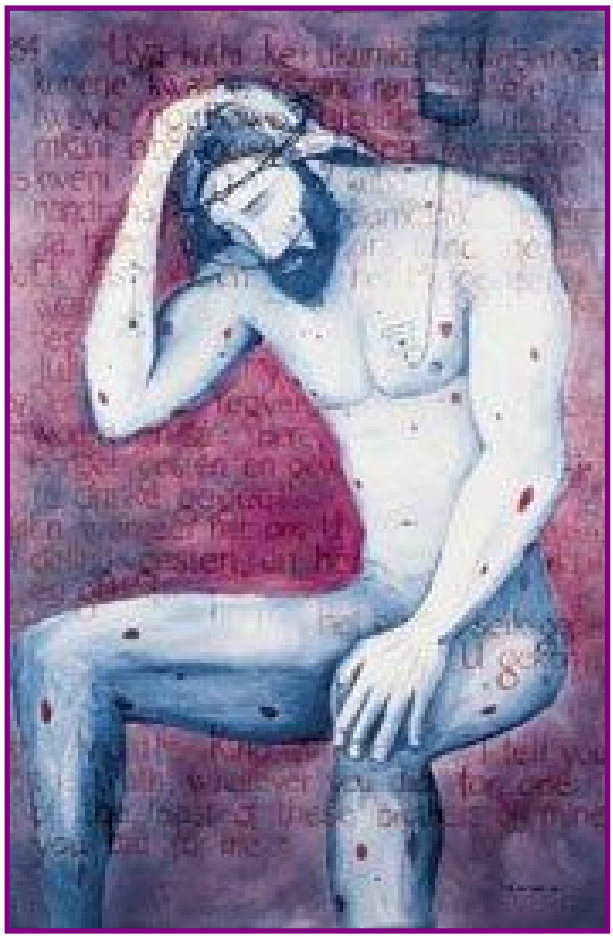
Churches Committing To An AIDS-free Society

2 – 5 June 2008



Report on the Diakonia Council of Churches HIV and AIDS Summit
Sierra Ranch, KwaZulu-Natal, South Africa

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About The Summit

This HIV and AIDS Summit was convened by Diakonia Council of Churches (DCofC) with the aim of providing the church with an ecumenical platform, in order to reclaim its prophetic role in ensuring an AIDS-free society.

The Summit was open to all member churches of the DCofC whose leaders were invited to attend, together with their nominated delegates.

The high prevalence of HIV and AIDS in our country - and more specifically in KwaZulu-Natal, which has the highest infection rate in the world, demands that the church rethink some of its strategies and responses to the pandemic, which has killed millions and left countless others hurting, orphaned, sick and alone.

Inspired by its mission to work in partnership through faith and action with member churches, DCofC offered this Summit in the hope that the local church would be further inspired to respond more meaningfully, react more effectively, and be able to strategize more appropriately.

The Report

This report is divided into three sections: A **Process** report, which outlines the process step by step, and gives a sense of the flow of the process; a **Thematic or Content** section, which presents summaries of presenters' inputs and the discussions that followed; and an **Additional Issues** section, that covers the main themes coming out of discussions.

One: Process Record

Opening of the Summit : 2 June 2008

Welcome
Bishop Barry Wood, Chairperson of Diakonia Council of Churches, welcomed all present and said that this get together was a reminder that all present were partners in faith and action and that this was a time to reflect and strategise on HIV and AIDS.

He gave a special welcome to Dr Cheryl Anderson from Garret University, the exhibitors: Debbie Heustice, from the Centre for HIV/AIDS Networking (HIVAN) and Fern Girdlestone from Art for Humanity (AFH) as well as to Harvey Sambo from Southern Africa Network of Religious Leaders Living with or Affected by AIDS (SANERELA).

He shared a devotion, reading from the gospel of St Luke where he spoke about Jesus' willingness and availability to those who needed healing. He asked for strength for those who heal. He then lit the HIV and AIDS candle, a symbol of hope, which remained lit for the duration of the Summit.

It was stressed that this summit was not about Diakonia Council of Churches (DCofC): often, DCofC facilitated events and then was given a mandate to follow up on issues arising out of these events. An important principle of this summit was that what came out of it belonged to delegates; and the onus was thus on delegates to follow up and takes things back to their churches and contexts.

The structure of each day was discussed and three ground rules were agreed to: punctuality, maximum participation, and cellphones off.

Keynote Address: Bishop Paul Verryn

Bishop Verryn focused on two untouchables for the church – sex and death.

With sex, the issues of condoms being a taboo was a thing of the past, he said. 'We need to advocate vigorously for people who are HIV positive to protect themselves.' He said that if one provided condoms in a church they were considered to be encouraging sex and that this needed to end. He said that no one needed to be encouraged to have sex. People would do it anyway.

He spoke about an 11th Commandment that was in circulation, 'Thou shalt not get caught' and said the issue was to help people make wise choices around building relationships and norms focused on treating each other with respect – going back to the heart of who we are.

His message about death was that there needed to be an acknowledgment of the need to grieve – that people, in particular women, had lost so much but were taught to be strong through it all. People needed a chance to heal their wounds and grieve over their loss. With regard to care, he said that the church had mobilised and had an outstanding record in this regard.

However, the way the issue of HIV had been handled politically had almost resulted in genocide. 'I think we do need to be anxious about exploitation by western pharmacies, but when you see a person whose life is going and opportunistic infections are taking away every scrap of dignity in a person trying to hold on to every morsel of life… then that is obscene.'

He likened it to a boat sinking with 5 000 people and arguing about whether it was in your water or our water. 'We need a vigorous voice to people in leadership; a vigorous somersaulting of attitudes and ideas of what we can do – almost like a military operation but with compassion, that is focused and effective. We need a prophetic intervention. We need to strategize carefully for the healing of the broken.'

Prof Cheryl Anderson thanked Bishop Verryn for his and eloquence and inspiring message. In particular she appreciated the challenge to grapple with the untouchables of sex and death.

Day One : 03 June 2008 "REFLECTIONS"

Revd Sandile Ngiba leads morning devotion

Morning Devotion

The morning devotion was led by Revd Sandile Ngiba with the theme, 'Reflections'. Revd Ngiba reflected that this day in particular would serve to provide delegates with a time to reflect on our shortcomings as the church, likening it to the cleansing of a festering sore. This was not always easy or painless, but very necessary, and offered hope for renewal and regrowth.

Morning Session, Chair: Mpendulo Nyembe

The Chair welcomed all the delegates. He explained that he represented the Natal Coastal District of the Methodist Church, replacing Revd Smanga Khumalo. He thanked Bishop Paul Verryn for his inspirational talk the previous evening, and Revd Sandile Ngiba for leading the morning's devotions.

Revd Scott Couper, on behalf of the Listening Committee, invited delegates to write requests, thoughts, sharings, insights, comments, etc. on slips provided at the entrance to the dining room.

Revd Couper introduced the first guest, Professor Jerry Coovadia. Professor Coovadia is International Vice-Chair: Paediatric AIDS Clinical Trials Group; The Internal Maternal Paediatric Adolescent AIDS Clinical Trials Group (IMPAACT); Deputy Chair: Transitional National Development Trust: PSA Government; Director: Nelson Mandela School of Medicine, UKZN; Director: Centre for HIV/AIDS Networking (HIVAN).

Professor Jerry Coovadia: A critique of our response to HIV and AIDS

Professor Coovadia said he was particularly glad to be speaking at a Diakonia function as the organisation had played a huge role in support of the struggle and had a rich history behind it. He said that DCofC staff were inheritors of a wonderful organisation with the likes of Archbishop Hurley and Paddy Kearney as predecessors.

He started by talking about truth and that we each had different ways of speaking our truths, science being one of them, faith being another. The reason science is important is that if we

do not understand it we can be hugely misled by what we see in the media. He said he hoped, in his presentation to give 'the best reality science can muster for South Africa' as it has been a problem for people to understand 'what is reality, what is myth and what is falsehood' about HIV and AIDS in South Africa.

He provided a critique of the National AIDS Plan and shared some of the results of the 'Countdown to Millennium Development Goals (MDGs) 2015 (2008) Report' on progress on the world around health matters, an exercise which checks progress regarding goals for health in 2015. He discussed the question, 'Why is it that South Africa has the worst HIV epidemic in world?'

TEA

Revd Mandla Mdabe introduced the next speaker, Revd Phumzile Zondi-Mabizela, CEO of KwaZulu Natal Christian Council. Revd Zondi-Mabizela is a Presbyterian minister, a member of African Network of Religious Leaders (ANERELA) and Chairperson of SANERELA.

Revd Phumzile Zondi-Mabizela: How has the church response affected HIV positive women?
Revd Zondi-Mabizela shared her own experiences of feeling stigmatized by the church because of her status. 'I have to deal with the reality of having HIV every day as a black woman.' She said that religions were dominated by men but that the responses to HIV realities were largely carried by women.

The chairperson thanked Revd Zondi-Mabizela for an intense but enlightening session and for the reminder of the challenges the church faces, including the need to create safe places for marginalized people in communities.

LUNCH

Afternoon Session, Chair: Revd Dr Anné Verhoef

Mpendulo Nyembe introduced the next speaker, Ds Christo Greyling. Ds Greyling is the World Vision global advisor on HIV and AIDS and faith based partnerships. He has been instrumental in the development of *Channels of Hope* and he trains trainers on *Channels of Hope*. He served on the scientific committees for two AIDS conferences, and he serves on ANERELA.

Ds Christo Greyling: A Personal Story
Ds. Greyling shared his personal story about testing positive in 1987 and the response from his congregation and the Dutch Reformed Church. He spoke about the difficult decision he and his wife took to try to have children, and the consequences of that. His testimony highlighted a number of issues, including the stigma that people experience because of HIV and the shortcomings of the ABC message. He urged the church to stop fighting about how people contract HIV. 'We cannot lose each other through fighting,' he said, and urged the church to adopt a multi faceted approach to HIV and AIDS.

The chair thanked delegates for their input and closed by thanking Ds Greyling for his inspiring talk. He said that Christo's name was very appropriate, with its clear association to

the name “Christ” and the brokenness experienced by Christ, but also the hope which shines through, as evidenced by Christo’s inspiring message and testimony.

Group work
Delegates were invited to form small groups and debate and reflect on the input of the three speakers. The responses are captured in section two of this report.

The Chair thanked all for their participation.

Evening Service

The evening service was led by Cardinal Wilfrid Napier and focused on ‘Repentance’. Cardinal Napier conducted a cleansing ceremony, blessing those present with holy water – offering a sense of renewed hope at the end of what had proved to be a challenging day.

Day Two : 04 June 2008 “DISCERNMENTS”

A delegate reflects on the proceedings of the day

Morning Devotions

The morning devotions were led by Revd Jenny Sprong with the theme, ‘Discernment’ and a call for delegates to open their hearts to what God was saying to them. The service included a short DVD called ‘*God of the Moon and Stars’*, and participants were invited to reflect on what God might be saying to them through the message contained therein.

Morning Session, Chair: Revd Mandla Mdabe

Listening Committee Report
After announcements and an icebreaker, the Listening Committee reported back the following comments/questions from the notice board, these having arisen from the proceedings and debates of the previous day:

- Should women and men be assigned specific roles?
- What does choice mean in a relationship based on gender justice?
- It is clear that as church leaders and AIDS activists, we don't understand what making HIV and AIDS a notifiable disease entails. Is it not an issue that violates confidentiality?
- Is the comment that HIV is not a disease true, or is this semantics, or perhaps another example of denial?
- Can we accept the stripper, the junkie, the whore and gays in our churches?

- Can we address and eradicate HIV and AIDS, and if we don't?
- It is time now to be a church that prophecies an end to HIV and AIDS and one that knows and lives out its role as healer and protector, minister and commissioner. This is what Jesus would do.
- The church has, for too long, alienated women. Men and women have not always protected each other. We must accept the hard fact that gender discrimination continues to exist, and repent of that if we are going to make progress in love.

Bishop Kevin Dowling was introduced by Revd Gilbert Filter. Bishop Dowling is the Roman Catholic Bishop of the Diocese of Rustenberg in South Africa. He is best known for his position, contradicting the official Vatican position, that the Catholic Church should reverse its position on the use of condoms to prevent HIV transmission.

Dowling first announced his position on condom use in 2001, in a response to a question by a Catholic news agency reporter during a bishops' conference in southern Africa. After stating that the Southern African Bishop's Conference had not taken a position on condom use, Bishop Dowling was asked for his personal opinion, and said that he believed condoms should be used to prevent the spread of HIV.

Bishop Kevin Dowling: Challenging the 'Sacred Cows'

Bishop Dowling raised a number of issues with delegates, particularly the need for the church to respond to HIV in meaningful and practical ways. He urged the church to make decisions and standpoints based on scientific facts rather than what was hoped those facts would be. His talk included startling findings from a study which highlighted the sexual practices of young people. He raised the issues of stigma, prevention, cultural attitudes and gender. In particular, he spoke about the need to respond to the crisis of orphaned and vulnerable children and to take care of the caregivers.

Group work

Delegates formed groups and were tasked with working for ten minutes each one of the following questions:

- Is the comment that HIV is not a disease true, semantics or denial?
- Should the church prophecy an end to HIV and AIDS? How? What should the church be saying and doing?
- Should women and men be assigned specific roles?
- What does choice mean in a relationship based on gender justice?
- Are there ways that the church can heal the divide between men and women?
- Can we accept the stripper, the junky, the whore, the gay person into the church?
- What would members of the church say about making HIV and AIDS notifiable? What are the issues, and what information do we need?"

LUNCH

Afternoon Session, Chair: Revd Chundran Chetty

Revd Simphiwe Mkhize introduced the next speaker, Professor Suzanne Leclerc-Madlala.

Professor Leclerc-Madlala is an anthropologist with the Human Sciences Research Council (HSRC). She has been active in the field of HIV for the past 15 years. She is interested in bringing knowledge to communities and sits on the South African National AIDS Committee (SANAC) HIV prevention task team.

Professor Leclerc-Madlala spoke about the drivers of HIV, how these put people at risk and the requirements for dealing with HIV. She said that Southern Africa is the global centre of HIV and is set to remain that way. She shared some startling outcomes of research around sexual practices and how these put men and women (particularly women) at higher risk of HIV infection.

The chair thanked Professor Leclerc-Madlala for her thought provoking input.

Individual Reflection: What would Jesus be telling us to do?
Delegates were given the time to relocate themselves in the grounds of the venue and invited to sit on their own and reflect on the question, 'What would Jesus be telling us to do?'

Evening Service

The Evening Service was led by Bishop Purity Malinga with a focus on 'Discernment'. Bishop Purity reflected on the need for us, as a church and as individuals, to listen more. She reminded those present that sometimes, as biblical stories reveal, even a small slave girl has a pertinent and life changing message for leaders.

Day Three : 05 June 2008 "COMMITMENTS"

A cold morning on day three with snow on the mountains

Morning Devotions

Morning Devotions were led by Revd Dr Anné Verhoef. Delegates were asked to reflect on the vision that God might be unfolding for an AIDS free society. Personal meditation time allowed for reflections on strategies and discerning the next step in the fight against HIV and AIDS.

