDS.

1.4 RESEARCH QUESTIONS

The study wished to answer the following questions:

(1) What is the current role of the Anglican Church in the prevention of the spread of HIV and AIDS, or more precisely, to what extent are

- HIV and AIDS-related messages included or discussed in the main Church activities
- HIV and AIDS prevention issues addressed in the main activities organised by the church
- HIV and AIDS activities organised by the church?

(2) What do the congregants believe about the spread of HIV and AIDS?

(3) What is the future role of the Anglican Church in the prevention of the spread of HIV and AIDS as perceived by the members?

1.5 SIGNIFICANCE OF THE STUDY

The study has the potential to contribute to the body of knowledge on HIV and AIDS, more precisely to provide guidelines on the current and future roles of the Anglican Church in the prevention of the spread of HIV and AIDS in the Limpopo Province. Church leaders and health professionals could use the proposed guidelines as a basis to formulate HIV and AIDS prevention strategies relevant to the beliefs and values of the Anglican Church members

in Limpopo Province. Nurse educators and researchers could also use the findings as a basis for educating student nurses and conducting further research in the field of HIV and AIDS among Church members.

1.6 CONCEPTUAL FRAMEWORK

The 1997 WCC recommendations to the Churches as responses to the challenges of HIV and AIDS were used as framework for the study. The WCC (1997:93-94) recommended that churches should

- Provide a climate of love, acceptance and support for those who are vulnerable to or affected by HIV and AIDS. This can be expressed by providing space for those concerns to be raised in regular worship, by special worship events such as the observance of World AIDS Day on 1 December, through support groups and by visits to those affected by HIV and AIDS.
- Reflect together on the theological basis for their response to the challenges posed by HIV and AIDS.
- Reflect together on the ethical issues raised by the pandemic, interpret them in their local context and offer guidance to those confronted by difficult choices.
- Participate in the discussion in society at large of ethical issues posed by HIV and AIDS, and support their own members who, as health care professionals, face difficult ethical choices in the areas of prevention and care.

1.7 THEORETICAL FRAMEWORK

The researcher used the social cognitive theory (SCT) as the theoretical framework in this study (Baranowski, Perry & Parcel 2002:165). The SCT addresses the psychosocial dynamics influencing health behaviour and methods of promoting behavioural change as in health promotion. The Church involvement in educating members and the community on HIV and AIDS and related issues to create awareness is intended to influence health behaviour by promoting behavioural change among the people.

The SCT recognises the relationship between behaviour, personal factors and the environment. Educators and behavioural scientists have creatively used SCT to develop interventions that influence these underlying cognitive variables, thereby increasing the likelihood of behavioural change (Baranowski, Perry & Parcel 2002:165). Table 1.1 depicts the SCT and its implications for intervention.

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Table 1.1 SCT and implications for intervention

Concept	Definition	Implications
Environment	Factors physically external to the person	Provide opportunities and social support
Situation	Person's perception of the environment	Correct misperceptions and promote healthful norms
Behavioural capability	Knowledge and skill to perform a given behaviour	Promote mastery learning through skills training
Expectation	Anticipatory outcomes of a behaviour	Model positive outcomes of healthful behaviour
Expectancies	The values that the person places on a given outcome; incentives	Present outcomes of change that have functional meaning
Self-control	Personal regulation of goal directed behaviour or performance	Provide opportunity for decision making, self-monitoring, goal setting, problem solving, and self-reward
Observational learning	Behavioural acquisition that occurs by watching the actions and outcomes of others' behaviour	Include credible role models of the targeted behaviour
Reinforcements	Responses to a person's behaviour that increase or decrease the likelihood of reoccurrence	Promote self-initiated rewards and incentives
Self-efficacy	The person's confidence in performing a particular behaviour and in overcoming barriers to that behaviour	Approach behaviour change in small steps to ensure success; seek specificity about the change sought
Emotional coping responses	Strategies or tactics that are used by a person to deal with emotional stimuli	Provide training in problem solving and stress management; include opportunities to practise skills in emotionally arousing situations
Reciprocal determinism	The dynamic interaction of the person, behaviour, and the environment in which the behaviour is performed	Consider multiple avenues to behavioural change including environmental, skill, and personal change

Source: Baranowski et al (2002:169)

1.8 DEFINITIONS

In this study, the following terms are used as defined below:

Church: The church here denotes an assembly of the congregation of the Zoutpansberg parish of the Diocese of St Mark the Evangelist (Anglican Church), Limpopo Province.

Diocese: The Diocese is the provincial administrative umbrella of the Anglican Churches. The Diocese of St Mark the Evangelist is one of the twenty-three (23) dioceses of the Church of the Province of Southern Africa. It has one hundred and eighty (180) Chapels organised into twelve parishes in the Limpopo Province.

Parish: A parish is “a geographical area as ordered by the Diocesan Synod containing one or more chapelries and/or recognised congregations” (CPSA 2003:5).

Chapelry: A chapelry is “a district where a separate congregation assembles for divine worship, established as provided for in the rules and which is within a parish” (CPSA 2003:4).

Congregation: A congregation is “a group of congregants who meet together for worship, recognised by the Bishop as a congregation, who are under the authority of a licensed cleric subject to the Bishop and operate in terms of the Canons of the CPSA and the Rules of the Diocese” (CPSA 2003:5).

Parishioner: A parishioner is a person “who, being baptised and not being under church censure and not being a member of any religious body not in

communion with the Church of the Province, is a regular worshipper in the church or place of worship of the parish" (CPSA 2003:5).

1.9 OUT LINE OF THE STUDY

Chapter 1 describes the background to the study, including the purpose, objectives, significance, and conceptual and theoretical framework of the study, and defines key terms used.

Chapter 2 discusses the literature review undertaken for the study, with reference to four main sections, namely the biomedical aspects of HIV and AIDS, global, regional and church responses to HIV and AIDS, the ethical approach of the Anglican Church, and the theoretical aspects of health promotion and health prevention.

Chapter 3 outlines the research design and methodology used in the study

Chapter 4 presents the data analysis and interpretation.

Chapter 5 discusses the findings and limitations of the study and makes recommendations for future research.

1.10 CONCLUSION

This chapter introduced the study, discussing the problem, purpose and objectives of the study. The researcher formulated the research questions to be answered and defined certain key terms.

Chapter 2 covers the literature review conducted for the study.

CHAPTER 2

Literature review

2.1 INTRODUCTION

This chapter covers the literature reviewed on biomedical aspects of HIV and AIDS, global and regional responses to HIV and AIDS, the African Anglican Communion response to HIV and AIDS and the theoretical aspects of health promotion and HIV and AIDS prevention. The researcher also reviewed the socio-cultural responses to HIV and AIDS with specific reference to culture and myths.

2.2 BIOMEDICAL ASPECTS OF HIV AND AIDS

This section of the literature review focused on the patho-physiology, clinical manifestations, and mode and pattern of transmission of HIV and AIDS.

2.2.1 Patho-physiology of HIV and AIDS

In 1983, French researchers identified a new virus now known as HIV (Human Immuno-Deficiency Virus) as the cause of AIDS. This type of HIV also became known as HIV-1. In 1985, a second type of HIV was identified in sex workers from Senegal. This virus, called HIV-2, is found mostly in West Africa and seems to be less easily transmitted and slightly less harmful than HIV-1. It has since been found that there are many different strains or subtypes of HIV. In South Africa, subtype C is most common. The early cases of AIDS

were observed in gay men (homosexuals). After that, major epidemics were seen in another marginalised group, intravenous drug users, in Western Europe, South East Asia, China and India. But HIV and AIDS is not a disease of gay men or intravenous drug users. Once in the blood stream, the virus targets the CD4 T-lymphocyte cells, which constitute a vital component in the immune system, as they coordinate antibody production and all immune responses (Webb 1997:3).

Retroviruses are able to cause infected cells to translate the viral genetic material, ribonucleic acid (RNA) into another type, deoxyribonucleic acid (DNA) with which it infects new cells. HIV infects mainly white blood cells called T-lymphocytes (Obi 2001:12). The virus is roughly spherical and about one ten-thousandth of a millimetre across under a high-resolution microscope. The outer part or envelope is made of a double layer of lipids studded with proteins. The envelope also consists of viral protein spikes referred to as glycoproteins. The proteins play a role in binding and invasion of the host cells by the virus. The virus makes DNA from RNA using the enzyme reverse transcriptase once the virus has entered a cell. The DNA is then inserted as provirus such as into the host cell DNA where it remains latent or is copied again into viral RNA to produce new viral particles (Obi 2001:14).

The viral protein binds to the CD4, a protein on the membrane of the immune system cells and they fuse together. The virus core and the content are then taken into the cell. Replication of the cell results in viral replication possibly concentrated within the lymph nodes throughout the body (Obi 2001:14; Webb 1997:3). Webb (1997:3) adds that recorded drugs such as

Azidothymidine (AZT) slow down this viral replication. The immune system is compromised when a proportion of the T-cell is gradually destroyed, thus affecting immune responses. The whole process of HIV-related acquired immune deficiency (AIDS) can take over a decade in many individuals. However, in environments where there is a high background level of pathogens such as in many developing countries, this process of immune deficiency is believed to be considerably shorter than the average of ten years.

In the United States (USA), children infected with HIV have entered mid-teenage and remained asymptomatic (Webb 1997:4). Webb (1997:4) cites the exceptional case of a 15 year-old girl who became pregnant despite being HIV positive since birth whereas the onset of AIDS is usually before a decade after infection. In the West, the average is about six years between HIV infection and death. In Southern Africa the compromised immune system fails to halt the development of the opportunistic infections and the period of full-blown AIDS usually lasts no more than two years, with eventual death resulting from the combined impact of the opportunistic infection.

Since the availability of antiretroviral drugs, the anti-retroviral process of HIV immune deficiency has been slowed down and people with HIV and AIDS can now live longer. For example, giving expectant mothers Zidovudine (ZDV) orally after 14 weeks, intravenously during labour and to the neonate for six weeks in a non-breastfed population, has significantly reduced mother-to-child transmission of HIV-1 (McIntyre1999:19).

Cullinan (2005:10) reports on an alternative to ARV in the form of nutrition. The Health Minister, Manto Tshabalala-Msimang has approved of the diet as it has no known side effects. It is commonly referred to as nurse Tinie van der Maas's diet based on garlic, lemons, ProNutro, olive oil and a supplement called "Africa's solution" containing African potato. According to Cullinan (2005:10), the Director-General of Health, Thami Mseleku, confirmed that Nurse Tinie has been allowed to put patients on her diet in various clinics in all the provinces and claims to have been able "to cure aliments from epilepsy to Aids symptoms". Although this claim still needs to be subjected to further studies, there is general consensus that good nutrition is an essential part of any HIV and AIDS treatment plan, and should complement anti-retroviral treatment.

2.2.2 Clinical manifestation/presentation

The clinical manifestations of AIDS are similar for the two strains, although the onset of immune deficiency appears to be slower with HIV-2. The viruses are both transmitted through the mixing of body fluids (Webb 1997:3). HIV destroys the immune system cells and the body becomes unable to resist other infections, even by low-grade pathogens, giving rise to opportunistic infections. Due to weakened defence mechanisms, symptoms appear alone or severally and include:

- chronic fatigue or weakness
- diarrhoea

- minor skin infections
- respiratory problems
- sustained weight loss
- persistent swelling of the lymph nodes
- deterioration of the central nervous system (CNS)

The above symptoms constitute the cluster of conditions known as AIDS-related complex (ARC). As the weakening of the immune system continues, more severe diseases manifest themselves, including cryptococcal meningitis, pneumocystis carinii pneumonia (PCP) and cancer such as Burkitt's lymphoma and Kaposi's sarcoma. This more severe form can take up to two years before death during which time relative well-being alternates with acute or chronic infections (Obi 2001:16).

The World Health Organisation (WHO) (Reuter 2003:7) classifies the clinical manifestations of HIV and AIDS into the following four stages:

- ***Stage1***– HIV positive but no symptoms, except perhaps some minor illness following the early period of contact with the virus. Some people have swollen glands in the neck, high fever, tonsillitis, diarrhoea and in very rare cases PCP pneumonia. However, this normally goes away after 4-5 days and many people do not take it seriously. For years after that, they might not get any major illnesses.
- ***Stage 2*** – HIV positive with minor illnesses, such as skin problems, flu, tonsillitis and ear infections.

- ***Stage 3***– HIV positive characterised with weight loss of about 10% of the individual's usual body weight, diarrhoea, running a temperature for more than one month, thrush in the mouth and pneumonia or TB of the lung.
- ***Stage 4*** – This stage is called AIDS. During this stage, illnesses that only people with weak immune systems can get are classified here, including PCP, pneumonia, toxoplasmosis, stroke, isospora diarrhoea and cryptococcal meningitis, as well as more severe illnesses like TB of body parts other than the lungs, thrush of the oesophagus and herpes lasting more than a month, Kaposis sarcoma, cervical cancer, lymphoma, and HIV dementia.

2.2.3 Mode and pattern of transmission

The HIV virus is transmitted through body fluids such as blood, semen, vaginal fluid, and breast milk. The virus can be transmitted when there is mixing of body fluids during unprotected sexual intercourse, and through infected blood or blood products transfused into a patient not screened for HIV (Barrett-Grant & Heywood 2003:13; Gennrich 2004:27). Transmission from mother to child can occur *in utero*, during labour and delivery, or postpartum through breast milk (McIntyre 1999:1).

Other methods of transmission include contaminated needles, used legally as well as illegally; intravenous drug use through sharing of infected needles; needle prick injury or reuse of an infected needle as in a medical setting which

can result in health care exposure to AIDS (Barrett-Grant & Heywood 2003:15; WCC1997:62; Snidle & Yeoman 1997:136). The use of infected blades in circumcision, rituals and scarification could also enhance transmission of the virus (Akande 1997:326).

The above transmission methods have their own geography and, on a global scale three epidemiological patterns were defined in 1986-1987 which have since been categorised into ten “geographic areas of affinity” (Webb 1997:11). Each area is characterised by a specific epidemiological profile of transmission types, along with similar societal contexts. Pattern I spread is primarily through homosexual activity and intravenous drug use (IVDU). Males dominate among those infected, with a male-to-female infection ratio of about 10-15:1. Regions with this pattern are the USA, Western Europe and Australia. The early stages of the epidemic in South Africa were characterised by this pattern. Pattern II spread is primarily through heterosexual intercourse with a male-to-female ratio at roughly 1:1 due to vertical transmission. It is also characterised by an increasing incidence of paediatric AIDS. Regions affected are those of sub-Saharan Africa and, increasingly, Latin America along with parts of South America and India. Pattern III spread is primarily through the use of infected needles as in a children’s hospital in Romania and in Africa as a result of health care exposure (Webb 1997:11; Gisselquist, Potterat, Brody & Vachon 2003:151). The virus is contained within a small prostitute population. Regions affected by this pattern are South East Asia, especially Thailand, with its active sex tourism industry, also Eastern Europe, given the taboo nature of sex in some societies.

In all the regions where HIV is spreading, it is most predominant in urban areas, with an estimated urban-rural ratio of 3,6: 1 in sub-Saharan Africa. The reasons for this geographical differentiation relate to the concentration of high-risk behaviour in urban localities, linked to prostitution and multi-partner behaviour, as well as that cities and large towns are often the first entry point of the virus into a country (Webb 1997:11-12).

According to UNAIDS (2002:25), no single factor, biological or behavioural, determines the spread of HIV infection. Many factors have been associated with the spread of HIV and AIDS, including “poverty, illiteracy, rising unemployment, cultural belief and practices, sexual behaviour, myths and perceptions, economic devastation, political manoeuvring, and other forces, which the individual hardly understands, let alone controls” (Saayman & Kriel 1991:161).

With particular reference to Southern Africa, Gennrich (2004:7) and Zawaira (1999:26) assert that past employment practices and apartheid laws have contributed significantly to the spread of HIV. The social devastation caused by migrant labour and the apartheid laws, which prevented families from settling as families near their places of work increased the risk of exposure to HIV. According to Gennrich (2004:7), the spread of HIV and AIDS is also associated with secrecy, prejudice, ignorance, fear, denial and late presentation of signs and symptoms of the infection presented by many infected persons. The WCC (1997:13) associates the spread of AIDS with

socio-economic and cultural contexts to areas where poverty, the subordinate status of women and children, and discrimination are prevalent. Helman (1997:149) states that cultural factors could be causal, contributory or protective in their relation to ill health.

Sexual behaviour such as promiscuity, pre- or extra-marital sexual relations, homosexuality both male and female, and transactional sex are also associated with the spread of HIV and AIDS (Helman 1997:149-153; Webb 1997:18). HIV is clearly linked to certain patterns of human behaviour, especially sexual behaviour, thus a truly biological and socio-cultural phenomenon (Helman1997:346). Young women, who have strong economic or consumer needs, are often exposed to risk. They may partner older men for greater protection and support, or engage in sexual intercourse for exchange of status items, such as cash, cars or cell phones. Promiscuity is often perceived as the outcome of a combination of behavioural and contextual/ economic factors (Gennrich 2004:7).

