

**THE ROLE OF CHURCHES IN HIV PREVENTION AMONG YOUNG
ADULTS IN POLOKWANE MUNICIPALITY, LIMPOPO PROVINCE**

by

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DECLARATION

I declare that **THE ROLE OF CHURCHES IN HIV PREVENTION AMONG YOUNG ADULTS IN POLOKWANE MUNICIPALITY OF LIMPOPO PROVINCE** submitted for Master of Arts in Sociology (Social Behaviour Studies in HIV/AIDS) is my own original work. All the sources used or quoted have been indicated and acknowledged.

.....
SIGNATURE (MOSWANE PCN)

.....
DATE

SUMMARY

The study investigated the role of churches in HIV prevention among young adults in the Polokwane Municipality of the Limpopo Province. Qualitative research method was followed. Data was obtained and tape-recorded during the in-depth face-to-face interviews. Fourteen churches are affiliated with the Limpopo South African Council of Churches, seven of which run HIV/AIDS programmes and services. They were the target of this study, which investigated how churches could give more support to people infected with HIV.

Results show that churches are determined to assist in the prevention of HIV. They have already contributed to supporting those with HIV and those affected by HIV and AIDS. The findings show that churches should teach young adults holistically about the virus.

Key words: Church, Church leaders, HIV prevention, Pastor, Polokwane Municipality, Young adults

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LIST OF ACRONYMS AND ABBREVIATIONS

ACSA	Anglican Church of Southern Africa
AIDS	Acquired Immune Deficiency Syndrome
AME	African Methodist Episcopal Church
PABA	People affected by AIDS
CBO	Community-Based Organisation
DOH	Department of Health
ELCSA	Evangelical Lutheran Church of Southern Africa
FBO	Faith-Based Organisation
HIV	Human Immunodeficiency Virus
HBO	Home-Based Organisation
HSRC	Human Science Research Council
LPDoE	Limpopo Provincial Department of Education
MCEA	Moyahabo Change Education Agency
MCSA	Methodist Church of Southern Africa
NGO	Non-Governmental Organisation
NSP	National Strategic Plan
SACC	South African Council of Churches
UPCSA	Uniting Presbyterian Church in Southern Africa
URCSA	Uniting Reformed Church in Southern Africa

CHAPTER 1

SITUATING THE RESEARCH PROBLEM

1.1 Introduction

In 2010, Statistics South Africa estimated the South African population to be 50 million, and the overall HIV prevalence rate to be 10.5% (Stats SA 2011:3). Although the HIV infection rate is stabilising and the country is experiencing a gradual decline in HIV prevalence, the total number of people living with HIV was estimated at approximately 5.7 million (UNAIDS 2010:28). During the early 1990s, when knowledge about the epidemic was still being disseminated through rumours and vague information, AIDS prevention efforts focused on changing personal behaviour and on encouraging people, often through the media and the community development approach, to adopt lifestyle practices that reduced people's risk of infection. These efforts focused predominantly on encouraging communities to "abstain from sex, be-faithful and condomise". However, the levels of infection in the country increased at an alarming rate. The incidence of HIV among pregnant women increased from 10.4% in 1994, to 28% in 2007, stabilising at 29% in 2010 (Department of Health 2010).

Although women bear the brunt of the epidemic and account for 55% of people living with HIV and AIDS in South Africa, the most vulnerable population is young adults. This phenomenon is more pronounced in the age groups 20-24 and 25-29 years. According to the HSRC report (2008), HIV prevalence among women of 25-29 years, increased from 32% in 2002 to 33.3% in 2005, but showed a decline to 32.7% in 2008. The rate for males in the same age group decreased from 22% in 2002 to 12.1% in 2005, but increased to 15.7% in 2008 (Shisana, Rehle, Simbayi, Parker, Zuma, Bhana, Connolly, Jooste & Pillay 2008). Some of the drivers of HIV and AIDS in South Africa include: male attitudes and behaviours; intergenerational sex; gender and sexual violence; stigmatisation; lack of openness; untreated viral sexually transmitted infections; lack of consistent use of condoms in long-term multiple and concurrent partnerships; mother-to-child HIV transmission; low use of condoms among the general population (DoH2007-2011).

The tragic toll of the epidemic compelled governments to renew their commitment to improving and ensuring access to HIV prevention, promotion, treatment, care and support, as well as mitigating the impact (comprehensive health) worldwide (UNAIDS 2007). HIV and AIDS cause enormous human suffering for the infected individuals, and the affected members of their families, communities and countries. It is therefore vital to reinforce the prevention programmes.

The World Health Organisation (WHO) 2004 report on protecting young people from HIV and AIDS emphasises the urgent necessity for widening access to prevention and treatment services for young people. These services should be accessible, available, acceptable, appropriate, and effective and targeted at young people's needs (WHO 2004).

1.1.1 The role of church leaders in HIV prevention

Although many church leaders in Africa and elsewhere in the world regarded HIV infection as the consequence of individual sin, and required people who were infected with HIV to repent of their sins and pray for healing through faith, many churches began to participate in efforts aimed at preventing people from being infected with HIV and mitigating its impact (Byamugisha, Steinitz, Williams & Zondi 2002). In the past, HIV prevention was simplistically reduced to the idea of returning to the "traditional" moral values and standards of sexual behaviour, which largely reinforced judgmental attitudes on the part of communities, and denial and secrecy on the part of people who knew they were infected with the virus. These attitudes in turn undermined efforts to encourage people to change their behaviour, as well as to mitigate the impact of HIV and AIDS and to prevent its further spread (Mbonu, van den Borne & De Vries 2009: 14).

The Church plays a crucial role in family and community life. For example, when individuals become infected with HIV, they begin to reflect on their lives in an effort to understand why they contracted HIV. While this process can be emotionally demanding, it is always an opportunity for individuals to examine their past and think about their lives up to the point of diagnosis. This also includes trying to understand or imagine what life is going to be like after diagnosis. In such instances, religion and

spirituality tend to help individuals examine their lives, interpret what they find, and apply what they have learned to their new life with HIV. Consequently, spirituality and religion help people find “new meaning in life” after their HIV diagnosis.

In 2001, the All African Council of Churches (AACC) and the World Council of Churches called on all church-related partners to actively participate in building awareness of HIV/AIDS and helping those who are infected (World Council of Churches 2005).

A growing number of religious leaders and institutions, especially at the international level, have realised the urgency of exploring new ways of responding to HIV and AIDS, and helping communities to cope with its impact. The Council of Churches called on countries to (1) increase resources for prevention, care, and treatment; (2) encourage churches to practice solidarity with those infected with HIV; (3) position prevention of basic causes of HIV infection in the various target groups; and (4) increase access to treatment. It is, therefore, required that prevention measures should call for a change in behaviour, for both the youth not-yet-infected and for those who are infected, and emphasis be placed on positive living.

1.1.2 Why church leaders in Limpopo?

Almost all South Africans profess some religious affiliation, and their attitudes toward religion and religious beliefs vary widely. Limpopo, in particular, is dominated by African spirituality. Christian communities comprise Christian Missionary Churches which include, among others, the Catholic, Anglican, Methodist, Presbyterian and Dutch Reformed Churches. There are also Pentecostal/Evangelical churches, whose main emphasis is on the workings of the Holy Spirit. These include, among others, the Assemblies of God, the Full Gospel, God’s Tabernacle and El Shaddai. Most African Independent churches, such as the Apostolic and various Zionist Christian churches, have roots in African traditional religion. Minority religions include the Jewish and Islamic/Muslim religions, the Baha’i Community and the Buddhists. Out of a population of 5,273,637 in the Limpopo Province, the Christians make up 86.5%; other religions make up 4.7%, and the remaining 8.8% of the population does not belong to any religion (The Media Connection ([sa])). The role played by these religious communities in HIV prevention efforts has not been adequately examined. In particular, understanding their role in HIV prevention among young adults will

enhance and strengthen targeted HIV prevention programmes and ensure that young adults' needs are adequately addressed.

1.2 Problem Statement

Research has shown that HIV and AIDS among young people is a problem that requires systematic and robust solutions (AIDS Action 2001). In Namibia, for instance, many parents and guardians choose rather not to talk at all about sexual development or things in connection with sex. Thus, many children and adolescents learn only from their peers and the information they get is mostly not accurate (Otaala 2003:152). It has been proven that early sexual health education can delay sexual debut of adolescents by several years. The challenge is that even among those who know that condoms use prevent HIV, few actually use them (Children and Youth 2006:2). While there have been attempts to employ both the languages and the vocabularies of the young people in prevention messages, HIV prevalence and HIV incidence among them remain high (Shisana *et al.* 2008: 21). Condoms, abstinence, and monogamy are the most common methods of HIV prevention known to young people (Anderson & Beutel 2007), but they are yet unable to translate their knowledge into behavioural change. Through the formation of Civil Society Organisations (CSOs), such as Non-Governmental Organisations (NGOs), Community-Based Organisations (CBOs) and Faith-Based Organisations (FBOs), South Africa has managed to contribute to HIV prevention by focusing on health education, along with care and support of the affected and infected people at community level (Parry 2008). On the other hand, UNAIDS (2002:16) in Otaala (2003:69) has also noted that “community mobilisation is the core strategy on which success against HIV/AIDS has been built”. It also states that the ones who maintain the most immediate and direct contact with the grass roots are NGOs, FBOs, Civic and community leaders, as well as the business sector. As a result, the interventions offered by these CSOs could be expanded and strengthened by programmes in churches.

The HIV prevalence trends in Limpopo among the 15 – 24 years were 13.6% in 2008. There was a slight increase in HIV prevalence among young women in the age group 15 – 24 year olds to 13.7% in 2009 and 14.2% in 2010 (DoH 2010:58). This increase among people who are in their economically active and reproductive

years requires concerted efforts at community level to intensify and integrate HIV prevention.

This study endeavoured to understand the role of the Church in HIV prevention among young adults in the Polokwane Municipality of Limpopo Province in South Africa.

Research Questions

The study sought to answer the following questions:

- What contributions have churches made to the fight against HIV and AIDS and to the prevention strategies proposed for young adults?
- What HIV prevention programmes and services are available for young adults at local churches?
- Do young adults recognise the role of the Church in preventing the spread of HIV infections among them?
- Do young adults benefit from HIV prevention programmes and services?
- What has to be done to improve HIV prevention among young adults?

1.3 Significance of the study

As HIV prevalence and the impact of AIDS continue to intensify in communities and households, a basic fact is that people who are infected and affected constantly need physical and emotional care and support from their families, the community and the Church. The HIV and AIDS, STIs Strategic Plan for South Africa (DoH 2007-2011) states that the aim of HIV prevention and other interventions is to strengthen the community's social, cultural, political and economic competence. The strategic plan acknowledges HIV prevention approaches and interventions by the FBOs and other CSOs, and encourages them to continue taking responsibility to contribute to the national response to HIV and AIDS. Aligning such interventions with government and other CSOs activities would, therefore, enrich the socio-political, economic and cultural skills of most communities, as well as contribute to the emotional and physical well-being of individuals infected with HIV and affected by HIV and AIDS.

During the conversation held with the Ecumenical Secretary of the South African Council of Churches (SACC), Rev. Mautji Pataki in Limpopo Province (on the 15 July

2009), he suggested that “although some churches have coordinated HIV prevention programmes and services with good intentions, there is lack of clarity about who their target groups are”. Therefore, examining the role of churches in HIV prevention provided a clear understanding of the strengths and challenges that churches faced in their attempt to effect HIV prevention activities.

1.4 Aims and objectives of the study

The overarching aim of the study is to investigate the role of churches in the prevention of HIV infections among young adults in the Polokwane Municipality of Limpopo Province. The specific objectives are to:

- identify the nature and types of programmes and services relating to HIV prevention that are available to young adults in different churches in Polokwane;
- investigate the role played by the Church in preventing the spread of HIV infections among young adults in Polokwane;
- explore the benefits to young adults for HIV prevention programmes and services rendered by the Church in Polokwane;
- explore what needs to be done to improve HIV prevention among young adults in Polokwane;
- explore the challenges and successes that these churches experience during the implementation of their HIV prevention programmes for young adults in Polokwane.