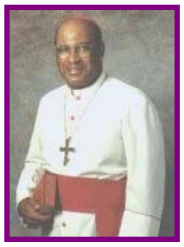
Morning Session, Chair: Nozuko Mtshali

Listening Committee

After a song item, the Listening Committee shared the following from the notice board:

1) We have considered the many factors that impact HIV such as concurrent relationships, culture, media attitudes, fatalism, transactional sex, yet as the church have we considered the possibility of a spiritual agenda to destroy the image of God? Genesis 3:15
2) The question, 'What would Jesus be telling us to do' should be rephrased to 'What is Jesus telling us to do?' He is alive and is the head of the church.
3) We need to develop evidence-informed intervention strategies otherwise we will not be effective in dealing with HIV and AIDS.
4) This has been a very good summit. We learned that HIV damages the immune system. We also learned many other things that we will teach others at home.
5) It occurs to me that the most vulnerable group aged 20 – 30 is exactly the group that doesn't attend our church. Could we have HIV and AIDS information as part of confirmation? Should we be working with pentecostal churches on this issue?
6) This is a request: the next time the Minister of Health must be invited to address us concerning HIV and AIDS.
7) It is not the time to dilly dally anymore. We, the church, must step out and remain ahead of the pandemic – even if we must have bold new leaders to do so.
8) God is the one from whom every family on earth is named. Family is at the heart of God. God help us to rebuild the devastated and shattered family life of our nation. Jesus, you raised the dead. With your help we can do this.

Recapping the Journey: Cardinal Wilfrid Napier



Cardinal Napier shared his learnings from the Summit and offered the following summary.

As in any journey undertaken by people from different backgrounds with different reasons, there are also a variety of starting points and means, and different times, and thus the way undertaken will differ.

A second feature of this HIV pandemic is that it has been at a different pace for different people. For some it started early and they have also negotiated challenges and difficult paths, (part of which is a lack of understanding of what HIV is about) and the experiences of people with HIV.

There have also been major differences in the quality of what they've set up. Some are like a *spaza*[1] shop, or *1-stop*[2] or some even like the *Pavillion*[3].

Basic to all are four pillars of intervention:

- information and awareness – getting as much knowledge for prevention.
- care for those infected, especially home-based care.
- care for orphans and vulnerable.
- ARV treatment and all that goes with that.

As the journey progressed, other areas of need have come to light, such as care of caregivers, hospice care or care centres and drop-in centres, where orphaned children can be cared for.

For these reasons I think it is necessary, when we have something like this Summit, that at the beginning there should be a contribution from each participant about where they are in this journey. This would avoid unfair generalisations.

What I have learnt here at Sierra Ranch

Everyone is here because they want to be. There is an unmistakable willingness to learn even when the information given has been uncomfortable. This began with the address by Bishop Verryn, challenging the church to talk about sex in church circles. This is a delicate but vital matter and needs to be talked about. But with the challenge is the need for development of the skills to do it in a way that won't be offensive or trivialising, but seriously communicated - so that it is taken as given, so that it is seriously deal with.

The second untouchable he spoke about was the death and grieving that goes with it. For example, the child who appeared to be coping but was actually falling apart; and here again we need to learn the skills to deal with it. Also, as an aside, there is the 11th commandment:

1 small, informal, local shop
2 the name for the 'Engen' service station's stops on major highways
3 A large, popular shopping center in Durban

'Don't get caught'. This is one of the untouchables we need to expose and face.

Another issue was the importance of working from a position of truth - a truth that is scientifically, religiously and where possible, experientially sound. What is the true meaning of our sexuality and the true use of it, we could ask.

Another aspect which was brought out by Ds Christo Greyling's input, was the combination of the scientific, spiritual and personal. But as with all personal stories one cannot take it as is and apply it in a different context, but rather aspects of which work and fit. One cannot just quote it without thought, hence the importance of accurate testimony that can help others and does not give the wrong impression of how it would work.

With Bishop Kevin Dowling, most significant for me was the CADRE survey which shows how young people have veered away from acceptable moral behaviour. This culture will take an equally strong effort to change around. It involves the age group 20 to 30 - our future leaders - people that the young are looking up to. We need to develop a really good communications strategy to help them know that the road they are on is a road without a defined end and we have to help them make a choice.

The point is that scare tactics have not worked. It is about an inner conversion which helps one realise that there is more to being a full human being than this way.

I also found the Ugandan example interesting. Uganda is an important prototype on how to deal with HIV and we would benefit from someone from there helping us have a closer look at what they did.

There are prevention programmes being tried out that could be of benefit – like VCT (Voluntary Counseling and Testing) and behaviour change programs like *Education for Life*, which grew out of the Ugandan experience and was adapted to our youth (and one of the major difference is that our youth appear to be more economically affluent). *Education for Life* started as an anti-AIDS/AIDS prevention programme but became an inner challenge for youth to become better people, to have fuller lives. It is not just about HIV, but – in the course of the retreat – young people are called upon to make choices based on the gospel, gearing them up to having Christ as their backbone. From there, peer educators are trained to then teach others.

I found it rather challenging and important that, instead of addressing teenagers and young adults, we should be adapting our work to adolescents – ten to 14 year olds –talking to them about sex and sharing values at this age. But the home and family must be brought in here. With the question of stigma – and I would love to ask a Ugandan how much of a problem stigma is in Uganda today, because the impression I got from people in this work in the country is that people spoke openly and that is how they dealt with it – I wonder if there may be a link between the infection rates climbing again and stigma.

Another issue is that we should step back and let government do its thing regarding condom distribution. The question in my mind is whether it is true that in Uganda they had a condom distribution program as their main focus. From personal discussions, it appears that behaviour change was the main focus, with A and B being the main messages, and C being promoted only for discordant couples.

The condom culture was promoted by aid agencies and I wonder if this is the reason the rate is going up - because people are not so vigilant anymore. I don't see how you can run change-of-behaviour programmes if you are also saying 'use a condom'. For me this is one of the potholes we have to work around. I don't know how deep it is, but for me it is, and we have to deal with it radically if we want change.

Suzanne's presentation gave a frightening picture and confirmed things like prevalence of concurrent partnerships. But most frightening is that older men are the drivers, and if that group is not going to take responsibility – they are the fathers of our children - then where will children find the role models to behave differently?

And yesterday when I was reflecting, I jotted some things down using the pastoral cycle:

- immerse yourself in the problem - read the signs of the times, think of the experience if possible.
- analyse the problem - its causes, key things that have to be tackled (social analysis/ situational analysis).
- evaluate it in light of the scriptures and traditions out of which these were written.
- decide on the approach that should be taken.

For me this translates to:

Immersing in the problem and analysing it: what is the basic cause of current behaviour around sex?

- Individualism and relativism – if it is right for me it is true and right
- God does not feature in this. The human rights in the constitution may be directly opposed to the scriptures. How can we exclude God who made us?
- Many are not even including natural law as a guideline to human behaviour. It is only logical that if you get together and have children you must stay together and look after each other and those children.

These are aspects of the readings of the signs of the times.

Evaluating the problem involves looking at the values – the value of human life and dignity of a human. Why is it wrong to hurt someone? And the body encapsulates that life.

And then the action is the next step we will be taking in this Summit as we work in our different groups.

Lastly, we must never forget: we say we must call God into our presence. But we are in His presence. We must just listen.

Delegates then divided into denominational groups to discuss and develop actions and strategies

TEA

Report Back

Participants divided into their respective denominations and deliberated on the way forward.

The responses have been captured in Section three of this report.

Closure by Bishop Purity Malinga

"On behalf of member churches of Diakonia Council of Churches I would like to start by thanking DCofC staff and the planning team - the people who have made this summit possible. As member churches, this is where we need to start. You can see that a lot of work has gone into planning and inviting speakers etc. and we really appreciate it as member churches.

In the absence of all the speakers, I want to say that all those who have been part of this Summit have been well fed with information, and clearly there is excitement about what we will share. To all presenters, facilitators and organisers, thank you.

Thank you to all the delegates – coming from various churches and even from other provinces. This Summit would not have happened without the delegates.

Partners like Art for Humanity and HIVAN, thank you.

We thank the Sierra Ranch staff and the audio visual sound people for their hard work. While it has been cold here, the warmth and the food made it all okay.

Listening to the strategies, it is clear that people fully participated, and plans show this was not a waste of time. We pray for safe journeys and that as we go back we will have the courage to do the things we say we will, and not get tired.

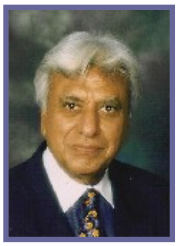
It has been a wonderful time as churches from different denominations have all been encouraged. Thank you to Diakonia Council of Churches. God Bless You."

Evaluation
Roland Vernon handed out evaluation forms and implored delegates to do justice to them and respond as fully as they could.

Closing Worship
Delegates participated in a closing worship and a communal breaking of bread, led by Revd Jenny Sprong and Revd Gilbert Filter. This was a particularly moving ceremony, providing space for reflection and personal and collective commitment to the journey ahead.

Two: Thematic Record

Professor Jerry Coovadia: A critique of our responses to HIV and AIDS



Professor Coovadia started by saying that we all have different ways of speaking our truths, science being one of them, faith being another. The reason science is important is that if we do not understand it we can be hugely misled by what we see in the media. He said he hoped, in his presentation to give 'the best reality science can muster for South Africa' as it has been a problem for people to understand 'what is reality, what is myth and what is falsehood' about HIV and AIDS in South Africa.

Some of the facts he shared were:

- The epidemic is killing a third of a million people a year, and thousands who need treatment or prevention do not get it.
- Unlike other African countries, we do not have many child headed households – it is not a big problem for us.
- Government delayed interventions of treatment and for every delay, at least a half or third of those who died could have been saved. The drugs are as good as a vaccine. 'What better prevention measure could have been asked for?' Thousands of children who should be getting it are not. Approximately 60 000 children need it and about 30 000 are getting it.

HIV is an incredibly complex disease so we need to be aware of that when we criticize government.

'Why is it that South Africa has the worst HIV epidemic in world?
Professor Coovadia said that he particularly wished to discuss the question of what made South Africa so vulnerable to HIV when it is one of the richest in Africa. In 1998, South Africa and Uganda had the same level of HIV. Now, one in three women attending clinics is positive in South Africa; yet Uganda has brought the infection rate down.

He said that HIV could not even be compared with the *Black Death* in Europe, which wiped out about one third of the population and took 150 years to recover from. HIV does not work drastically like a plague but 'permeates and can cause socio-political problems'.

Two of the best indicators of child health anywhere are the under five mortality rate; and of all children born, how many die under the age of one year. This tells everything about a country.

One of the successes of government is that, despite shortfalls, in the last eight years, there has been huge expansion on social services and dealing with poverty. About eight million children are getting child support grants, which means that almost every poor child is

receiving a support grant and this is a huge benefit for the population.

'The prevalence of HIV in children is not very high – only 2%, meaning that more than 95% are not HIV infected. This is an indication that we should not only be focusing on HIV and AIDS. So much money goes towards HIV and AIDS and we must remember that there are still 95% of children to look after. To just concern ourselves with the 2% is not fair and not just.'

300 000 children are infected; 50 000 need treatment; and about 30 000 are receiving treatment. Government alone cannot be blamed. We can blame them for delaying, but we also need to bear in mind that the health infrastructure is poor.

Not enough women are being treated for their own health. 'And all of us health workers did this to the mother. But now we know that if a mother has severe HIV she should be put on treatment for herself.'

The National Strategic Plan on HIV and AIDS
He said that it was good that we now have a plan, but this is meaningless without action. He also reminded that the National Strategic Plan (NSP) was drawn up through wide consultation. The concern is that it is implemented.

He also mentioned the importance of research and monitoring – especially monitoring. While ARV (Anti-Retroviral) care seems quite straightforward, we do not have information about what happens afterwards.

Countdown to MDGs 2008
The United Nations Millennium Development Goals (MDGs) are a blueprint agreed to by all countries in the world towards eight ideals, including halting the spread of HIV and AIDS. The aim is to reach these goals by 2015.

Professor Coovadia shared some of the outcomes of an audit of the MDGs in South Africa. This audit is done regularly by an independent outside group. The purpose of the audit is to check on progress around health matters:

- Immunisation has reached 99%, which is very good. Measles is very infectious so even this can improve;
- Treatment for pneumonia and malnutrition still requires a lot or attention;
- Maternal mortality is still very high;
- Under-five mortality is increasing.

‘Our country is a country of contrasts and I'm not talking about colour. I'm talking about the gap between rich and poor.'

> A personal story: I was quite sick about 20 years ago and went to a general ward at King Edward Hospital. I had a friend there who had taken me out of St Aidan’s because he knew how delicate the operation was, and that I would get the best treatment at King Edward. I had a recurrence two years ago but I couldn't go back there or I would definitely not have survived. To get that care I had to go to a private hospital. So, although I am committed to a national health care service, I could not use

these myself. And this is because the private sector spends more money on 20% of the population than is spent on the other 80%.

Professor Coovadia shared some of the findings of a paper he came across in the ***National Journal of Science*** which asks the questions, 'Why is this disease so severe here? Why here? What's special about us?' The writer made three points:

1) It is very severe in Southern Africa;
2) It is less common in Western Africa (Muslim countries);
3) Circumcision is a factor.

He looked at the maps of Africa when it was colonised, and compared them with now. This appears to point to the issue of large groups of coherent African populations who were uprooted and taken to the goldmines. In Mtubatuba, for example, 80% of the men from this area, (far north KwaZulu-Natal) work in Carltonville, (west of Johannesburg). Migration predisposes people to HIV. It was found that where there is migrancy, HIV is much higher. Migration destroyed family life.

Professor Coovadia asked the question, 'What are these mining companies doing now? Are they providing houses for families? And then we hear that in the midst of a food crisis a major food company works a deal about food pricing!'

Southern Africans are 26 times more likely to have HIV than West Africa. Professor Coovadia suggested that there is something missing in our population. 'Is it apartheid? We did not lose more people than Ruanda and Vietnam. We were not too different from other dictatorial regimes. So there is something in our makeup and it expresses itself in so called xenophobia. Because if you can discriminate and fight against someone who looks like you… and we can do it to women and children, and people who are HIV positive, and then you look at me and see an Indian and then respond.'

He said the government is culpable and asked how it was that such literate people in power can make such horrendous mistakes. 'And it is still happening to this day! The Minister of Health repeatedly makes outlandish statements and shames us to the world. And if they say those things, then they won't do the things that need to happen. And that is the tragedy of South Africa.'

Discussion

Q: Is the issue of the increase of networks and concurrent partners a factor in South Africa? What is the difference between consecutive and concurrent partnerships and how do they factor?

A: Yes, having concurrent partners (which is far more dangerous than having a life time of consecutive partners) is a factor. Concurrent partnerships refer to partners overlapping and consecutive refers to having one partner at a time.