2.3 CULTURE, MYTH AND BELIEF

2.3.1 Culture

The culture of silence that surrounds sex education in all societies, more especially in African cultures, is another contributory factor. It means that the youth are exposed to sexual practices before they know much about the consequences or how to protect themselves. The mass media, especially

television (TV), contributes to the myth that “sex is cool” and a normal part of any casual relationship (Gennrich 2004:12).

Webb (1997:18-19) found that pre-marital pregnancy is sometimes beneficial for the girl in that her proven fertility consolidates her “lobola” value while in Mpolweni, a community in KwaZulu-Natal, teenage pregnancy has a stigma attached to it. According to Helman (1997:152, 325), marriage patterns that permit extra-marital relations, polygamy, frequent divorces, or the exchange of partners may all contribute to the spread of the virus. Other sexual practices, such as the ritual of cleansing, also known as widow cleansing, and levirate union, are associated with the spread of HIV and AIDS. It is believed that “to be purged of the ‘evil forces’ assumed to have caused the death of a spouse, the widow or the widower is ‘cleansed’ through the act of sexual intercourse with a relative of the deceased this practice is widespread in many countries” (Helman 1997:359).

Culturally sanctioned bodily mutilations or alterations, such as male or female circumcision, scarification, tattooing, ear and lip piercing, foot binding and some forms of cosmetic surgery (like augmentation mammoplasty) are also associated with the spread of HIV and AIDS. Artificial changes in the shape, size and surface of the body, which are widespread throughout the world, can also have social implications. This applies also to the more extreme forms of bodily mutilation such as female genital cutting (FGC). Inherent in most of these are culturally defined notions of ‘beauty’ – usually of women (Helman 1997:326).

Female genital cutting (FGC) is widely practised among Africans. FGC is a procedure that involves the partial or total removal of the external female genitalia. Generally performed without anaesthesia by traditional elders, in some cases for pay, FGC has health consequences that include haemorrhage, shock, pain, infection, psychological and sexual problems, and difficulties during childbirth as well as a high risk for HIV transmission (Collymore 2004:1; Helman 1997:326).

2.3.2 Myths

Myths about HIV and AIDS and the fears associated with HIV/AIDS can undermine attempts to identify, treat and control the disease and to offer its victims the care and compassion they deserve. Thus the moral and ideological attitudes of a society towards AIDS are just as relevant to its control as the search for an effective vaccine. In the USA, the discourse on AIDS defines the victim as the ultimate “other, alien, antisocial, unnatural, dangerous and threatening; their disease is a manifestation of their inner moral evil and/or mental illness” (Helman 1997:348).

One of the “most pernicious myths currently in circulation is that sex with an old woman or a virgin cures a man of HIV/AIDS. This could not be further from the truth. Sex with an old woman or a virgin will NOT cure anyone. What it will do is to pass on a deadly virus to an innocent child or young woman, deeply injuring her sexuality for the rest of her life. The increasing number of rape

victims who are babies and children would seem to be associated with this myth" (Jones 2004:16, 37).

Some people will avoid an AIDS sufferer like the plague for fear of being infected by mere touching. Yet, others believe that HIV and AIDS is just another colonial way of oppressing Black people, calling it the "American idea to destroy sex", and in defiance continue indulging in a risky life style that will expose them to HIV infection (Gennrich 2004:7). Another myth is that women mostly infect men with HIV/AIDS (Gennrich 2004:13). The fact is that women are more vulnerable to HIV/AIDS and more likely to get sick quickly than men through biological factors that make them more susceptible to infection because they have a larger surface area of genital mucous membranes than men.

2.3.3 Belief

Cultural representations of AIDS are a blend of medical and indigenous beliefs: as a physical disease, and a punishment for sinful behaviour (Helman 1997:348). Many hold this belief. Knust (2003) says that in Indonesia, it is believed that HIV is a curse from God and sinners catch the disease. African-Americans in the USA regard AIDS as "punishment for sin"; a result of breaking religious and moral laws, especially those against homosexuality or extra-marital sex. In Botswana, some traditional healers see it as just a folk illness caused by the breaking of certain sexual taboos; others blame the disease on a sent sickness, or sorcery, due to envy because a person

infected with HIV has been bewitched (Helman 1997:349). This leads the victim's family to consult a voodoo priest to confirm this and find someone to blame as responsible. Such erroneous beliefs make it difficult for HIV-positive people to openly seek help early from the hospital. They delay seeking treatment and die from loneliness and fear of stigma, and rejection.

Cultural and religious beliefs that insist that women should obey their husbands at all costs and that men naturally need more than one sexual partner make it difficult for wives to insist on their husbands' faithfulness or to refuse unsafe sex, even within marriage. Violent or exploitative relationships experienced by women and children also contribute to the spread of HIV in some places (Gennrich 2004:13).

2.3 GLOBAL AND REGIONAL RESPONSES TO THE SPREAD OF HIV AND AIDS

The literature review covered initiatives taken by world leaders and the Church in controlling or combating the HIV and AIDS epidemic at global and regional levels. Accordingly, the UN, WCC, Southern Africa Development Countries (SADC), the All African Council of Churches (AACC) and the Anglican Church of South Africa responses to HIV and AIDS were examined.

2.3.1 Global level

In April 2001, at the African Summit on HIV and AIDS, tuberculosis and other related infectious diseases, in Abuja, Nigeria, the UN Secretary General Kofi

Anan issued a global call to action in the fight against AIDS (UNAIDS 2002: 11). According to Anan, AIDS is a prominent item on the agenda of summits and decision-making forums of the G8 and G7 nations, the Organisation of American States, the Organisation of African Unity (OAU), the Commonwealth of Nations, the European Union (EU), the Association of South-East Asian Nations, and the Caribbean Community Secretariat (CARICOM).

The World Economic Forum and the World Social Forum (in Porto Alegre) held key sessions on AIDS and its global implications. The UN Security Council held its first-ever debate on AIDS in January 2000 – the first time it had examined a health or development issue. Since then, it has held two more public debates on AIDS (UNAIDS 2002:11).

For years, the theological and ethical concerns that churches had about condom use served to block any discussion of prevention, care, or the de-stigmatisation of HIV/AIDS (Steinitz. 2005: FHI). But the Church could not afford to remain silent for long when they realised the havoc the HIV pandemic was causing both in and outside the Church. The Anglican Communion across Africa repented of this ‘silence’ and committed to fight and stop the spread of the HIV infection (CPSA HIV/AIDS [sa]:5).

The WCC health desk has been active in the area of HIV/AIDS since the 1980s. Its main emphasis then and during the 1990s was the development and distribution of educational and study materials, also supported innovative community initiatives in countering HIV/AIDS. In 1997 the WCC called on the

churches to address the urgent challenges posed by the spread of HIV/AIDS throughout the world. Appealing for an immediate and effective response in the areas of pastoral care, education for prevention and social ministry as they noted that “the AIDS crisis challenges the Church to be the Church in deed and in truth: to be the Church as a healing community” (WCC 1997:96).

At a meeting held in Johannesburg, the WCC (1997:96-97) commissioned a comprehensive study on AIDS focusing on theological and ethical issues raised by the HIV/AIDS pandemic, questions of human rights in relation to pastoral care and counselling within the church as a healing community.

The UN (UNAIDS 2002:11-13) and WCC (1997:107-108) share the same concern about the havoc caused by HIV and AIDS pandemic and call for

- more resources to fight AIDS and ensure that a wide range of prevention programmes are available to all
- at least 90% of young people to have access to information, education and services necessary to develop the life skills needed to reduce their vulnerability to HIV, the rate of HIV infection among young people in the most affected countries, and the proportion of infants born with HIV
- anti-discrimination and human rights protection for people living with HIV and AIDS and for vulnerable groups
- participatory programmes to protect the health of those most affected by HIV and AIDS
- women to be empowered as an essential part of reducing vulnerability to HIV

- national strategies to strengthen healthcare systems and address factors affecting the provision of HIV-related drugs, including affordability and pricing, and make treatment and care for people with HIV and AIDS as fundamental to the AIDS response as its prevention.

This Declaration of Commitment was adopted unanimously and serves as a benchmark for global action (UNAIDS 2002:12-13), (see appendix 6).

In addition, the WCC (1997:107) encouraged the churches to provide a climate of love, acceptance and support for those who are vulnerable to or affected by HIV/AIDS, to reflect together on the theological basis for their response to the challenges posed and ethical issues raised by HIV/AIDS, interpret them in their local context, to participate in the discussion in society at large of ethical issues posed by HIV/AIDS, and to support their own members who, as health care professionals, face difficult ethical choices in the areas of prevention and care.

The Redeemed Christian Church of God, a Pentecostal church in Nigeria, responded to HIV and AIDS with compassion and a comprehensive plan to discuss HIV/AIDS openly and to educate the faithful to prevent infection (Success stories:2003)**.** In August 2001, the Anglican Church held “the All African Anglican Conference” in Boksburg, South Africa, attended by leadership from the worldwide Anglican Communion, and formulated policies to guide the worldwide Anglican Communion’s response to the HIV/AIDS pandemic (CPSA HIV/AIDS.2002: 4).

Gennrich (2004:3) emphasises the need for churches and individual Christians to resist the temptation to cut off from one another because of differing views about such things as the issue of abstinence or condom use. This could prove fatal to the efforts to prevent the sexual transmission of HIV.

2.3.2 Regional level

Member states of the SADC region have implemented HIV and AIDS programmes since the mid-1980s in order to prevent or reduce the transmission of HIV and other STDs and reduce the socio-economic impact of HIV and AIDS among individuals, families and communities. In the early stages of the epidemic, many countries were guided in the implementation of HIV and AIDS programmes by the WHO's Global Programme on HIV and AIDS (GPA) and by UNAIDS in 1996 (Department of Health. 2000:7).

The early HIV and AIDS response centred mainly on raising awareness of HIV and AIDS through information, education and communication (IEC) for behaviour change (abstinence, mutual faithfulness), condom promotion, treatment of STDs as well as clinical and home-based care. The approach was predominantly medical and health-focused and largely neglected the participation of other sectors in the response. In addition, it emerged that there was and still is the challenge of narrowing the gap between knowledge and behaviour (Department of Health. 2000:7).

In the 1990s the health sector realised it could not respond to and cope with the wide-ranging socio-economic consequences and manifestations alone.

Therefore, there was a shift in the programming paradigm from a medical to a multi-sectoral, participatory and inclusive approach. The main actors in the HIV and AIDS response in the region are the government, NGOs, CBOs and religious organisations that have increasingly played a bigger role in the prevention, care, social support and other forms of impact mitigation, thereby complementing efforts (Department of Health.2000:7).

Many African churches have begun to intensify their battle against AIDS. In August 2001 the AACC called on all its church-related partners to actively participate in building awareness about HIV/AIDS and helping those who are HIV-positive. The AACC promotes a holistic approach, involving both prevention and care, as the most effective (Steinitz. 2005**:** FHI).

The Anglican Church of Southern Africa (ACSA) HIV and AIDS office, established in April 2003, launched its first province-wide campaign in response to the HIV and AIDS pandemic with the vision "*a generation free from AIDS*". Since then it has been involved in sourcing for funds, funding and training to build capacity and lay the foundation for HIV and AIDS work in all its 24 dioceses, over 1 000 parishes in six African countries: Angola, Namibia, Mozambique, Lesotho, Swaziland and South Africa (Anglican AIDS News. 2005).

The Government and the Church, at global, regional and local level, acknowledge that the prevention of HIV transmission requires people to be properly informed about how the virus can and cannot be transmitted from

one person to another. It is assumed that understanding these facts would enable people make responsible choices that will prevent HIV transmission. Various measures can be taken to prevent HIV transmission (Barrett- Grant & Heywood 2003:14-18), including

- abstaining from (not having) sex before marriage;
- practising safe sex by using the male or female condom, staying faithful to only one uninfected partner, practising sex without penetration;
- taking universal precautions;
- post-exposure prophylaxis as seen in needle stick injury, accidents and sport injuries, rape and sexual assault;
- early diagnosis and treatment of other STDs;
- safe blood transfusions (all blood to be transfused should be tested and confirmed negative for antibodies against HIV);
- proper sterilisation of needles and other skin-piercing instruments;
- provision of sterile instruments for users of intravenous drugs;
- provision of comprehensive physical, emotional and spiritual care for persons living with HIV and AIDS;
- reducing discrimination and advocating for the rights of people who are vulnerable to HIV;
- preventing mother–to-child transmission by increasing the accessibility of anti-retroviral treatment;
- HIV testing and counselling.

2.4 ETHICAL APPROACH OF THE CHURCH WITH EMPHASIS ON CONFIDENTIALITY

Strydom (2001:24) defines ethics as “a set of moral principles suggested by an individual or group and subsequently widely accepted, which offers rules and behavioural expectations about the most correct conduct towards experimental subjects and respondents”. The Church also has its own set of rules or codes of professional conduct for clergy and lay volunteers to follow called *Pastoral standards, practice and procedures for all in ministry in the CPSA* (2002). With regard to HIV and AIDS, knowing that confidentiality is a key value in the ministry and in the prevention of spread of HIV and AIDS, the CPSA states that disclosure of one’s HIV status is important to others, and is generally encouraged by the Church. Nevertheless, every person is entitled to privacy and confidentiality of personal information, including information related to HIV status. Hence all “ministers, employees and parishioners shall respect the right of all persons to confidentiality. All parishes shall institute systems to ensure that all reasonable precautions are taken to protect confidential information” (CPSA 2002:8). Although the Church regards confidentiality as a key value in its ministry, the degree required may vary from one pastoral situation to another therefore judgement is required (CPSA 2002:9). The WCC (1997:103) emphasises that this judgement would require making ethical decisions from gathered information, wrestling with deeply sensitive issues and weighing differing, sometimes conflicting, views and interests.

The parishioner and the minister need to agree on the level of confidentiality in any given situation and abide by it. Where the ministry is to be shared between two or more ministers, “shared confidentiality” agreement about this aspect is required and if it is necessary to seek guidance from a colleague or superior, the minister should either obtain the parishioner’s permission or in the case of a person living with HIV get his/her permission, or disguise the case (CPSA 2002:9). Confidentiality should only be breached where the well-being of the parishioner or the safety of another person is manifestly at risk and only after careful consultation with a senior and experienced person in authority.

2.5 CHURCH AND HEALTH PROMOTION: FOCUS ON HIV AND AIDS

This section deals with definitions of health promotion and theories and models of health behaviour and health behaviour changes and the Church’s role in the prevention of the spread of HIV and AIDS.

2.5.1 The role of the Church in health promotion

Minkler (1997:4) defines health promotion as “a process of enabling people to increase control over and to improve their health”. “Different perceptions about the nature of health and factors contributing to it underpin interpretation of health promotion. The dominance of a medical model has meant that health promotion is frequently seen as the prevention of disease, often through

targeting high-risk groups who have an increased likelihood of developing a specific disease.

Health promotion has its roots in many different disciplines and activities. These activities involve education, prevention, protection and legislation and relate to the concepts of positive health, well-being, and life style (Kirsten 2001:3).

In practice, health promotion encompasses different political orientations that can be characterised as the individual versus structural approaches (Minkler 1997: 4). According to Naidoo and Wills (2002:85), health promotion "recognises that health and wealth are inextricably linked, and seeks to address the root causes of ill health and problems of inequity, using radical and challenging approaches". In its response, the Church adopted the above approach to tackle the root cause of the HIV pandemic; used education and training of clergy and laity to address ignorance and create awareness of HIV and AIDS; spoke openly about responsible sexual behaviour that prevents the transmission of HIV, and against stigma and discrimination; promoted voluntary counselling and testing in the hope that this would encourage people to want to know their HIV status and be responsible for their behaviour, make informed decisions and practise responsible sexual behaviour that would prevent the spread of HIV infection (CPSA 2002:7). The Church does not see the fight against HIV and AIDS as an individual's responsibility alone but calls for compassionate community and institutional

leadership at every level to prevent infection and care for the ill and dying (CPSA 2002:7).

Naidoo and Wills (2002:82-83) state that health should be viewed as a collective responsibility of society that needs to be prioritised by organisations and governments in their decision-making as the concern for the health of individuals transcends the boundaries of race, religion, culture and national origin. Since the 1990s, the international community has increasingly focused on the importance of maintaining or improving an individual's health status through the practice of health-enhancing activities, the promotion of wellness and healthy lifestyles.

2.5.2 Health promotion models and theories

Several health promotion models and theories attempt to explain health behaviour and behavioural change. These models and theories are classified into three main categories according to their focus on the individual, the community and the organisation.