1.5 Definition of key words, concepts and variables

The following definitions helped to explain and specify meanings of concepts as used in the study:

Church - A Church is an organisation or a group of Christians who have their own beliefs and forms of worship (Sexual Health Exchange 2004:3). The Church can also denote a church building or a group of buildings belonging to a Christian community, local or universal, with its leadership, members and teachings.

Church leaders – The Church has certain structures within its framework, each with its own leadership and style. Leaders include pastors, lay preachers, officers, trustee and steward boards and Church workers, such as Sunday school teachers and HIV/AIDS counselors.

Pastor – an ordained, inducted or appointed person on the senior leadership staff of a Church, including priests, reverends, bishops and deans. In other African Independent Churches they are called Apostles (Gennrich 2004:9).

Polokwane Municipality - is a local municipality located in the Capricorn District in the Limpopo Province of South Africa. It shares its name with the city of Polokwane (formerly Pietersburg). It accounts for 3% of the total surface area of Limpopo, but over 10% of the population of Limpopo resides within its boundaries.

Prevention – In this study, prevention refers to the provision of HIV/AIDS education to prevent new infections. This word is reserved for those interventions that occur before the initial onset of HIV. It is achieved through the application of multiple strategies.

Young adults – The United Nations defines young adults as persons between the ages of 20-24. This is the most vulnerable group of people, as they have just passed the teenage stage and are entering midlife crisis (Youth and the United Nations 2004).

1.6 Conclusion

This chapter introduced the study and provided basic information about the role of the Church in HIV prevention. The focus was on the problem statement, the rationale for the study, and its purpose. The researcher formulated the research questions and the objectives of the study. Chapter 2 will present the literature review conducted during the study.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter presents the literature reviewed on the role of churches in HIV prevention among young adults. It also points to existing research that needs to be studied or developed further (Bless & Higson-Smith 1995:23). Gallant & Matlack-Tyndale (2004:1137) state that there are several strategies to decrease HIV infection rates. These strategies include the social marketing of condoms and peer education for groups with the highest infection rates (such as sex workers). The most commonly cited areas of prevention are the promotion of abstinence, changes in sexual behaviour, the use of condoms and improved life skills (*AIDS Guide* 2009:30). Most of these strategies are used by churches as well.

Churches have positive and negative perceptions of HIV/AIDS; and responses to the disease are varied. Positive responses include signboards that portray community churches as *“HIV-friendly churches that form networks with different denominations for greater impacts”*. On the other hand, negative responses come from churches that do not perceive HIV and AIDS as a concern to the Church. Such churches give messages that focus on abstinence as the only form of HIV prevention (Parry 2005:27). The Pontifical Council (Roman Catholic Church) made a number of strongly-worded pronouncements on the “evils” of condoms, maintaining, amongst other points, that they offer little protection against the transmission of HIV, because they promote promiscuity and trivialize sex (Flint 2011:132). The Catholic Bishop of Mozambique, Archbishop Francisco Chimoio (*Guardian* 27/09/2007), cited in Flint (2011:132), expressed his belief that condoms cannot protect people against HIV; and that *“there are two countries in Europe ... that deliberately manufacture condoms with the virus”*. Consequently, the Church is perceived as accountable for fuelling the AIDS epidemic through its teachings and increased stigmatisation that may alienate people who are HIV-infected and those who are living with AIDS.

AIDS is considered a taboo subject owing to the sexual mode of HIV transmission from one person to another. Okaalet (2002) maintains that fear of associating with ‘sinners’ was seen as the reason why some pastors believed that churches were not

responding adequately to the AIDS epidemic. Other pastors maintained that it was not a problem for the Church to get involved in AIDS issues. Primarily, sexuality should be seen as something to be celebrated as a gift from God. However, because of our sinful human nature, sexuality can also be distorted (*Agenda* 2010:124).

The former leader of the Anglican Church, Archbishop of Cape Town Njongokhulu Ndungane, told the World AIDS Campaign that faith leaders “*should shout from the rooftops that AIDS is not a punishment from God but a medical condition which is preventable*” (Roberts 2008).

According to Van Dyk (2001:320), the Church should not just disseminate information and provide care and support, but should also equip people with the necessary skills and empower them to prevent infection and to care for those already infected with HIV. A view common among the Muslim communities is that HIV and AIDS is the result of disobedience to the law of God. The prophet Mohammed said: “*when sexual depravity and all that it brings with it manifests itself in a society, that society brings God’s punishment down upon itself*” (Josephine, Agapit & Komla 2001:9). This suggests that there exists among some of the clergy, a strong belief that HIV infects only the immoral and that it is a subject that pastors would rather not talk about. Churches have criticised the ABC strategy that prioritises “A” for abstinence, “B” for being faithful and “C” for use of condoms. For instance, the Roman Catholic Church emphasises chastity before marriage rather than reliance on condoms (Baxen & Breidlid 2009:28).

Although some churches are influential in the sense that they act as the moral conscience of society, they are often called to render counselling and advice on ethical, moral and behavioural issues affecting the societies in which they function. Sometimes their advice and responses to issues can be contradictory or out of touch with the realities and experiences of members of their communities (Baxen & Breidlid 2009:47).

2.2 Involvement of churches in addressing HIV and AIDS

According to Pillay (2003:109), many churches in various communities engage in “caring” work, and they conduct regular “awareness” workshops on HIV and AIDS. These awareness workshops influence those who are infected and affected

with HIV and AIDS. On the other hand, there are certain church groups who believe the disease will never affect their congregation i.e. their members are immune and they are protected against; or are naturally resistant to HIV. In 2006, the Evangelical Christian Community in Africa highlighted the role that the Church could play in assisting development:

“The Church has a big role to play in bringing about social changes which in turn can enable development” (Jansen 2009:68).

Archbishop Njongokhulu Ndungane made the following appeal during the 59th Session of the Diocesan Synod of the Diocese of Cape Town during August 2000:

“Until and unless we begin to measure the pandemic in terms of broken hearts, orphans, fear, loneliness, pain and grief, we will not adequately respond to a disease which is impacting on all of humanity” (Pillay 2003:109).

Churches may have good ideas for initiating programmes on HIV prevention, but the ideas are not translated into plans of action and implementation. That is, these churches may not be able to support and counsel people infected with HIV and affected by HIV and AIDS as well as educating them on the prevention of HIV. It is also not reasonable to assume that all churches have either the information or the ability to effectively communicate information to their wider audience.

One person who was infected with HIV and was AIDS-ill puts it:

“Churches need to be helped to include teaching on sexuality and condoms because people are going to hear about condoms elsewhere and we need to give them guidance”.

Another one pointed out:

“The Church can’t pretend that youth aren’t having sex, so we need to face the need for sex education that responds to the reality” (Gennrich 2004:17, 18).

The Rev. Dr Molefe Tsele (Northern Province Council of Churches 7th Annual Conference 2005:5), the former General Secretary of the SACC, made a call to the Church to take an active part in combating HIV infections and AIDS. In his call, Tsele describes the challenge as war: *“...there are battles that we must at best avoid*

simply because they are unwinnable. There are battles that, no matter the outcome, you never emerge unscathed. There are battles which, we cannot evade, which we do not engage because we are assured of (any) victory, the kind where conscience obliges us to get in. One such battle confronting the Church in our times is the battle against the HIV and AIDS pandemic.”

According to Bates (2003:197), cited in Buffel (2006:7), the Roman Catholic Church was initially slow in its response to the crisis, influenced by socio-political realities as well as its own inability and that of its community leadership to recognise the signs of the impending calamity. According to the Catholic Church, condoms condoned extramarital sex and promiscuity.

While in countries like Uganda, Senegal and Botswana, churches started out with a negative attitude, they eventually became instrumental in spreading messages about HIV prevention, such as educating their members about HIV and AIDS. However, the Evangelical Christian Community in Africa (2006) still noticed shortcomings in the way in which the churches played out their role in the prevention of HIV.

According to studies conducted in Southern Africa, Christian Aid, the World Council of Churches (WCC) and the KwaZulu Natal (KZN) Church AIDS Network found that:

- While good work is being done in and through a few local churches, it tends to be in small packages and is often uncoordinated.
- Where national and provincial challenges have developed systematic HIV/AIDS programmes, they are not always implemented at the local level, and in some cases the attitudes of local clergy contradict their national or provincial church policies.
- The main strength of the Church lies in its home-based care programmes, which include care and support.
- Linking religious rhetoric and HIV/AIDS leads to the prevalence of moralistic messages, which often leads in churches to the further stigmatisation and isolation of people living with HIV/AIDS, thus undermining any attempts at prevention.

- There is a lack of coherent theology on issues of sexuality, sickness and HIV/AIDS, often combined with a deathly silence on social justice issues such as gender, poverty and domestic violence (Gennrich 2004:12-13).

Despite the fact that the Church has, over the years, been important to society in terms of the dissemination of information to encourage behavioural change, there has been no understanding of its role of making HIV/AIDS information accessible to members and society. It is, therefore, crucial to understand that role, especially in the Polokwane Municipality of Limpopo.

2.3 Peer education and support for HIV-infected people

There is more likely to be a change in behaviour if peers educate and support each other. According to Van Dyk (2001:93), youth programmes run by the youth themselves are more effective in promoting practices and behaviour leading to a reduction in HIV transmission. Sexual practices, drug-taking and other risky behaviours are more likely to be openly discussed, explored and understood within safe group environments. Empowerment is evidenced through peer education programmes. Peer education also allows for group debates, as peers openly speak up. In this way, the educational process becomes more accessible and less intimidating.

In a study conducted in Quebec, Canada (Caron, Godin, Otis & Lambert 2004:186), to evaluate AIDS/STD peer education programmes on postponing sexual intercourse and on condom use among young adults attending high school, it was realised that peer education was popular because youth became effective educators and they were credible and effective role models. Bandura (1986) cited in Caron *et al.* (2004:186) concurs that, according to Social Cognitive Theory, adolescents are more likely to enact modeled behaviour if they perceive the models to be warm, supportive, and similar to themselves when it came to gender, ethnicity and age. This aspect could be encouraged in the Church if the members were warm, accepting and supportive.

2.4 Views of different churches on condom use by young adults

There are varying attitudes on condom use among Church leaders. While some advocate for their use, others do not. Attitudes towards condom use fall into the following categories:

- (a) anti-condom (condoms are a bad thing);
- (b) silence on condoms (don't ask/don't tell);
- (c) promote/mention condoms under limited circumstances and for limited purposes (e.g. for sero-discordant couples);
- (d) promote condoms use in communities, but as the least important mechanisms of ABC (abstinence, be faithful, and condomise);
- (e) promote condoms as the equally or most important mechanisms in general prevention (Derose, Kanouse, Kennedy, Patel, Taylor & Leuschner 2010:32).

According to Josephine *et al.* (2001:11), the Roman Catholics, the Evangelicals, the Adventists and the Muslims advocate abstinence rather than the use of condoms. For them, promotion of condoms is an antireligious act and an invitation to extramarital sex and promiscuity. As a result, they do not embrace the idea of condom use and distribution, and they are not on their list of priorities. On the other hand, the Methodists, the Baptists, the Anglicans and the Presbyterians accept condoms because they claim to be realistic and in favour of any means of protecting the faithful from HIV infection (Josephine *et al.* 2001:11). Even when they make specific exceptions, church leaders are reluctant to be seen as promoting the use of condoms. For example, a Protestant religious leader in Honduras explained that sometimes the context requires teaching the use of condoms, even though FBO policy is not to promote them (Derose *et al.* 2010:34).