Q: Is it true that the under-25 infection rate is decreasing?

A: There does seem to be an indication that there is a decrease in infection rates of ages 25 and under but it is too soon to judge this with certainty.

Q: I thought that the strain of HIV is different in South Africa than in the West or East Africa?

A: There are difference strains. We have Clade C (a particular strain of the HI Virus) and yes, it is responsible for most of the world's HIV infection and spreads very easily and does seem to be more aggressive. However, because India has the same strain and many other places that have lower prevalence, it does not look like the primary reason for the high prevalence here.

Q: I understand that the Minister of Health is moving for increased nationalisation of health care. One of the fears though is that if this happens, we would have a mass exodus of doctors and nurses and this would destroy the health system. You spoke about the inequity and that this favoured the rich, and that you advocate for health care for justice reasons, but that you went to private hospital. Could you comment about how we could advocate as a church to government and what we should be saying to civil society?

A: The issue of nationalisation of health care is a difficult question. I believe that there should not be a financial interchange between you and the doctor. The money must come from some insurance – a tax, a financial scheme, etc. - and reduce this disparity and inequity. In the private sector, the money is not going to family practitioners. It is going to private hospitals and specialists. Somehow this must be balanced. I have seen it work - I lived for two years in the UK and visited a hospital in Scandinavia, where, no matter who you were you would get the same access to services. It isn't that we cannot do this; it is more that we do not have the will to tackle these issues. It is unfortunate that the government doesn't inspire confidence.

Delegates discuss and debate the issues in small groups

Revd Phumzile Zondi Mabizela: How has the Church's response affected HIV positive women?

My brief today is to talk about how the churches' response has affected HIV positive women. I would like to start off by saying that most of our churches have not responded.
The few responses have ranged from being judgmental to almost ignoring the pandemic.
It is common knowledge that most religions are patriarchal and the leadership dominated by men. In response to HIV and AIDS, even the few religious responses, mostly developed by men, have been implemented by women. This is the irony of it all. This system which has been used to justify the exclusion and oppression of women has given women the freedom to choose resilience and strength in the midst of all the suffering and pain of HIV and AIDS.

When we look at the members of religious movements, we can say without doubt that women are in the majority. There are many reasons for this. To mention a few, in most communities it is more desirable for women to be religious than it is for men. Socialisation plays an important role in shaping the behavior and positions of people in society. Women, in most cultures, have also been discouraged from asking questions about their religion and culture, and this has led to the internalisation of religious teachings. However this has not stopped women from appropriating these into a positive force in their lives and the transformation of their communities. I would like to share with you some positive responses and then move on to the challenges or weaknesses of our responses to HIV and AIDS.

ANERELA
ANERELA was born out of Canon Gideon Byamugisha's vision for religious leaders in Africa living with or personally affected by HIV and AIDS to support each other and fight against stigma, silence, shame, discrimination, denial, inaction and misaction (SSSDDIM). It was launched in October 2003. It has grown from eight members to more than 3 000. ANERELA has been challenged by the international community to extend the network to countries outside the continent. This is being developed and strengthened and is already known as INERELA. ANERELA members continuously advocate for the eradication of HIV related stigma within Africa and globally.

Amongst its goals, ANERELA seeks to "Overcome stigma and break silence among men, women and children and address the social and economic vulnerabilities and discriminations of the girl child." ANERELA always strives for the inclusion of all genders in all its activities.

Women's Voices
Ms Kari A Hartwig in her article titled, "*Confronting Religion, AIDS and Gender in Tanzania: Church Leaders at the Crossroads*", in *The Journal of Constructive Theology, Volume 12, No. 2 (2006),* cites the following as one of the challenges:

> Men's social roles in 'community politics' and the higher status of pastors and evangelists as compared to the women's roles as women's group and bible study leaders, suggests that they had a greater sense of authority and responsibility in speaking out on the issues of AIDS, sexuality and gender, both publicly and privately, while women generally spoke only in the private sphere with other women." (p33)

The few women religious leaders who are members of the network, most of whom are Christian, have played an important role in specifically addressing issues that affect women, and encouraging women in different religious communities to publicly speak out against all systems which increase their vulnerability. To mention a few, the inclusion of women as Board members and National Coordinators has challenged the traditional notions of leadership in Africa. The inclusion of women's voices in the ranks of religious leadership has encouraged faith communities to be transformed. Women's issues are mainstreamed as opposed to being seen as sectarian and of lower priority. Women are claiming their dignity within the different religious communities.

In response to the Abstinence, Be faithful and Condomise (ABC) prevention strategy, which is moralistic and did not work for women and focused mainly on sexual behaviour, ANERELA developed a more holistic strategy, **SAVE**.
S stands for *Safer Practices*: this includes making sure that blood transfusions are tested for HIV, ABC and the use of hygiene precautions like gloves and sterile or new needles for all patients.
A stands for *Access to medication, treatment and nutrition*.
V stands for *Voluntary Counseling and Testing.*
E stands for *Empowerment*, including the empowerment of women and the empowerment of people living with HIV so that they can make informed decisions.

I truly believe that empowering women to read the Bible with their own eyes could also make it possible for them to challenge negative attitudes towards them. We are all created in the image of God and in our weakness, God's grace and power are made perfect. HIV can make women stronger; we don't want to be seen as victims. I also would like to mention that the Circle for Concerned African Women Theologians has been very supportive. Women from other continents can learn a lot from their approach to the issues of Women, HIV and AIDS.

Women's Sexuality

I would like us to look at the story of the "woman who was caught in adultery" in John 8:1-11. I, as a woman who is positively living with HIV, have often felt like this woman. I feel judged and prosecuted even though people do not know how I got infected. Of course this is not important information; it does not empower members of the Body of Christ to support me, but fuels the judgmental and discriminatory attitudes which we have become used to.

Gail R. O'Day, in the *Women's Bible* commentary, says the following about this text: "*In the most prevalent reading of this text, which can be traced back to Augustine, Jesus is the embodiment of grace and the woman is the embodiment of sin. Careful reading of the story, however, shows that this narrow polarity between Jesus and the woman, distorts the text*." (1998: 385).

The woman in this text is silent and nothing is said about the man that she was committing adultery with. For some reason, the teachers of the law, who take her to Jesus, forget that she has no say in her sexuality. When one considers the culture of the day, she must have been approached.

We, as women, are regarded as the tempters, the Eve's of today. Women are sexual beings who also have a right to celebrate this gift that comes from God. I have heard of scientists who even talk about the importance of being celibate, especially after a woman has been diagnosed as HIV positive. This is another level of stigma and discrimination leveled especially against women. Heterosexual sexual intercourse in Africa is known as the dominant mode of transmission. But we always forget that our cultures encourage women to be recipients and not initiators of sexual activity. Being HIV positive does not take away my sexuality, therefore expecting women who are living with HIV to become asexual, does not make sense. We continue to have all our senses and continue to desire motherhood as our highest calling.

Churches still have problems with talking about condoms!! It is our responsibility to make our members aware of all prevention tools, and condoms are one of them. Let the people decide what will protect them the most. We would like the church to support us in our attempts to lobby for women-controlled prevention strategies and tools like microbicides and the female condom.

Another contentious issue about this text is, we are not sure whether this was consensual or not. This woman may have been forced to grant the man a sexual favour. This is our reality as well. Most women, especially young women, are infected by men who know their status. This has been perpetuated by the myth that when you sleep with a younger woman, she may be HIV free. There is another myth, which has ruined many girls' lives, that claims that sleeping with a virgin cures HIV. Women who are victims of violence do not get a lot of support in our churches. The last thing they want to do is disclose their status, which would add another layer of shame and lead to extreme discrimination.

Judgmental Attitudes

In the text, the Scribes and Pharisees are the ones who take the woman to Jesus. They do not even ask questions. The way they use the law is unacceptable and can be a lesson for us today. In the New Revised Standard Version (NRSV) of this text they claim that, "In the law Moses commanded us to stone such women." In Leviticus this is not how this law is articulated. According to Leviticus 20:10: "If a man commits adultery with the wife of his neighbour, both the adulterer and the adulteress shall be put to death." Why do these accusers want to apply one part of the law? This is a clear distortion of the law.

Women who are living with HIV in the church are supposed to feel guilty because they brought this condition on themselves. Women are blamed for the high infection rates. Women who become infected by their husbands, after 'keeping themselves pure until marriage", are often accused of bringing HIV and AIDS into the family. Women are biologically more susceptible to HIV infection. For some reason this is often forgotten when we look at the current statistics and realise that the number of women who are HIV positive is always higher. According to the United Nations AIDS (UNAIDS) report in 2006, "In Africa women constitute 57% of all HIV positive people and account for 77% of all women living with HIV worldwide. The vast majority of HIV positive women in Africa (76%) are between 15 and 24 years old. For young women the risk is 3 to 6 times higher than that of their male counterparts."

Stigma

The woman in this text does not even have a name. She is just known as an adulterous woman. There are lots of women in our pews who are just known as HIV positive women. If

these women are single, the possibility of getting married becomes even less. Stigma is an attitude which is visibly demonstrated through discrimination. Most women would rather not reveal their status because of their fear of being ostracised or discriminated against. In our churches, more often than not, women who care for the sick end up being infected themselves. We have high numbers of elderly people who are living with HIV who will not dare talk about it.

Single mothers who are members of the church always remain a challenge. In cases where there are Mothers' Unions, the reality is that most of the members are married. Young women's associations usually only accommodate women who are not yet mothers. Single mothers will do their best to attract even unsuitable men to become husbands in order to get some kind of status and respect within communities and churches. These strong desires to be married often put their lives more at risk. The stigma of being unmarried for most women drives them to engage in behaviors that further make them vulnerable. One question that we need to think about carefully is whether marriage still protects women? Do the vows that we use in our churches encourage both partners to be responsible or do they place more responsibility on the shoulders of the bride?

If I were to interpret this woman's position from a cultural perspective, the assumption is, it is her responsibility to reject the advances of the men she committed adultery with. This attitude has been transferred into our churches. It is worse when she ends up being HIV positive because it is her prerogative to make sure that protection is used.

Let me raise another issue which may be controversial, but it will definitely help us in our attempts to mitigate against stigma. It is highly improper for us to always assume that women are infected because of their sexual activities. David Gisselquist in his book "*Points to consider: Responses to HIV and AIDS in Africa, Asia, and the Caribbean"* asserts:

> "*More than 40% of women in Botswana aged 25 to 39 years are HIV positive. Harvard University, CDC, and other foreign organisations fund and advise HIV research in Botswana. Through late 2007, no one has reported research that has asked any Motswana woman (or man for that matter) about injections or other blood exposures as risks for HIV infection. Sexual acquisition is assumed."(*2008: 161).

Several studies have shown that the virus can survive in dry conditions, such as on a glass slide, for several hours to more than a day. Research published in 1999 showed that it can survive for weeks at room temperature in wet conditions, such as in a used syringe or needle. UNAIDS has accepted the estimate from the World Health Organisation (WHO) that claims that medical injections account for 5 percent of HIV infections in the world. This excludes other practices which are common in Africa like tattooing, drawing blood and minor surgeries. Much that this may be a debatable and controversial matter, it cannot be summarily ruled out.

The issue is that, as churches, we have not done enough to deconstruct the systems that have made sections of society more vulnerable - to HIV, to poverty and to other factors.

Sindre Arnfred asserts that "*the argument is not that subordination of women does not take place. Of course it does, and increasingly so, and clearly, subordination and oppression of women should be fought against. The argument concerns lines of thinking and analysis: how*

and from which vantage points, in what kinds of theoretical/conceptual contexts, are women's lives conceived and conceptualized? And what consequences do they have for strategy and politics?"

I have found the methodology described as *Reconstructionist theology,* that Susan Rakoczy, (2004:17) proposes, most helpful. While *Reformist theology* seeks liberation without changing structures, and *Revolutionary theology* seeks to find liberation outside the structures, *Reconstructionist theology* attempts to find liberation from within the tradition itself, and therefore takes the Bible seriously while also attempting to transform oppressive interpretations of the Bible. This methodology is defined as a theology that seeks, "*a liberating theological core for women in the Christian tradition, whilst also envisioning a deeper transformation, a true reconstruction, not only of their church structures but also of civil society"* (Rakoczy 2004:17)

I believe Jesus' response is an excellent example of this methodology. Let's look at Jesus' response closely and how we could transfer it to our responses to HIV and AIDS.

Jesus' Response

Jesus realizes that the scribes and Pharisees are trying to trap him. According to O'Day: "Jesus' focus is not on the woman alone but is evenly divided between the scribes and Pharisees and the woman. When the scribes and Pharisees brought the woman to Jesus, they dehumanized her, turning her into an object for debate and discussion." Jesus does not single out the woman as "sinner." Rather, the text identifies all the characters as in need of and receiving an invitation to new life." (1998:385-386)

Jesus extends an offer of grace and mercy equally to the scribes, Pharisees and the woman. I would like to suggest that we are all in need of God's grace and mercy, especially if we still have the audacity to discriminate against women who are living with HIV.

Disclosure

It takes a long time for women to be able to disclose their status within the church. There is too much to be lost if they are falsely perceived as women with poor morals. It is our responsibility to create open environments where all people living with HIV and AIDS (PLWHA) can share their stories with the hope that they will be supported.

Conclusion

"HIV IS A VIRUS AND NOT A MORAL ISSUE." I hope we will all treat it as such in order to protect and care for each other. The scientific advances and theological resources that we have to address this issue can destigmatise HIV and make it possible for PLWHA to live full and longer lives.

Increased access to treatment for the OIs (opportunistic infections) and anti-retrovirals (ARVs) would have a great impact and encourage people to be open about their status. We as churches should be in the forefront, making sure that women have access to treatment in order to protect their unborn babies.

Theologies of survival are not enough and the challenge is for the church to expose women living with HIV to theologies of life and abundance.

It is important for us as the church to understand both the National Strategic Plan (NSP) and Provincial Strategic Plan (PSP) in order to initiate meaningful interventions which are in line with government plans. Men should be part of the solution. Let us challenge them to be involved in all our interventions, including taking care of the sick and orphans.

In John 8: 10, Jesus asks the woman where the people were who had brought her to him and who had disappeared. I hope common sense will prevail in our churches and there will be less judgment and condemnation. Thank you.

Discussion

Q: The focus is appropriately on stigma and you have mentioned reports that HIV can exist outside the body for a long time. Is the inference that HIV can be casually transferred, and what does this mean about increasing stigma? This worries me. I have been taught that it cannot be casually transferred. Does conveying this notion mess with science – does it have scientific basis?

A: The reason I referred to HIV living in such conditions is an attempt to mitigate against stigma. We have a few cases of babies being HIV positive sometimes not from their parents and who have not been exposed to situations where they have been violated. There is the possibility of getting it from injections that are not sterile. I do not mean that we should not hug, etc, but we should use safe practices.

Q: In the story you mentioned, the woman being referred to was Mary Magdalene and Jesus was not trying to humiliate her, but trying to set the stage for a miracle. She had been a prostitute but became a person of good means.