In order to encourage behavioural change in people with regard to HIV and AIDS, the Church adopted an approach that focused on the individual, the community and organisations within and outside the church. This approach supports health promotion models and theories that explain health behaviour and behavioural change (Naidoo & Wills 2002: 222; Baranowski, Perry & Parcel 2002:171).

2.5.2.1 Health Belief Model (HBM)

According to Naidoo and Wills (2002:222), whether or not people change their behaviour is influenced by weighing the feasibility and benefits against the cost. In other words, people considering changing their behaviour engage in a cost-benefit or utility analysis.

Furthermore, this may include their beliefs on the likelihood of the illness or injury happening to them (their susceptibility), the severity of the illness or injury, and the efficacy of the action and whether it will have some personal benefit, or how likely it is to protect the person from the illness or injury (Naidoo & Wills 2002:223). Most people go through several stages when trying to change or acquire behaviours thus making it a lengthy and complex process.

The Church as an agent of change provides information in the form of education, workshops and counselling to help people make that decision. Naidoo and Wills (2002: 226 -227) point out that before decisions to change are made the theory of reasoned action comes into play, as individuals' intention resulting from their attitudes and subjective norms are important determinants of behavioural change. The theory differs from the health belief model (HBM) in that it stresses social norms as a major influence on behaviour. The motivation to comply with perceived social pressure from significant others, like the Church, could cause individuals to behave in a way

that they believe the group would think is right. The Church can influence a positive change if the individual values membership or wants to belong to it.

2.5.2.2 Social cognitive theory (SCT)

The SCT concerns the psychosocial dynamics influencing health behaviour and methods for promoting behavioural change. This theory explains human behaviour in terms of a triadic, dynamic and reciprocal model in which behaviour, personal factors (including cognitions) and environmental influences all interact to bring about behavioural change (Baranowski, Perry & Parcel 2002:165). The SCT is based on a number of concepts including environment, situation, behavioural capability, outcome expectancies, and self-control (Baranowski et al (2002:168).

Baranowski et al (2002:168) define *environment* as “social factors such as the Church and its teaching, norms and policies that can influence a person’s behaviour” and *situation* as “the cognitive or mental representation of the environment. The environmemt and situation provide an ecological framework for understanding behaviour.”

This definition indicates that factors, such as knowledge, church activities and teaching, beliefs, myths, traditions and culture, would influence the role of the Church in the prevention of the spread of HIV and AIDS. The challenge facing leadership of the Church as it responds to HIV and AIDS is to engage in activities that cause change in behaviour and lifestyle amongst congregants.

According to Baranowski et al (2002:165), behavioural capability refers to the knowledge and skill to perform a given behaviour. Health educators and others interested in changing health behaviour must clearly specify their targeted behaviour. In its teaching, norms and doctrines as well as the information and facts given on HIV and AIDS in workshops, the Church clearly specified the target behaviour. The implication of behavioural capability is to promote mastery of learning skills training (Baranowski et al 2002:165-171). Tones Model regards education as the key to empowering both lay and professional people by raising consciousness of health issues. People are then better able to make choices and to create pressure for healthy public policies. The model maintains that there is a reciprocal relationship between self-empowerment and community empowerment because changes in the social environment achieved through healthy public policies facilitate the development of self-empowered individuals. The support of individuals is also necessary for implementing change (Naidoo & Wills 2002:108-109).

The SCT describes self-control as “personal regulation of goal-directed behaviour or performance to provide opportunities for decision-making” (Naidoo & Wills2002:103-105). Baranowski et al (2002:167) argue that self-control includes many aspects of social change, which moves behavioural change from the domain of mechanistic theories of human behaviour to the views of the person as an agent in control of his or her own life (see chapter 1, table 1.1).

2.6 CONCLUSION

This chapter discussed the literature reviewed on the biomedical aspects of HIV and AIDS, responses to HIV and AIDS, the ethical approach of the Anglican Church, and theories and models on health behaviour and behavioural change and the role of the church in health promotion and prevention of the spread of HIV and AIDS.

The literature review indicated consensus on the causes, clinical manifestations, mode and pattern of transmission of HIV and AIDS. It also supported no single biological, behavioural and psychological factor that can explain the spread of HIV and AIDS. Moreover, HIV/AIDS has moved from being a medical or health problem to a public health issue as demonstrated by responses and initiatives of various organisations.

Chapter 3 describes the research design and methodology.

CHAPTER 3

Research design and methodology

3.1 INTRODUCTION

The study was undertaken with the aim of describing the current and future roles of the Anglican Church in the prevention of the spread of HIV and AIDS in the Limpopo Province as perceived by the congregants of the Zoutpansberg Parish.

A quantitative approach and the WCC (1997:93-94) recommendations on HIV and AIDS were selected to guide the study and achieve the objectives. This chapter describes the research design, sample and sampling technique, data-collection technique, data analysis method and ethical considerations.

3.2 RESEARCH DESIGN

A quantitative descriptive survey research design with self-administered questionnaire was used in this study. Thyer (1993:94) defines the research design as a “blueprint or detailed plan for how a research study is to be conducted”. Burns and Grove (2001:30) define a quantitative descriptive research design as “an accurate portrayal or account of the characteristics of a particular individual, situation or group”. The survey design is the most commonly used descriptive method. It gathers data at a particular time with the intention of describing the nature of existing conditions, identifying

standards against which existing conditions can be compared, or determining the relationships that exist between specific events (Cohen & Manion 1989: 98-100).

In planning for any survey design, researchers need to specify firstly, the exact purpose of the investigation and translate it into specific objectives that will allow them to select the most appropriate way of collecting data. Secondly, researchers need to specify the population on which the study will focus in order to decide on the sampling methods (Cohen & Manion 1989:88; Oppenheim 1992:112). In the above context, then, the researcher selected a descriptive survey design to describe the current as well as the future role of the Anglican Church in preventing the spread of HIV and AIDS. This method was selected because there is little information documented on the role of the Anglican Church in the prevention of the spread of HIV and AIDS despite their involvement in the care of those infected with and affected by HIV and AIDS.

3.3 SAMPLE AND SAMPLING TECHNIQUE

The sample for the study was drawn from the Zoutpansberg Parish of the Diocese of St Mark the Evangelist, Anglican Church in Limpopo Province, RSA. The setting was the five chapelries of the Zoutpansberg Parish, namely St Mark's Anglican Church in Makhado (formerly Louis Trichardt), St Augustine's in Magau, Simon of Cyrene in Vleifontein, Peter Masiza in Waterval settlement and St John's Anglican church in Musina. The Parish had a total of hundred and forty (140) members, excluding children under the age

of 16 on its register. Systematic probability sampling was used to select 70 participants from the 140 members. In a probability sample, every element in the population has the same probability or chance of being included (Lemeshow, Hosmer, Klar & Lwanga 1990:65-68; Bless & Higson-Smith 1995:34). This equal probability depends on the availability of the sample frame or list of the elements of the population representing the characteristics of the sample. Systematic or interval sampling is based on the selection of elements at equal intervals, starting with a randomly selected element on the sample frame (Bless & Higson-Smith 1995:26-27).

The Church register was used as a sample frame for this study. Every second member, starting from the first name on the register, was selected until a total of 70 was reached. The sample size in a survey design depends on “the nature of the data to be collected and the type of statistical tests the researcher wishes to conduct” (Oppenheim 1992:77).

Burns and Grove (220:367) refer to inclusion criteria as “characteristics that must be present for the element to be included in the sample” and exclusion criteria as “exceptions to the inclusion criteria”. Furthermore, the researcher must provide logical reasons for the inclusions and exclusions. To be included in the study, participants

(1) Had to be registered members of the Zoupansberg parish of the Anglican Church to ensure that the responses came from people specifically exposed to the doctrines and teachings of the Church.

(2) Have had a minimum of formal primary education. People with no education were excluded because the researcher wanted people who could read and write so that they could express themselves on paper.

(3) Had to be between 16 and 65 to ensure that they were of a sexually active and marriageable age and were likely to have experience that could contribute to the study.

3.4 DATA-COLLECTION INSTRUMENT

The researcher developed a self-administered questionnaire to collect data. The questionnaire was divided into four parts: general information, description of the current role of the Church in the prevention of the spread of HIV and AIDS, the congregants' beliefs regarding the spread of HIV and AIDS, and description of the future role of the Church in the prevention of the spread of HIV and AIDS as perceived by participants.

The general information included the demographic data (age, gender, formal education, and employment status) and the Parish Church membership status (length of membership, position in the Church, level of involvement in Church activities). The second part of the questionnaire consisted of three main questions with statements related to the extent to which (1) HIV and AIDS messages are included in the main Church activities, and (2) HIV and AIDS prevention activities are organised in the Church. The third part of the questionnaire consisted of statements describing myths and beliefs about HIV

and AIDS, and the last part covered the future role of the Church in the prevention of the spread of HIV and AIDS (see Appendix 2).

3.4.1 Advantages and disadvantages of questionnaires

According to Polit and Hungler (1991:193, 218), questionnaires have the following advantages:

- They can be self-administered; that is, the respondents read the questions and answer them in writing.
- Considerable information (data) can be collected in a short time.

The disadvantages are:

- The person conducting the survey may not be present at the time the questionnaire is completed to answer respondents' questions.
- Questionnaires are often distributed through the mail and this generally results in low response rates.

In this study there was personal contact with most of the respondents in order to improve the response rate.

3.4.2 Validity

The content validity of the instrument was ensured by carefully formulating the questions and statements to include every component of the conceptual

framework. Furthermore, the questionnaire was given to two experts in the Department of Health Studies, University of South Africa, and a statistician for item analysis. All three individuals expressed their satisfaction with the instrument. The content validity of an instrument can be achieved by referring to literature on the research topic, or by consulting experts in the field for comment. If the instrument measures all the components of the variables in question, a researcher can be confident that the instrument has a high content validity (Polit & Hungler 1991:375).

3.4.3 Reliability

No statistical reliability test of the instrument was conducted. However, the instrument was pre-tested using a sample of five members of the Church from a different parish who did not participate in the actual study. The completed questionnaire was given to the two research supervisors who were satisfied with the degree of consistency with which the respondents answered the questions. Polit and Hungler (1991:367) refer to the reliability of an instrument as “the degree of consistency with which it measures the attribute it is supposed to measure”.

3.5 DATA-COLLECTION PROCEDURE

The questionnaires were mailed and hand delivered to some participants during the Sunday services. Each participant received a self-administered questionnaire. A self-administered questionnaire is the best form of data

collection for a survey design. It has the potential for reaching respondents who live at widely dispersed addresses or abroad, is the cheapest way of data collection, offers anonymity and respondents can complete the questionnaire when it is convenient for them and check personal records, if necessary (Neuman 1997:141). Bless & Higson-Smith (1995:54) emphasise the risk of a low response rate with mailed questionnaires. To enhance the response rate, the questionnaire was mailed or hand delivered together with a self-addressed return envelope.

3.6 DATA ANALYSIS

The researcher scrutinised and compared the returned questionnaires to see the response patterns and any abnormalities in the completion of the questionnaire. The respondents were consistent in the completion of the various items and no questionnaire was discarded. Thereafter, each questionnaire was assigned a number and the answers were coded and captured on the computer. The coded data were analysed, using frequencies and percentages of responses with the statistical package for social sciences (SPSS) program version 11.00. The answers to the open-ended questions were analysed qualitatively then quantified.

3.7 ETHICAL CONSIDERATIONS

Strydom (2001:24) defines ethics as “a set of widely accepted moral principles, which offers rules and behavioural expectations about the most

correct conduct towards experimental subjects and respondents". The researcher upheld the following ethical considerations:

- Permission to conduct the study was obtained from the Bishop of the diocese and the Rector of the Parish (see Appendix 3).
- A clearance certificate (Project No: 004/2004) was issued by the Health Studies Research & Ethics Committee (HSREC), Faculty of Human Sciences, University of South Africa (see Appendix 4).
- A covering letter was attached to each questionnaire explaining the aim and objective of the study and requesting participation in the study (see Appendix 1).
- The researcher informed the participants that the return of the completed questionnaire would be considered as consent to participate in the study; the general information included in the questionnaire would be used only for statistical purposes, and the results of findings would not be traced to any participant.
- The returned questionnaires were treated with confidentiality and anonymity by the researcher.

3.8 CONCLUSION

This chapter covered the research design and methodology, including the population, sample, data-collection instrument and procedure, and ethical considerations.

Chapter 4 presents the data analysis and interpretation and results.

CHAPTER 4

Data analysis and interpretation

4.1 INTRODUCTION

A descriptive survey design and self-administered questionnaire were used to describe the role of the Anglican Church in the prevention of the spread of HIV and AIDS in the Limpopo Province as perceived by Zoutpansberg Parish congregants. This chapter discusses the data analysis and interpretation and results, according to the objectives of the study. The respondents' demographic profile covered personal details (e.g., age, gender) and church membership details.

A total of 70 questionnaires were sent out and 51 (73%) were retrieved. The high response rate can be attributed to two reasons: the researcher's personal contact with most of the respondents (Polit & Hungler 1991:193), and the relevance of the topic to the participants and the significance of the problem to the community. When the questionnaires were handed out, the researcher asked the respondents when the completed questionnaire could be collected. Some undertook to return their questionnaires themselves while others gave a convenient time for collection. Ultimately, only 51 of the 70 questionnaires were returned.

4.2 RESPONDENTS' PROFILE

The respondents' profile was described in terms of their demographic characteristic (gender, age, formal education, employment status and church membership status (duration of membership, position in the church, level of involvement in activities organised by the church).

4.2.1 Respondents' demographic characteristics

- **Gender**

Of the respondents, 63% (n=32) were females, and 37% (n=19) were males (see table 4.1).

- **Age**

Of the respondents, 27% (n=14) were between 25 and 34, 25% (n=13) between 17 and 24, 20% (n=10) each between 35 and 44 and 45 and 54, and 4% (n=4) between 55 and 64. None of the respondents was older than 64 while 67% (n=34) were between 25 and 54.

- **Educational level**

Of the respondents, 57% (n=29) had tertiary education, 27% (n=14) had secondary education, 10% (n=5) had no formal education qualification, and 6% (n=3) had only primary education.

- **Employment status**

Of the respondents, 47% (n=24) were in formal employment, 43% (n=22) were unemployed. Of the respondents, 3,9% (n=2) indicated that they had tertiary education, 2% (n=1) had secondary education and there was none with only primary education and they were all formally employed (see Table 4.1)

Table 4.1 Respondents' demographic characteristics (n= 51)

Characteristics	Frequency	Percentage (%)
Gender		
Male	19	37%
Female	32	63%
Age in years:		
17-24	13	25%
25-34	14	27%
35-44	10	20%
45-54	10	20%
55-64	04	8%
Highest level of education		
None	05	10%
Primary education	03	6%
Secondary education	14	27%
Tertiary education	29	57%
Employment status		
Unemployed	22	43%
Self-employed	05	10%
Formal employment	24	47%

4.2.2 Church membership status

The respondents' membership status was described in terms of length of membership, position or responsibility in the Church and level of involvement in church activities (see Appendix 2).

- **Length of membership of the Anglican Church**

For statistical analysis, membership was divided into three categories: less than one year, one to five years, and more than five years. The study revealed that 67% (n=34) of the respondents had been members for more than five years, 26% (n=13) for between one and five years, and 8% (n=4) for less than one year (see table 4.2). These results were further analysed according to gender. It was found that the majority of the respondents who had been members of the Anglican Church for more than 5 years 71% (n=24) and between 1 and 5 years 54% (n=7) were females.

Of the males, 75% (n=3) had been members of the Church for less than one year, 46% (n=6) for between one and five years, and 39% (n=10) for more than five years (see table 4.2 and figure 4.1).