Young adults cannot protect themselves if they do not know the facts about HIV and AIDS. The role of the Church in empowering young adults by giving them the HIV-related facts before they become sexually active cannot be emphasised enough. The information should also be regularly reinforced. It is crucial for young adults to realise that health promotion strategies empower them to be responsible and not promiscuous.

2.5 Stigma and discrimination relating to HIV infections among young adults

UNAIDS (2007:9) defines HIV-related stigma and discrimination as: "... a process of devaluation of people either living with or associated with HIV and AIDS...". Stigma is a condition that causes one to be shunned, discriminated against and even persecuted for perceived moral, ethical, gender, health, economic, physical, religious class or social impropriety.

Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status. Stigma and discrimination associated with HIV and AIDS interfere with prevention measures, as people are not free to participate in prevention activities. Karim and Karim (2010:588) add that stigma and discrimination are some of the most critical reasons for the failure of prevention programmes, providing a major barrier to accessing HIV prevention, care and support services. People who are infected with HIV and those who are AIDS-ill are afraid to speak openly about their HIV status. This, in turn, perpetuates secrecy and denial of personal risk, as well as the HIV epidemic. This is supported by UNAIDS (2007:9), who maintain that people are less likely to come for HIV testing, disclose their status to others, adopt HIV preventative behaviour, or access treatment, care and support. If they do, they could lose everything.

According to Strode and Grant (2001), cited in Nattrass (2006:142), the stigmatisation of people infected with HIV contributes to their pain and suffering, and increases the social and economic vulnerability of those (particularly young people) living in AIDS-affected African households.

The perception that HIV is contracted as a result of sin has caused stigmatisation and discrimination against people who are infected with HIV and those who are AIDS-ill. Church leaders could make a special and strong impact in this area. Messages that refer to sex primarily as a sin, that promote abstinence before marriage as the only option, and those that proclaim AIDS as God's punishment for sin stigmatise people who are infected with HIV and affected by HIV and AIDS across South Africa. Thus the Church may be seen as an institution that fuels the spread of HIV through teachings that increase this stigmatisation and drive people who are infected with HIV and are AIDS-ill "underground" (Gennrich 2004:12).

Ndungane (2005:78) states that the Church must take much of the blame for the issue of stigma. People are afraid of it, so they remain silent if they know that they are infected with HIV. Stigmatisation is an impediment to HIV prevention and treatment efforts. Karim and Karim (2010:376) share the same view that fear of stigmatisation discourages health-seeking behaviours among those who suspect they may already be infected with HIV. The tendency to delay seeking health assistance after the onset of the disease results in increased debilitation and morbidity.

Analysts have spoken about the effects churches' attitudes have on people infected with HIV and affected by HIV and AIDS (Gennrich 2004:13). People who are infected with HIV are discriminated against because HIV is regarded as a death sentence. HIV transmission is often associated with violations of social mores regarding proper sexual relations. This is why people who are infected with HIV are thought to be promiscuous. Eventually, stigmatisation prevents such people from seeking counseling, obtaining medical care and even taking preventive measures to avoid infecting others.

Stigma and discrimination result in harmful and destructive exclusion, setting the scene for "us" and "them". In their study, Bujo and Czerny (2007:51) relate that a religious sister in Nairobi who told her community that she was infected with HIV was given her own cup, plates, glass and cutlery. In Swaziland, Prince T. Fohlongwane commented in favour of segregating those infected with HIV and affected by HIV and AIDS: *"One should not keep rotten potatoes in the same bag with good ones because they will all get spoilt in the end"*. In South Africa, Gugu Dlamini's own community killed her because she went public about her HIV status. People were afraid that living with her would stigmatise the whole community (Bujo& Czerny 2007:51).

According to Ndungane (2005:379), *"those who see HIV and AIDS as a punishment from God stand under the judgment of the Son of Man"*. He went on to say that the Church must not allow people to be marked out, labelled, categorised or judged, whether because of their own HIV status, or the HIV status of family members, or poverty, or blindness or anything else.

People who are infected with HIV still face many kinds of discrimination:

- Many people are refused employment or membership of employee benefit schemes.
- Insurance companies refuse to offer life insurance to people with HIV, and banks often refuse to give such people bonds.
- Many people are refused proper health care and equal membership of medical aid schemes.
- Children and students with HIV, or whose parents have HIV, are victimised at school.
- Many people are tested for HIV in our hospitals, without giving informed consent, or are told about their HIV status without being counseled.
- Breaches of (breaking of) confidentiality and privacy happen almost every day (e.g. disclosing someone's HIV status without their consent) (Barrett-Grant, Fine, Heywood & Strode 2001:38).

Many of the people infected with HIV or affected by HIV and AIDS are unable to speak openly about issues such as sexuality and health. This can be exacerbated by a hostile or uncomprehending environment, as is the case with certain churches whose doctrines are not sufficiently well-versed in the teachings of Christianity. Where such doctrines are aligned with Christian teachings, communication, personal empowerment and counseling would be informed by these teachings.

Secretary General Kofi Annan said the following when addressing a special session of the United Nations (2001):

"We cannot deal with AIDS by... making out it is their fault [those who are sick] ... Let no one think that we can protect ourselves by building barriers between them and us. For in the ruthless world of AIDS, there is no us and them" (Van Niekerk & Kopelman 2005:208).

Churches ought to work in partnership with CBOs, whose patient-care through caregivers cannot be over-emphasised. Caregivers like church-based home carers provide care for the terminally or chronically ill in the comfort of their homes or familiar communities.

HIV and AIDS have affected all aspects of humanity: cultural, spiritual, economic, political, social and psychological. Massicame (in *One Body* 2005:38-39) believes that the Church could play the following important roles:

- Teaching and talking to communities about human sexuality;
- Lobbying and advocating for people living with HIV/AIDS in order to reduce stigma and discrimination;
- Counselling and taking care of the sick by offering them much-needed love and care;
- Protecting orphans and vulnerable children;
- Promoting and encouraging treatment for HIV/AIDS-related illnesses.

Creating a conducive and enabling environment for people infected with HIV and those affected by HIV and AIDS could be achieved by enacting legislation at the church level that ensures abdication of stigma and discrimination, developing policies which protect people's rights, sensitising communities' positive support for such people, and ensuring that they have continuous counseling. UNAIDS (in Karim & Karim 2010:378) lists a number of multi-pronged interventions to address stigma and discrimination. Those include, inter alia:

- Community mobilisation and continuing advocacy supporting a change in societal views of political and religious leaders in response to HIV/AIDS-related stigma and discrimination.
- Broad-based action to counteract gender, racial and sexual inequalities and stereotypes on which HIV/AIDS-related stigma and discrimination often feed.
- Promotion of life-skills education, risk-reduction counseling and support groups to help HIV-infected and affected individuals cope with stigma in the home, school and community.

Frohlich (in Karim & Karim 2010:378) states that to combat stigma in the epidemic, CBOs, NGOs, health service providers, community health workers and social services all need to work toward sensitising local communities to the needs of those infected with HIV and affected by HIV and AIDS.

2.6 Economic, social and cultural factors relating to HIV infections

Other factors contributing to the spread of HIV infections are related to socio-economic and cultural conditions. People infected with HIV are often condemned for their status with little consideration of the social complexities like poverty that exacerbate the pandemic. Pillay (2003:109) maintains that the social and economic impact of HIV and AIDS, which knows no age, race, class, gender, religion or sexual orientation, is experienced by thousands of people who are infected with HIV and those who are AIDS-ill. Pillay (2003:116) goes on to say that economic and social circumstances force children to leave school to look after a sick parent/adult. According to the World Bank (2001:139), in Nattrass (2004:24), if the AIDS pandemic had not happened in Southern Africa, life expectancy would have reached 64 by 2010-15. Instead, it will have regressed to 47, reversing the gains of the past 30 years. In other words, people die much younger because of AIDS-related diseases.

About half the total number of people infected with HIV live in Africa, where death rates have increased dramatically in the age group 15-39 (Nattrass 2004:24). Hunter (2003:44) puts it succinctly when he says that young adults get sick just as they reach their prime productive years. The United Nations Development Programme claims (in Hunter 2003:44) *“never before in history have death rates of this magnitude been seen among young adults of both sexes and from all walks of life”*. This also applies to 20-24 year-olds who are the most vulnerable group and are the focus of this study.

2.6.1 Economic factors relating to HIV infections among young adults

AIDS usually strikes people who are raising children and are at or near the peak of their income potential. When young adults die, this results in loss of productivity and an income, however low it might be. HIV and AIDS retard economic development and the growth rate, which is estimated to be reducing by a minimum of 0, 3-0, 4 % per annum (Parry 2005:15).

Children, especially young girls, are likely to be withdrawn from school and forced into exploitative situations, sometimes into prostitution, because that is the only way to “survive”. These young girls have little or no say or control over their sex lives

(Nattrass 2004:27). Sex with older men out of economic need and suffering domestic violence inhibit girls' ability to negotiate for safer sex, which consequently exposes them to HIV infections. DeJong (2003:12) concurs that adolescent women typically lack power over their sexual relations. He further argues that this indicates the inclination by older men to seek sexual relations with younger women. Whiteside (in Karim&Karim 2010:418) shares the view that poverty drives many women into sexual associations to provide for themselves and their children. It also leaves women powerless in relationships.

Karim (in Karim & Karim 2010:298) states that anecdotal data suggest that very young girls are perceived to be "HIV-free" and are preferred as sexual partners by older men. He further suggests that some young women often form partnerships with older men who have some source of income and who are able to give them personal gifts and grant them favours and money for household necessities, not to mention school fees. Other items young women expect from older men include stylish clothes, jewellery and cosmetics.

Longman (in Feldman 2008:93) conducted a study on the factors that influence Ivorian women's risk perception of STIs and HIV. In the study, a twenty-one-year-old was quoted as saying: *"If you want to have a lot of money, you have to do whatever it takes because there aren't a lot of jobs available to girls."* As a result of their lower social and economic status, many women and girls cannot negotiate sexual encounters, so they become vulnerable to HIV infections.

From the above discussion, it is clear that young women and girls are more susceptible to HIV infections than are young men, and require more socio-cultural and emotional support from their communities and their church leaders. Flint (2011:12) agrees that prevalence rates among young women far outstrip those among their male counterparts because of the physiological differences. According to Fox and Thomas (1987/1988, in Macklin 1989:32), the economic consequences of HIV infections for the individuals and family can be devastating, as the economic burden of direct and indirect costs is eventually shared among patients, their families, employers, employees and the government. The impact of the AIDS epidemic derives from the fact that the individuals who fall ill and die are predominantly breadwinners, thus affecting negatively on the household production

of income capacity. This raises some serious concerns, as those people are young and are essential to the economic growth of the country.

It was found that a decline in household economic status is caused by, among other things, special medical treatment and care, nutrition and funeral costs, which may constitute a major financial burden on the household budget. In addition, productivity is affected when skilled or experienced staff fall ill, go absent or die. This is exacerbated by the costs and actual expenditure, which increase if the employers have to pay for additional employee benefits, such as group life insurance, pensions and medical aid, thus diverting resources from savings and consequently, reducing the rate of economic growth overtime (DoH 2010).

According to Page, Louw and Pakkiri (2006:94), it is estimated that the annual per capita growth (i.e. the economic growth of the country expressed as a percentage per head or per population member) in half the countries of sub-Saharan Africa will drop as a direct result of HIV and AIDS. South Africa has one of the largest populations infected with HIV in the world. Consequently, this will affect economic growth in the future, because it results in:

- A decline in the size of the working-age population;
- A reduction or downturn in their productivity;
- Rising medical costs and health care (Page, Louw &Pakkiri 2006:94).

Young women with no income-earning opportunities seek support from men, at times trading sex for economic security. Some girls may acquire a “sugar daddy”, that is, an older man who offers compensation in cash or in kind in exchange for sexual favours, or “an older man who engages in one or more sexual relationships with young girls, some of whom are still in primary or high school, in exchange for gifts and cash” (Feldman 2008:183). This engagement in transactional sex (the occasional exchange of sex for money or goods) may be instigated by periods of financial hardship (*HIV and AIDS and Young People* 2003:350). There is a common perception that young women’s relationships with “sugar daddies” are purely for financial gain. Unfortunately, this is another detrimental factor fuelling HIV infections.