A: Referring to the scripture, I did not realise it was Mary Magdalene but the reason I chose it was to highlight that women are blamed when there are two people involved. We don't want to be used as statistics and objects.

Q: I am not a New Testament scholar but I have never come to a source that said that woman was Mary Magdalene, so I will look for that. But my contribution is about how we do theology and how we sometimes, unconsciously, define humanity in terms of gender. I would like to argue that there is no male and female. We cannot be defined as humanity by gender. Our thinking should be moving towards non-gender theology so we can undo the masculinity and feminicity of theology; so that men and women can enjoy human sexuality that has been given by God.

One of the questions I have grappled with for many years is the notion around empowerment of women. One of my concerns is what this is doing to the male part of our society and our churches, and do we not need to start thinking of empowerment of men not to be threatened by the empowerment of women? So I would suggest the notion of equal empowerment and empowerment of society rather - gender empowerment rather than of women.

A: Yes, the issue is about gender justice and not about only the empowerment of women. We have, in KZNCC, a programme on men and masculinity where we are working with traditional men. And men are realising that their traditional notions have been depriving them of full enjoyment of their partners. The truth is, though, that unfortunately we are starting at the point where women are disadvantaged. Gender justice is the issue but we must acknowledge that women should be uplifted.

Q: My concern is what is truth? And how do we arrive at truth? Some of the notions need to be challenged. One of these is patriarchy and that it is responsible for just about anything in society. I would like us to look at what is different in a man and in a woman that makes them that way? We need to take our history into consideration – that men had to defend the women and family, etc. And it must be something in our nature – the Bible tells us, science tells us and my experience tells us. I feel hurt about some of the things that are being said about the church – that it is blaming women and not supporting HIV positive people. So I think this is where we must try to respect the truth. The other remark is what are we going to do to make the church more effective in responding to HIV? I would like to see that we choose a value and make that supreme - and that is that we are alive. Anything that neutralises or works against our life should get out of the way and anything that transforms and supports should be supported. One of the things we have to look at is orphans and to work with them in a way that makes them feel important.

A: Yes, we need to look at ourselves as people and not male and female. However, when we look at the story of creation, Genesis Chapter 2 is more popular than Genesis 2. Whilst Genesis 2 speaks about women being created out of man's rib, Genesis 1 says women and men were created in God's image. I respect the Cardinal's comment on patriarchy and its non- existence, but we as women know about it first hand – where decisions are made on our behalf, where women bear the brunt of putting food on the table. So for us women it is real and affects us on a daily basis and it is important to be aware of it. We are saying these systems do not work for us as women and we must find ways of dealing with that. The truth is subjective. And when I talk about men and masculinity, I mean we need to start challenging those understandings of masculinity in order to respect each other as men and women created in the image of God. This is why I mentioned marriage. There was a time when it had status, but nowadays it makes women more vulnerable as it cannot protect them. I appreciate that we should not throw blame as it is not helpful. There are churches that are progressive like the Catholic Church – their arguments make sense about not ordaining women (but we can discuss this outside). But who is caring for the sick and dying? It is done by women. We have these policies created by male leaders but the implementation is done by women.

Q: Thank you for the presentation. I appreciated it. I am concerned about the focus on other ways of transmitting HIV. In this country there are a lot of lies and dangerous statements being made and there has been this problem with getting at what is real. You are right about the different modes of transmission. However, other forms of transmission are almost zero - it is such a small part of the research. Even the issue of rape of babies was less than a fraction of a percent. There are all these other means of transmission. It just so happens that in South Africa it is heterosexual; in the US, it is often men who have sex with men; and in places in India it is intravenous drug injection. In saying it is not heterosexual, this implies it is bad, and in a way stigmatises itself.

A: With regard to the issue of the focus on other ways of transmission: the reason for stigma is sex and death, and other modes of transmission are forgotten. So I am just saying we need to balance this. Nowadays a lot of young people are using drugs and I have not heard of successful harm reduction in this regard.

Q: I would like to know if ANERELA reaches rural women. My concern is about the women who get condoms but are not able to use them to protect themselves because their boyfriends will leave them if they do not have 'flesh to flesh'; and what can we do as the church?

A: ANERELA is a network and we cater mainly for religious leaders, but there are other churches reaching out to people. We as KZNCC do not do the work on our own but rely on others such as Diakonia Council of Churches, Practical Ministries, KwaZulu Regional Council of Churches (KRCC) etc.

Q: I recently heard a presentation at PACSA, and there is overwhelming evidence that the church is still stigmatizing. My question is about sexuality, especially from a Christian perspective. I am glad that Bishop Verryn has said we should revolutionise the way we preach about sex. But in an African tradition, sex has different connotations. When we are liberating the women, we need to liberate sex itself so that it can be viewed differently. But then the question arises, how do you liberate women in African tradition for things like virginity testing?

A: Yes, we do need to liberate sex. We want to condemn people and make them feel guilty about this gift from God. In African culture we are taught about it in a certain way and women have sex done to them. That is why most women are under pressure to have their sexual debut at a young age and to please men; virginity testing is a violation of women's rights. It is not balanced. It still places a lot of responsibility on women.

A small group of participants workshop together

Dominee Christo Greyling: A Personal Story

I tested positive in 1987 when I was a student. I always said I wanted to be a different kind of dominee (minister). And God has a sense of humour because I am. At that stage this was a death sentence and I had lots of questions of God. But I had the gift of friends that God gave me. All the theological students could have told me all the truths and testimony of what a friend I had in Jesus. Instead they showed what a Jesus I had in friends.

I told my girlfriend I had that I couldn't stay with her because of the stigma and risk to her. But she said that she was there because God brought her to me. In fact, she asked me to marry her. And twenty years later, we are still together. I didn't know who would want a Dominee with AIDS, or if I would be accepted into homes etc, so we disclosed to only the closest friends and family.

> *"But I don't place any value on my own life. I want to finish the race I'm running. I want to carry out the mission I received from the Lord Jesus - the mission of testifying to the Good News of God's kindness." Acts 20:24*

But then I started to get my first symptoms. I felt I needed to disclose as I wanted to make a difference while alive, and here I was starting to die. It was a daring step. Before this I had gone to the Dutch Reformed Church and asked if we could start an HIV ministry and they said, 'Why? We don't have anyone with HIV. People thought it was a gay disease, and a Black disease, and associated it with promiscuity. Then Old Mutual asked me and my wife to start an HIV ministry. It is anyone's disease, and I was able to make a difference by sharing from first hand experience.

When I first announced my status I had immense support. The old *tannies*[4] were crying and I wondered why I got support. The thing is, they knew how I got it – because I was a haemophiliac. And they would say, 'We support you, you got it innocently – they got it for themselves.' And this is prevalent in churches.

A little bit of hope

But there is hope. Hope is not just a theological concept. It is an existential thing when you need something to hold onto. This is what helped me live. Fully, flat out, every day!

Eventually, after 1998, ARVs came on the scene and this changed things. Before, we believed that we could never have children.

I learnt so much from friends who asked me, 'What can I do for you practically when you become sick?' and reminded me of the words of Corrie Ten Boom: 'If God leads you onto rocky roads he will always provide you with strong shoes.' This is what my friends have been. They made it possible for me to stand here today.

Which brings me back to the issue of having children: I never wanted to have to take the risk

4 Ladies

of my wife getting HIV, so we were so careful never to have unprotected sex. But then came the research which showed that there is a direct correlation between high viral load and the ability to transmit to someone. So we started to look at this: what if I went on ARVs and lowered my viral load to next to nothing? And research, although at its early stage, was showing this possibility. At this stage my drugs failed and I couldn't afford ARVs.

We did background work, going to find out if we were both fertile, and later, my wife Liesl's ovulation peak, etc. Then I had to go back onto drugs, not because I needed to, but to lower my viral load. We made the decision that we would only try for three months, and only have unprotected sex on the previous and following day of Liesl's ovulation peak. It worked the first month and our daughter came into our lives. Two years later, a second daughter was born. And Liesl stayed negative and thus, so are the girls. Now isn't this a message of hope? God does provide miracles – sometimes in miraculous ways and sometimes in scientific miraculous ways. So it was not about free, unrestrained sex. We were very careful, but it does change our ideas around sex.

Conflict over messages

From 1990 to 1999 the question was how do we get HIV on the agenda. Then from 2000 to 2006 it became a novelty for the church. At the same time, there was a big conflict raging around the ABC message. It originated in Uganda when it was needed at the early stage, but what are the limitations?

- It is moralistic and judging.
- Some women do not have the freedom to practice one or all.
- It is not practical for me – especially the abstinence.
- It only talks about sexual transmission.

People spent hours fighting one another on this. In Uganda, they also debated it, then realised that people were dying and they needed to do something.

And this is why ANERELA came up with SAVE:
Safe(r) practices
Access to treatment
Voluntary testing
Empowerment

So I think we should each do it the way that is best for us.

Stigma

The other issue is that stigma is still there. I have heard horror stories over the last three months about stigma. It is causing people not to access treatment.

We say to people, 'God made you special. Choose life.' I used to tell young people, 'You are responsible for your own sexual health.' The truth is, you can only do this when all conditions are okay. Maslow's theory shows taking responsibility is way up at the top of people's needs. We know that many are barely surviving. So how can they take responsibility for their own sexual health?

Ds Greyling then gave each table a question. Their task was to answer either 'yes' or 'no'. The group consensus has been included for information purposes.

1) Should Christians have sex outside or before marriage?
   NO
2) Are Christians having sex outside or before marriage?
   YES
3) Should Christians use condoms when having sex outside or before marriage?
   YES
4) Does condom use fall in the biblical perspective?
   NO
5) Should Christians use condoms for the prevention of HIV infection?
   YES
6) Can Christians contract HIV when having sex outside and before marriage?
   YES

These questions illustrate why it is difficult for the Christian Church to deal with the issue, but there are two things:

- We cannot lose each other through fighting.
- We must have a multi-faceted approach which takes into account what is lawful and what is safe.

How do we become channels of hope?

- We need to sensitise church leaders who do not have all the information;
- Ministers need people around them to do all the things they need to do – a leadership group of sorts;
- But sensitisation without follow up is meaningless. We need to link up with a community response – developing sustainable, empowering groups and community owned initiatives.

I have failed to see that integrated response to HIV.

Discussion

Comment: I have been to a number of HIV and AIDS summits and workshops, and when I received an invitation to come to this one, I asked myself if there would be anything new I would learn. This is in appreciation of your input. You have, for me, balanced your input to talk about your experiences and the scientific together. So even when you say you are not speaking to convert, you have converted me. I say this because one of the problems I have with the church is that, (I have said this over and over), I am waiting for a time when we stop being critical of what science is doing and being critical of what people are doing, and do our work. You have helped me see some of the things the church is using. We are known as the church to be anti-condoms but the little research you have done clearly shows that amongst ourselves we are confused.

Thank you, Christo. You tried to make the link between science and theology. I will try too. In the centre of the brain is a place called the *Hope Centre*. It is linked to the hypothalamus. It can form antibodies to fight cancer cells. Some of our miracles can be explained by this. If we

create hope and laughter we can stimulate the immune system to the extent that the immune system wins.
Response: Yes, positive life is an important part and can help people survive longer.
Q: What was the reaction of the church to you having children?
A: What I didn't tell you was how we disclosed this. We waited for the pregnancy test, and then to see the first sonar test (and seeing the heart beating – it made my heart break into pieces). And I couldn't bear to stay silent but we had to wait three months to see that Liesl stayed negative. We could not afford the viral test so had to wait for the window period to be up. Then we felt we had to tell our parents. When Liesl phoned her mother, she put the phone down on her saying, 'How could you?' before Liesl could even tell her she was still negative. My father just walked out and my mother broke down crying. It was just too much for them.

I then sent an email to my friends. Very soon the news got out and immediately after that, on one of the websites, there was a poll about whether or not I was irresponsible. 65% said it was irresponsible but we had been thinking about that a long, long time before we decided.

Q: I have a two-fold question: I am interested to know about viral loads. Could you share with us what happens if a viral load becomes undetectable. What happens?

A: The idea of using ARVs is to keep the viral load down while the immune system builds. I hear behind the question, what if a person was undetectable for four years, can we talk about a cure? That was the thinking but NO, it is not so. At the time, they stopped patients from using drugs, and within days they started shooting up again. The problem is that there are always latent cells which will start to multiply. If you are on them, at this stage you are on them for life.

Q: I am positive but my viral load is not increasing?

A: You are what is called a non-progressor. People like you will become guinea pigs and the hope that we might find a vaccine.

Delegates debate some of the questions posed by Ds Greyling

Bishop Kevin Dowling: Challenging the 'Sacred Cows'

Challenging the Sacred Cows

"How can I understand a figure or a statistic unless I have held the hand that it represents? The people we are talking about are the same as us. By the way we treat them, we know just how much like Jesus we have become." (Dr. J.P. Muliyil – in reference to people living and dying with HIV).

The statistics are appalling, frightening – but statistics can numb the mind and heart and can lead to a fatalistic attitude of non-involvement because the issue is just too huge to cope with. It is only when we "hold the hand" and "look into the eyes" and begin to allow the unique and personal suffering of a human being to enter one's spirit, that we become aware of attitudes, of perhaps prejudices or a tendency to judge too quickly. And aware, too, of even a challenge to faith – just who is the God I believe in when I am in the presence of this individual, person or child - and the circumstances which have led to them becoming infected - and now dying in front of me? Who or what is God in this pandemic?

The responses of church people to the actual living person and their circumstances in life – whether it be church leaders, pastors/priests, church workers and community members – can do so much in terms of caring, but can also reveal particular attitudes and moral standpoints which need to be reflected on. Some of the different attitudes, practices, statements or traditions in religious communities have already been noted; for example, unmarried pregnant mothers are expected to sit at the back of the church and HIV being seen as a punishment from God – made worse because it involves sexual relationships and perceived sexual sin. Also the widespread stigma and discrimination which hinders people coming forward to be tested because of fear, where they sense a question in the observer: how did you get infected? Which means, in effect, making a judgment about their sexual behaviour. And all the issues around male dominance and patriarchy; cultural attitudes towards women; gender-based violence; questions like what is to be done when one partner in a marriage becomes infected; myths like having sex with a virgin as a cure for HIV, and so on.

On the other hand, there are the systemic issues in society which are at the root of the escalation in the infection rate – grinding poverty and misery, lack of proper sanitation, water and food, a collapsing health system, unemployment driving migrant and refugee women in particular to high-risk sex as a means to survive; the resulting fatalism in so many of our young people/young adults, and the hopelessness which breaks the spirit of a person and prevents them living positively.

All these, and others, are/contain the "sacred cows" with which we as church leaders and our entire church communities need to grapple if, as Dr. Muliyil indicates, we want to know "just how much like Jesus we have become". The tragedy is that all those issues are factors which actually drive the pandemic. And so, in addition to dealing with ethics and morality which are at the heart of so many of the difficult challenges we face, it is also so important to deal with the personal realities of the person infected and affected, and the cultural norms and practical consequences of attitudes and standpoints in communities if we hope one day to turn this

pandemic around. This is quite apart from transforming the fundamental systemic reality of poverty and dehumanising conditions of life which leave people with little hope in any kind of future.