Table 4.2 Respondents' gender and duration of Church membership

Duration	Total (n=51)	Gender	
		Female	Male
Less than one year	4 (8%)	1 (25%)	3 (75%)
One to five years	13 (26%)	7 (54%)	6 (46%)
More than five years	34 (67%)	24 (71%)	10 (39%)
Total	**51 (100%)**	**32 (63%)**	**19 (37%)**

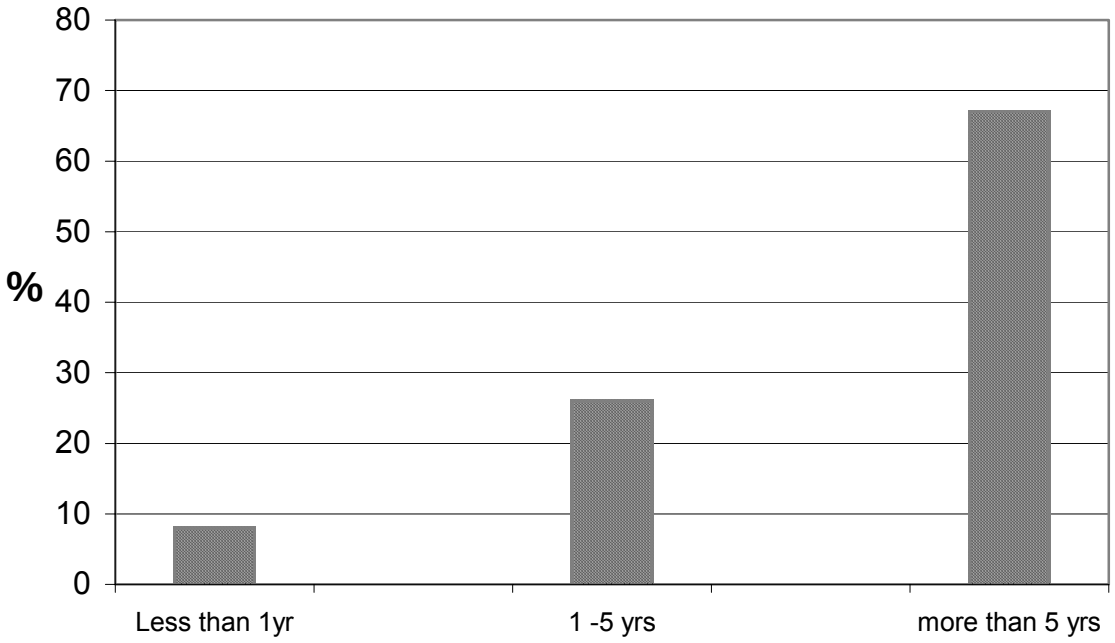

Figure 4.1 Duration of Church Membership

- **Position or responsibility in the Church**

The respondents were asked to describe their position in the church by selecting one of the following: Clergy (priest, archdeacon, rector, deacon, lay minister, Church warden), Church worker (Sunday school teacher, choir member, etc) and ordinary member. The results indicated that none of the respondents occupied the position of clergy or deacon (see table 4.3). Of the respondents, 61% (n=31) had specific positions or were actively working in the church and 39% (n=20) described themselves as ordinary members. Of the respondents, 77% (n=21) of the females had various responsibilities in the church, while 60% (n=12) of the males were ordinary members.

Of the respondents, 49% (n=25) described themselves as Church workers (Sunday school teachers, choir members, or members of different committees); 39% (n=20) as ordinary members, and 6% (n=3) each as lay ministers and churchwardens. Females represented 80% (n=20) of the church workers, 67% (n=2) of the churchwardens, 67% (n=2) of the lay ministers and 40% (n=8) of the ordinary members (see table 4.3). Males represented 60% (n=12) of the ordinary members, 33% (n=1) each of the lay ministers and the churchwardens, and 20% (n=5) of the church workers

Table 4.3 Respondents' position or responsibility in the Church

Position/Responsibility in the Church	Total (n=51)	Gender	
		Female	Male
Lay minister	3 (6%)	2 (67%)	1 (33%)
Churchwarden	3 (6%)	2 (67%)	1 (33%0
Church workers	25 (49%)	20 (80%)	5 (20%)
Ordinary member	20 (39%)	8 (40%)	12 (60%)
Total	**51 (100%)**	**32 (63%)**	**19 (37%)**

- **Involvement in church activities**

The respondents were asked to use a three-point scale (never, sometimes, and always) to rate their participation in six main church activities: Sunday services, Bible study group, Sunday school teaching, choir meetings, youth meetings, and HIV and AIDS task meetings (see Appendix 2). These activities were compared against each other in terms of their level of attendance (never, sometimes, and always). Of the respondents, 70% (n=36) indicated that they always attended Sunday services, 51% (n=26) admitted attending Bible study groups sometimes, and 67% (n=34) indicated that they never taught at the Sunday school.

In terms of the activities respondents always attended, 70% (n=36) indicated that they always attended Sunday services, followed by 26% (n=13) for Bible study group, 20% (n=10) for HIV and AIDS activity meetings, 14% (n=7) taught Sunday school, 12% (n=6) for youth meetings, and 8% (n=4) for choir meetings (see table 4.4).

In relation to the activities respondents sometimes attended, 51% (n=26) attended Bible study group sometimes, followed respectively by 36% (n=18) for youth meetings, 27% (n=14) for choir meetings, 22% (n=11) for Sunday services, 19% (n=10) taught at the Sunday school and 17% (n=9) for HIV and AIDS activity meetings (see table 4.4).

The results of the activities that respondents never attended showed that 67% (n=34) indicated that they never taught at the Sunday school followed respectively by 65% (n=33) for choir meetings, 63% (n=32) for HIV and AIDS activity meetings, 52% (n=27) for youth meetings, 23% (n=12) for Bible study group, and 8% (n=4) for Sunday services (see table 4.4).

Table 4.4 Respondents' participation in main church activities

Church activities	Rating of participation (n=51)		
	Always	Sometimes	Never
Sunday services	36 (70%)	11 (22%)	4 (8%)
Bible study group	13 (26%)	26 (51%)	12 (23%)
Teaching at the Sunday school	7 (14%)	10 (19%)	34 (67%)
Choir meetings	4 (8%)	14 (27%)	33 (65%)
Youth meetings	6 (12%)	18 (36%)	27 (52%)
HIV and AIDS activity meetings	10 (20%)	9 (17%)	32 (63%)

The respondents' participation in church activities were further grouped into two categories: negative response (referring to never) and positive response (a combination of sometimes and always). The results were compared to determine the most and least attended church activities. It was shown that Sunday service was the activity most attended with 92% (n=47), followed by 76% (n=39) for Bible study group, 48% (n=24) for youth meetings, 37% (n=19) for HIV and AIDS activity meetings, 35% (n=18) for choir meetings, and 33% (n=17) taught at the Sunday school. In the other hand, teaching at the Sunday school was the activity least attended with 67% (n=34), followed by 65% (n=33) for choir meetings, 63% (n=32) for HIV and AIDS activity meetings, 52% (n=27) for youth meetings, 23% (n=12) for bible study group, and 8% (n=4) for Sunday services (see table 4.5).

Table 4.5 Respondents' negative and positive participation in church activities

Church activities	Rating of participation (n=51)	
	Negative response	Positive response
Sunday services	4 (8%)	47 (92%)
Bible study group	12 (23%)	39 (76%)
Teaching at the Sunday school	34 (67%)	17 (33%)
Choir meetings	33 (65%)	18 (35%)
Youth meetings	27 (52%)	24 (48%)
HIV and AIDS activity meetings	32 (63%)	19 (37%)

4.3 CURRENT ROLE OF THE ANGLICAN CHURCH IN THE PREVENTION OF THE SPREAD OF HIV AND AIDS

The first objective of the study was to describe the current role of the Anglican Church in the prevention of the spread of HIV as perceived by the congregants of the Zoutpansberg Parish. Three main questions assisted the researcher to explore this objective. The respondents were asked to rate the extent to which (1) HIV and AIDS messages were included in the main church activities, (2) HIV and AIDS prevention issues were addressed in the main activities organised by the church and (3) HIV and AIDS activities were organised by the church and to rate their beliefs regarding the spread of HIV and AIDS (see Appendix 2).

4.3.1 HIV and AIDS messages in the main church activities

The respondents were asked to rate the extent to which HIV and AIDS messages were included in the following five activities of the Church: Sunday services, Bible study group, Sunday school teaching, choir meetings, and youth meetings. Of the respondents, 57% (n=29) indicated that HIV and AIDS messages were always included in Sunday services, followed by 35% (n=18) in youth meetings, 22% (n=11) in Bible study group, 14% (n=7) in choir meetings and 10% (n=5) in Sunday school teaching (see table 4.6).

The Bible study group was the highest activity where HIV and AIDS messages were sometimes included as indicated by 53% (n=27) of the

respondents, followed by Sunday school teaching with 43% (n=22), Sunday services and choir meeting with 37% (n=19), respectively, and youth meetings with 35% (n=18).

Choir meetings were the highest activity where HIV and AIDS messages were never included as indicated by 49% (n=25) of the respondents, followed by Sunday school teaching with 47% (n=24), Bible study group with 25% (n=13), youth meetings with 24% (n=15), and Sunday services with 6% (n=3).

Table 4.6 Inclusion of HIV and AIDS messages in main church activities

Church activities	Rating of the inclusion of HIV and AIDS messages (n=51)		
	Always	Sometimes	Never
Sunday services	29 (57%)	19 (37%)	3 (6%)
Bible study group	11 (22%)	27 (53%)	13 (25%)
Sunday school teaching	5 (10%)	22 (43%)	24 (47%)
Choir meetings	7 (14%)	17 (37%)	25 (49%)
Youth meetings	18 (35%)	18 (35%)	15 (30%)

4.3.2 HIV and AIDS issues addressed in the main church activities

The respondents were asked to rate the extent to which the following HIV and AIDS issues were addressed in the main activities or forums organised by the Church: (1) Cultural beliefs and practices that expose people to HIV and AIDS, (2) Sexual practices that expose people to HIV and AIDS, (3) Risk behaviour that exposes people to HIV infection, mode of transmission of HIV, (4) High risk or vulnerable group for HIV infection, (5) Myths about HIV and AIDS and Meaning of AIDS, (6) Ethical issues related to HIV and AIDS, (7) Prevention of HIV and AIDS, (8) Professional issues related to HIV and AIDS, and (9) Care of HIV and AIDS (see Appendix 2).

Of the respondents, 63% (n=32) indicated that issues related to the care of HIV and AIDS people were always addressed in the main activities organised by the Church, followed by the prevention of HIV and AIDS 55% (n=28); the meaning of AIDS 43% (n=22); risk behaviour that exposes people to HIV infection 27.5% (n=14); the high risk or vulnerable group for HIV infection 26%(n=13); sexual practices that expose people to HIV and AIDS 25,5% (n=13); the ethical issues related to HIV and AIDS 24% (n=12); the general mode of transmission of HIV and AIDS 24% (n=12), cultural beliefs and practices that expose people to HIV and AIDS 23,5% (n=12); various professional issues related to HIV and AIDS 23,5% (n=12), and myths about HIV and AIDS 20% (n=10) (see table 4.7).

Of the respondents, 55% (n=28) indicated that the mode of transmission of HIV and AIDS was sometimes included in the main activities organised by the Church, followed by professional issues related to HIV and AIDS 53% (n=27); cultural beliefs and practices that expose people to HIV and AIDS 51% (n=26) Similar percentages also indicated that the ethical issues related to HIV and AIDS were addressed in church. The respondents rated the issues sometimes addressed in the church as follows: sexual practices that expose people to HIV and AIDS: 49% (n=25); myths about HIV and AIDS: 49% (n=25); risk behaviour that exposes people to HIV infection: 47% (n=24); the high risk or vulnerable group for HIV infection: 43% (n=22); the meaning of AIDS: 39% (n=20); care of people living with HIV and AIDS: 29% (n=15), and the prevention of HIV and AIDS: 27% (n=14) (see table 4.7).

Of the respondents, 31% (n=16) rated issues related to the high risk or vulnerable group exposed to HIV infection as well as myths about HIV and AIDS as “never addressed” in the main activities organised by the church, followed by cultural beliefs and practices that expose people to HIV and AIDS 24.5% (n=13), sexual practices that expose people to HIV and AIDS 24.5% (n=13), risk behaviour that exposes a person to HIV infection 24.5% (n=13), ethical issues related to HIV and AIDS 24.5% (n=13), professional issues related to HIV and AIDS 23.5% (n=12), mode of transmission of HIV and AIDS 21% (n=11), meaning of AIDS 18% (n=9), prevention of HIV and AIDS 18% (n=9), and care of HIV and AIDS people 8% (n=4) (see table 7).

Table 4.7 Rating of HIV and AIDS issues addressed in main church activities

Activities	Rating of HIV and AIDS issues addressed in main church activities (n=51)		
	Always	Sometimes	Never
Cultural beliefs and practices that expose people to HIV and AIDS	12 (23,5%)	26 (51%)	13 (24,5%)
Sexual practices that expose people to HIV and AIDS	13 (25,5%)	25 (49,0%)	13 (24,5%)
Risk behaviour that exposes people to HIV infection	14 (27,5%)	24 (47%)	13 (24,5%)
Mode of transmission of HIV and AIDS	12 (24%)	28 (55%)	11 (21%)
High risk or vulnerable group for HIV infection	13 (26%)	22 (43%)	16 (31%)
Myths about HIV and AIDS	10 (20%)	25 (49%)	16 (31%)
Meaning of AIDS	22 (43%)	20 (39%)	9 (18%)
Ethical issues related to HIV and AIDS	12 (24%)	26 (51%)	13 (24,5%)
Prevention of HIV and AIDS	28 (55%)	14 (27%)	9 (18%)
Professional issues related to HIV and AIDS	12 (23,5%)	27 (53%)	12 (23,5%)
Care of people living with HIV and AIDS	32 (63%)	15 (29%)	4 (8%)

4.3.3 HIV and AIDS activities organised by the Church

The respondents were asked to rate the extent to which the following HIV and AIDS activities were organised by the Church:

(1) HIV and AIDS workshops, seminars

(2) HIV and AIDS conferences

(3) HIV and AIDS awareness campaigns

(4) HIV and AIDS premarital counselling

(5) HIV and AIDS counselling

(6) HIV and AIDS training

(7) HIV and AIDS support group

(8) Voluntary HIV counselling and testing (VCT)

(9) Programme for children orphaned by AIDS

(10) Prayer for people living with HIV and AIDS (see Appendix 2).

The results showed that 75% (n=38) of the respondents indicated that prayer for PLWHA was always organised by the Church, followed by 24% (n=12) each for programme for children orphaned by AIDS, and HIV and AIDS training, 22% (n=11) for HIV and AIDS awareness campaigns, 20% (n=10) each for HIV and AIDS workshops, HIV and AIDS support group, and HIV and AIDS counselling, 18% (n=9) for HIV and AIDS premarital counselling,12% (n=6) and 8% (n=4), respectively, for HIV and AIDS seminars and voluntary HIV counselling and testing.

Of the respondents, 69% (n=35) indicated that HIV and AIDS activities were sometimes organised by the Church, followed by 67% (n=34) for HIV and AIDS seminars, 65% (n=33) for HIV and AIDS workshops, 62% (n=32) for HIV and AIDS support groups, 55% (n=28) each for HIV and AIDS awareness campaigns and HIV and AIDS training, 51% (n=26) for HIV and AIDS counselling, 45% (n=23) for HIV and AIDS premarital counselling, 41% (n=21) for programme for children orphaned by AIDS, 27% (n=14) and 23% (n=12), respectively, for Voluntary HIV counselling and testing and prayer for people living with HIV and AIDS.

Table 4.8 indicates that of the respondents, 65% (n=33) commented that Voluntary HIV counselling and testing were never organised by the Church, followed by 37% (n=19) for HIV and AIDS premarital counselling, 35% (n=18) for programme for children orphaned by AIDS, 29% (n=15) for HIV and AIDS counselling, 25% (n=13) for HIV and AIDS conferences, 23% (n=12) for HIV and AIDS awareness campaign, 21% (n=11) each for HIV and AIDS seminars and HIV and AIDS training, 18% (n=9) for HIV and AIDS support group, 15% (n=8) for HIV and AIDS workshops, and 2% (n=1) for prayers for PLWHA.

Table 4.8 Rating of HIV and AIDS activities organised by the Church

Activities	Rating of HIV and AIDS activities organised by the Church (n=51)		
	Always	Sometimes	Never
HIV and AIDS workshops	10 (20%)	33 (65%)	8 (15%)
HIV and AIDS seminars	6 (12%)	34 (67%)	11 (21%)
HIV and AIDS conferences	3 (6%)	35 (69%)	13 (25%)
HIV and AIDS awareness campaign	11 (22%)	28 (55%)	12 (23%)
HIV and AIDS premarital counselling	9 (18%)	23 (45%)	19 (37%)
HIV and AIDS counselling	10 (20%)	26 (51%)	15 (29%)
HIV and AIDS training	12 (24%)	28 (55%)	11 (21%)
HIV and AIDS support group	10 (20%)	32 (62%)	9 (18%)
Voluntary HIV counselling and testing	4 (8%)	14 (27%)	33 (65%)
Programme for children orphaned by AIDS	12 (24%)	21 (41%)	18 (35.%)
Prayer for people living with HIV and AIDS	38 (75%)	12 (23%)	1 (2%)

4.4 BELIEFS ABOUT HIV AND AIDS

The respondents' beliefs about HIV and AIDS were described in terms of common myths associated with HIV and AIDS. They were asked to rate the following statements related to the common myths associated with HIV and AIDS: a circumcised man cannot contract HIV, HIV is mostly transmitted by HIV positive women rather than men; having sexual intercourse with a virgin

cures AIDS; having sexual intercourse with an old woman cures AIDS; AIDS is a punishment from God; HIV-positive people are responsible for contracting the virus, HIV and AIDS is caused by witchcraft; the recognition of polygamy will decrease the spread of HIV; AIDS is an imagination of people who want to discourage others from “enjoying sex”, and a healthy-looking person cannot be HIV positive. A five-point Likert scale, ranging from “strongly agree”, “agree”, “undecided”, “disagree” to “strongly disagree”, was used to rate their responses (Burns & Grove 2001:431) (see Appendix 2). The results of the ratings were analysed and presented as “agree” (by combining the responses of strongly agree and agree), “undecided” and “disagree” (by combining the responses of strongly disagree and disagree) (see table 4.9).