The above-mentioned facts suggest that most people infected with HIV are in their economically active years. Being infected with HIV means they become less

productive with time, and, when they die, their knowledge, training and experience are also lost. On the other hand, the low income and low standard of living of the poor add to the lowering of their economic productivity as well as making it impossible for them to access basic health services. Productivity levels are worsened by HIV infections and those who are AIDS-ill, because they result in absenteeism and a further loss of labour. The Church should provide training for its members on combating the HIV infections and AIDS pandemic from a Christian perspective (Jansen 2009:77). Successful training and preventative strategies would reduce economically-related issues like low productivity. The Church should also support those suffering in the epidemic.

2.6.2 Social factors relating to HIV infections among young adults

AIDS is undermining already fragile families, communities, national economies and governance. It creates or exacerbates social disruption and conflict. Pillay (2003:116) makes it clear that the fact that children are leaving school in order to look after a sick parent perpetuates the poverty cycle, as there is a correlation between levels of education and standard of living. It is also argued that poor women turn to sex work or to multiple sex partners to make ends meet (Feldman 2008:251). The poor and destitute are, therefore, more prone to contracting the disease and, in that sense, poverty exacerbates the pandemic. Poverty creates a fertile ground for activities conducive to HIV transmission because poor people are likely to be without adequate health care and education.

According to Jansen (2009:7), conditions of poverty facilitate HIV transmission partly because the body's defense mechanisms are already run down through, inter alia, malnutrition and vitamin and trace element deficiency. Maintaining a healthy way of living is thus, in itself, a substantial step in the direction to preventing HIV infections. Part of the task of administering prevention requires church members and the community at large to deal with poverty in a comprehensive manner. The poor cannot be healed by prayer alone, because their immediate needs are food, shelter and clothes.

2.6.3 Cultural factors relating to HIV infections among young adults

It is crucial to understand the cultural beliefs that are likely to contribute to the spread of HIV infection in the Polokwane Municipality. Cultural factors, such as polygamy, extramarital relationships, widow inheritance, and men having multiple sexual relations while at the same time insisting on strict female fidelity increase women's vulnerability to HIV. Gennrich (2004:13) states: *"such cultural beliefs which insist that women should obey their husbands and beliefs that men naturally need more than one sexual partner make it extremely difficult for wives to insist on their husbands' faithfulness or else to reject unsafe sex, even within marriage"*. Culture empowers men, who consequently, take the upper hand in decisions on sexual matters.

2.7 Attitudes towards people who are infected with HIV

Some church leaders see HIV infections as a divine punishment. This opinion exacerbates the stigma against those who are infected with HIV. A study conducted in KZN (Gennrich 2004:14) shows that ministers were for the most part judgemental about how people become infected with HIV. About 70% mentioned "promiscuity", "immorality" or "revenge" in their judgemental statements. The percentage indicates that people are still judged negatively for their status. Furthermore, the results of the study show that most of the church leaders agreed that the distribution of condoms in the church halls was not a good idea, as that would equate with the Church promoting sex. On the other hand, those directly affected felt it would be of no use obtaining condoms in churches if they could not speak about sex. On the issue of love and acceptance of people infected with HIV, the study showed that church leaders often added conditions, such as, "if they repent" (Gennrich 2004:18), in which case they would be accepted within the community of faith.

The belief that AIDS is a punishment from God causes confusion and anguish among the members who are infected with HIV and those who are ill due to AIDS. It also gives the impression that there is no room for them in the Church (Gennrich 2004:14). A comment by a person infected with HIV reveals how some teachings by the church leaders can impact negatively on individuals:

I do not pray anymore and I do not believe that God is there for me. Otherwise, what type of a sin did I commit to make him so angry? (Gennrich2004:20).

HIV prevention programmes should include issues that address harmful gender norms. UNAIDS (2002:84) in Van Dyk 2008) concurs that such programmes should, inter alia:

- encourage men and boys to talk with each other and their partners about sex, violence, drug use and AIDS;
- teach female assertiveness and negotiation skills in relationships, sex and reproduction;
- teach and promote respect for, and responsibility towards, women and children; support actions to reduce male violence, including domestic and sexual violence.

Machyo ([sa]:7) supports the foregoing statements that women infected with HIV bear the brunt of rejection more than do their male counterparts, as the property of deceased spouses is sometimes appropriated by family members who may not recognise the widow and children. The Kenyan bishops reaffirmed their support for such vulnerable people to better their conditions, especially by providing education, training opportunities and income-generating opportunities for them.

2.8 Prevention of HIV infections

Meassick in Feldman (2008:91) states that there is no cure in sight and no preventative vaccine, and the repeatedly high incidence of HIV infections on every continent continues unabated. Even if antiretroviral drugs are indeed available, they are not accessible by many poor people, because they are still so expensive. It is against this background that preventing the spread and transmission of HIV must be a priority strategy.

National Strategic Plan (NSP) (DoH 2007 – 2011) states explicitly that South Africa's future depends on its young people and that the key message of the strategic plan, which is also a challenge, is to influence and change the behaviour of young people, particularly those under the age of 24, in order to try reducing HIV infections in the age group that is most at risk.

Van Dyk (2008:212) asserts that no HIV prevention programme could succeed in Africa without the cooperation of traditional leaders. These people are effective

agents of change because they have authority and influence in matters relating to sex in their community.

According to Derosé *et al.* (2010:30), HIV prevention activities range from primary prevention education to HIV testing. Primary prevention education focuses on risk, transmission and protective strategies for the general population or high-risk groups. Secondary prevention education or positive prevention is education of people who are infected with HIV and those who are ill with AIDS and their families to encourage safe sex practices and self-care.

HIV prevention activities seek to bring about change in individual behaviour by encouraging people to learn their HIV status, to take precautions not to transmit HIV to others if they are positive and to protect themselves against HIV infections if they are negative. Although knowledge does not necessarily lead to a rapid change in behaviour, the level of awareness and knowledge regarding HIV and AIDS increases. Prevention also has its challenges. Some of the challenges of prevention activity are:

- Lack of information [People are not well-informed about preventative measures];
- Lack of awareness and understanding of HIV [There is very little coordinated information or few awareness campaigns or programmes to conscientise people about HIV];
- Persistent myths about HIV e.g. that condoms spread HIV or that women are responsible for spreading HIV;
- Stigmatisation of HIV-positive people (Bendtro, Brokenleg & Bockern, 1998:34).

Given all that, people are afraid to go for testing and disclose their HIV status, as they are uninformed and ignorant about HIV and AIDS issues. Barnett and Whiteside (2002:46) agree with the above-mentioned statements that interventions seek to prevent exposure to HIV infections by altering sexual behaviour. These interventions include *knowledge, attitudes, practices and behaviour*.

NSP (Department of Health) (DoH) 2006:10) aims to reduce the national HIV incidence rate by 50% by 2011 and to reduce the impact of HIV and AIDS on

individuals, families, communities and society by expanding access to appropriate treatment, care and support to 80% of people infected with HIV and their families by 2011. A key message of the NSP (2007-2011:65) is that one of the greatest challenges is to influence and change the behaviour of young adults, particularly those under 24 years of age. This group is most at risk.

The Limpopo Provincial Department of Education (LPDoE) has been identified as an implementing agency of the NSP in the Province. In other words, it is mandated to develop an HIV and AIDS strategy and implementation plan to respond to the epidemic. The DoE focuses on certain components of the NSP e.g. raising awareness about HIV and AIDS among educators and learners; integrating HIV and AIDS into the curriculum; and developing models for analysing the impact of HIV and AIDS on the system. LPDoE plans to mitigate the impacts of HIV and AIDS using this strategy. It has also developed the HIV and AIDS Strategy, which is aimed at guiding and coordinating the activities and initiatives of different stakeholders to manage the impact of HIV and AIDS in the public education sector in Limpopo (DoE 2008-2012:16). Another key to a good prevention programme is to understand the dynamics of disease transmission.

According to the study conducted by Clapp, Herbert and Zizak (2004:1-2) cited by Maluleke (2007:14), the young adults in religious organisations who were provided with information about STIs and contraception were less likely to have sexual intercourse than their peers who did not have access to such information. However, these teenagers were involved in other sexual behaviours, including oral sex, thinking that they were protecting themselves against STIs. This is because they live under the misconception that it is only through sexual intercourse that HIV is transmitted. DeJong (2003:11) agrees that young people who lack access to correct information about the potential consequences of unsafe sexual behaviour are particularly at risk of contracting sexually transmitted infections in general, and HIV infections in particular.

In a study conducted in Uganda it was found that the decline in infection rates is greatest among the 15-19 age group, and that HIV prevention activities carried out by the Church had a significant direct impact on the particular populations targeted. Those who advocated abstinence and fidelity have realised a significant reduction

rate in HIV infections. Like Uganda, which some reports continue to claim is the world's greatest success story in HIV prevention (Green 2001:5), Senegal is another country widely recognised as an AIDS success story.

For instance, in Dakar, Senegal's major urban area, HIV prevalence rates range between 0 and 0.8% (Green 2001:5). FBOs became involved in HIV prevention and the survey conducted among Muslim and Christian leaders in 1989 (Green 2001:5) found that churches needed and wanted more information about HIV and AIDS, so that they could in turn educate those in religious communities. AIDS became a regular topic in Friday sermons in mosques throughout Senegal, and senior religious figures addressed the issue on television and radio. Senegalese churches of all faiths were "*to act freely in the promotion of prevention strategies*" (Green 2001:6). However, during the first stages of the AIDS epidemic, the majority of churches condemned those infected with the virus, calling the illness a "divine curse" (Green 2001:6). Consequently, this impacted negatively on the church members, including young adults.

In Botswana, key HIV prevention activities include preaching or otherwise teaching abstinence and fidelity; encouraging condom use among both the married and unmarried; providing counseling services; empowering the youth with risk avoidance life skills, sometimes in the form of abstinence classes and encouraging HIV testing (Togarasei, Tembo & Jensen 2008:10-12). There is also Youth Psycho-Social Initiative which is a coalition of four churches in Gaborone i.e. the Anglican, the Church of the Nazarene, the Roman Catholic and the Salvation Army. The initiative started in 2002 with the aim of addressing the psycho-social issues faced by children who have been left either orphaned or vulnerable as a result of HIV and AIDS (World Health Organisation 2007).

According to Africa Youth Ministries (2010:2), churches and faith-based communities should:

1. be places of openness where persons whose lives have been touched by HIV/AIDS can express their pain and reach out for compassion, understanding, and acceptance in the presence of persons who bear Christ's name;

2. provide care and support for individuals and families whose lives have been touched by HIV and AIDS;
3. be centres of education and provide group support and encouragement to help men, women, and youth refrain from activities and behaviours associated with transmission of the HIV infection;
4. advocate for increased levels of funding for HIV/AIDS, and encourage people to consult their Members of Parliament to urge for adequate funding to provide resources for the reproductive health of women and girls, as well as HIV/AIDS prevention; and
5. observe World AIDS Day on or around December 1 each year.

HIV prevention and AIDS messages should be appropriately targeted, constantly and consistently being reinforced. On the other hand, tools and services must be affordable and easily accessible to all who need them.

One of the pillars of the Methodist Church of Southern Africa (MCSA) is drawn in their report as “Justice and Service” (Vika 2006:9). The objective of this report is to develop a rigorous response to HIV and AIDS. Each district is encouraged to establish or strengthen similar existing structures for multi-disciplinary HIV and AIDS and poverty alleviation groups. The report also aims to implement appropriate actions for the context. People responsible for this are Bishops and District Secretaries.