Our moral and ethical standpoints need to be based on accurate scientific research
One important consideration in dealing with complex issues like we face in the HIV pandemic is that we should be careful as church leaders to begin with facts and the outcomes of good research, rather than with what we would like the facts to be.

A South African Study: "Concurrent sexual partnerships amongst young adults in South Africa".

During 2006, CADRE, working in partnership with Johns Hopkins Health and Education in South Africa (JHHESA), Johns Hopkins University Centre for Communications Programs in Baltimore, Health and Development Africa (HAD)/Khomanani and Soul City, conducted a national HIV/AIDS communication survey in South Africa. The survey followed a cross-sectional design with a nationally representative sample of 7 006 respondents aged 15 – 65.

This survey was followed by a *qualitative* study comprising interviews and focus groups with respondents aged 20 – 30, that was conducted by CADRE during October 2006 and March 2007. So the information covers quantitative and qualitative data related to the 20-30 year age group with a focus on concurrent sexual relationships amongst heterosexual respondents.

The term 'concurrent sexual partnerships' is used to define a situation where partnerships overlap in time, either where two or more partnerships continue over the same period, or where one partnership begins before the other ends.

In the qualitative study, sexual relationships were seen as a pathway towards a number of benefits such as material goods and money. The concepts of sex and love are often separated, as is sex with love for a 'main' partner, and sex without love for 'other' partners. This duality is widely accepted as the norm and thus the meaning of being 'faithful' shifts to a concept where keeping infidelity secret is enough to be considered faithful.

Being part of a sexual partnership where one's partner is known to have another partner – often a 'main' partner – is not seen as an issue.

The context of concurrent sexual partnerships, in combination with the socio-economic and cultural underpinnings that reproduce such sexual patterns, is not governed by a strong moral framework. The challenge for HIV prevention strategy, and in particular HIV prevention communication strategy, is to identify and implement appropriate focal areas and concepts that take into account lived experience in the context of a severe HIV epidemic.

Interventions should avoid the dualities of meaning in the concept of 'faithfulness' in favour of more direct and pragmatic guidelines. The following key concepts are thus suggested for primary HIV prevention:

- Manage your risk to HIV by managing your relationships;
- The more sexual partners you have, the higher your risk of becoming infected with HIV;
- Avoid 'one-night stands' and get to know someone well before starting a sexual relationship;
- Having more than one sexual partner in the same month puts you at very high risk of becoming infected with HIV;
- Space your relationships and avoid having overlapping sexual partnerships.

Condom promotion remains an important cornerstone to HIV prevention, but in the present context of high overall HIV prevalence in conjunction with exposure to concentrated sexual networks, it is necessary to focus on reducing concurrency. In this context, condom promotion should focus on correct and consistent condom use.

One challenge this report lays before us is what will our pastoral and spiritual approach be to the perceptions of the 20 – 30 age group regarding "faithfulness", and the evident lack of awareness of morality or moral values in this age-group study. We have to ask ourselves: How does the church community challenge or invite change in behaviour in the face of an evident lack in moral awareness and huge peer pressure? Will such people listen to arguments proceeding from the natural law which might make sense to us; what communication strategy or approach do we need if we are going to reach them where they are and encourage/inspire them to act and choose differently?

A Ugandan study

One of the perceptions about the HIV pandemic is that Uganda is the unique success story in Africa and that we can learn so much from this here in South Africa. However, another perception is that this success is predicated on the fact that, unlike other countries, e.g. South Africa, which promoted condoms as a prevention strategy, the government of Uganda promoted abstinence before marriage, and mutual faithfulness within marriage, as its prevention strategy – and not condom use – and that this has been the reason for its success in reducing the infection rate in Uganda. That would be a wonderful example to quote in support of these two great moral and ethical values, if it were true. I think it is important that we allow the government of Uganda to speak for itself so that claims we make are based on fact or scientific research evidence.

- Last year I was invited by Hospice Uganda to give a series of talks on spirituality and HIV/Aids. One of the workshops I attended was with Church leaders – bishops and others – from the ecumenical family. I was part of a panel with a high-ranking Minister in the President's Office who spoke to us with frankness about the findings of their own Ministry of Health. He firstly indicated that he was aware that certain Churches were against the promotion of condoms as a prevention measure in the HIV pandemic. While he respected those views, he said that the official government Public Health Policy in Uganda had always been: abstinence before marriage (and trying to persuade the youth in particular to put off their first sexual encounter until much later in their life); faithfulness to a single partner in a marriage; and if you cannot or will not follow these two norms, then the consistent and correct use of condoms.

  As a result of this policy, he said, implemented with strong political leadership and collaboration from all partners in civil society, Uganda had succeeded in reducing the

infection rate from about 30% to about 5%. However, he said, their latest findings showed that the infection rate in 2006 had climbed again to 6.4%, that there were at least 1 million infected in Uganda, that the number of new infections was now at 132,500 annually, and that 42% of the new infections were occurring in married couples. In other words, an increase in sexual relationships between married partners and others, with most being unaware of their status. In the age-group 18-39 years old, he said only 13% of women and 11% of males had actually been tested. He also indicated that the decline in the infection rate among youth seemed to be holding, and they put this down to more of them abstaining from sex and putting off their first sexual encounter until later. Other Ugandan researchers state that the 6.4% increase indicates that there is now a stabilisation in the infection rate, as opposed to a decline in the years prior to that date.

- Every five years the Ugandan Ministry of Health, together with research partners such as the Makerere University in Kampala produce what they call the "Uganda HIV and AIDS Serio-Behavioural Survey" (UHSBS) for ongoing strategic planning, programme evaluation, policy formulation and calibration of their surveillance system. In the latest survey, that of 2004-2005, right at the beginning, in section 1.2 the report deals with "National Policy on HIV/AIDS". I quote from the first paragraph:

  "From the outset of the pandemic, the Uganda government recognised the gravity of the problem it posed and initiated public health strategies for containment. Recognising that the majority of new infections were transmitted through heterosexual contact, the strategy to contain the spread of the pandemic sought to address sexual behaviour risk factors, to avert further HIV transmission by promoting primary and secondary sexual abstinence, mutual faithfulness among married or cohabiting partners, and condom use, especially in higher-risk sexual encounters. This approach to prevention has continued to form the backbone of HIV prevention strategy to this day. The ABC strategy has since been expanded to the ABC Plus, to include voluntary counseling and testing (VCT), prevention of mother-to-child transmission (PMTCT), anti-retroviral treatment (ART), and HIV/AIDS care and support services."

- In February, 2005, a landmark study conducted by researchers from Johns Hopkins University (Baltimore), Columbia University, Uganda's Makerere University, and local health officials was published. The team followed 10,000 adults for 10 years in Uganda's Rakai district, or about 85% of the population in 44 villages. The study noted that the A, B, and C method had been followed from the beginning in Uganda. It found that in the Rakai district there had been a major drop in the incidence rate, but among all age groups and in both sexes, only condom use had increased. For example, about 30% of women with non-marital partners used condoms consistently. They also found that 50% of men and boys and men aged 15 – 49 reported using condoms consistently with their most recent non-marital sex partner. The study director, Dr. Maria Wawer, stated: "We are seeing somewhat less abstinence, somewhat less monogamy." But, she added, the findings do not mean that the strong promotion of abstinence and monogamy should stop. This report was issued in February 2005, and also indicated that at that time AIDS mortality figures were keeping the prevalence rate down; in other words, so many people were dying of AIDS that the number of new infections could not keep up, but that this situation could change (and it did). Also, the advent of anti-retroviral drugs had led to people mistakenly believing that they cured the virus or that

they could help prevent its spread, and that this had resulted in some people abandoning prevention measures or safe-sex practices.

- Another study, published by the Uganda AIDS Commission in 2006 with professors and researchers from the Institute of Public Health and the Faculty of Social Sciences in Makerere University participating, and coordinated by the Uganda Health Department, came to similar conclusions. But they made some telling comments about what happens after many years of strategies and programmes, when HIV/AIDS becomes, as it were, "normal" in communities. I quote:

"*Uganda experienced a high rise in HIV prevalence in the 1980s, a sharp fall during the 1990s and, now, tendencies towards stabilization since 2000. Progress in reducing the prevalence rate of HIV infection between 1993 and 2000 is accredited to the emphasis put on a wide range of programme interventions resulting into reduction in number of non-regular sexual partners, increase in condom use, and delaying sexual debut. The key outcome variable was the collaborative development of a widespread perception that all sexually active people were at risk and that changing sexual behaviour was the best way to reduce risk of infection. The experience of Uganda, especially between 1992 and 2000, suggests that by working with individuals, leaders, social networks and institutions throughout communities, it helps foster and reinforce shared perceptions that certain risk behaviours are both personally unwise and raise the burden and effects of the disease for all…..*

However, the situation since about 2000 shows that the expected change in HIV prevalence has occurred only too slowly. Overall the current HIV prevalence of 6.4% in the general population is unacceptably high. It indicates a high burden of HIV infection in Uganda. Compared to the past, no more clear declining trend in HIV prevalence is being seen. Instead, a stabilization pattern is becoming more apparent. Current trends in HIV prevalence are showing a rise among populations such as married people. There is also an apparent shift from the peak of the epidemic from young people to adults 30-39 years. More recent data from the Ministry of Health shows a fall in the use of condoms among men at the most recent high-risk sexual encounters. UNHBS reveals an increase in reported STI infections in the past year….

"The normalisation of HIV/AIDS by some sections of the community has contributed to some form of disengagement from preventive behaviour. Poverty, too, is still a leading socio-economic driver of HIV/AIDS. It influences people to engage in 'prostitution', survival sex and transactional sex… Sexual behavioural patterns especially among the out-of-work school youth show a reversal of earlier progress." (From the Executive Summary, *The Road towards Universal access to HIV prevention in Uganda*).

We can gain insights from the Ugandan experience. It is important as Church leaders, that our pronouncements, standpoints, policies, while deeply informed by our moral, ethical and spiritual values, should also be firmly rooted in scientific research and the currently available findings. Otherwise we run the risk of making unwise or potentially embarrassing statements which will only be contradicted by the scientific community, and thinking and informed people. It is one thing to proceed from our unique standpoint of the holistic values and virtues which should underpin all human and societal behaviour, values which will protect and promote the

common good of humankind; it is another thing to try to use poorly researched perceptions about particular factors as a support to our moral and ethical standpoint.

Abstinence and being faithful are indeed the only 100% safe ways of preventing infection. Our challenge is how to communicate the necessary values and ethical behaviours to achieve our prevention objective as churches, and how to deal with the very complex socio-cultural issues which still drive the pandemic in our country, and which show no sign of being turned around.

The church's role in responding to people who are infected and affected by HIV – Prevention, Stigma, Discrimination, God, Care and Spirituality

Prevention Programmes

Discovering a vaccine will clearly be a huge breakthrough in HIV prevention – but that is years away from being developed. While that is awaited, a multi-strategy approach has been recommended: voluntary counseling and testing (VCT), the provision of anti-retroviral therapy (ART), the prevention of mother-to child transmission (PMTCT), and HIV care and support services. The other aspect of prevention focuses on change in sexual behaviour, especially high-risk behaviour patterns, and how to engage with groups like youth, young adults, adults and married couples around the issue of behaviour change. For young people and young adults there are the so-called "Youth Alive" groups which conduct workshops and programs called "Education for Life" inspired by the mottos "True Love Waits" and "Choose Life". I have not come across any significant research on how effective these programmes are in terms of *sustaining* the behaviour-change choices. But, the point is, they are one method of prevention which is particularly adapted to young people and young adults, and its strength is that it is delivered through peer ministry.

One "sacred cow" which needs to be addressed is the widespread fear or inability to speak about sex and sexuality, especially by parents and guardians. Education and awareness about the God-given mystery of sexuality needs to begin at a young age, in fact at primary school age, if we hope to develop positive attitudes and responsible awareness of and reverence for sexuality in our young people. Leaving it until they are teenagers is too late, because by then they will be subjected to all kinds of peer pressure to engage in irresponsible sexual behaviour. But, in addition to what can be done in schools, we must affirm that the primary teachers should always be the parents, and the pastors and church communities, leaders and teachers, must both encourage and show parents how to communicate with their young people from an early age about the gift of sexuality, a gift from God to be held in reverence.

Condoms and Prevention: There are differences in approach in the various church communities on the question of the use of condoms as a prevention measure in the HIV pandemic. Some communities would allow their use in order to protect or save life, and especially in the case of sero-discordant couples, where one partner becomes HIV+ for whatever reason.

Sero-Discordant Couples

What is the approach of the different Church leaders and communities to the issue of one partner in a marriage becoming infected with the HI Virus, or indeed a couple wanting to get married where one partner is HIV+? How is the expression of marital, sexual love in that context viewed? Should the couple be encouraged to abstain from sex in order to prevent the

possible infection of the other partner who is not infected? Should they be encouraged to take the available means in order to prevent such infection, of which one could be the careful and consistent use of a condom? Or are condoms viewed as essentially contraceptive in nature and therefore their use morally wrong?

Cultural Attitudes

One of the critical issues in this pandemic, and which is responsible for the escalation in infections, is that of patriarchy, patriarchal and cultural attitudes and determinants which condemn women to an inferior position and to having no say over their sexual lives, gender-based violence and the abuse of power in heterosexual relationships. And this is not only so in South Africa, or sub-Saharan Africa.

Have we the courage as Church leaders, as pastors and Church workers, to name what needs to be named? The simple fact is that unless these cultural attitudes and determinants are transformed/changed, there will be an insidious and silent force present in our families, our communities and our society which will continue to drive up the HIV infection rate in this country.

Many women, especially in the informal settlements, actually end up depending on a "boyfriend" for economic survival. He keeps her in a shack in exchange for sex. Later the woman may be diagnosed as HIV+. This woman is too afraid to begin an anti-retroviral programme, even though it is available, because she fears that if the "boyfriend" sees her at home taking pills he will suspect that she is HIV+. Then what happens is that he will strip the shack of everything, and walk away leaving her alone and destitute. Rather than letting such a fate befall her, she will continue in the relationship for economic survival, and thus get re-infected and eventually succumb to the disease.

Responding to these realities and cultural perceptions and norms will not be easy, but it is fundamentally based on whether or not we really believe in the full equality and equal dignity of male and female based on their creation in God's image. If we really believe what we quote from scripture, viz. "Let us make man in own image, in the likeness of ourselves…….God created man in the image of himself, in the image of God he created him, male and female he created them" (Genesis 1:26-27) - is not a profound transformation of attitude required with regard to the equal dignity of women, and the consequences which result from this in practical daily life?

What about the culturally acceptable attitude or practice that a man can demand sex of his wife or partner and that she has simply to submit? If we are truly Christian, and followers of the Lord, then that has to be questioned.