More than 50% of the respondents disagreed with all the statements. The level of disagreement varied from 98% to 51% while the level of agreement varied from 20% to 0%. The percentage of those who were undecided ranged from 29% to 2%.

The respondents disagreed as follows: “having sexual intercourse with an old woman cures AIDS” 98% (n=50); “having sexual intercourse with a virgin cures AIDS” 94% (n=48); “HIV and AIDS is caused by witchcraft” 92% (n=47); “AIDS is an imagination of people who want to discourage others from enjoying sex” 92% (n=47); “a healthy-looking person cannot be HIV positive” 92% (n=47); “a circumcised man cannot contract HIV” 88% (n=45); “AIDS is a punishment from God” 80% (n=41); “HIV is mostly transmitted by HIV-positive women rather than men” 74% (n=38); “the recognition of polygamy will

decrease the spread of HIV" 68% (n=35), and "an HIV-positive person is responsible for contracting the virus" 51% (n=26) (see table 4.9).

The respondents agreed as follows: "an HIV-positive person is responsible for contracting the virus" 20% (n=10); "AIDS is a punishment from God" 10% (n=5); "the recognition of polygamy will decrease the spread of HIV" 6% (n=3); "AIDS is an imagination of people who want to discourage others from enjoying sex" 6% (n=3); "a healthy-looking person cannot be HIV positive" 6% (n=3), and "a circumcised man cannot contract HIV" 6% (n=3). None of the respondents agreed with the rest of the statements (see table 4.9).

The respondents were undecided as follows: An HIV-positive person is responsible for contracting the virus" 29% (n=15); "HIV is mostly transmitted by HIV-positive women rather than men" 16% (n=8); "the recognition of polygamy will decrease the spread of HIV" 14% (n=7); "AIDS is a punishment from God" 10% (n=5); "HIV and AIDS is caused by witchcraft" 8% (n=4); "a circumcised man cannot contract HIV" 6% (n=3); "having sexual intercourse with a virgin cures AIDS" 6% (n=3); "having sexual intercourse with an old woman cures AIDS" 2% (n=1); "AIDS is an imagination of people who want to discourage others from enjoying sex" 2% (n=1), and "a healthy-looking person cannot be HIV positive" 2% (n=1).

Table 4.9 Respondents' beliefs about HIV and AIDS

Statements	Rating of personal beliefs about HIV and AIDS (n=51)		
	Agree	Undecided	Disagree
A circumcised man cannot contract HIV	3 (6%)	3 (6%)	45 (88%)
HIV is mostly transmitted by HIV positive women rather than men	0 (0%)	8 (16%)	38 (74%)
Having sexual intercourse with a virgin cures AIDS	0 (0%)	3 (6%)	48 (94%)
Having sexual intercourse with an old woman cures AIDS	5 (10%)	1 (2%)	50 (98%)
AIDS is a punishment from God	10 (20%)	5 (10%)	41 (80%)
An HIV-positive person is responsible for contracting the virus	0 (0%)	15 (29%)	26 (51%)
HIV and AIDS is caused by "sent sickness" or witchcraft	9 (18%)	4 (8%)	47 (92%)
The recognition of polygamy will decrease the spread of HIV	3 (6%)	7 (14%)	35 (68%)
AIDS is an imagination of people who want to discourage others from "enjoying sex"	3 (6%)	1 (2%)	47 (92%)
A healthy-looking person cannot be HIV positive	3 (6%)	1 (2%)	47 (92%)

4.5 FUTURE ROLE OF THE ANGLICAN CHURCH IN THE PREVENTION OF THE SPREAD OF HIV AND AIDS

The respondents' were asked to describe the future role of the Anglican Church in the prevention of the spread of HIV and AIDS with regard to the steps or actions to be taken by the Church in so doing. They were asked three main questions (see appendix 2). The first question consisted of statements on the steps to be taken by the Church in the prevention of HIV and AIDS. The second question consisted of statements on the role the Church should

play in the prevention of the spread of HIV and AIDS. The last question was an open-ended question on the role to be played by the Church in the prevention of the spread of HIV and AIDS.

The respondents were expected to answer the first two questions using a five-point Likert scale ranging, from “strongly agree”, “agree”, “undecided”, “disagree” to “strongly disagree” (Burns & Grove 2001:431). The results of these rating were analysed as “agreed”, including “strongly agree” and “agree”; “undecided”, and “disagree”, including “strongly disagree” and “disagree”. The answers to the open-ended questions were also quantitatively analysed. The results of the findings are presented as general and specific steps or actions to be taken by the Church.

4.5.1 General steps or actions to be taken by the Church

The respondents had to rate the following general steps or actions to be taken by the Church:

(1) The Church should provide a climate of love, acceptance and support for people affected by HIV and AIDS.

(2) HIV and AIDS issues or concerns should be raised in regular worship.

(3) The Church should allow HIV and AIDS issues or concerns to be raised only in special worship events.

(4) The Church should reflect on the theological basis for responding to challenges posed by HIV and AIDS.

(5) The Church should participate in public discussions and/or debates on HIV and AIDS.

(6) The Church should support their own members who are working as health professionals to deal with ethical issues in the areas of HIV and AIDS prevention and care.

(7) The Church should address ethical issues and concerns related to HIV and AIDS (see Appendix 2).

The level of agreement with the above statements varied from 86% to 29%. The results showed that the respondents agreed as follows that the Church should: (1) provide a climate of love, acceptance and support for people affected by HIV and AIDS 86% (n=44); (2) support their own members who were working as health professionals to deal with ethical issues with regard to HIV and AIDS prevention and care 86% (n=44); reflect on the theological basis for responding to challenges posed by HIV and AIDS 82% (n=42); raise HIV and AIDS issues or concerns in regular worship 79% (n=40); address ethical issues and concerns related to HIV and AIDS 79% (n=40); reflect on the theological basis for responding to challenges posed by HIV and AIDS 63% (n=32), and allow HIV and AIDS issues or concerns to be raised only in special worship events 29% (n=15) (see table 4.10).

The level of disagreement varied from 57% to 2%. The respondents disagreed as follows that the Church should: allow HIV and AIDS issues or concerns to be raised only in special worship events 57% (n=29); raise HIV and AIDS issues or concerns in regular worship 15% (n=8); reflect on the theological basis for responding to challenges posed by HIV and AIDS 15%

(n=8); participate in public discussions and/or debates on HIV and AIDS 14% (n=7); support their own members who were working as health professionals to deal with ethical issues in the areas of HIV and AIDS prevention and care 8% (n=4); provide a climate of love, acceptance and support for people affected by HIV and AIDS 8% (n=4), and address ethical issues and concerns related to HIV and AIDS 2% (n=1) (see table 4.10).

The percentage of undecided ranged from 22% to 4%. The respondents were undecided as follows on whether the Church should: reflect on the theological basis for responding to challenges posed by HIV and AIDS 22% (n=11); address ethical issues and concerns related to HIV and AIDS 20% (n=10); allow HIV and AIDS issues or concerns to be raised only in special worship events 14% (n=7); support their own members who were working as health professionals to deal with ethical issues in the areas of HIV and AIDS prevention and care 6% (n=3); raise HIV and AIDS issues or concerns in regular worship 6% (n=3); provide a climate of love, acceptance and support for people affected by HIV and AIDS 6% (n=3), and participate in public discussions and/or debates on HIV and AIDS 4% (n=2) (see table 4.10).

Table 4.10 General steps or actions to be taken by the Church

Statements	Rating of personal beliefs about HIV and AIDS (n=51)		
	Agree	Undecided	Disagree
The Church should provide a climate of love, acceptance and support for people affected by HIV and AIDS	44 (86%)	3 (6%)	4 (8%)
HIV and AIDS issues or concerns should be raised in regular worship	40 (79%)	3 (6%)	8 (15%)
The Church should allow HIV and AIDS issues or concerns to be raised only in special worship events	15 (29%)	7 (14%)	29 (57%)
The Church should reflect on the theological basis for responding to the challenges of HIV and AIDS	32 (63%)	11 (22%)	8 (15%)
The Church should participate in public discussions and/or debates on HIV and AIDS	42 (82%)	2 (4%)	7 (14%)
The Church should support their own members who are working as health professionals to deal with the ethical issues of HIV and AIDS prevention and care	44 (86%)	3 (6%)	4 (8%)
The Church should address ethical issues and concerns related to HIV and AIDS	40 (79%)	10 (19%)	1 (2%)

4.5.2 Specific steps or actions to be taken by the Church in the prevention of the spread of HIV and AIDS

The respondents were asked whether the Church should play an active role in educating and informing its members on

(1) Cultural beliefs and practices that could expose people to HIV infection

(2) Sexual practices that could expose people to HIV infection

(3) Risk behaviour that could expose people to HIV infection

(4) The mode of transmission of HIV

(5) High-risk or vulnerable groups for HIV infection

(6) Myths about HIV and AIDS, and the correct meaning of AIDS

(7) The prevention of HIV and AIDS by addressing professional issues related to HIV and AIDS, and in advocating the use of anti-retroviral drugs in the prevention of HIV and AIDS (see Appendix 2).

Between 92% and 67% of the respondents agreed with the above statements. The respondents agreed as follows that the Church should play an active role in: addressing professional issues related to HIV and AIDS 92% (n=47); the prevention of HIV and AIDS 90% (n=46); informing its members on the meaning of AIDS 88% (n=45); educating its members on sexual practices that expose people to HIV infection 82% (n=42): advocating for the use of anti-retroviral drugs in the prevention of HIV and AIDS 82% (n=42); educating its members on risk behaviour that exposes people to HIV infection 80% (n=41); educating its members on the mode of transmission of HIV 80% (n=41); educating its members on cultural beliefs and practices that could expose people to HIV infection 74% (n=38); addressing myths about HIV and AIDS 73% (n=37), and educating its members on high-risk or vulnerable groups for HIV infection 67% (n=34) (see table 4.11).

Of the respondents, between 13% and 4% disagreed with the above statements, the respondents disagreed as follows that the Church should play

an active role in: educating its members on high-risk or vulnerable groups for HIV infection 13% (n=7); educating its members on cultural beliefs and practices that expose people to HIV infection 8% (n=4); educating its members on risk behaviour that exposes people to HIV infection 8% (n=4); addressing myths about HIV infection 8% (n=4); educating its members on sexual practices that expose people to HIV infection 6% (n=3); advocating for the use of anti-retroviral drugs in the prevention of HIV and AIDS 4% (n=2); the prevention of HIV and AIDS 4% (n=2), and informing its members on the correct meaning of AIDS 4% (n=2) (see table 4.11).

Of the respondents, between 20% and 6% were undecided regarding the role of the Church. The respondents were undecided as follows on whether the Church should play an active role in: educating members on the mode of transmission of HIV 20% (n=10); educating members on high-risk or vulnerable groups for HIV infection 20% (n=10); addressing myths about HIV and AIDS 20% (n=10); educating members on cultural beliefs and practices that expose people to HIV infection 18% (n=9); advocating for the use of anti-retroviral drugs in the prevention of HIV and AIDS 14% (n=7); educating members on sexual practices that expose people to HIV infection 12% (n=6); educating members on risk behaviour that expose people to HIV infection 12% (n=6); informing members on the meaning of AIDS 8% (n=4); addressing professional issues related to HIV and AIDS 8% (n=4), and informing members about the prevention of HIV and AIDS 6% (n=3).

There were similarities between the answers generated from the open-ended question and the results presented above. Of the respondents, 55% (n=28) indicated that the Church should: (1) provide homes and orphanages for children orphaned by AIDS; (2) conduct training and workshops for members and the community to educate them on HIV and AIDS-related issues; (3) involve the youth in HIV and AIDS activities; (4) teach members to abstain from premarital sex and to be faithful in their marital relationship; (4) educate members on the dangers of extramarital sex and monitor their compliance with biblical values; (5) encourage members to use condoms and also provide members with condoms. Of the respondents, 45% (n=23) indicated that the Church should care, love and support people infected with and affected by HIV and AIDS.

Table 4.11 Steps or actions to be taken by the Church in the prevention of the spread of HIV and AIDS

The Church should play an active role in:	Rating of personal beliefs about HIV and AIDS (n=51)		
	Agree	Undecided	Disagree
Educating its members on cultural beliefs and practices that expose people to HIV infection	38 (74%)	9 (18%)	4 (8%)
Educating its members on sexual practices that expose people to HIV infection	42 (82%)	6 (12%)	3 (6%)
Educating its members on risk behaviour that exposes people to HIV infection	41 (80%)	6 (12%)	4 (8%)
Educating its members on the mode of transmission of HIV	41 (80%)	10 (20%)	0 (0%)
Educating its members about high-risk or vulnerable groups for HIV infection	34 (67%)	10 (20%)	7 (13%)
Educating members about myths about HIV and AIDS	37 (73%)	10 (20%)	4 (8%)
Informing its members on the meaning of AIDS	45 (88%)	4 (8%)	2 (4%)
Educating members on the prevention of HIV and AIDS	46 (90%)	3 (6%)	2 (4%)
Addressing professional issues related to HIV and AIDS	47 (92%)	4 (8%)	0 (0%)
Advocating for the use of anti-retroviral drugs in the prevention of HIV and AIDS	42 (82%)	7 (14%)	2 (4%)

4.6 CONCLUSION

This chapter covered the data analysis and interpretation of the respondents' views on the Church's role in the prevention of the spread of HIV/AIDS.

Chapter 5 concludes the study, discusses its limitations and makes recommendations.

CHAPTER 5

Findings, limitations and recommendations

5.1 INTRODUCTION

This chapter discusses the findings on the respondents and the current and future role of the Anglican Church in preventing the spread of HIV/AIDS, briefly describing the limitations of the study and making recommendations for practice and further research.

5.2 THE RESPONDENTS

The respondents were described in terms of their demographic characteristics (gender, age, formal education and employment status) and Church membership status (length of membership, position in the Church, and the level of involvement with the activities organised by the Church). The study found that of the respondents, 63% (n=32) were female; 72% (n=37) were between 17 and 44 years old; 90% (n=46) had formal education; 57% (n=29) had a tertiary education qualification; 57% (n=29) were formally or self-employed; 10% (n=5) did not have any formal education, and 43% (n=22) were unemployed.

These findings suggest that the congregants of the Zoutpansberg Parish are mostly of a young and productive age (17-44), well educated, mostly females, and less than 60% have secure sources of income. However, the level of

unemployment (43%) amongst the congregants, despite the number with tertiary education qualifications (57%), is a matter of concern. Unemployment means a lack of secure income and poverty. Zawaira (1999:26) found a high correlation between HIV infection and poverty and maintains that the spread of HIV infection is strongly associated with poverty and unemployment. The Church leadership can take advantage of the high literacy rate (90%) among the congregants by training them as HIV and AIDS-related workshop trainers and facilitators in Church-organised activities, and remunerate them with monetary tokens, which would alleviate their penury.

The study found that of the respondents, 67% (n=34) had been members of the Anglican Church for more than five years; women were the longest serving members, representing 71% who had been in the Church for more than five years and 54% who had been members between 1 and 5 years. Furthermore, of the respondents, 61% (n=31) were actively involved and assumed responsibilities in the various activities organised by the Church; females were more active (77% assumed various responsibilities in the Church) than males (60% were just ordinary members); 70% (n=36) indicated that they always attended Sunday service; 67% (n=34) never attend Sunday school teaching, 65% (n= 33) never attend choir meetings, 63% (n=32) never attend HIV and AIDS activity meetings, and 52% (n=27) never attend youth meetings.

The findings on the respondents' membership status indicate that Zoutpansberg Parish is made up of long-standing members, the majority of

whom are females. The congregants are involved in various activities organised by the parish, and Sunday service is the activity most attended. Accordingly, provision should be made to include HIV and AIDS activities or issues during the Sunday services.

5.3 CURRENT ROLE OF THE ANGLICAN CHURCH IN THE PREVENTION OF THE SPREAD OF HIV AND AIDS

The current role of the Anglican Church in the prevention of the spread of HIV and AIDS was described in terms of the extent to which HIV and AIDS messages are included in the main activities of the Church; HIV and AIDS prevention issues are dealt with in the main activities organised by the Church, and HIV and AIDS activities are organised by the Church as well as the congregants' beliefs about the spread of HIV and AIDS.

With regard to the respondents' perception of the current role of the Anglican Church in the prevention of the spread of HIV and AIDS, the study found that 70.6% (n=36) of the respondents indicated that HIV and AIDS messages were "always" included in the Sunday service. Although this is a good effort, the Church could nonetheless extend to other church activities like Sunday school and youth meetings. This is one area to reach young people with the right information on HIV and AIDS in order to empower them so that they are in a better position to prevent the further spread of the HI virus in the community.