The MCSA made HIV/AIDS resolutions, which were adopted by Conference in 2005. Conference resolved:

1. To adopt the manual *The Church in an HIV Positive World* and make sure that each minister and lay leader in every society has a copy of the handbook;
2. That the Presiding Bishop be the Champion for the Church’s response to HIV and AIDS;
3. That every district run a workshop to be attended by all ministers and one lay person from each circuit in which the manual will be explained and used as a resource by June 2006;
4. That each circuit should establish a Multi-Disciplinary HIV and AIDS Action Group;

5. That HIV and AIDS be part of the agenda of every leader's meeting, quarterly meetings, synods and conferences;
6. That the HIV/AIDS MCSA Strategic Plan be made available to MCSA leaders;
7. That a Coordinating Body be established at all levels of our Church, viz. Connexion, District, Circuit and Society;
8. That a special fund for HIV and AIDS programme of the MCSA be established and that an amount be allocated from mission funds, Millennium and cash management;
9. That circuits and societies be asked to allocate a proportion from their funding and that they undertake fundraising for HIV and AIDS;
10. Churches be asked to form partnerships with FBOS, CBOs, NGOs, Government and other role players in the fight against HIV and AIDS;
11. That churches develop a programme to capacitate and empower the leadership to find creative ways of removing stigmatisation and discrimination;
12. That all ministers and stewards be held accountable for HIV and AIDS programmes and projects in their circuits and societies.

Based on the resolutions mentioned above, it is clear that the Church cannot exclude anyone, especially those who are infected by HIV and those who are ill owing to AIDS, and that all these people need the care and support that the Church can offer.

Moyahabo Change Education Agency (MCEA 2007) was founded on the premise that change education in every nation is essential for development at all levels. Individuals and organisations need change education if they are to survive in a continually-changing environment. The Agency is a non-profit organisation in terms of the Non-Profit Act (Act 71 of 1997). MCEA's perception is that it is a principle of creation that institutions and individuals exist in seasons of change. Major events that constantly occur in life or in the world bring with them momentous transformation in social, economic, potential and spiritual conditions, as is the case with HIV and AIDS.

MCEA is geared for a positive contribution to achieving change education for community development through capacity building and skills development for handling change, as well as for initiating and managing community development progress. The Agency has identified HIV and AIDS as one of the challenges, and the

people who are infected with HIV and those who are ill owing to AIDS as the community to be served. To support the initiative and as part of implementing their turnaround strategy on HIV and AIDS, the Agency organises HIV/AIDS awareness and capacitation seminars on a regular basis. MCEA (2007:2) also came up with the motivation for offering change education:

- Parents do not teach children about change;
- Schools do not include change education in their curriculum;
- People are not naturally skilled for handling change;
- Change education is not an instinct within human nature;
- Institutions and individuals learn about change the hard way, through experience;
- Most institutions and individuals never learn to respond effectively to change;
- Many people are never taught to develop certain skills that would allow them to initiate change that would change their lives and the lives of other people, and enhance community development;
- Community development projects without the backup of change education are likely to fail.

A partnership was established between the United Reformed Church in Southern Africa (URCSA), the Northern Synod and the Reformed Church in America (Canada Synod), where commitment was forged to support and fund HIV/AIDS-related projects in the Northern Synod. The National AIDS Forum of the Dutch Reformed Family of Churches is to receive funding from the Global Fund to support projects that address the problem of AIDS, Tuberculosis and Malaria (Agenda 2010:274).

In The World Bank (2000:57-59), it is stated that HIV and STIs can be prevented in the following way:

Behaviour-change communication: Multiple media channels such as radio, television, newspapers, as well as small-scale personal outlets, such as local drama, brochures and posters, counseling, school curricula, peer education and workplace programmes in all local languages should be used to reach those at the greatest risk of infection, as well as the general public, to help people identify and change risky behaviours.

Workplace intervention: The workplace offers a venue to efficiently reach large numbers of vulnerable people with HIV and AIDS interventions. All sectors in the workplace will help slow the spread of the epidemic and minimise its impact. Churches should develop communication strategies and also address workplace HIV prevention, particularly because they are usually in direct communication with their respective communities on a regular basis.

Voluntary Counseling and Testing (VCT): VCT is highly effective in changing people's behaviour to reduce their risk both of being infected and of infecting others. The challenge is to strengthen counseling and testing centres, create a demand for these services, and provide them on a sustainable basis, making them available to all those who need them.

Management of STIs: This is an important mechanism to control the spread of HIV, for two reasons (1) the presence of other STIs facilitates the transmission of HIV; and (2) diagnosing and treating STI patients provides an opportunity to counsel them about their high-risk behaviour and provide them with condoms. The STI management programme includes teaching people how to recognise STI symptoms and where to seek treatment, as well as how to reduce the risk of contracting HIV.

Condom supply and logistics: The proper and consistent use of condoms is a highly effective means of preventing the transmission of HIV and other STIs. Affordability and accessibility are important factors once people have learnt the importance and use of condoms when it comes to HIV and STIs infections. Condoms are widely distributed at subsidised prices through social marketing, commercially by the private sector and in government programmes.

Blood Safety: A comprehensive blood-safety programme includes a number of voluntary blood donors as opposed to paid donors, and screening all blood for HIV and other infectious agents.

Reducing MTCT of HIV: MTCT can occur during pregnancy, delivery, or breastfeeding. Thus, it is important that HIV-positive women be given Antiretrovirals (a regimen at the time of delivery) in addition to a one-week postpartum regimen for both the women and her newborn. Access to VCT and adequate infrastructure to

procure and administer ARVS drugs cannot be over-emphasised for intervention purposes.

2.9 Networking on HIV prevention

In reality, churches are totally unequipped to confront the epidemic independently. Churches, CBOs and FBOs already involved in HIV prevention programmes ought to meet regularly to share information and research outcomes in the fight against HIV infection and AIDS.

2.10 Advocacy on HIV prevention

According to Seele (2003: 1-2), the Church is the only institution able to mobilise the masses and disseminate appropriate information. It can be effective in doing so because it still enjoys the respect and the support of the people. Seele further asserts that we can no longer afford the luxury of succumbing to the “NIMBY” syndrome: *“Not in my backyard”*.

The power of the media should be harnessed. For example, Soul City, a South African NGO, makes use of television, radio and printed presentations in an effort to promote socially acceptable behaviour in everything that relates to HIV and AIDS (as well as other fields). The organisation reaches and exerts significant influence on large numbers of listeners. Other examples that present rich potential as channels for HIV preventive education messages are street theatre, drama, music, song and dance. If properly conceived and presented, all these media and entertainment industries could contribute significantly to enhancing knowledge, skills and positive attitudes on the part of those who are less likely to participate in more organized programmes (Michael 2002:10). It has become generally recognised that knowledge alone will not achieve the aim of curtailing the spread of HIV. There is a need for people to learn about the context in which HIV is transmitted and how to prevent it.

2.11 Theoretical perspective

Many of the HIV prevention interventions often depend on the socio-cultural, political, or economic situation of the country rather than using the behavioural theories to draw models that are suitable for population. There is still limited recognition that behaviour change is complex; and its influence on a group or individuals’

behaviors depends on many factors. Theories are important because they identify patterns and causal relationships among beliefs, attitudes, and actions. Van Dyk (2008:123-124) highlight the most frequently used behaviour change theories and their application in HIV prevention, and states that before people can change any particular behaviour, they first need to recognise the need to change that behaviour. In order to change behaviour, it is important to identify the action, target, context and time of the behaviour that you want to change.

2.11.1 Social Learning Theory

The Social Learning Theory (SLT) is considered the most appropriate as it involves learning behaviour change through prevention programs. The theory asserts that sexual behavior is influenced by personal knowledge, skills, attitudes, interpersonal relationships, and environmental influences. It is grounded in the belief that human behaviour is determined by the relationship between cognitive factors, environmental influences, and behavior. This theory suggests that people can learn new information and behaviours by watching other people. Most importantly, the theory suggests that factors such as social support, self-control, self-efficacy and awareness need to be taken into account. In relation to this study, the model would suggest that the following factors are important for efficient HIV prevention among youth: (i) Modeling of the skills needs to be included in teaching young adults (ii) Including information that will enable young adults to implement each new skill (iii) Verifying whether young adults believe that the new skill or behaviour will be appropriate in their environment; and whether they feel confident when correctly using the new skill. Social Learning Theory has been proved to make predictions about human behavior, and has generated useful applications in the areas of HIV prevention.

The relevance of this theory to HIV prevention is informed by the fact that behaviour is learned. Almost all learning can occur by observing the behaviour of others and the subsequent consequences (i.e. what they get out of it). The environment informs the knowledge and behaviours of the participants (Edelman & Mandle 2002:222). One can conclude that change in behavior can be learnt through modelling and the benefits can be evidenced if the spread of HIV infection is maximally controlled and people become motivated if the spread is curbed. Furthermore, the basis of the Social Learning Theory in this study is that health behaviour decisions on information

received from church leaders, who are seen as both having knowledge on the topic and being an accessible, trustworthy source is important.

2.11.2 Self-Efficacy

Bandura (1997, cited in Edelman & Mandle 2002) emphasises the influence of self-efficacy, or efficacy beliefs on health behaviour. This is the most important characteristic that determines an individual's change in behaviour. Churches need to encourage self-efficacy, which refers to people's belief in their ability to abstain from sexual contact. Thus, highly efficacious individuals activate sufficient effort which, if well executed, produce successful outcomes, whereas those with low self-efficacy cease their efforts prematurely and fail at the task. The behavioural assumption is that there is a functional link between behaviour and its consequences. Edelman and Mandle (2006:223) outline the framework based on a cognitive behavioural approach for developing interventions for behavioural change that can be used as follows:

- Assess the behaviour;
- Educate about the need for and benefits of change;
- Motivate using personalised messages;
- Assess and increase self-efficacy;
- Decrease barriers to change;
- Modify behaviour;
- Maintain behaviour change.

The preceding points are an indication that the ultimate maintenance in behaviour change is an accumulation of factors, such as the needs, benefits and increase in self-efficacy. Emphasis is also on the person's belief in his or her ability to perform the behaviour. This is central to any person's ability to function.

2.12 Conclusion

The researcher reviewed the literature on the role of churches in HIV prevention, theories and models on behavioural change and advocacy and networking as some of the strategies for curbing the spread of HIV. The literature review suggested that there should be more involvement on the part of churches and NGOs to help either

fill the gap in prevention and/or be involved in advocacy efforts. The role of the Church in urging young adults to delay their initial sexual encounter, encouraging them to remain faithful to their partners and supporting the proper and consistent use of condoms for those who are unable to do these could not be emphasised enough. More HIV prevention resources and activities need to be allocated to the Church in order to prevent the spread of HIV infection.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

The chapter describes the type of study, data collection, issues of reliability and validity as well as ethical considerations. According to Bless and Higson-Smith (1995:63), research design deals with the planning of any scientific research from the first step to the last. In other words, it is a procedure or outline to guide the researcher in collecting, analysing and interpreting observed facts. A qualitative approach was selected to guide the study and achieve the objectives.

3.2 Type of study

The study is exploratory in nature, and it uses qualitative research method. Exploratory study aims to establish facts and to identify important variables (Babbie 2010:3). The qualitative approach emphasises meanings that are not statistically measured. The method is found to be suitable for addressing the objectives of the current study by exploring the role of the church in HIV prevention. Marshall and Rossman (2006:2) state that qualitative research uses multiple methods which are naturalistic, interactive and humanistic and which focus on context. Qualitative studies are all fundamentally suitable for locating the meanings people place on the events, processes and structures of their lives (Babbie 2010:275). The researchers that use qualitative research method are able to be flexible and creative in formulating their questions, and as a result, the study provides rich and detailed information. The researcher was in a better position to learn more about the factors that are considered important in HIV prevention in the Church environment.