None of these questions can be easily answered. What reaction do we encounter when we press the "gender" button, or begin to speak of gender violence, or discrimination against women? It is one of the most difficult issues to deal with honestly and openly, and perhaps these challenges and problems need to be dealt with by men themselves in peer relationship with other men. Informed and committed leadership by men in our communities is crucial to overcoming the extremely high incidence of rape and violence against women and girl children, and the abuse of power in marital and sexual relationships.

AIDS as a punishment from God

In the AIDS programme for which I am responsible, I have been deeply disturbed by encountering sick people, and those dying in the hospice, those who have experienced profound stigma and discrimination not only from their own families and friends, but also from their own church communities. A lot of this has to do with perceptions around sex, and that getting a disease like HIV is because you have been indulging in sex with more than one partner. This sort of makes you "dirty", it is sinful behaviour, against the 6th and 9th Commandments, and so forth. The result is people being told, or being made to feel in one way or another, that because of their errant sexual behaviour they have transgressed God's law and that this is God's punishment for what they have done, their sin. The consequence has been expulsion from families, a refusal by family members to care for their sick member, and "exclusion" in different forms from what should be a home for them, even in their own church community. Their own religious or spiritual dimension of life can therefore become a source of suffering for them.

The reality of Stigma

Stigma is a profoundly painful experience because it can be both internal and external. External stigmatisation comes from others who are external or outside of us – from family, neighbours, parents, community and church members, doctors, nurses, teachers, and so on. It is other people judging or discriminating against us. The internal stigmatisation comes from within, if we let ourselves believe or accept the stigma. It results in a belief that I deserve to be treated differently, or even badly, because the sickness I now have is my fault, because I have sinned.

One sees the effects when someone opens up to us. Because of external stigma, they keep their worries and troubles inside to avoid more stigma and rejection. They withdraw or isolate themselves for protection, and they avoid seeking help or support from others to prevent more rejection. As a result of internal stigma they may have trouble accepting themselves and their HIV-status because they accept - or even believe - the stigma. They believe that they are somehow bad and deserve the stigma. HIV+ persons fear being treated differently, they fear they will lose support; they fear family and friends will stop loving them. And clearly, those responsible for stigma react this way because of fear, insecurity, and lack of knowledge or ignorance about the disease.

The stigma can have further more lasting effects. It can cause them to lose hope, to believe it is not worth living positively with the disease, to stop fighting for their life and their health. They keep their status a secret and lose trust that there is any help for them. To maintain such secrecy takes great emotional effort, and causes stress which, coupled with poverty and malnutrition, lowers the immune system, and enables the disease to spread even further. The church has a hugely important role to play in confronting stigma and discrimination itself, and the effects on the person. Our goal should be to help people and show them, through counseling and spiritual care and support, how to reject external stigma, and to realise that other people inflict stigma because of fear and ignorance; how to let go of internal stigma so that they can begin to grow again as a person, live more positively and accept themselves as they are; to believe that they deserve love and support from family and friends, care workers and the faith community; and to gain the confidence they need to speak, to disclose their status and gain even more support from others – especially the members of the church community. But do our pastors and priests preach about these issues regularly?

In all our teaching and preaching, workshops, all gatherings of church people for worship or whatever, we need to share our message, based on the person and values of Jesus. This is what I believe are the core aspects of the message:

- God loves and accepts you as you are;
- God loves and accepts you no matter what has happened in your life – God always forgives with love and compassion (cf. John 8:1-11), and invites you to a new beginning in your life;
- God will never reject you – we will not either;
- God cares for you and the way you are feeling – you are precious to God, and to us;
- God wants to heal your hurt and pain, to heal your spirit;
- God wants you to feel peace, and to live positively in peace with your sickness;
- We – the carers – will support, love and care for you, so that you may be truly healed in your spirit.

The community-caring response of the church – orphans and vulnerable children

Church communities are uniquely placed to provide holistic care to those infected and affected by the disease. So often, government cannot be present in all affected communities. The church is present, and can make a significant contribution – provided we can find the human resources and adequate funding to enable our programmes to be sustainable. And that is a crucial issue - sustainability: as church communities we could not accept the sudden termination of programmes and turn our back on the poorest and most vulnerable in our society. Above all, these are the people who need to find a word and a presence of hope in the churches, and to know we will be with them for the long term no matter what it takes.

And that is why it is important that communities identify potential partners, from the business sector or from other NGOs through whom “relational” partnerships built on trust and accountability can be built up.

One very challenging reality which encapsulates the tragedy we are facing is that of orphans, child-headed households and vulnerable children. It is hard to quantify the numbers but some time ago I came across estimates that we have 1.2 million AIDS orphans and this is expected to rise to 2 million by the year 2010, and 0.7% of homes are in the care of a child. Whatever the correct figures are, nothing – but nothing – can describe the trauma and suffering of God’s precious little ones.

The cultural value and inspiration comes from the proverb: “Your child is our child”. The spiritual values of love and compassion, and committed care of the least of our sisters and brothers does not need comment. That is our vision, and that must keep motivating us no matter what the obstacles.

Our communities – and here I am talking about all the church communities in a village, or informal settlement, or township, Reconstruction and Development Programme (RDP) housing or suburb – our communities, under the leadership of the pastors from the different churches, can be organised into blocks with leaders. An emergency home, with foster mothers, could either be identified or built simply, depending on the possibilities. When the community workers in a block come to know of children being orphaned, and there is no extended family, the children can be brought immediately to the emergency home.

Community members can be trained very easily as child-care workers by making use of NGOs like *Heartbeat*. Other NGOs like *LifeLine* can be invited to train our local community members in basic counseling skills to respond both to adults and children. We can invite experienced NGOs like *Noah* to provide us with the caring programmes required for this crucial need, orphans. Community members can be invited and challenged by the pastors to offer their homes as foster homes to welcome orphaned and vulnerable children. We just cannot, as churches, allow the painful story of child-headed households to continue apace. Contact can be made with social workers, either from the government or NGOs, in an effort to access child-care grants and grants for foster parents from government – it requires tenacity and patience because we do not have anything near the number of qualified social workers to cope with this crisis.

So many refugee mothers and families are in our country. They often do not have identity documents (IDs) and therefore cannot access the available grants. That is a particular challenge which we as the churches need to take up – how to provide for these very lonely and desperate people when they face the crisis of illness and death from AIDS. But there are also many others who have not been able, for a variety of reasons, to obtain their IDs. Innovative programs can be run by church communities, if the need is not being met by government. One which I was able to implement several years ago involved finding and training some young adults. We went to the Department of Home Affairs to explain the project and to request a contact person in the Department to deal with our applications. They were then given a pile of application forms. I obtained funding to buy a Polaroid camera. Then the young adults went from door to door in an area, checking each household, finding out who was eligible for IDs, filling in the forms, taking the photos, and then bringing them back to the Department to be processed. In one settlement they managed to process 5 000 IDs. Then they went back to assist the responsible adults to access the grants for which they were eligible.

All these programmes can be run by ordinary people once there is passion and commitment from our leadership.

Traditional Healers

Another important initiative with regard to anti-retroviral drug therapy is to be aware that some of the traditional remedies supplied by traditional healers, especially those which act like enemas, can make the anti-retroviral therapy become toxic and even lead to death. Traditional healers, in whom so many people trust, need to be brought on board, given the correct information about diagnosing HIV, and then invited to work with the nurses at clinics so that herbal remedies can be used which will help support the immune system and not prove to be harmful when a person is taking ARV drugs.

Caring for the Carers

It is vitally important that we as leaders and pastors also develop support programmes and a spirituality for our closest co-workers, the carers, who are the first contact with the sick and dying, and the children, so that always they respond out of deep reverence for the mystery of this person and their life – as it is. And for that to be achieved, we need as church communities to give quality time to our carers so that they can live positively and spiritually while they have to deal with dying and death, especially with dying children. They have many experiences which can break their heart, and feel a sense of helplessness at times. They need regular counseling, a spirituality, and ongoing spiritual formation and accompaniment so

that they can continue to be the presence and experience of our loving and compassionate God.

Conclusion

Sometimes I feel that the questions and challenges are so great that it is difficult to know where or how to find the answers. I feel that it is important that we hold the questions and challenges in a discerning attitude in the presence of our God and wait in faith for even the partial answers to become a little clearer, and in the meantime try to discern what may be best for this individual person in the context of their actual living situation.

This means that, as church leaders, we try to develop policies and implement practical strategies out of a spirit and practice of contemplation in life and in the realities of life, seeking consciously for the word God may wish to address to us, but seeking this in quietness within. I take inspiration from two texts with which I close:

> *When you lose touch with inner stillness, you lose touch with yourself.*
> *When you lose touch with yourself, you lose yourself in the world.*
> *Your innermost sense of self, of who you are, is inseparable from stillness.*
> *This is the I Am, that is deeper than name and form. (Eckert Tolle)*

Discussion

Q: Thanks for an inspiring talk. I would like to comment on community workers and how to create the passion to serve within them. Our experience is that there are a number of very dedicated women, but it always comes down to issues of stipends and financial support and how do you see the stipends issue within the church? Does offering a stipend mean that we are breaking down the ethos of serving?

A: *Yes, I have had experience and I think the community workers are the way to go – I believe this strongly. We cannot depend on professional staff as there is such a shortage and they already have to extend their capabilities. Community workers can be child care workers, carers etc, and perhaps you could have a professional heading the team. We get people to think about what would the sick, little ones, suffering, expect from care, and we get them to dialogue about respect, care, love, non-judgment, etc. And this is part of the interview process so that people who come forward to be community workers are assessed on a range of things, including their ethos and values. The problem is to sustain that, and if you are in a poor area, the issue of stipends is an issue. Our approach was to try and provide a stipend according to ours, enter into a contract, and then get supervising professional nurses. The leaders would then lead reflections on issues of ethos, starting the day with prayer, etc. But it is not without problems, and we found as time went on and we tried to introduce training to upgrade community workers who were capable to qualify as assistant nurses. Immediately, the issue becomes salary and no longer stipend. But it is just something we have to work with and keep in mind – motivating the spirit of service within the expectations of life today. It is difficult and is about balancing the needs of people who are really poor and keeping the spirit and ethos of service.*

Q: I want to know about Noah and other information on organisations in rural areas.

A: Noah works within KwaZulu-Natal. Their strength is to mobilize community members, give them training and form little arks - a team of child-carers who work voluntarily. They and others could be accessed via DCofC.

Q: You moved me to tears by your expression so deeply. I need help with the concept of punishment because I agree with you. However, we live in a moral universe. Jesus created laws and people cannot break law, the law breaks you. People don't understand that the effects of sin remain even if the guilt of sin is gone. There are people who believe that prayers can make you negative. So what do you say to a person who comes to Christ and expects the effects of sinful behaviour to go (eg a smoker with emphysema from smoking). So they may be forgiven but still sit with results of it.

A: This is a difficult one. If you look at the fact that a person is HIV positive because of having had concurrent sexual partners, the effects are plain to be seen. For me the fundamental approach is that they suffer at all levels – stigma, emotions, own stigma, own poorly formed spiritual awareness of God and therefore self-punishment. I think the punishment they go through is so excessive in every way that our approach must be to focus on how they can be healed from within. Because they may never be physically healed and instead have to face death. A mother with a baby that is positive, has to live worrying what will happen to the baby if she dies first. And our response must be to assure her that we will take care, we will find a home, we will make her well again and make sure she goes to school. Inner healing is crucial to enable them to come to peace. We must not focus on the suffering or punishment from actions that could or could not have been their fault. Holistic programs of spiritual care and counseling are needed – that say God and we want you to be healed, free, so you can live more and more positively with what you are going through.

Q: Thank you for a sane, sober, gentle and clear presentation. I want to talk about concurrent sexual practice. Back when I was in a pastoral situation, a mother shared that both her children - boy and girl - came home and said 'Mom don't talk to us about one partner relationships because the new way is concurrent relationships.' I wonder if there is any research addressing this issue: what is informing our young people? Why are they feeling it is okay? This is a way of life now. Do you have any clarity as to what may be informing it?

A: No I haven't come across the answer but the perception is that it has become most pervasive with young people. Peer pressure is very serious in our communities, so for the more mature amongst us, talking to that group is a futile exercise. The only way is to capacitate and inspire our own youth leadership to be present and witness to an alternative. I found that report very worrying. It seemed that right across the board it has become the norm. There is a sense of fatalism and the fact that there are no jobs, etc only compounds this sense of fatalism.

Comment: Speaking as a young person at tertiary level, there is this unwritten code about what is wrong is right and what is right is wrong; and young girls want to be accepted, and want to experience the good life; and live life to the full, and get involved in relationships with guys that are party animals; and want to be accepted into that inner circle because they don't have role models and people to guide them. Boys compete over how many girls they can sleep with and girls compete over how many, and which, guys they can go out. They all want

to be part of the 'cool group'.

Q: Special thanks around your experiences in informal settlements. This is a good example of how the church can work without waiting for resources from outside. If I look at this kind of summit, most of us are involved at an administrative level of church programmes and I see a gap between administration and those who implement. There are lots of reports and information but those doing the work don't have that information. Is there a way of bridging the gap? Also, is there any way for us to stimulate interest? Even church leaders sometimes have delegated work to other people. How can we help people work together and move together?

Q: Another gap is that most research is initiated by NGOs and the findings, etc. are not immediately avail to everyone. Is it possible for the church to commission research projects as well, so that at one level it has credibility?

A: Church leaders have so many challenges to respond to, but this particular one of HIV challenges the family and we need to think how as leaders we can commit quality time to making that gap less by helping our co-workers be equipped and informed. But also not to lose heart at the enormity of the task. We do need to be hearing what our co-workers are facing and also work at the coalface with them. We have to give time to continual workshops, to accessing the necessary resources, etc, recognising that research is couched in certain language, and overcome that barrier. In leadership, it is going to demand that we give quality time to it and see the line functions of the other things we do focus on HIV as well. And we have to do our best with the time we have available.

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Q: I heard people talk about educating men. Do you have helpful or practical advice? And how do we re-educate youth and adults about sexual values and faithfulness, etc?

A: I think we need to focus on critical issues of gender and put them in a well prepared workshop fashion so that they can really get to grips with the issue, then form teams of male animators and they go to communities and teach, starting with basic things like what it means to be a real man in your home or community, and go deeper into attitudes towards women and sex, etc.

Q: In my context – African American - I question an emphasis on abstinence because of one thing: marriage is not as probable for black women as it is for white. Abstinence implies you will get married. Have you observed that in your work here and how does that change the emphasis on abstinence? How do we develop a Christian response?

A: In the area where I am the situation is very similar to yours. Marriages are few and far between and if they happen, are at a much older age. This does pose the question of how you help people prepare for traditional marriage when there is this kind of cool reality that young people are growing up with, which is outside the church community and is determining the choices.

Q: To what extent does *lobola* contribute to a) the delay of marriage and b) the increase in the problem?