As for HIV and AIDS activities organised by the Church, 74, 5% (n=38) of the respondents indicated that prayer for people living with HIV and AIDS was

“always” done; 64, 7% (n=33) indicated that voluntary HIV counselling and testing (VCT) was “never” done, and 45,1% (n=23) indicated that marital counselling was “never” organised by the Church. It is important for the Zoutpansberg parish congregation to know that VCT and marital counselling are vital to the prevention of HIV spread in the community, the Province and beyond.

The need to organise regular workshops, seminars, and conferences to share and pass on correct information about HIV and AIDS to others is an integral aspect of the prevention strategy. The initiation of HIV and AIDS support groups in and around the Church community is important for people living with HIV to meet together share experiences, support and encourage one another. This can give longevity, as rejection and discrimination will not be experienced in a group of people with similar needs.

The respondents had a poor perception of the extent to which other aspects of HIV and AIDS (such as cultural beliefs and practices that expose people to HIV, myths about AIDS) were discussed in various church activities. According to most of the respondents, high-risk or vulnerable groups for infection and myths about HIV and AIDS were “never” discussed in the various church activities while cultural beliefs and practices, sexual practices and risky behaviour that exposed people to HIV infection, and ethical issues related to HIV and AIDS were “not usually” mentioned. The Zoutpansberg parish need to speak more openly about these issues as many could be infected by the HI virus through ignorance while upholding cultural beliefs and practices that could expose them to the infection. One example is the ritual

cleansing that requires a family member of a deceased person to have sexual intercourse with the widow or widower. If the deceased died from AIDS-related causes and has infected the partner, the family member that observes this cultural practice will be exposed to the infection unless he/she knows the danger involved, and an informed decision is made that will prevent the further spread of the HI virus.

The Church doctrine or the respondents' relatively high level of formal education seemed to have influenced their cultural beliefs. This was seen from the responses to issues on rating of personal beliefs and culture. Of the respondents, 98, 1% (n=50) disagreed that having sexual intercourse with an old woman cured AIDS and 94,1% (n=48) disagreed that having sexual intercourse with a virgin cured AIDS; only 19,6% (n=10) indicated that an HIV-positive person was responsible for contracting the virus, while 51% (n=26) disagreed.

5.4 FUTURE ROLE OF THE ANGLICAN CHURCH IN THE PREVENTION OF THE SPREAD OF HIV AND AIDS

The study supports Snidle and Yeoman's (1997:7) finding that the participation of various age groups in church activities is vital to the integration and equipping of Church members with the basic knowledge and skills that will assist in reducing stigmatisation, victimisation and discrimination suffered by people living with HIV and AIDS. The high response rate for prayer for

people living with HIV and AIDS can be attributed to the weekly prayers said during the Sunday service.

Of the respondents, 62,7% (n=32) indicated that care of people infected and affected by HIV and AIDS was “always” mentioned in Church organised activities, and 31,4% (n=16) indicated that myths about HIV and AIDS, and high-risk or vulnerable groups for HIV infection were “never” discussed in Church organised activities. Of the respondents, 98, 1% (n=50) disagreed that having sexual intercourse with an old woman cured AIDS and 19.6% (n=10), agreed that an HIV-positive person was responsible for contracting the virus. Jones (2004:16, 37) found that having sexual intercourse with a virgin or an old woman did not cure AIDS and Webb (1997:2) emphasises that although there is no known cure for AIDS at present, there may be a breakthrough in the future. Helman (1997:348) points out that the belief that HIV-people are responsible for contracting the virus is widely held by many people all over the world and that cultural representation of AIDS may be a blend of medical and indigenous beliefs that it is a physical disease, but also “a punishment for sinful behaviour”.

The high response rate (62, 8%) revealed that people expect the Church to have answers to the HIV pandemic. People expect moral guidance from the Church, as the Church has a unique opportunity to convey a relevant message to the world in a time of moral and political crisis and the HIV pandemic is regarded as a major crisis in the world today (WCC 1997:49).

Of the respondents, 82,4% (n=42) indicated that the Church should participate in public discussion and/or debates on HIV and AIDS. This high response rate would seem to suggest that in the respondents' view the Church is probably not doing enough in this area.

The Church should support their own members who are working as health professionals to deal with ethical issues in the areas of HIV and AIDS prevention and care. HIV and AIDS ethical issues confidential and should be treated seriously. People infected with the virus usually want to keep it to themselves until they are ready to disclose and would like it to remain that way. This could be due to their fear of rejection and discrimination by others. These feelings must be respected and the respondents indicated that the Church should support their own members working as health workers to deal confidentially and respectfully with HIV-positive people they encounter in the course of their duty.

Of the respondents, 86,3% (n=44) agreed that the Church should provide a climate of love, acceptance and support for people affected by HIV and AIDS and should support their own members who were working as health professionals to deal with ethical issues in the areas of HIV and AIDS prevention and care. The WCC (1997) and Snidle and Yeoman (1997:2, 3) state that Christians should respond to AIDS sufferers with compassion. Moreover, of the respondents, 56,9% (n=29) disagreed that the Church should only allow HIV and AIDS issues or concerns to be raised in special worship events"; 92,2% (n=47) agreed that the Church should play an active

role in dealing with professional issues related to HIV and AIDS, and 13,7% (n=7) disagreed that the Church should play an active role in educating its members on high-risk or vulnerable groups for HIV/AIDS. The high response rate can be attributed to the need felt by people to be empowered with the right information to prevent the further spread of HIV infection. This concurs with the WCC (1997:49) recommendation and societal expectations of the Church.

Saayman and Kriel (1991:163) maintain that unless the idolatrous view of sex and sexuality becomes the focus of the campaign against AIDS, the chances of winning the fight of preventing the spread are slim. The Church should encourage open discussion and try to understand members' cultures and traditions, preach the word of God to reduce the spread, provide information on the Church's stance on HIV and AIDS, offer prayers for the sick and set up homes and orphanages for children orphaned by AIDS.

5.5 LIMITATION

The study was restricted to one out of twelve parishes of the Diocese of St Mark's Anglican Church, Limpopo Province, therefore the findings cannot be generalised to all the Anglican Church parishes in Limpopo Province or South Africa. The role of the Zoutpansberg Parish in the prevention of HIV and AIDS might have been influenced by the members' perceived needs in relation to HIV and AIDS issues hence their response might differ significantly from other parishes.

5.6 RECOMMENDATIONS

In view of the findings of the study, the researcher makes the following recommendations:

- More emphasis should be placed on encouraging people to participate in HIV and AIDS-related activities, such as VCT, to know their HIV status.
- The Church should be more open on issues of HIV and AIDS and speak out on cultural and sexual practices that can expose people to HIV infection; create a forum for members of the congregation and the public to discuss the beliefs and myths about HIV and AIDS common to our community and society, and provide VCT as well as premarital counselling for people in need of counselling.
- More HIV and AIDS-specific educational material with the focus on Biblical doctrines and “No sex before marriage” should be encouraged, especially among the youth and unmarried people, teach people the correct way of using the condom for the sake of those who can not abstain to practice safe sex by using condom for protection while mutual faithfulness is encouraged among the married people.
- Choirs and other church ministries should encourage and adopt HIV and AIDS-related songs that express Christ and Christian unconditional love, and use drama and plays to educate members on HIV and AIDS.

- Family activities with the focus on males' roles in marriage should be organised to include more men in HIV and AIDS education within the parish and community.
- The Church could also use the sermon time on certain Sundays to allow PLWHA to share their life experience with the congregation. Since the majority of the respondents (70%) indicated that always attended the Sunday service, this could be an opportunity to witness this sharing experience. This might encourage others living with HIV and AIDS in the congregation to talk about and deal with their struggles. Allow congregants time and space to speak openly about their pains, fears and concerns as this would help create and provide a climate of acceptance, understanding, love and commitment from all to do something about HIV and AIDS. Listening to others who are free to talk about their personal fear, pains and concern would help others to learn and better understand what it feels like to live with HIV. This should make people more tolerant, supportive and understanding towards people living with HIV and AIDS.

  These activities might influence behavioural changes as well as make people want to take responsibility for their lives and decide to know their HIV status. People with any kind of sexually transmitted disease (STD), in turn, might seek early treatment knowing that treatment is available for most STDs and where to go for proper treatment as well as abstaining from sexual intercourse or using a condom for protection from HIV infection. Pregnant women who tested positive would know

that their unborn babies could be protected from HIV infection if they go to the hospital and attend an antenatal clinic where they can access anti-retroviral drugs. Anyone who tested positive would know that having the virus is not a death sentence. If they seek treatment early, take the anti-retroviral drugs, adhere to the regime and live a healthy life style, they could still live long enough to realise their life's ambition and their children would not be orphaned from AIDS.

If these processes are implemented and succeed, issues of denial, stigma, rejection, judgemental attitudes, and breaking the silence will be addressed. The congregation and community will be educated and the Church will have contributed to the prevention of the spread of HIV.

Bearing in mind the limitations of this study, the researcher recommends that

- A broader study of Anglican Church parishes in more Provinces be undertaken for a co-ordinated approach to the prevention of HIV and AIDS.
- A comparative interdenominational study of Church approaches to and roles in preventing the spread of HIV and AIDS. The Roman Catholic, Methodist and Dutch Reformed Churches' approaches could be compared and co-ordinated, for example.
- A comparative interdenominational study of the perceptions of urban, White lay members of the Anglican and Roman Catholic Churches on

the causes of and the Church's role in the prevention of the spread of HIV and AIDS.

5.7 CONCLUSION

The study examined the Anglican Church's response to and role in the prevention of the spread of HIV and AIDS in one parish in the Limpopo Province. The findings indicated a section of the South African population's perceptions of the causes of HIV and AIDS and their Church's response to the pandemic. Although this was a relatively limited study, the findings provide much food for thought for all believers.

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APPENDIX 1

LETTER OF CONSENT

Dear Sir / Madam,
Re: Request for participation to a study

I hereby request your participation to the study entitled "**The role of the Anglican church in the prevention of the spread of HIV and AIDS in the Limpopo Province"** by completing the attached questionnaire and by returning the completed questionnaire using the self- addressed envelop provided or personally to the researcher.

The study is undertaken in partial fulfilment towards the degree of Masters in Health Studies at the Department of Health Studies, University of South Africa (UNISA). Your participation to the study is optional and the return of the completed questionnaire will be considered as your consent to participate to the study.

The questionnaire does not include any personal information and the returned questionnaire will be handled with confidentiality. The results will be presented in such a way that the information will not be trace back to the individual participants.

Church leaders might use the results of this study as guidelines to formulate specific interventions aimed at preventing the spread of HIV and AIDS in Limpopo Province. A summary of the findings will be made available to the participants on request.

I look forward to your participation.

Blessings

Mrs. Rosa I Useh
(If you have any questions concerning the questionnaire contact me at 0155163633, or email: rosauseh@yahoo)

APPENDIX 2

RESEARCH QUESTIONNAIRE

SECTION A: GENERAL INFORMATION

Please answer all the questions by placing a cross (X) at the relevant block/space provided except where specific information is required.

i. Demographic data

1. Gender

- ☐ Female
- ☐ Male

2. Age in years

- ☐ 17-24
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65 and over

4. Formal Education

- ☐ None
- ☐ Primary
- ☐ Secondary
- ☐ Tertiary

5. Employment status

- ☐ Unemployed
- ☐ Self-employed
- ☐ Formal employment
- ☐ Other (specify) _____

II. Church membership status

Note: Please answer all the questions by placing a cross (X) at the relevant block/space provided except where specific information is required.

1. How long have you been a member of Anglican Church?

- Less than one year
- 1-5 year
- More than five year

2. Which of the following describe your position in the church?

- Clergy (Priest, Archdeacon, Rector)
- Deacon
- Lay-Minister
- Church warden
- Church worker (Sunday school teacher, Choir member etc)
- Ordinary member

3. How do you rate your participation to the following church activities?

Note:

- Answer this question using the following keys:
  1: Never; 2: Sometimes; 3: Always.
- Answer by placing a cross (X) in the block under the corresponding key.

E.g.

Activities	**1**	**2**	**3**
Sunday services			**X**

Activities	**1**	**2**	**3**
Sunday services			
Biblical study group			
Teaching at the Sunday school			
Choir meetings			
Youth meetings			

SECTION B: CURRENT ROLE OF THE CHURCH IN THE PREVENTION OF THE SPREAD OF HIV AND AIDS

Note:

- Answer questions 1 to 3 by using the following keys:
  1: Never; 2: Sometimes; 3: Always.
- Answer each statement by placing a cross (X) in the block under the corresponding key.

Question 1.

How often are HIV and AIDS messages included in the following church activities?

Activities	**1**	**2**	**3**
Sunday services			
Biblical study group			
Teaching at the Sunday school			
Choir meetings			
Youth meetings			

Question 2.

How often are the following HIV and AIDS activities organized in your church?

Activities	**1**	**2**	**3**
HIV and AIDS workshop			
HIV and AIDS seminars			
HIV and AIDS conferences			
HIV and AIDS awareness campaign			
Pre-marital HIV and AIDS counselling			
HIV and AIDS counselling			
HIV and AIDS Training			
Support group for HIV and AIDS			
Home visit for HIV and AIDS affected family and people			
Voluntary HIV Counselling and Testing			
Programme for children orphaned by AIDS			
Prayers for people living with HIV and AIDS			

Question 3.

How often the following aspects of HIV and AIDS are addressed in your church?

	1	2	3
Cultural beliefs and practices that expose to HIV infection			
Sexual practices that expose to HIV infection			
Risk behaviour that expose to HIV infection			
Mode of transmission of HIV and AIDS			
High risk group or vulnerable group to HIV infection			
Myths about HIV and AIDS			
Meaning of AIDS			
Ethical issues related to HIV and AIDS			
Prevention of HIV and AIDS			
Professional issues related to HIV and AIDS			
Care of HIV and AIDS			

SECTION C: YOUR PERSONAL BELIEF ABOUT HIV AND HIV

Note:

- Answer this **question** by using the following keys: **SA: Strongly Agree; A: Agree; U: Undecided; D: Disagree; SD: Strongly Disagree**
- Evaluate each statement by placing a cross (X) in the block under the corresponding key.

Statements **I believe that:**	**SA**	**A**	**U**	**D**	**SD**
A circumcised man cannot contract HIV					
HIV is mostly transmitted by HIV positive women than men					
Having sexual intercourse with a virgin cures AIDS					
Having sexual intercourse with an old woman cures AIDS					
AIDS is a punishment from God					
HIV positive person is responsible for contracting the virus					
HIV and AIDS is caused by ‘sent sickness’ or witchcraft					
The recognition of polygamy will decrease the spread of HIV					
AIDS is an imagination of people who want to discourage others to ‘enjoy sex’					
A healthy looking person cannot be HIV positive					

SECTION D: FUTURE ROLE THE CHURCH IN THE PREVENTION OF THE SPREAD OF HIV AND AIDS

Note:

- Answer **questions 1 and 2** by using the following keys: **SA: Strongly Agree; A: Agree; U: Undecided; D: Disagree; SD: Strongly Disagree**
- Evaluate each statement by placing a cross (X) in the block under the corresponding key.

Question 1.

Actions to be taken by the church:	**SA**	**A**	**U**	**D**	**SD**
The church should provide a climate of love, acceptance and support for people affected by HIV and AIDS					
HIV and AIDS issues or concerns should be raised in regular worship					
The church should allow HIV and AIDS issues or concerns to be raised only in special worship events					
The church should reflect on the theological basis for responding to challenges posed by HIV and AIDS					
The church should participate in public discussions and/or debates on HIV and AIDS					
The church should support their own members who are working as health professional to deal with ethical issues in the areas of HIV and AIDS prevention and care					
The church should address ethical issues and concerns related to HIV and AIDS					

Question 2.

The church should play an active role in:	**SA**	**A**	**U**	**D**	**SD**
Educating its members on cultural beliefs and practices that expose people to HIV infection					
Educating its members on sexual practices that expose people to HIV infection					
Educating its members on risk behaviour that expose them to HIV infection					
Educating its members on the mode of transmission of HIV					
Educating its members regarding high risk group or vulnerable group to HIV infection					
Addressing the myths attached to HIV and AIDS					
Informing its members on the meaning of AIDS					
The prevention of HIV and AIDS					
Addressing professional issues related to HIV and AIDS					
Advocating for the use of anti-retroviral drugs in the prevention of HIV and AIDS					

Question 3.

What other role do you think the church should play in the prevention of the spread of HIV and AIDS?