3.3 Description of the research participants

According to Babbie (2010:254), a research participant is a person who provides data for analysis by responding to a survey questionnaire. The research participants in this study comprised church leaders as the key informants, and as leaders of churches affiliated with the Limpopo SACC. The researcher interviewed seven (7) church leaders out of fourteen (14) SACC-affiliates, as they were the only ones whose churches were involved in HIV/AIDS programmes and services. The basis for

identifying these research participants as key informants was that they were more knowledgeable about the programmes that they organised and managed in their respective churches.

3.4 Sampling techniques

Purposive sampling was used in order to select only those churches which had HIV/AIDS programmes and services. Purposive sampling, also known as judgemental sampling (Hagan in Berg 2009: 50), is a type of non-probability sampling in which the units to be observed are selected because of the researcher's judgement (Babbie 2007:215). Researchers use their special knowledge or expertise about some group to select subjects who represent this population. In this study, church leaders whose churches are affiliated with the Limpopo SACC within the Polokwane municipality were selected.

3.5 Data-collection techniques

Data was obtained mainly through face-to-face interviews, which lasted for 30-45 minutes. Interviews were conducted in English, which was the language preferred by all the participants. Semi-structured interview schedule was used to ensure that all research participants were asked the same questions.

The interview schedule (see Appendix E) consisted of both close-ended and open-ended questions. The questions in the interview schedule did not elicit participants' personal information, but it predominantly focused on the church leaders' roles in HIV prevention, church leaders' perceptions, experiences, feelings, thoughts, opinions and the challenges they perceived to be impeding HIV prevention among young adults.

Prior to the interview, research participants were contacted telephonically to secure an appointment and explain the purpose of the study. The procedure included introducing the research topic and inviting church leaders in the Polokwane Municipality to participate in the study (see Appendix B).

Questions in the interview schedule were compiled in line with the purpose and objectives of the study. The researcher probed to obtain more clarity, and to elicit

sufficient information for analysis (Babbie 2010:277). The researcher obtained permission to record all the interviews.

3.6 Data analysis

The researcher used the following steps as outlined by Terre Blanche and Durrheim (2002:141-144):

- Familiarisation and immersion;
- Inducing themes;
- Coding;
- Elaboration;
- Interpreting and checking.

Data collected from church leaders within the Polokwane Municipality was transcribed from the audio-tape. The researcher initially familiarised herself with collected data, identified common issues and developed them into themes; and analysed the data with a view to develop synergy and coherence. Themes were developed and coded according to the purpose and objectives of the research to identify similar patterns, relationships, similarities and differences based on the data from the transcript.

3.7 Ethical considerations: The rights of research participants

The following documents (see attached Appendices) are a proof that the researcher considered the ethics implicit in the research before embarking on the study:

- An ethical clearance letter was obtained from UNISA giving permission to conduct research (Appendix A).
- A letter was sent to the Limpopo SACC Ecumenical Secretary requesting permission to conduct research with SACC-affiliated churches (see Appendix B).
- An access letter or permission to conduct the study was obtained from the Limpopo SACC (see Appendix C).
- The contents of the consent form were discussed with the research participants before the interviews (see Appendix D).

- The research participants were informed that data collected during the interviews would be treated in the utmost confidence.

According to May (2008:59), ethics is concerned with an attempt to formulate codes and principles of moral behaviour. Babbie (2010:64) agrees that ethics is typically associated with morality and both words concern matters of right and wrong. Ethical decisions are therefore concerned with what is right or just, in the interest of not only the research, but also of the research participants in the study.

The importance of gaining access to the research participants or reaching them by negotiating with the gatekeeper, in this case, the Ecumenical Secretary of the Limpopo South African Council of Churches (SACC), cannot be emphasised too much. Denscombe (2007:71) agrees that identifying key people who can grant permission, and successfully negotiating access to research participants, places and events, is always a prerequisite, without which the field-work cannot begin. However, the influence of gatekeepers goes beyond a simple granting or denial of contact with research participants. Denscombe (2007:71), citing Burgess (1984), supports the foregoing statement that access is a continual process, because research is generally conducted over a period of time.

3.7.1 Informed consent

According to Bailey (1994:458), informed consent entails making the research participants fully aware of the purpose of the study, its possible dangers and the credentials of the researcher. The researcher must be sure that the research participants are aware of the positive or negative aspects or consequences of their participation (Bless & Higson-Smith 1995:62). Direct or indirect coercion, as well as undue inducement in the name of the research should be avoided (UNISA 2007:10). The participants must be aware of the facts before they can give informed consent. The facts are, inter alia,

- the title of the study;
- duration of the study;
- a reasonable explanation of the purpose of the study and the procedures to be followed;
- an identification of the individuals performing the procedures;

- a description of the possible risks and discomforts;
- a description of the potential benefits or reimbursement;
- an offer to answer any enquiries concerning the study at any time;
- participants' rights to refuse, withdraw or discontinue participation in the study at any time;
- an assurance that the information provided by the participants will be kept confidential;
- sharing the results and giving the assurance that participants will be informed and their consent re-obtained if the study design or the use of collected information is changed (Bailey 1994:459).

Informed consent requires two-way communication between the researcher and the research participants. Berg (2004:64) agrees that individuals who participate need to know that the content of the research is free of any trace of fraud, deceit, duress, or similar unfair inducement or manipulation. In this study, informed consent was obtained from all selected leaders whose churches are affiliated with the SACC and have HIV and AIDS programmes and services. This was after a detailed and clear explanation had been provided so that research participants could make an informed choice to participate voluntarily in the research (Terre Blanche & Durrheim 1999:66-67).

No one was coerced to participate in the research. Research participants were free to withdraw their consent to participation in the study if they experienced discomfort, as mentioned in the consent form. All the research participants signed the consent form prior to the actual interview process after they had been adequately informed about the nature of the research (Babbie 2010:64). Newman (2006:135) concurs that research participants could become aware of their rights and what they are getting involved in when they read and sign a statement giving their informed consent (see Appendix C).

3.7.2 Confidentiality of data and research participants

Research participants were assured of confidentiality. In other words, they were asked only for information that was central to the study to reduce the risk of invasion of privacy and confidentiality. To ensure anonymity, codes were used instead of

research participants' names. Anonymity is essential and research participants were assured and convinced that they would be respected. Any limits of confidentiality were clearly specified and explained to the research participants (Terre Blanche & Durkheim 1999:68).

3.7.3 Protection from harm

Harm may include emotional distress, which is a possibility in studies involving sexuality (Babbie 2007:68). The researcher therefore, carefully constructed sensitive questions in a way that would avoid emotional harm. Permission was obtained after explaining to the research participants the reasons why the interview needed to be recorded, who would have access to such records and how the information would be used. The audio-tape recorder also allowed for more comprehensive records than did notes taken during the interviews.

3.7.4 Issues of reliability and/or validity

Research participants were informed on the consent form that a tape recorder would be used to gather data. It was easy to transcribe a recorded interview that involved one research participant at a time. This statement is informed by the fact that audio recordings offer permanent records and lend themselves to being checked by other researchers. The credibility or validity would not be easily judged. Lincoln (1985, in Denscombe 2007:297) supports this, agreeing that it is not possible for qualitative researchers to prove in any conclusive way that they had "got it right". Concurring with the foregoing argument, Bailey (1994:177) lists the following interview pitfalls or errors that may adversely affect the data:

1. Deliberate lying occurs because the research participant does not know the answer, the question is too sensitive, or he/she does not want to give a socially undesirable answer;
2. Unconscious mistakes, such as research participants believing mistakenly that they are giving an accurate account of their behaviour. This occurs most frequently when research participants have socially undesirable traits that they will not admit even to themselves;
3. Accidental errors occur when the research participant simply misunderstands or misinterprets the question; and

4. Memory failures occur when research participants do their best to remember but cannot remember or are not sure, even though data can be checked for accuracy and relevancy as they are collected.
5. In the case of face-to-face interviews, the audio recorder can inhibit the interviewee (Denscombe 2007: 202-203).

The researcher assured the research participants of confidentiality. Prompts were used when the research participants seemed not to understand the question. On the other hand, the researcher ensured that her views or orientations towards HIV/AIDS did not influence the way questions were phrased.

3.8 Conclusion

The researcher described the type of study, and the type of data and/or sources of data. Data collection, sampling techniques, ethical considerations (the rights of research participants) and issues of reliability and/or validity were also discussed and explained in this chapter. There was a brief description of how data was to be analysed.

Chapter 4 focuses on the findings and interpretation of the results.

CHAPTER 4

FINDINGS

4.1 Introduction

The purpose of the study was to investigate the role of churches in the prevention of HIV infection among young adults in the Polokwane Municipality of Limpopo Province. The specific objectives were

- to identify the nature and types of programmes and services relating to HIV prevention that are available to young adults in different churches in Polokwane;
- to investigate the role played by the Church in preventing the spread of HIV infections among young adults in Polokwane;
- to explore the benefits to young adults for HIV prevention programmes and services rendered by the Church in Polokwane;
- to explore what needs to be done to improve HIV prevention among young adults in Polokwane;
- to explore the challenges and successes that these churches experience during the implementation of their HIV prevention programmes for young adults in Polokwane.

This chapter presents the findings of the research and describes the results based on the foregoing purpose and objectives. Challenges faced by church leaders' involvement in HIV prevention are also discussed. The data collected is interpreted according to the central themes extracted from the research participants' answers. Themes that emerged from the interviews were used in data analysis.

To obtain profile of the church, participants were asked to provide information on the name of the church, how long has the research participant been a leader or served in the church, the estimated number of church members, as well as the participant's role in the church. Seven (7) research participants occupied varied roles in their respective churches, and the estimated number of churchgoers ranged from 120 to 43199.

Research participants were asked about their roles in HIV prevention, the challenges and successes that these churches experience in their attempt to make churchgoers and communities aware about HIV prevention, and whether they perceive HIV prevention programmes beneficial to young adults.

4.2 Church membership/Research participants' profiles

Seven (7) research participants; four (4) males and three (3) females, were interviewed. The table below summarises key issues pertaining to the church leaders who participated in the study.

Table 1: Church leaders and their profiles

Research participants	Name of the Church	Congregation	Status in church	Period of membership
1	Evangelical Lutheran Church of Southern Africa (ELCSA)	120 members	Church leader	46 years
2	Methodist Church of Southern Africa (MCSA)	120 members	Lay preacher	63 years
3	African Methodist Episcopal Church (AME)	350 members	HIV/AIDS coordinator	45 years
4	Uniting Presbyterian Church in Southern Africa (UPCSA)	300 members	Pastor	45 years
5	Evangelical Lutheran Church of Southern Africa (ELCSA)	43199 members	Retired Bishop Emeritus	69 years
6	Uniting Reformed Church in Southern Africa (URCSA)	350 members	Pastor	35 years
7	St Albans Anglican Church of Southern Africa (ACSA)	200 members	HIV/AIDS Coordinator	30 years

4.3 The role of the Church in HIV prevention

The first question aimed to establish the actual role of the Church in HIV prevention. Research participants provided varied responses. One research participant stated,

“They make youth aware by inviting relevant speakers to address youth on HIV and AIDS”.

Others highlighted that they provide counseling before and after HIV testing. The selected churches were perceived to have the responsibility of empowering members of their congregations, initiate dialogues on HIV prevention; and to support awareness programmes. The role of the church was predominantly seen as coordinating campaigns through workshops, seminars, healing services and candle-lighting events; which are used to create awareness. As stated by Akers and Wesley (2012), one of the concepts associated with the Social Learning Theory is differential association; which asserts that a behavior is learned when based on an individual's surroundings and how others define the behavior. Therefore, if the surroundings for young adults include family members, friends and other members of the church, behaviour change may result.

Although it was revealed that all the selected churches had committees that were responsible for HIV prevention programmes, it was clear from the data that church leaders had basic knowledge about HIV and AIDS-related matters, and they used their knowledge to discuss HIV prevention. Specifically, the Evangelical Lutheran Church of Southern Africa (ELCSA) had an HIV/AIDS Committee established to address HIV and AIDS-related matters. Uniting Presbyterian Church in Southern Africa(UPCSA) developed peer education programme that address issues such as advocacy, HIV prevention and treatment, counseling and testing.