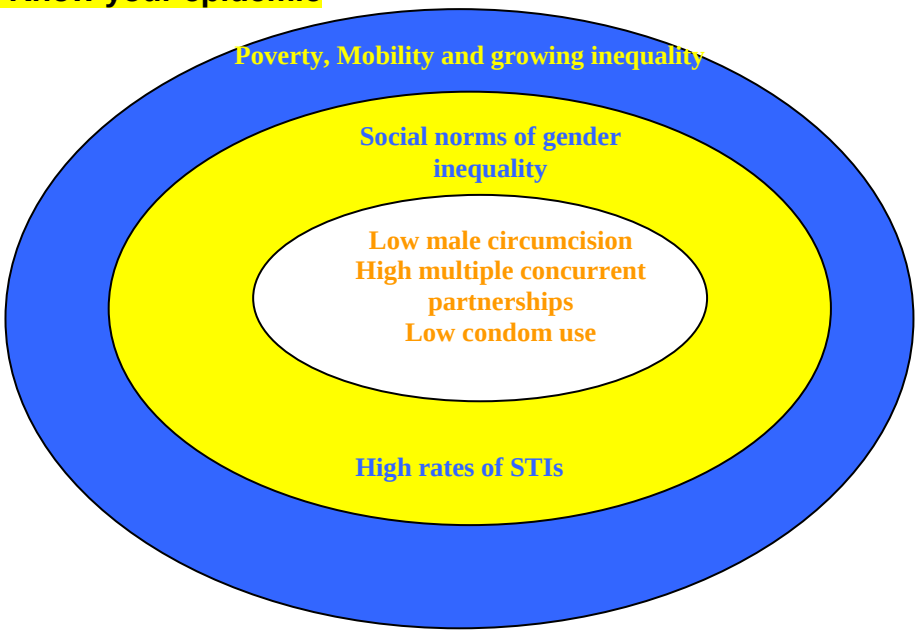
A: It does take years for a young man to find the money for lobola and a couple will often live together before that. And this is where the pastors from our communities have to try to

understand the dynamics and think about how we can accompany the process. It is a long process involving two whole families, and it all needs to be taken account of with great respect. And linked with this is the cultural idea of when a marriage has happened as opposed to the church's idea of this. Lobola is another untouchable. This is a big issue and black ministers must do something about it. If it doesn't start with us, then who? Dealing with stigma must start with leaders. This is why I joined SANERELA. We must name the things that need to be named.

Professor Suzanne Leclerc-Madlala: Requirements for a Psychosocial Shift in Behaviour towards an AIDS free Generation

Professor Suzanne Leclerc-Madlala said she would be looking at Southern Africa as a region, and to South Africa within this context.
There are a few requirements when working in the field of HIV:

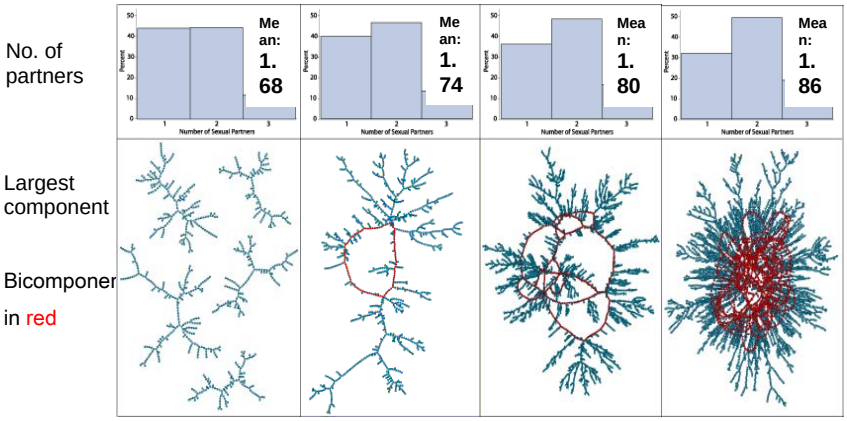
1. Know your epidemic



Consensus findings from "UNAIDS/SADC Expert Think-Tank Meeting on HIV Prevention in High Incidence Countries", Maseru 2006

2. Know how your drivers put people at risk

Even low degree sexual networks create a transmission core



Source: Martina Morris, Univ. of Washington, used with permission from a presentation given at a meeting on concurrent sexual partnerships and sexually transmitted infections at Princeton University, 6 May 2006.

3. Understand how the context shapes vulnerability
Most southern African societies are traditionally polygamous, patrilineal and patrilocal, with large bride-wealths conferring large degrees of jural rights over women and children.

The social implications of this are that values and norms are developed to uphold men's privilege and constrain women's autonomy; and a man's wealth, standing and manhood is closely tied to his ability to secure women (wives) and cattle as property.

Today, we have a modified polygamy: 'monogamy *de jura* - polygamy *de facto',* or multiple concurrent partnerships. Many socio-cultural norms and values for gender relations that support this system still persist.

4. Identify dominant messages or 'scripts' that are problematic for HIV prevention
A similar constellation of cultural scripts for sexuality exist throughout the region.

These scripts are learned through socialisation and circulate as messages, expressing recipes for living. They prescribe appropriate behaviour and often reveal and set moral standards. They play a major role in making southern Africa the absolute epicenter for the global HIV and AIDS pandemic

What are some of these pervasive scripts? (And how might the faith-based sector address them?)

1. Male sexuality, unlike female sexuality, is non-restrainable. Men are biologically programmed to need sex regularly and with a variety of women.
2. Sex is one of very few ways to show love and to get love.
3. Sexual violence can be a way to demonstrate passion, affection or caring. Understanding of normal male behaviour is closely aligned to understandings of rape.
4. Pleasurable sex is to be found outside marriage; marriage is for procreation.
5. To show respect a woman is conditioned to accept, endure and forgive a partner's bad/irresponsible behaviour, including infidelity.
6. A man should not be expected to be faithful when his partner is unavailable (during confinement, out of town, sickness, etc.)
7. A woman with self-respect does not give sex for free. She expects an exchange of goods, services or money for sex. Conversely, a man demonstrates his social worth, affections, or commitment through the giving of goods, services or money.

How does this socio-sexual system catalyse the rapid transmission of HIV?
Throughout southern Africa multiple concurrent partnerships are common and are viewed as normal. These partnerships are legitimised through enculturation of boys and girls with supportive ideas, beliefs and values (i.e. male sexuality is unrestrainable, or men 'cannot eat cabbage every night').

Exchange of money, gifts or services (transactional sex) have long been and remain an important and normative part of courtship and sexual relationships. Transactional sex is about more than 'survival sex'. Consumerism plays a part, with the expansion of economies, growing aspirations, and widening wealth gaps. Many young women today are active agents in seeking multiple partners and exploiting them for gain.

Age-disparate relationships are common, have cultural resonance, and are quasi-acceptable.
Our stereotype of 'sugar daddies' is far too limited. They can be rich or poor, and 'sweet mammas' seemingly a growing phenomenon.

What are young women's motivations for seeking multiple partners, especially older ones?

There is always the possibility of finding love, affection, or marriage:

- Vulnerable victims report hunger, coercion, manipulation, pressure to conform, cultural expectations to obey and show 'respect', need for protection, employment.
- Active agents boast of taking charge, 'milking the cow', seeking fun/adventure/opportunities to make contacts among 'sponsors', 'investors' or 'ministers' for present or future social mobility, looking for 'top-up' income.

Urban-Rural distinctions:

- Urban - fashion clothing, cellphones, jewelry, desires consistent with urban lifestyle/glamour and entertainment
- Rural - food, fees, clothing, simple cosmetics, needs consistent with rural poverty[5]

What reasons do women give to justify multiple concurrent partnering?
Different partners largely fulfill different needs i.e. one for companionship, sexual fulfillment, transportation, help with school work, one for food or necessities, one for entertainment.

Faithfulness is often perceived as 'unstrategic' or even 'stupid', and concurrency is viewed as a back-up strategy, a hedge against inevitable disappointment, a way to 'keep up' with peers, or a distraction from personal/family problems.

Continuum of 'needs' in sexual exchange

Subsistence	Consumption
●Food	●Cellular phones/jewelry
●Rent	●Outings/entertainment
●Clothing	●Clothing (fashion)
●School Fees	●School fees (tertiary)
●Transportation	●Transportation +

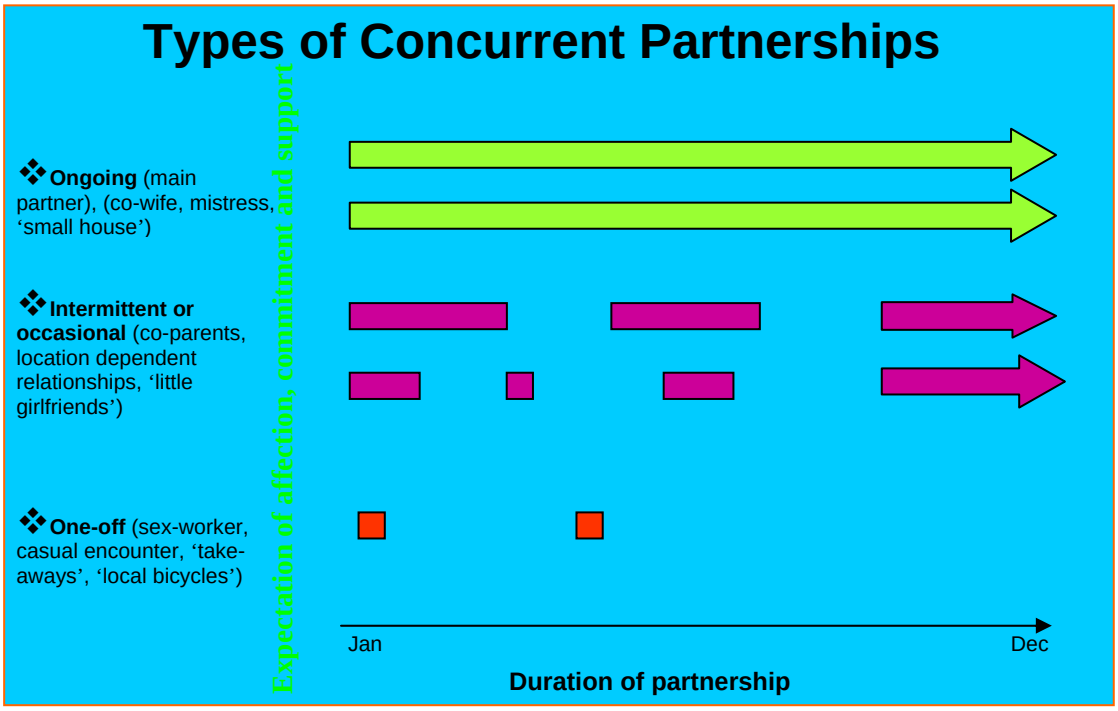
Source: S. Leclerc-Madlala (2003). Transactional Sex and the Pursuit of Modernity. Social Dynamics 29(2):224.

[5] *(Kambou et al 1998, Mukondo 1998, Silberschmidt & Rasch 2000, Leclerc-Madlala 2002, Hunter 2002, Kaufman & Stavros 2004, Karlyn 2005, Nshindano 2006, Poulin, 2006, Nkosana & Rosenthal, 2007)*

What are men's motivations for multiple concurrent partnerships?

Young men: Peer pressure to prove normality and masculinity was identified as the #1 factor. Concurrency was also viewed as 'strategic', a hedge against disappointment, recreational, and meaning constant availability of a woman.
Older men: report the need for variety, relief from stress or boredom, desire for 'clean' partners, desire for sexual rejuvenation, and also pressure to demonstrate manhood and social worth. They often perceive themselves as victims of women's attractions and societal pressures.

"Throughout sub-Saharan Africa as a man's wealth increases so does his sexual access increase and social expectations of sexual access increase (Swidler and Watkins 2006)"



What is required for a psychosocial shift towards an AIDS-free generation?

Roadblocks on the bridge that moves HIV between generations

- A great increase in awareness of the evidence on HIV risks and multiple concurrent partnering.
- Need for greater awareness on the specific risks involved in age/wealth disparate (intergenerational) relationships.
- More efforts to keep girls in school and alert them to dangers of the consumer revolution.
- More effort and creativity required to directly engage men for change, young and old. Local champions for HIV prevention need to be identified, mentored and supported to promote and model new norms of masculinity that protect the self and others from HIV.
- HIV prevention is about the disadvantages of unsafe sex. What about the advantages? There is a need to explore opportunities for promoting advantages of

mutual faithfulness and/or partner reduction…(less sexually transmitted infections (STIs), less expensive, less stress due to deception, contribute to building trust and partner faithfulness, intimacy and emotional fulfillment, family stability, etc).

- HIV/AIDS will continue to ravage communities across southern Africa if its underlying drivers remain unaddressed (WHO/UNAIDS 2008)
- A change in current sexual norms and behaviours still remain the only hope for long-term sustainable protection of our communities against this disease.
- If rates of HIV in the region do not markedly go down within the next 3-5 years, treatment will simply not be sustainable. The world cannot be expected to pay this bill. (*Kent Hill, US Assistant Administrator for Global Health*)

Discussion

Q: Has there been any research on the affects of abortion on the disease and its progression?

A: I don't know and can't imagine what the impact would be, but I would think that it would have a huge stress on a women's body.

Q: I return to the United States in six months and for most of the presentations, I am happy to report back what is fueling the epidemic in South Africa. However, with this kind of presentation, I am afraid I will be labeled a missionary obsessed with sex and sin, and a racist. What advice would you give about giving a talk of this nature?

A: *Yes, it is difficult to talk about these issues and there are a lot of political and racial sensitivities. Being in the field, I can see that as time goes on it becomes easier because people realise that we have to talk about these things and go beyond the racial, the gender, etc. It is not easy, and you may be accused, but so what? We need courage in fighting this epidemic.*

Q: To what extent are concurrent sexual partners an issue in white and Indian communities?

A: There are not many studies yet but we do know that western society promotes a different model of sexual practice. It doesn't work all the time, but it is a different model and my guess is it would be less.

Q: Your presentation reflects the truth and I am a witness to that. Such things are happening in our society. But what is the way forward? What tools or strategies can we use to make all these things stop?

A: With this epidemic, there is no single solution. We have to think of the short term, medium and long term. For example, poverty reduction is a long term goal. There is a need for young men to dialogue with other young men to change norms.

Q: There are traditional communities or leaders who have rebelled against stopping virginity testing and they contrast that with abortion which is constitutionally allowed for 12 year olds without consent from their parents.

A: Virginity testing is not a synch. From my perspective it doesn't help girls feel control over their bodies and doesn't teach them the skills to challenge advances. It only helps instill fear and make them feel unclean – which is not going to help. Research shows that girls then do other things that make them more vulnerable, like inserting something up their vaginas and having anal sex.

Q: Old people believe that abortion is abominable, and yet virginity testing has been done before and been proved to sustain communities.

A: I can see why they say it is akin to abortion because it is an infringement of biological/bodily integrity. But the fault is always put on women – like non-virginity falls from the sky.

Q: The new research on circumcision suggests that it reduces prevalence. My concern is that it will encourage young people to do things behind parents' backs that will put them more at risk.