APPENDIX 3

PERMISSION TO CONDUCT A STUDY IN THE DIOCESE

The Diocese Of St Mark The Evangelist

(THE ANGLICAN CHURCH IN THE NORTHERN PROVINCE)

P.O. Box 643
0700 Pietersburg
South Africa

18 May 2004

Mrs. Rosa Useh
P.O. Box 731
Louis Trichardt
0920

Dear Rosa,

Greetings in the name of our Lord and Saviour Jesus Christ, who calls his Church to reach out to all those who are suffering in poverty and sickness.

Re: Permission to conduct a study in the Diocese

I am very glad to give you my permission to conduct a study in the Diocese of St. Mark the Evangelist on the role of the Church in prevention of HIV/AIDS. Hopefully this study will not only enable you to complete your Masters degree at UNISA but will also benefit the Diocese of St. Mark the Evangelist with the implementation of its strategies with regard to HIV/AIDS.

I wish you every blessing in your studies and ongoing ministry as Diocesan HIV/AIDS co-ordinator.

Yours in our Lord Jesus Christ,

+Martin

Bishop M. A. Breytenbach
cc: Rev. Peter Wilson
Mr. Philip Moseki
18 may 2004-Rosa Useh

Tel: (015) 297 3297 Fax: (015) 297 0408 e-mail: stmarks@pixie.co.za

APPENDIX 4

CLEARANCE CERTIFICATE

UNIVERSITY OF SOUTH AFRICA (UNISA)
Faculty of Human Sciences
Health Studies Research & Ethics Committee (HSREC)

CLEARANCE CERTIFICATE- Project No: 004/2004

Date of meeting: 7 September 2004

Project Title:
The Role of Anglican Church in the prevention of the spread of HIV and AIDS in the Limpopo Province

Researcher:
Mrs. RI Useh (student number 33106517)

Supervisor/Promoter:
Prof. M Ganga-Limando (PhD, MCUR)

Joint Supervisor/Joint Promoter:
Mrs. E. Monama (MCUR)

Department:
Health Studies

Degree:
MA Health Studies (Community Health)

DECISION OF COMMITTEE

This is to certify that the project No.004/2004 described above, was approved by the **Health Studies Research & Ethics Committee (HSREC)** on its meeting of the 7 September 2004 for the degree of MA Health Studies.

Date: 21September 2004

Prof TR Mavundla
RESEARCH COORDINATOR

Note: Should any department be contemplated from the research procedure as approved, the researcher(s) must submit the protocol to the committee.

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRES

APPENDIX 5

NOTE FROM EDITOR

Tel: (012) 667-1265
Mobile/Cell:
073-782-3923

53 Glover Ave
Doringkloof
0157 Centurion

1 March 2006

TO WHOM IT MAY CONCERN

This is to certify that I edited Rosa Isegbuyota Useh's master's dissertation on **The role of the Anglican Church in the prevention of the spread of HIV and AIDS in the Limpopo Province** for language and content.

Ms Iauma M Cooper
192-290-4

APPENDIX 6

DECLARATION OFCOMMITMENT FROM THE UN AND THE CHURCH

The Special Session's Declaration of Commitment, adopted unanimously, now serves as a benchmark for global action. Its targets and goals include the need to:

- Secure more resources to fight AIDS increasing annual spending to US$7-10 billion in low-and middle-income countries;
- Ensure that by 2005, that a wide range of prevention programmes are available in all countries;
- Ensure that by 2005 at least 90% of young people aged 15-24years have access to information, education and services necessary to develop the life skills needed to reduce their vulnerability to HIV, and 95% by 2010;
- Reduce by 25% the rate of HIV infection among young people aged 15-24years in the most affected countries by 2005 and globally by 2010;
- Reduce by 20% by 2005 and 50% by 2010 the proportion of infants born with HIV;
- Enact or strengthen antidiscrimination and human rights protection for people living with HIV and AIDS and for vulnerable groups by 2003;
- Develop or strengthen participatory programmes by 2003, to protect the health of those most affected by HIV and AIDS;
- Empower women as an essential part of reducing vulnerability to HIV;
- Develop national strategies by 2003to strengthen health-care systems and address factors affecting the provision of HIV-related drugs, including affordability and pricing; and
- Make treatment and care for people with HIV and AIDS as fundamental to the AIDS response as its prevention (UNAIDS 2002:12-13).

MEASURES TO BE TAKEN IN ORDER TO PREVENT HIV TRANSMISSION

The HIV / AIDS and the Law Project (2003 :14-18) document indicated that the prevention of HIV transmission requires that people are properly informed about how the virus can, and cannot be transmitted from one person to another. It is assumed that understanding these facts would enable people make responsible choices that will prevent HIV transmission.

The above document suggested a number of measures to be taken in order to prevent HIV transmission. Some of these measures include:

- Abstaining from (not have) sex before marriage;
- Practising safe sex by using the male or female condom, staying faithful to only one uninfected partner, practising sex without penetration;
- Taking Universal Precautions;
- Post- exposure prophylaxis as seen in needle stick injury, accidents and sport injuries, rape and sexual assault;
- Early diagnosis and treatment of other sexually transmitted diseases;
- Safe blood transfusions. All blood to be transfused should be tested and confirmed negative for antibodies against HIV;
- Proper sterilisation of needles and other skin-piercing instruments;
- Provision of sterile instruments for users of intravenous drugs;
- Provision of comprehensive physical, emotional and spiritual care for persons living with HIV and AIDS;
- Reducing discrimination and advocate for the rights of people who are vulnerable to HIV;
- Prevent Mother- to- Child Transmission by increasing the accessibility of anti-retroviral treatment;
- HIV testing and counselling (HIV / AIDS and the Law 2003:14-18).

The world council of churches recommendations to the church in response to the HIV and AIDS pandemic (Facing AIDS 1997: 107-8)

1. Churches to provide a climate of love, acceptance and support for those who are vulnerable to, or affected by HIV/AIDS.
2. To reflect together on the theological basis for their response to the challenges posed by HIV/AIDS.
3. To reflect together on the ethical issues raised by the pandemic, interpret them in their local context and to offer guidance to those confronted by difficult choices.
4. To participate in the discussion in society at large of ethical issues posed by HIV/AIDS, and to support their own members who, health care professionals, face difficult ethical choices in the areas of prevention and care.
5. Work for better care for persons affected by HIV/AIDS, give particular attention to conditions of infants and children affected by HIV/AIDS pandemic and to seek ways to build a supportive environment.
6. Churches are asked to help safeguard the rights of persons affected by HIV/AIDS and to study, develop and promote the human rights of people living with HIV/AIDS through mechanisms at national and international levels.
7. To promote the sharing of accurate information about HIV/AIDS and a climate of open discussion as well as work against the spread of misinformation and fear.

8. Advocate increase spending by governments and medical facilities to find solutions to the problems- both medical and social- raised by the pandemic.
9. Churches are to recognise the linkage between AIDS and poverty and advocate measures to promote just and sustainable development.
10. Churches are urged to focus special attention on situations that increase the vulnerability to AIDS such as migrant labour, mass refugee movements and commercial sex activity. In particular work with women as they seek to attain the full measure of their dignity and express the full range of their gifts.
11. To educate and involve youth and men in order to prevent the spread of HIV/AIDS. As well as seek to understand more fully the gift of human sexuality in the contexts of personal responsibility, relationships, family and Christian faith.
12. Churches are to address the pandemic of drug use and the role this plays in the spread of HIV/AIDS as well as develop locally relevant responses in terms of care, de-addiction, rehabilitation and prevention.

APPENDIX 7

COMMUNIQUE OF PROCEEDINGS OF THE VALENTINE'S DAY LOVE LIFE CELEBRATION

14 FEBRUARY 2004.

THEME: *YOUTHS AND SEXUALITY IN THE ERA OF HIV/AIDS*

PARISH OF ZOUTPANSBERG

On 14 February 2004, the HIV/AIDS Task Team of the parish of Zoutpansberg organized a program of HIV/AIDS awareness and call-for-action that focused on youths. The program drew on youths from all chapelries of the parish as well as other churches, schools and youth organizations in the area. The theme of the program was “Youths and Sexuality” and activities in the day’s program called for Abstinence and Christian morals among young people in the era of HIV/AIDS.

The following report documents the proceedings of the program. Although presented as a report document, it contains a communiqué of understanding developed and agreed upon by young people[Ψ] (hereafter referred to as youths) who attended the program. Given the wide representation of attendance (see list of participants), the opinions and views can be extended and necessarily translate to those of the entire Youth group of the Parish of Zoutpansberg.

MOTIVATION FOR THE VALENTINE’S DAY LOVE LIFE CELEBRATION

Certain realities about how HIV/AIDS is distributed in our population are particularly disturbing- of the estimated 5 million South Africans infected with HIV, half a million are youths of ages 15-24years[γ]. If this estimate is anything to go by, 1 in every 10 HIV infected person in South Africa is a Youth! This is frightening- more frightening when it is noted that this statistic has been on the increase over the years. The mode of transmission of infection is

[Ψ] Young People is more accurately used to describe persons less than 25 years old and is sometimes divided into Adolescents (12-18 years) and Youths (19-25years). In this document, it includes all non-married individuals.

[γ] Human Science Research Council/Nelson Mandela Study on HIV/AIDS in South Africa, HSRC, 2002.

predominantly through sexual intercourse- an activity that should not be within the domain of individuals in this age group *except if married*.

The church has a responsibility to preach HIV/AIDS prevention to her youths. Secular teaching on prevention has overly emphasized condom use. This is not only unscriptural when applied to young unmarried individuals, but has resoundingly proved ineffective in halting HIV/AIDS spread. The church should correct this erroneous notion. The truth is contained in the bible- *abstinence till marriage and faithfulness thereafter is the remedy to this scourging epidemic.* Unfortunately, there have been cursory attempts at educating Youths in the Parish of Zoutpansberg about these truths.

A special program that focuses on Youths and Sexuality is therefore needed. This should entail information dissemination on Christian conduct as well as advise to youths on how to deal with peer-pressure. Christian Youths have the potential of making a difference in the spread of HIV infection.

The HIV/AIDS task team of the Parish of Zoutpansberg has identified a program that could get Christian Youths into action in 2004. Tailored around a project on Youth and Sexuality, a program on HIV/AIDS awareness among Youths was organized on the 14th February 2004. This was to coincide with the Valentines' day celebration and was dubbed "Valentine's Day Love Life celebration" intended to urge youths to celebrate Love and Life as Christians. The day was also intended to launch the parish's *"Virgin Power, Virgin Pride"* project that has young people acclaiming the value of being virgins till marriage.

PARTICIPANTS AT THE VALENTINE'S DAY LOVE LIFE CELEBRATION OF THE PARISH OF ZOUTPANSBERG, 14th FEBRUARY 2004

NAME	CHURCH/ORGANISATION	CONTACT NUMBER
1. Baloyi Admire	Worshiping Centre Church	0822985846
2. Baloyi Ntsako	Peter Masiza, Waterval	0722599650
3. Baloyi Tiyani	E.P.C	0822985846
4. Berenguer Maureen	St. Marks, LTT	0155160354

5. Blunden Gail	St. Marks, LTT	0155165165
6. Davhana Arinaho	Magau Anglican Church	
7. Igumbor Ehi	St. Marks, LTT	0828673872
8. Igumbor Eunice	St. Marks, LTT	0155162705
9. Loliyong Janet	St. Marks, LTT	0723417936
10. Mabeba Hlekani	Makomba-Ndlela Youth Movt.	
11. Makinde Kolade	St. Marks, LTT	
12. Makinde Lumi	St. Marks, LTT	
13. Malima Fulufhelo	Magau Anglican Church	
14. Maluleke Dada	Makomba-Ndlela Youth Movt.	
15. Maluleke Javulani	Makomba-Ndlela Youth Movt. 072 7555314	
16. Maluleke Koki	Makomba-Ndlela Youth Movt.	
17. Maluleke Raymond	Makomba-Ndlela Youth Movt.	0734253385
18. Maluleke Thami	Makomba-Ndlela Youth Movt.	
19. Maluleke Tiyani	Makomba-Ndlela Youth Movt.	0725763973
20. Mamburu Maemu	Assemblies of God LTT 0155164621	
21. Mamburu Phumudzo	Assemblies of God LTT	0155164621
22. Manganyi Matomba	Makomba-Ndlela Youth Movt.	
23. Manganye Sylvia	St. Peter Maziza 0732153987	
24. Maphangulo Funi	Methodist Church, LTT 0726684454	
25. Maphangulo Phathu	Methodist Church, LTT	0726684450
26. Maphote Terry	Makomba-Ndlela Youth Movt.	
27. Masengana Israel	Makomba-Ndlela Youth Movt.	
28. Mashige Bongani	Samass 0833300573	
29. Matjutla Annah	St. Marks, LTT	0826745763
30. Mbulaheni Taki	St. Marks, LTT	0848721491
31. Minnaar Renee	Magau Anglican Church	0827106020
32. Moyo Gabriel	Makomba-Ndlela Youth Movt.	
33. Mpai Ethel	St. Marks, LTT	0826610333
34. Msimeki Hlamalani	Makomba-Ndlela Youth Movt.	
35. Mudau Khodani	Rhema Kingdom Life 0825102172	
36. Mulauzi Sylvester	Full Gospel	
37. Muthelo Kingsley	St. Peter Masiza 0155564351	
38. Ralepelle Clement	Makomba-Ndlela Youth Movt. 0843653808	
39. Ramakhanya Lusa	Corpus Christi 0825102172	
40. Ravele Nungo	Lutheran Church, LTT	0843554995
41. Sadiki Hilda	St. Marks, LTT	
42. Sadiki Lufuno	St. Marks, LTT	0734917976
43. Sadiki Mercy	St. Marks, LTT	0822177687
44. Sadiki Olive	St. Marks,LTT	0839239577
45. Sadiki Rubi	St. Marks, LTT	0826449196

46. Sambana Mudzonga	St. Marks, LTT	0733264726
47. Silika Ndivhuwo	Magau Anglican church	0837204038
48. Useh Avorwe	St. Marks, LTT	0155165861
49. Useh Kowho	St. Marks, LTT	0155165861
50. Useh Obaro	St. Marks, LTT	0155165861
51. Useh Ruth	St. Marks, LTT	0155165861

PROGRAM

1. Introduction and Welcome 1000Hrs
2. Opening Prayers- Led by Archdeacon Gail Blunden 1002Hrs
3. Opening Remark by Coordinator of HIV/AIDS Task Team – Janet Loliyong 4. Welcome Remarks by Coordinator of Youth Group – Ehi Igumbor 1008Hrs
5. Praise and Worship- led by Archdeacon Gail Blunden 1012Hrs
6. *Greetings/Expression of Love* Youth Activity 1025Hrs
7. Scripture Message: Youths and Sexuality – Archdeacon Gail Blunden 1027Hrs
8. Music – Makomba Ndlela Youth Movement 1050Hrs
9. HIV/AIDS Awareness speech/ Motivational talk- Janet Loliyong 1120Hrs
10. Youth Workshop/ Group Discussions 1130Hrs
11. Refreshment 1215Hrs
12. Youth Drama- "*We have killed*" Makomba Ndlela Youth Movement 1220Hrs
13. Workshop Feedback and Symposium 1300Hrs
14. Message from the Rector – Archdeacon Gail Blunden 1330Hrs
15. Music 1340Hrs
16. Closing Prayer 1400Hrs
17. Video Watching and END…… 1400Hrs till depart

MINUTES

Introduction and Welcome:

The day's program commenced at 1110hrs with introductions led by Ehi Igumbor (Program Director). In the introduction, Ehi Igumbor explained that the "Valentine's day love life celebration was the Christian church's intrusion into a not-always Christianly celebration in a bid to make a difference". In this vein, he continued, "the day's program was intended to present activities that celebrated love and life different from the secular way as a good alternative to unbiblical and often immoral conduct". Furthermore, he added, "the important issues of HIV/AIDS, Youths and sexuality were to be addressed".

The program director then introduced individuals who would be contributing to the day's activities. Amongst those whose presence was recognized are the Rector of the Parish, Archdeacon Gail Blunden, the Co-ordinators of the Parish Task Team; Mrs. Ethel Mpai and Mrs. Janet Loliyong; members of the task team; Dr. Eunice Igumbor and Mrs. Annah Matjutla, and guest performers from Waterval, the Makomba Ndlela Youth Movement. A member of the parish youth group, Ms. Mudzonga Sambana was also invited to chair the program.

Opening Remarks by HIV/AIDS Task Team Coordinator- Mrs. Janet Loliyong:

Mrs. Janet Loliyong thanked young people for coming together in such an august occasion in which the Parish of Zoutpanberg, for the first time, attracted young people from all chapelries for a workshop on HIV/AIDS. She stated that repeated attempts were made in 2003 to have a workshop of HIV/AIDS awareness among youths but none of which materialized. She explained that "youths are at the center of the HIV/AIDS epidemic which is killing too many people all over the world but worse off in Africa". Youths are heavily affected with HIV/AIDS- even "Christian" youths, and they may be at a unique position of making a difference in halting the spread of HIV/AIDS, she added. Mrs. Janet Loliyong stressed that there was need for young people in South Africa to take a leaf from experience in Uganda where behaviour

change- and not merely condom promotion, allowed the country to stabilize the HIV/AIDS epidemic.