When asked if church members recognised the role of the Church in HIV prevention, all research participants indicated that some church members support the programmes such as provision of food, clothes and spiritual support through prayer. One of the research participants revealed that there are instances when some churchgoers do not accept education on HIV prevention in their churches. He said:

“There are those who still resist accepting the teachings about HIV and AIDS”.

Another research participant said that some church members respond positively towards HIV prevention messages. He added:

“...some of our church members are able to modify their behavior according to the teaching they received from the church, and they become role models, good leaders and practice what they preach. Again, myths about HIV/AIDS are addressed, and questions asked about the disease are answered using the basic information that we have”.

It was also evident that in some of the churches, members have committed to provide care and support to child-headed households and to families where young girls carry the care and support of their infected family members.

The seven research participants agreed that young adults do benefit from HIV prevention programmes and services that they have established in their churches. For example, one research participant stated that church members utilise information they receive to go for HIV testing. He said:

“They take an advantage of the programmes to get tested for their status”.

The other one said:

“Healing services helped in dealing with the pain and suffering of HIV in families”.

The findings showed that church members were willing to utilise biblical teachings in HIV prevention, and they collectively used the principles in their communities.

When asked about areas of HIV prevention that needed to be improved, the research participant indicated that reinforcing the abstinence, being faithful and the consistent use of condoms was crucial. He said:

“HIV prevention can only be effective if we increase knowledge and skills on moral values of ABC, and become realistic in teaching youth on how to negotiate safer sex”.

Harrison cited in Karim and Karim (2010:316) concur with the foregoing statement. They stated that abstinence (refraining from sexual activity) is an often-cited

prevention strategy among young adults, especially women, and the church need to highlight the importance of such acts.

Two research participants stated that the role of the church should go beyond HIV prevention messages to include increasing donations that are provided to the needy. Churchgoers should be encouraged to donate food and clothing to the needy. One research participant explained:

“Church members still need to expand their contributions towards the HIV prevention programme; and others need to perceive HIV and AIDS as a disease that could affect anybody, but not as God’s punishment on people who commit sin”.

Two research participants highlighted the importance of encouraging infected members of communities and churches to disclose their HIV status, and share their experiences in dealing with the condition. They believe that such strategies will add value to the HIV prevention workshops and seminars in different churches. One research participant said:

“...we need to encourage members to disclose their status in the hope that those who disclosed their status will become HIV/AIDS ambassadors, and their experiences will allow young adults to change their behaviours”.

This statement corroborate with the Social Learning Theory in that the church leaders believe that the experience of infected people may influence behavior change among young churchgoers.

4.4 HIV prevention in collaboration with other stakeholders

It became clear from the interviews that some of the activities (workshops, conferences, Sunday school classes, and healing services) carried out in different churches were aligned with the HIV prevention mandate of the government and that of other international agreements. These activities included the commemoration of World AIDS day, Candle Lighting Service and the campaign to observe 16 days of activism on Abuse against Women and children. One research participant confirmed:

“We have committed to render certain activities according to the government and Department of Health’s calendar. For example, we try to remind church members about World Aids day and teach about abuse of women and children. The church should highlight this area when they plan annual activities”.

Another important aspect mentioned by research participants was encouraging churchgoers to go for testing. They see HIV testing as the most important activity that will minimise the spread of HIV, only if the infected members of the church change their behaviour after testing positive. The issues regarding HIV testing, behaviour change and traditional ceremonies were seen as important in HIV prevention interventions. Some research participants believed that the Church collaborate with the Department of Education and ensure that Life Orientation programmes take into account the biblical issues related to healthy living patterns.

Furthermore, research participants believed that to establish relationships with traditional leaders will ensure that communities and church members receive consistent messages that will reduce sexual abuse and other activities that are carried out at traditional ceremonies.

4.5 Themes

The following themes emerged during the interviews:

- Public education and awareness (advocacy; mobilisation)
- Partnerships and networks (liaising with the Department of Education, traditional Institutions, health practitioners);
- Church, morality and HIV/AIDS prevention
- Intervention strategies (prevention, care, support, treatment, counseling, testing).

4.5.1 Public education and awareness of HIV prevention

The study found that some of the churches such as the ELCSA, ACSA and MCSA, have capacity to obtain information and to disseminate it among their congregants, especially young people. This is done by compiling reading material according to the needs of church members. The reading materials are also used during bible studies,

seminars, workshops, preaching and teaching. Some of the youth are encouraged to participate in dramas that are meant to convey HIV prevention messages (Van Dyk 2008:142). One participant stated that medical personnel and health workers were requested to lead the discussions in HIV prevention workshops. This is important because health care personnel are highly trained in the field of HIV and AIDS.

4.5.2 Partnerships and networks on HIV prevention

The HIV/AIDS epidemic has continued to undermine the welfare and physical state of many people in the world. Therefore, a viable strategy to combat the effects of AIDS is to encourage partnerships and networking. Networking is the most important tool for any form of sustainable and development initiative. In this era of HIV/AIDS, sustainable and beneficial programmes need to be developed through collaboration and formation of viable networks. One research participant responded,

“...in the awareness campaigns, the Church try to collaborate with organisations such as Soul City and other civil society organisations. This collaboration helps the Church to learn more about new strategies and implementation plans”.

4.5.3 Church, morality and HIV/AIDS prevention

Addressing HIV/AIDS prevention in churches during this era of increased stigmatisation attached to the diseases, challenges the morality of the Church. HIV/AIDS has been connected to homosexuality, prostitution and low moral values. For the majority of Christians, homosexuality is regarded as a sin. Therefore, a person who is diagnosed with HIV infection is perceived to have indulged in immoral actions. Based on the negative inferences made about HIV infection and suffering from AIDS, most church leaders recede from preaching and discussing the epidemic. One of the research participants echoed:

“The nature of HIV/AIDS makes it difficult for other churches to discuss freely about the prevention methods without thinking that the congregation will not object...the idea of addressing HIV prevention in the Church contradicts the theology and the belief of many church leaders”.

Another participant elaborated:

“AIDS is a pandemic that could also be managed by establishing a moral value system that pays allegiance to family life. On the other hand, practices like faithfulness in marriage should be encouraged, as they contribute to family preservation...the fact that at the age of 20-24, some of the youngsters are pregnant, or are preparing for marriage and procreation, makes it important for the church to preach about the importance of being faithful in marriage”

Interestingly, another participant highlighted the relationship between culture and religion. He stated that the fundamental principles of “Ubuntu” revolve around the cultural values, and need to be observed within the context of religion. He stated:

“Observing cultural beliefs within the context of religion are the foundation upon which families are built. Again, in a family where the parents respect and love each other, and express positive opinion to their children, take care of one another; there is always stability and less chaos. One is inclined to think that these families may have fewer chances of being exposed to the high risks of HIV infection”.

Machyo ([sa]: 7) paid attention to the need of interpreting cultural beliefs and traditional norms within the context of religion and community building. Van Dyk(2001:159) also highlights that the positive attitudes and values that people demonstrate are inevitable towards building positive self-esteem and strengthening emotions of people who are HIV infected and those living with AIDS.

4.5.4 Views of the Church on HIV prevention intervention

The influence of Christian beliefs and ideology on HIV prevention needs to be positive and endeavour to provide care and support to people who are HIV-infected and those who are AIDS-ill. The views of research participants on the HIV prevention interventions varied. For example, five (5) research participants embrace the use of both female and male condoms. However, two participants highlighted abstinence before marriage as the important HIV prevention strategy for

young people. This idea was anchored in the belief that “sex before marriage is a sin”. While research participants were aware that pastoral support is needed for all churchgoers who are ill, the gospel also requires them to demonstrate compassion. They unequivocally believe that the NSP (2007-2011:10) requires the Church to render care and support to People Living with HIV/AIDS (PLWHA's) and People Affected by AIDS (PABA's) like orphans and widows.

Three (3) participants mentioned that instead of preaching messages that condemn HIV/AIDS, they view churches as places where infected churchgoers should be allowed to disclose their HIV status because Jesus said:

“the truth shall set you free” (John 8:32).

4.5.5 The challenges facing church leaders' involvement in HIV prevention

Lack of resources (such as relevant information and finance) makes it impossible for the churches to assist people who are infected with HIV and those who are AIDS-ill. The majority of pastors need adequate information to enlighten the churchgoers about the importance of adhering to treatment and treating medical recommendations with respect, accepting prayer service as an aspect that takes care of emotional healing. One of the research participants echoed:

“There are people who believe that a prayer can heal those who are infected by HIV and those who are AIDS-ill without taking medication. This increases mortality and morbidity because the infected and the AIDS-ill are misled and delayed in seeking medical assistance. Rightfully, the epidemic, its causes and the attitude of people should be addressed frequently in the church, but some churches still perceive the disease as a sin”.

The challenges were also addressed by the Archbishop of Anglican church. Ndungane (2005:380) agrees that it is a challenge for the Church to deal with HIV/AIDS and other related matters without taking into account the medical, psychosocial and environmental situation of the people who are infected and affected by the disease. He further asserts that communities must be realistic and considerate when teaching young adults about sexuality and HIV prevention.

4.6 Limitations of the study

The results of this study could not be generalised to all the churches in the Polokwane Municipality because the research participants represented churches that had been selected to participate in the study, namely, the Limpopo SACC-affiliates in the Polokwane Municipality; that had HIV/AIDS programmes and services. Church leaders' willingness to participate in the study was an indication that they were enthusiastic and ready to implement HIV prevention through their churches (Bailey 1994:462).

4.7 Conclusion

This chapter presented the views of research participants who represented different churches that manage HIV/AIDS prevention programmes in Polokwane. Two important issues emerged from findings. Firstly, while the response to HIV/AIDS is still driven by stereotypes and discrimination against the affected and infected people, some churches are opening discussions about HIV prevention, especially among the youth. Secondly, the research participants acknowledge that the linkages between theology, morality and culture have to be perceived within the context of the environment the societies live in. Lastly, if HIV prevention is important to all members of their churches, old, young, married and unmarried people should guard against being infected.

The conclusion and the recommendations of the study are provided in chapter 5.

CHAPTER 5

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary, conclusion and recommendations of the study. The aim of the study was to investigate the role of the Churches in the prevention of HIV infections among young adults in the Polokwane Municipality of the Limpopo Province.

The specific objectives were to:

- investigate the nature and types of programmes and services related to HIV prevention that are available to young adults in different churches in Polokwane;
- investigate the role played by the Church in preventing the spread of HIV infection among young adults in Polokwane;
- explore the benefits to young adults of HIV prevention programmes and services rendered by the Church in Polokwane;
- explore what needs to be done by the Church in Polokwane to improve HIV prevention among young adults;
- explore the challenges and successes experienced by churches during the implementation of their HIV prevention programmes for young adults in Polokwane.

5.2 Summary of the results of the study

The findings of the study revealed that some churches in Polokwane play a significant role in HIV prevention among young adults. Although there are challenges regarding up-to-date and relevant information available for some pastors, collaborative efforts are maintained with organisations such as Love life. The most comforting situation is that some churches have moved away from being judgemental and blaming HIV positive churchgoers, linking their moral values to the stigma and condemning them; towards empowering members of their congregations.

The findings corroborate with the Social Learning Theory (SLT) because the positive attitude of the church towards people who are infected and affected by HIV/AIDS can strengthen these people's knowledge, skills, attitudes towards their illnesses and their relationships with the community members. The assumption that "the learning process can produce both conforming and deviant behavior" by Chappell and Piquero (2004) cited in Rudolf (2010) is confirmed in the study because research participants demonstrated that they have moved away from judging HIV positive people to caring and supporting them. Therefore, if churches continue to preach positive messages and empower its members, there will be far-reaching care and support to people who are affected and infected by HIV.