She explained that this conviction had informed the task team to organize the Valentine's Day Love Life Celebration and invited youths to be participant in and enjoy the chain of different interesting activities lined-up in the day's program.

Praise and Worship- led by Archdeacon Gail Blunden

The program director invited Archdeacon Gail Blunden to lead the gathering with praise and worships. A number of worship songs were sang in praise of God with moments of prayers observed. Prayer points included offering the day's program to God for direction, praying for the needs of all infected and/or affected by HIV/AIDS, praying for young people in today's world and the challenges they face, praying for Christian families and the church of God.

The entire gathering participated in the praise and worship.

Scripture Message- Youths and sexuality in the era of HIV/AIDS by Archdeacon Gail Blunden

Archdeacon Gail Blunden gave a motivational message to attendants on Youths and sexuality in times of HIV/AIDS. Drawing on a number of scripture passages, she emphasized that although the world today accepts such vices as sex before marriage, it remains contrary to bible teaching and therefore unacceptable to God. She explained that "sex is a beautiful human function given by God that should be used only within marriage amongst married couple". To this end, "sex as a means of expressing love among youths is misplaced and unscriptural". Quoting the book of Corinthians, Archdeacon Gail Blunden emphasized that God's word about our bodies being his temple and that we must avoid things of the flesh applied just as well to youths.

On the prevailing scourge of HIV/AIDS, she explained that indeed Christian youths should feel happy that given the mode of infections, chances are that they are very unlikely to be infected as long as they adhere to bible teaching.

However, she called on a more positive response to those infected by HIV/AIDS. She explained that they should not be stigmatized or relegated as promiscuous individuals, but in Christianly love they should be supported and prayed for.

Archdeacon Gail Blunden also urged youths to dispel myths about HIV/AIDS such as that it is God's punishment for mankind because of its origins linked to homosexual practice; or that it is God's way of bringing the world to an end. She said these do not have any scriptural basis and can only be considered untrue.

She concluded by recommending a maxim that should characterize the Christian youths' response to HIV/AIDS in the following words;
" …whereas the world tells us to be wise and condomise, we as Christian youths choose to be sane and abstain!". This is our calling, she admonished, and "how we can make a genuine difference to the HIV/AIDS epidemic scourging our communities".

HIV/AIDS Educational lecture by Mrs. Janet Loliyong

Mrs. Janet Loliyong then gave a lecture on basic facts of HIV/AIDS. Employing an interactive-style lecture, she discussed the morphology of the HI virus, how it is spread \ transmitted, what it does to human systems and how it can be prevented. She stressed that there is no known cure for HIV infection and prevention is really the cure available for us today. Attempts at developing vaccines are on-going. In terms of prevention, the A-B-C (Abstinence, Be Faithful and Condomise) in order are considered effective. She however explained that abstinence is not just the only option for the unmarried Christian youths but also the best of all three options in ensuring that anybody is HIV-free.

Youth Workshop and Group Discussion

The program director introduced the youth workshop as the 'core activity of the day's program' as it was the forum for young people to talk amongst themselves about practical things affecting them regarding sex, youth life and HIV/AIDS. All youth attendants were put into four groups with each group asked to discuss and present on their conclusions on the following issues:

Group 1: explored the prevalence of HIV/AIDS in our communities; familiarity with any person(s) infected and/or affected by HIV/AIDS and their experiences; whether it was possible to identify HIV/AIDS infected or affected persons as well as what Christian youths can do to stop HIV/AIDS.

Group 2: discussed the prevalence of HIV/AIDS among young people specifically; the modes of transmission among young people and how Christian youths can prevent HIV/AIDS

Group 3: discussed the transmission of HIV/AIDS among youths, the problems of today's youths and how they relate to HIV/AIDS spread, and what youths can do in the HIV/AIDS era

Group 4: discussed the pragmatic issues of a Christian youth and sexuality and the role of Christian youths in the era of HIV/AIDS.

Each group was asked to nominate a group leader and secretary to preside and document discussions of the group. All participants were encouraged to contribute to group discussions. To ensure this, an "at-least-one-comment" approach was to be adopted by all the groups. With this approach, groups sat with chairs arranged to form a circle. At the introduction of each new topic by the group leader, everyone was expected to comment in turns as seated in the circle till the discussion came back to the group leader. New opinions or merely a statement of agreement with a former speaker was accepted as a "comment". Questions could also be raised. This was done to ensure unanimity with views to be presented.

The groups were expected to report on areas of disagreement or division of views so that they be treated in the full-house symposium during feedback.

The group discussions lasted for about 40 minutes.

Refreshment

Light refreshment of snacks and cold drink/ tea was offered to all participants of the program.

Youth Drama- Titled: "We have Killed" by the Makomba Ndlela Youth Movement.

The Makomba Ndlela Youth Movement performed a very interesting drama titled "We have killed". The drama was a satirical presentation of how today's society propagates HIV/AIDS among young people. It told the story of a young girl from a poor background who was admired by all in society for her beauty and good- behaviour. Upon the, lose of her father, she is forced to go to the city to learn a trade as her mother and her step-father are unable to cater for her. Pushed by peer-pressure and over-pressure from "sugar-daddies", she lives a very immoral live having sexual relationships with so many men in the community. Not surprising, she gets infected with HIV, suffers from AIDS related diseases and dies. This is where the drama theme dawns. At her death, a number of elders of community come together and the fact that "they (we) have killed" is brought to bear. They all saw the young girl turn from good church girl to prostitute and never corrected her- ironically, the most of them actually patronized her services. This was a girl as young as their grand-children. "We have killed…we have killed …we have killed" is the fading echo that is heard as lights of the drama stage fade out.

A representative of Makomba Ndlela Youth movement summarized the drama as challenging everyone, young and old alike, to realize that we may be part of the cause of HIV/AIDS deaths around us- by our actions or inactions! We need to make the difference.

Workshop feedback and Youth Symposium:

Following the very interesting drama, the program director invited group leaders to give feedback on their group discussions in a full-house symposium. In the feedback presentation, group leaders articulated the group topics, their discussions and conclusions. They were expected also to mention areas (if any) where the groups failed to arrive at unanimous conclusions. The presentations are presented according to groups below:

Group 1: Discussed the prevalence of HIV/AIDS in our communities; familiarity with any person(s) infected and/or affected by HIV/AIDS and their experiences; whether it was possible to identify HIV/AIDS infected or affected persons as well as what Christian youths can do to stop HIV/AIDS.

Regarding the prevalence of HIV/AIDS, they explained that 5 million South Africans are said to be infected with HIV/AIDS. Some group members reported knowing at least one person who was infected with HIV while all members said they were aware of friends, neighbours and others in their communities who were affected. The group discussed that stigma remained a big issue for those infected/affected by HIV. Many also are always sick and a good number die. It means lose of possible income from such people and hardship to families.

The group noted that it was not possible to pick out a HIV-infected person without blood test but noted that persons who are frequently sick especially with tuberculosis and other multiple sicknesses are most likely infected.

To stop HIV/AIDS, the group felt it was imperative that Christian youths started with themselves by abstaining from sexual activities till marriage. They re-itinerated the words of Archdeacon Gail Blunden of being “sane and abstain”.

Group 2: Discussed the prevalence of HIV/AIDS among young people specifically; the modes of transmission among young people and how Christian youths can prevent HIV/AIDS

The group reported that HIV/AIDS was very prevalent among young people who account for almost half of all HIV infected. They discussed that this high prevalence is because young people are failing to take heed to bible teaching of no sex before marriage. They further explained that at teenage years, individuals are discovering or experimenting and also are influenced by peer-pressure to indulge in sexual activity. Being young, immature and naive, they are often unable to protect themselves from HIV/AIDS. They also explained that “sugar daddies” have tended to infect a lot of young girls who obey their sexual demands, including unprotected sex, in order that they continue to enjoy economic benefits. The group de-cried this to be tantamount to prostitution.

They also discussed that the government child support grant is being abused by some young girls. They explained that girls deliberately get pregnant in order to receive the R160 per month grant. The group felt this was unfortunate as not only did it abuse a good government facility for genuine cases, but also put young girls at high risk of contracting HIV/AIDS for a meager R160/month.

On the modes of transmission, the group felt sexual intercourse (mostly heterosexual) was the predominant mode. They did not know of any case of transmissions through blood transfusion or needle-stick injuries. They stressed that HIV transmission through mouth-to-mouth contact such as with resuscitation is possible but is rare.

In response to the group discussion, Ehi Igumbor explained that another source of transmission is from mother-to-child during childbirth and through breast-feeding. This was not previously considered in the group discussion.

Finally, on the role of Christian youths, the group urged abstinence from sex till marriage and faithfulness thereafter. They also say young people should

ignore the message of condomise but should rather abstain. The group felt it was important to start educating young people about the effect of HIV/AIDS so that they stop wrong sexual practices.

Group 3: Discussed the transmission of HIV/AIDS among youths, the problems of today's youths and how they relate to HIV/AIDS spread, and what youths can do in the HIV/AIDS era.

On the mode of transmission of HIV/AIDS among youths, the group enumerated sexual intercourse, sharing needles and open wounds as possible means. They however stressed that sexual intercourse was the major means of infection among youths in South Africa.

Regarding the problems being faced by today's youths, the group discussed peer-pressure, lost value of self-control, lack of knowledge, sexual abuse, low self-esteem, coercion by a partner to prove their love by having sex, and abuse of their rights.

In response to HIV/AIDS, the group felt that Christian youths need to talk about it more and in public, have more Christian youth meetings, encourage young people to "say no and mean no", and respect their bodies.

Group 4: Discussed the pragmatic issues of a Christian youth and sexuality and how these could be best dealt with.

The group felt that youths are pressed with a hard dilemma on what to do with their sexuality. They explained that whereas their bodies feel sexually mature and sex is in vogue among their peers, Christian youths have the challenge of "holding-on" till marriage. This view is always unpopular and presents strong social difficulties to the Christian youth.

To deal with this, Christian youths are encouraged to date a Christian like themselves and preferably someone of about the same age. This way they share the same value and do not force each other on sex. They should also

set boundaries on how far to go in their relationship. They should respect themselves and let the bible be their companion. Before following peers, know what they are doing. Avoid using alcohol or any form of drugs as that may cause you to lose your rationality.

Symposium Submission on Youths and Sexuality in the era of HIV/AIDS

In South Africa today, the HIV/AIDS epidemic is having devastating impact to all spheres of human society. Overwhelming evidence exists of it's scourging impact to households, economic workforce, agriculture, education and health of populations. The church has not been any less affected by this epidemic; sitting on her pews are persons infected and/or affected by HIV/AIDS.

Certain facts about the nature of the HIV/AIDS epidemic are pertinent: Firstly, our current state of knowledge on the mode of contracting the virus places sexual intercourse as the major culprit in over 95% of cases. Secondly, (and not unrelated to the first point), is that the age group with highest prevalence is the 15 to 45 years age group. The Youths are covered within this group.

It is therefore imperative that Christian Youth groups have clear and organized programs addressing the prevention of HIV/AIDS among her members. This is incontrovertibly important considering that in the absence of a vaccine or drug for managing HIV/AIDS, prevention is for us the cure.

To this end, a plethora of calls have been made to the Christian youths to become (and seen to be) more participant in preventive measures as well as all other measures to manage the HIV/AIDS epidemic. Youths of the parish of Zoutpansberg have taken to this challenge and hope to heed to the calls. The following are our resolutions in our mission of making a difference with regard to HIV/AIDS, Sexuality and Youth living.

(A) UNDERLYING PRINCIPLES:

Certain fundamental principles should guide activities of Christian Youths, with regard to HIV/AIDS. These are tailored around a number of proclamations to which we hereby resolve. These are that:

(i) We, as Christian Youths, in line with scriptural teaching, profess no sex before marriage.

(ii) We, as Christian Youths, identify the HIV/AIDS as affecting every one of us and deserving collective efforts to tackle it.

(iii) We, as Christian Youths, abhor practice of stigmatization and discrimination of those infected by HIV/AIDS and professes love for all- HIV infected and uninfected alike.

(iv) We therefore devote ourselves to better understanding of HIV/AIDS, to improve our knowledge of the condition and hence be able to undertake christianly ministry to the world around us. We devote ourselves to behaviour change and communicating this to our friends and all around us. We devote ourselves to Christian ministry, as Jesus Christ is the answer to all problems. We devote ourselves to turning the tide against HIV/AIDS…**WE SEEK TO MAKE A DIFFERENCE!**

(B) STRATEGY:

Our strategy centres around three approaches:

- Actively engaging Youths in Christian activities that teach ways of socialization and values definition in a Christianly manner.
- Equipping Youths with Christian-based life skills including how to deal with peer pressure and moral conduct.
- Living exemplary moral lives that will draw others to emulate us.

(C) ACTIVITIES:

- Periodic Youth Bible studies and fellowships
- Periodic Youth games and social days
- Cell groups, prayer partners.
- HIV/AIDS seminars, talks, workshops with focus on the youths
- Youth HIV/AIDS rally and public walk as part of "Anti-stigmatization Campaign"
- "Real Youth- Virgin Power Virgin Pride" project (emphasizes no sex till marriage- see below)

Closing:

A vote of thanks was moved by Ehi Igumbor in which he thanked the entire participants and organizers of The Valentine's day program. He described the event as "epochal… and marking a new chapter for Christian youths in the Parish of Zoutpansberg".

He further informed the youths about the *"Real Youth Project- Virgin Power, virgin pride"* in which Christian youths publicly profess virginity and acclaim the values of being virgins till marriage. The idea, he explained, is to "tell the world that being a virgin till marriage is cool and makes one the REAL Youth!". This notion received approval of all present and was to be included as a resolution of the symposium

The closing prayer was led by Ehi Igumbor and grace of fellowship shared.

Activities ended at 1505Hrs.

A video on Ugandan HIV/AIDS experience was put on while youth members waited for their transport home.

Acknowledgments:

The HIV/AIDS task team of the Parish of Zoutpansberg would like to express their gratitude to the following:

- Arch.D Gail Blunden, Rector, Parish of Zoutpansberg for her sumptuous support with organizing the program
- Dioscesan HIV/AIDS Task Team for supporting with educational material and financing the program. (See budget in appendix)
- The Makomba Ndlela Youth Movement for special performance in the Youth day celebration
- Parishioners of the Parish of Zoutpansberg who assisted in different capacities
- All youth participants of the Valentine's day love life celebration
- All members of the HIV/AIDS task team for their efforts

Thank You All.

APPENDIX

LETTER TO DIOSCESAN TASK TEAM INFORMING THEM ABOUT THE VALENTINES DAY LOVE LIFE CELEBRATION AND REQUESTING SUPPORT.

To: The Dioscesan Cordinators, Mrs. Rosa Useh & Rev. Peter Wilson.

RE: YOUTHS HIV/AIDS PROGRAM

The HIV/AIDS task team of the Parish of Zoutpansberg is pleased to inform you about the intention of organizing a program on HIV/AIDs awareness with focus on youths scheduled for the 14th February, 2004 at St. Mark's Parish, Louis Trichardt.

The program has been dubbed "Valentine's Day Love and Life Celebration" and is intended to usher a project of the task team that looks into Youths and Sexuality. Christian lessons on sexuality will be the theme of the day with

drama, music, praise and worship all being used to drive-in this message. The program will also include an in-house symposium and workshop of the youths that explores issues on youths and sexuality. Scripture message will be given by the rector of the parish, Arch.D Gail Blunden.

Being the first major program of the rejuvenated HIV/AIDS task team, we hope to ensure that it will be viewed as both relevant and interesting by the Youth participants who are our target group.

Your assistance with our endeavours will be highly appreciated.

Yours in Christ

Ehi Igumbor

Secretary

HIV/AIDS Task Team

Ethel Mpai

Co-ordinator

HIV/AIDS TaskTeam

Janet Loliyong

Co-ordinator

HIV/AIDS Task Team

Kindly find below budget for the Youth HIV/AIDS program at the Paris of Zoutpansberg. We estimate that the program will cost R1000 and request release of stated amount to enable the execution of the program

Thank you for your anticipated cooperation.

Ehi Igumbor
Secretary
HIV/AIDS Task Team

Ethel Mpai
Co-ordinator
HIV/AIDS TaskTeam

Janet Loliyong
Co-ordinator
HIV/AIDS Task Team

Budget for the Parish of Zoutpansber's Youth HIV/AIDS Program

Activity	**Cost**
Publicity-	R300
Advertisement in newspaper	
Development of Banner	
Development of Flyers	
Refreshment- R450	
Tea and Snacks for all participants	
Feeding of drama performing group	
Transport-	R250
Transport of drama group to and from Waterval	
TOT	