According to the results of this study, all the selected churches have committees that are responsible for providing care and support, with counseling before and after testing. This is an important aspect of HIV prevention, because church members whose HIV-test results show that they are HIV positive, will immediately know that the church will provide emotional support to them. This is another important aspect suggested by the Social Learning Theory. The social support offered by the Church encourages the people, especially young adults to make informed decisions about HIV prevention, the spread of the infection and adapting their life style.

5.2.1 The role of the Church in HIV prevention among young adults in Polokwane

The research participants suggested that the role of the church in preventing the spread of HIV is crucial and they support any mechanisms that could strengthen the programme. They indicated that church members supported the HIV prevention programmes by offering food, clothing and spiritual support to the people who are affected and infected by HIV and AIDS. While there are those people who oppose the discussions about HIV and AIDS in the church, research participants acknowledge that the country requires people who can form synergy between the political, cultural and the religious aspects that compel communities to mitigate the impacts of HIV and AIDS, and take care of children who are made orphans and vulnerable by HIV and AIDS.

5.2.2 HIV prevention programmes and the services rendered to young people by the Church in Polokwane

Young adults benefit from the HIV prevention services rendered by their local churches. The churches that manage HIV prevention programmes provide pre-and-post counseling, which provides emotional support to the young and motivated members of community. The emotional support allows the young adults to know their HIV status, have positive attitude and become confident that they will adopt healthy life style. The spiritual and healing church services also reinforced the belief that the infected and affected people can maintain good standing in the community.

5.2.3 Improving HIV prevention among young adults

The importance of providing relevant and up-to-date information to the public is crucial. Therefore, church leaders and members who manage HIV prevention programmes need to be conversant with the beliefs, values and norms of the community. This knowledge will assist them to address the HIV prevention within the framework recognised by the community. As two research participants stated, strengthening of HIV-prevention workshops and seminars would benefit communities. The Church could invite knowledgeable speakers to address different aspects that are related to HIV prevention and mitigating the impacts of the disease. Furthermore, the Church should be held responsible for sending contradicting messages that fuel stigma and discrimination. The Church should unanimously inform its members to adhere to treatment and healthy life style.

5.2.4 The challenges and successes experienced by churches when implementing their HIV prevention programmes for young adults in Polokwane

The willingness to conduct workshops, conferences, Sunday school classes and healing services shows that the churches that research participants represented endeavour to sustain HIV prevention programmes. They embrace holistic approach to HIV prevention; which is supported by many scholars (Van Dyk 2008:327). They also embrace the rationale of abstinence, being faithful and the use of condoms. They do not compromise the moral values because they also encourage young people to be faithful to their partners, in the event where they are not able to abstain from sex before marriage. This resonated with Karim and Karim (2010:293) who

believe that abstinence and mutually faithful monogamous relationships are crucial as part of any comprehensive HIV prevention strategy. It was remarkable to learn that research participants aspire to include HIV prevention into the Sunday school and confirmation classes attended by youth. The findings of the study affirm the relevance of the Social Learning Theory because the participants believe that behaviour change is affected by environmental factors, personal factors and differential reinforcement.

The major challenges that participants disclosed were that some churches are opposed to their involvement in HIV prevention programmes because they still regard HIV/AIDS as the disease of immorality and not pleasing to God. Some of the churches opposing HIV prevention in church believe that such programmes do not belong to the place of worship (Green 2001:2). Another challenge faced by research participants was financial resources that could strengthen their programmes and allow them to visit other localities and families that are affected by the epidemic.

5.3 The recommendations of the study

5.3.1 Strengthening HIV prevention

- a) Accepting that HIV prevention and mitigating the impacts of AIDS in families requires a comprehensive approach and observing the relationships between cultural, political, personal practices and religious values in the community is important. The Church needs to formulate a coordinating body that will provide information to other churches that oppose HIV prevention in the church.
- b) The Church should collaborate intensively with other CSOs, so that they should avoid duplicating the services rendered by the CSOs. Their spiritual support could be integrated into the activities of the CSOs. This could strengthen holistic approach to HIV prevention in communities.
- c) Church should be discouraged from condemning and judging churchgoers who are affected and who are infected. Their stereotypes and negative perceptions about HIV and AIDS could be alleviated if the Church is vigorously involved in seminars and conferences.
- d) The NSP (2012-2016) request the Church to participate in the strategies to reduce HIV incidence and mitigate the impacts of AIDS. Therefore, the

Church should ensure that its implementation framework is aligned to the requirements of the NSP (2012-2016) as well as other national requirements.

- e) Formulating a monitoring and evaluation plan that will allow churches to review their implementation plans according to the needs of the communities is crucial.
- f) The Church should uphold the spirit of compassion to communities and encourage members of affected families to treat each other with respect. They should also be aware of other programmes in the locality, so that they can be able to refer their members who need help.

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APPENDIX A



From: Mr L Roets
Programme Convener: Postgraduate Programme of Social Behavioural Studies in
HIV/AIDS
Department of Sociology

To: Mrs Poppy Nkai
Supervisor: MA Social Behaviour Studies in HIV/AIDS

Mrs C Moswane (Student Number 08623287)

Date: June 2011

**RE: MA SOCIAL BEHAVIOUR STUDIES IN HIV/AIDS: THE ROLE OF CHURCHES IN
HIV PREVENTION AMONG YOUNG ADULTS IN POLOKWANE MUNICIPALITY,
LIMPOPO**

Dear Mrs C Moswane

Your supervisor, Mrs Nkai, and a colleague, Prof G du Plessis, reviewed your research proposal. As your intended interviewees are not a vulnerable group and your topic does not deal with sensitive issues, we wish to grant you permission to continue with your studies under the direction and guidance of Mrs Nkai.

The ethical principles as stated in your proposal is in compliance with the policy of the university. You should please adhere to such principles and report on this in your dissertation of limited scope.

Please contact us for any further inquiries.

Yours sincerely

GDuPlessis
Prof GE Du Plessis


Mr L Roets
Programme Convener



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APPENDIX B: INVITATION TO PARTICIPATE IN RESEARCH

Enq: Moswane P.C.N.

Cell No: 082 682 9660

P.O. Box 11121

BENDOR PARK

POLOKWANE

0713

26 April 2010

The Ecumenical Secretary

SACC Limpopo

P.O. Box 2039

POLOKWANE

0700

Dear Sir

RE: INVITATION TO PARTICIPATE IN RESEARCH

I am a registered student at the University of South Africa (UNISA) studying towards Masters Degree in Social Behaviour Studies in HIV/AIDS. Title of my study is: The role of churches in HIV prevention among young adults (20–25 years) at Polokwane Municipality in Limpopo Province.

Hereby permission is requested to conduct research with churches affiliated with the South African Council of Churches (SACC).

The main objectives of the study are to investigate the nature and types of programmes and services relating to HIV prevention that are available to young adults in different churches, and to explore the benefits for young adults in HIV prevention programmes and services rendered by churches in Polokwane.

The results as well as the recommendations of the study may be used by churches as guidelines to formulate specific interventions aimed at preventing the spread of HIV among young adults and will be made available to the Council and research participants on request.

Participation in this research is voluntary and research participants will have to withdraw at anytime. Information provided i.e. data gathered during the interviews including the names of the participants and names of churches will be treated with utmost confidentiality.

Hoping that my request will be considered.

Yours faithfully

.....

Moswane P.C.N.

APPENDIX C

HEADQUARTERS OF THE LIMPOPO OFFICE

19A Schoeman Street
Alfred Letswalo Building
Polokwane, 0699
P.O. Box 2039, Polokwane, 0700
Tel: +27 15 291 4567
Fax: +27 15 291 4284

26 April 2010

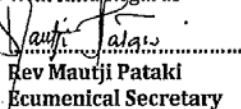
Moswane PCN (Ms)
P.O Box 11121
Bendor, Polokwane

Dear Madame

Request to Conduct Research

1. We are in receipt of your letter of request dd the 26th inst. for which we are very thankful.
2. Your request is granted and we would be very happy to share our information, resources required for your research project.

With Kind Regards


.....
Rev Mautji Pataki
Ecumenical Secretary

SACC 
LIMPOPO PROVINCE

APPENDIX D: INFORMED CONSENT FORM

Name of Participant : Date:

Name of Researcher :MoswanePerpetoa Constance Ngokwana

Institution : University of South Africa

Address : P. O. Box 11121, Bendor Park, POLOKWANE,
0713

INFORMED CONSENT

1. **Title of Study:** The role of churches in HIV prevention among young adults in Polokwane Municipality, Limpopo Province.
2. **Purpose of Study:** The purpose of the study is to understand the role of churches in HIV prevention among young adults.
3. **Procedures:** I will answer questions in an interview on the role of churches in HIV prevention among young adults. A tape recorder will be used.
4. **Risks and Discomforts:** There are no risks or discomforts identified in this study.
5. **Benefits:** The results and recommendations of the study will help other churches to improve on HIV prevention among young adults in Polokwane Municipality of Limpopo Province:
6. **Participant's rights:** I may withdraw from participating in the study at any time.
7. **Financial Compensation:** There is no financial reimbursement for participating in the study.
8. **Confidentiality:** My identity will be protected.
9. If I have any concerns or questions, I can call Moswane PCN at 082-682-9660 at any time during the day or night.

Signature of the Participant

Date

.....

.....

Signature of the Researcher

Date

APPENDIX E INTERVIEW SCHEDULE

Greetings

Good Morning/Day/Afternoon/Evening

My name is Perpetoa Constance Ngokwana Moswane. I am a registered M. A. student in Social Behaviour Studies in HIV/AIDS at UNISA. I would like to ask you some few questions on HIV prevention at your church. The study will help the church leaders to identify the strengths and gaps in their attempts to render HIV prevention in the Polokwane Municipality of Limpopo Province. Though participation in this study is voluntary, the success of this research is dependent upon your cooperation to answer the questions.

The purpose of the study is to understand the role of churches in HIV prevention among young adults in Polokwane Municipality. The specific objectives are to identify and understand: the nature of services and programmes related to HIV and AIDS that are available at your church; the role that the church leaders play in preventing the spread of HIV infections among the young adults; how the young adults benefit from HIV/AIDS services and programmes; what needs to be done to improve HIV prevention among the young adults; the successes and challenges church leaders experience during the implementation of their HIV prevention programmes.

For purposes of accurate recording of this conversation, I will use a tape recorder. I will not take down your name or address or tell anybody that I have asked you some questions. Any information by you including your personal identity will be treated with utmost confidentiality. The interview will take about 20 minutes. You are free to ask for clarifications in case you do not understand something.

THE ROLE OF CHURCHES IN HIV PREVENTION AMONG YOUNG ADULTS IN POLOKWANE MUNICIPALITY, LIMPOPO PROVINCE

Section C: Church Membership Status/Profile of the respondents

1. What is the name of your Church?
2. How long have you been a member of your Church?
3. What is your position in the Church? (Probe: Pastor, Lay Preacher, Church Worker e.g. Sunday school teacher, choir conductor).
4. How big is your membership?

Section B: Role of the church in HIV prevention

1. What services and programmes related to HIV and AIDS are available at your church?
2. Do Church members recognise the role that the Church plays in preventing the spread of HIV? (Probe: If yes, how?).
3. Do Church members benefit from HIV/AIDS services and programmes available at your Church? (Probe: If yes, how?).
4. Do you think there are areas that need improvement? (If yes, what are those areas?).

Section C: Churches and young adults on HIV prevention

1. What is the role of the Church in addressing HIV prevention among young adults?
2. What are the common preventative measures on HIV and AIDS that are taught in your Church?
3. What strategies could enhance HIV prevention among young adults? (Probe: Awareness campaigns, education, skills development, community development, and other relevant issues, etc. Probe: how?).
4. Share anything pertinent to the prevention of HIV.

Thank you for your time. Your comments are very valuable and may be used as guidelines to provide specific interventions in HIV Prevention.

END OF INTERVIEW