A: This is a difficult one because here it is part of ritual and cultural practice for some groups and not for others. It is therefore difficult to promote it for health reasons. With circumcision, one of the problems is getting out the correct message because of the fear that men will think they now don't have to wear condoms. There are problems with traditional forms of circumcision because they are done very late when some may already be infected. There is a lot of debate on this - do we mix the medical need with the cultural etc? For example, in Swaziland they haven't circumcised, ever since the days of Shaka, but now they are promoting it as an HIV prevention strategy.

Q: African culture and values have an important role to play in fighting HIV because of the concept of '*ubuntu*' - the soul of African culture - which is at times relegated into the margins because of research being seen as the solution. And the church is partly responsible because there were community structures which ensured that young men were brought up with strong moral values; but because sex is not spoken about in the church, they seek their own answers and western answers don't fit. Could we see a resuscitation of those African structures?

A: Yes, traditional structures have been undermined and they were effective in the past. But this is a new environment and a new way of life, and we have to look carefully at them before implementing them. We have to consider whether or not the message or practice is still relevant. There are examples of camps where boys are taught that in order to be a man they must push women around. We need to look at how practices can play a better role in a modern context and make a positive difference. Perhaps we should look at the concept of Ubuntu rather and see which are the related values which work.

Q: I am following up on my question and you mentioned young men talking to other young men, etc. My fear is that we don't have such a platform in our communities because in them there are authorities who were designed and structured to organise people and make them aware of such things but are not doing that. Instead they are sitting back and enjoying the benefits. When we try to organise, these authorities feel threatened. The bishop told us this morning about a group that organises people's identity documents, but if I tried to implement his system I will be a threat to certain people.

A: Maybe it is time to take up the challenge and be brave. HIV is a state of emergency. I once thought that all the orphans should launch a class action suit against government for making all their parents die! Wouldn't it be nice if the leader of the country would say that we have a state of emergency, and everyone has to play a role. And we are afraid to look at the media – scared of the apartheid days of censorship - but it is not about that. No wonder we are in the state we are in.

Q: If girls are in a position to negotiate a transaction for sex, why do they not see themselves able to negotiate condom use?

A: These women who conceive of themselves as active agents are not in charge, they are not ultimately in charge! It is the man. And the bottom line is if he has given her a gift of value, then even if she doesn't want to wear a condom she has to. She may have some power, in terms of saying yes or no to the relationship, but not otherwise.

Some participants discussing in small groups

Three: Additional Discussion

Group and Individual Reflections

The approach to HIV
What should be the approach of the church – ABC or SAVE?
ABC is good; it is about playing it safe and focuses on prevention.
SAVE is comprehensive, relevant, communal and gives options, and promotes action.
ABC is individualistic; you can hide behind ABC and not go for a test.

Information and Training
The church must spread information.

Can the church promote the disease as manageable and treatable? We need to get more training to those doing community basics, so that when they are delivering to communities they can give as much.

Prevention programmes must be linked to basic care.

Gender Issues
Male dominance and patriarchy – how do we change this so women are more involved in decisions?

How can we as the church respect the gendered nature of our Godly creation? God gave us freedom – men and female. Today, can we say we know how to respect male and female when it comes to sexuality?

How best can we promote and foster the value of sex within marriage? It is a sensitive issue but I also feel we need to take courage and address it. One of the ways I think we need to address it is to find out why people within marriages feel it is boring. And this is where cultural issues come in, and we can learn from them.

The Media
I am surprised that in all the presentations, the media and globalisation of the media is not mentioned. It seems that all we see on TV is violence and the media seems to suggest that if I am the good guy I can do whatever I want. And we know that every bad guy thinks they are a good guy. eTV is one channel that promotes multiple partners and promiscuity.

Care for children
What care is needed for vulnerable children? My concern is that the church has been silent and children have not had a place in the HIV debate. I work with orphaned and vulnerable children. One of issues we grapple with is the psycho social consequences of being orphaned – for those children and their elderly caregivers. Research has shown that there is no structure, no discipline, and caregivers are just too exhausted to deal with the teenagers. We

need to think about how we can help and support with setting boundaries, and with giving the psychological support needed.

The church's response to people who are positive
Ds Greyling shared how he received support because he contracted the virus 'innocently'. Instead of asking: 'How did you get it?' we should be asking, 'How can we help you?'

If we want to make the church a welcoming place of healing, we have to involve HIV positive congregants and make them part of the process.

Bringing back family values
Church communities: how can we as church communities bring back family values and create things that families can look on as of value, and teach this?

Family breakdown and migrancy is not just about poor people. If we look at modern families, how many of us are away from home a lot, and what impact does this have on families? What can the church do about that?

Talking about sex
We need to talk openly about sex.

We need to lobby local government on condoms.

We must encourage parents and schools to work together. For example, information given to children at schools needs to be good information.

As the community we must make sure that what is happening in church is also spread in communities. Sex education is important but complex. We should not be afraid to speak about sex.

To notify or not

For….
Should HIV be a notifiable disease? And to what extent does a third to a half of pregnant women override the need to be silent? In other words, the best needs of society override the best needs of individuals?

Making HIV a notifiable disease does not mean you have to compromise someone's privilege (that is a red herring in the argument).

What is a notifiable disease? It simply means that the disease is then picked up and that statistic is put in for statistical purposes.

Even as church and pastors we can make it notifiable in our parishes through, for example, not agreeing to marry a couple until they know each others' status.

Against…
I'm getting stomach cramps at this discussion about notifiable diseases. It takes me six/eight years back when government did try to make it a notifiable disease and it was at this time we

saw an increase of stigmatisation. Gugu Dlamini was stoned to death because of disclosure.

I want to support my brother about this issue of notifiability. HIV is not a disease. It is a virus. The discussion around James 2 reading: if you know you are positive and don't use protection, is that criminal or is that murder? This is something we need to think about.

Personal Reflections: What would Jesus be telling us to do?

The thought that came to my mind was 'the God of so many different kinds of people.' It struck me that what we are being told about behaviour patterns are ones which exclude God very much. What is going on in our country where 80% of people claim to be Christian, and yet people are behaving contrary to this? This led me to the conclusion that it is the relativism, the individualism, the absence of God. And to do anything to reverse it, we have to read the signs of the times and start plotting the way forward; and that is through looking at the basic teachings of the gospel. If we are to do anything as the church it is to put the law of God above human law (The Constitution); and to present a new value of human dignity and of a person, and how to enhance respect for that person.

When we talk of spirituality and theological reflections, we should remember what happened during the enlightenment period - how the church was challenged to move with scientific discourse in being practical; to engage with communities facing socio-economic and political challenges. HIV and AIDS is one challenge that will move us as a church from piety to scientific or rational ways of responding. We cannot use the excuse of being the church and deliberating on issues while people are dying. I say this because it pains me personally because the same pastors who say they are so overloaded with work, burying people all the time, take it so lightly when we deal with prevention. We are good on care, but not prevention. Speakers have spoken with elegance and pointed that these issues are scientific, not spiritual in nature. But some of us will go back and take nothing back, and carry on doing the same thing. I'm aware it is an overwhelming challenge, and some of us feel it is too big. Mother Theresa said, 'We can never do great things, but small things with great love.' This means that even if everyone else is not interested, including my priest and superior, I will start doing things, even if I'm on my own. And when I look back I will find peace and say, 'God, I did. I didn't do much but I did a little with great love and compassion.'

There is an overwhelming call to integrity. An uncompromising, even self-alienating stance: the call to be a man, a leader and role model; to demonstrate and live an abundant life; to bear the cost of calling things what they are; and to lose that professional carriage in order to engage; to move from a clergy attitude to engage the pandemic by looking into the eyes and holding the hands of those suffering - as father, leader, man of God, friend of God – to integrity.

There are three things I think God was saying to me:
This summit: we need to network with one another and be one;
The church: we must teach and lead by example;
Personally: Jesus is saying come, drink of the living water.

There is hope. In the summit we were bombarded by statistics which at times were scary, and we can lose hope. And I'm not talking about false hope, but sustainable and real hope based on the fact that one is not alone. There is God and there are sisters and brothers and there is relevant information and the lack thereof. God is saying to me and the summit that this battle will be won, but it needs us to take up our arms and restore the lost hope amongst the communities we serve.

For me it's the Luke 5 passage where the man seeks healing from leprosy and asks, 'Are you willing?' and Jesus says, 'I am willing.' And this should be our response; it is about our will to do and, like what Professor Coovadia said, we have imagination. And if we say we can't respond, then we don't have imagination.

Dear God
Here I sit on this green grass wondering if you hear me – crying for help.
Help me destroy the power of Ingculaza.

Ngculaza!!
Bakubiza ngamagama amaninzi
Abanye bathi uNgumashayabhuqe
Bambi bathi unguHlengiwe Ivy Vilakazi
Ingaba elona gama lakho leliphi?
Usibulele isizwe gqogqequqa nqwelo yokugoduka?
Sakwenzani lento ungenalo uvelwano nje.
Ivaliwe imizi ngenxa yakho mbulali ndini
Iinkedama zigcwele yonke indawo azinabani oziwolayo
Awu! Awunalo usizi.

Nabo abantu bakaNkulunkulu bahlanganise iintloko
Bafuna ikhambi lokukutyumza intloko
Unako na wena ukuba namandla okumelana nabo?
Bawo wethu sisebunzimeni silwa nesifo esibhuqa isizwe sakho.
Ingaba wena uphi na siphela nje?
Uphelile umhlaba wamangcwaba ngenxa yakho
Ngculaza ndini.

Wawuvelaphi we maqotha ilitye nembokodwa
Ukuba ndinganawo amehlo okukubona
Ndingakubamba ngezizam izandla ndikucudise
Kancane kancane ude ufe.

Usehluthe izihlobo zethu esizithandayo
Wathatha abantwana bethu
Awabashiya nabazukulu bethu wahamba nabo
Ukhukhulise wonke umntu osendleleni yakho
Akukhethanga sityebi nahlwempu
Nditsho nekholwa imbala
Hamba mthakathi ndini buyela kwelakini
Ungaphinde ubuye

Bonyawontle hlanganani nenze iketango
Nithethe ngengculaza ayinamandla
Qubulani izikhali zenu nihlabe ngamandla
Ncincilili!!

By: Nomsa Ntsalu (United Methodist Church)

(Translation: The poem is a lament against the indiscriminate ravages of HIV and AIDS, calling on God to help the nation and reflecting on the effects of the disease, especially on children left as orphans and those taken from us. It calls on those left behind to fight united against the disease.)

There was a conversation I was part of during tea and I want to report on that because it left a deep impression. Professor Coovadia said that the measure of a country is the mortality of under-five year olds. Ours is 70 per 1 000 which is a very bad record. Our methods haven't been working and we've been told by Professor Leclerc-Madlala that this won't be sustainable. For me, all black men grew up in culture where there was a method of guiding and controlling. But we have only heard one voice from an under 25. In this conversation the thought came up that in the coming of Christianity, the cultural ways were put aside as they were thought to be heathen. But the solutions we have had, have not worked. What about the African solutions? There seems to be something in African culture that we can be drawn to. What is Africa saying about its own solutions? And what are the young people saying?

What are we as the church saying about an under-age person being able to have an abortion? This is an issue of statutory rape. So where do we come in as the church? Is crime a crime when it is reported or when it is committed?

One of my biggest critiques of foreign policy is the inability to understand the wider dynamics of the world. I pray for change of leadership. We heard in the first lecture how important public policy is; and have heard throughout the summit the importance of holding our leadership accountable for their policies. We look at the decisions made in Polokwane, especially with the rise to power of the next president. If we look at all the dynamics – male, female, age, condoms not used, concurrent partners, etc, the next leader of South Africa represents them all! Is the church speaking to holding the leaders of the country accountable for the biggest problem we are facing?

The church has to play a great role because it is the place of hope. Jesus asked his disciples, 'Do you want to turn back?' and Peter asked, 'To whom shall we turn?' and Jesus replied, 'We turn, sometimes to the person we know and trust and who cares.' The church is the place in which people have trust and the Church should show that care and compassion as Jesus did. The church should try by all means to reach into all these corners and reach all those in need.

When I read Mathew 5:24, Jesus said, 'I am the light of the world. A person does not hide a light under the table, but puts it on top for all to see. You are the light of the world. Your light shines to all people so they will glorify God.' Now when I look at churches, they are all agreeing with the laws of Mandela. Children are not beaten. Our people used to share the law and they used to fear the law of the parents, but they don't anymore. And churches have become reluctant to use the law because they fear Mandela's law. There is no Sunday School anymore because children go wherever they want to; we really need to bring back the culture

of Sunday School. When they come home from school they need to do chores. Someone must teach them games and their minds will change because all that has been done after chores, and they will have fun playing, and then come back and do homework. Those who have children – the young people – they are not controllable, they don't want to go to church; they spend their time visiting their partners and they don't have time to go to church. When I look at my Catholic neighbours they are a bit better because they try. When we bring our children to church and faith, we can turn around the teachings through faith. Also, parents have this simple answer when you ask what's happening. They say all kids are the same. It is important to pray together and preach together. We need to give each other chances to preach and teach in our different congregations because they don't want to listen to those that are preaching all the time. Let us go back to Jesus' ways. Let Jesus' love shine though and deal with HIV.

Jesus would be telling us that we should never get tired along the way. We know that AIDS is a killer disease and we know this is not the first time people get together to come up with solutions. We fail to come up with solutions because we got tired along the way. We now need to hold our hands together and join them like a chain – one that is unbreakable - and take AIDS to the middle. And since it is a killer disease, we don't have to nurse it or massage it. All we need to do is take it into the middle and kill it! But I don't have the answer.

Jesus would say the church needs to be an open door to all people – gays, lesbian, etc. We need to preach the gospel of love and hope and the love of Christ – not by sermons but by the way we live.

Regarding the issue of getting tired along the way, just as God molded us, He knows our strengths and weaknesses, and we are broken down. And for renewed strength we must ask Him to help.

Denominational Commitments

Evangelical Lutheran Church of Southern Africa
and
Evangelical Lutheran Church of Southern Africa (NT)

We felt there was a need for a reformation so we thought we would start with the Lutheran 'Reformation' Plan

- Reporting:
  We need to report to all leadership at all structures – the leagues and ministries, in addition to leaders, to ensure that it gets down to congregations so that they will motivate churches as well to do something about the pandemic.
- Analysis
  We must gather information about what is going on in congregations, nationally and in our circuits, regarding HIV and AIDS work, formulate a database on progress and functionality of projects, and share this with the broader body through email and our website.
- Education
  Christian Education for Life through Sunday School, confirmation, marital

preparation, youth (junior, senior, young adults, family enrichment) promoting the importance of biblical foundations of the family. Our concern is how we can bring back the bible as the manual for life and we are currently busy with this as a church.

- Work on counseling programmes and establishing accountability groups.

Roman Catholic Church

We looked at different actions at different levels in the church, and as family is the centre, we will advocate for parishes to hold family congresses to check for the root causes of the problems and restore values that have been eroded.

- Analyse the state of the family.
- Search out root causes.
- Plan to restore the family (care, unity, dialogue, prayer and spirituality) .

Youth formation is where we have something going on but we want to strengthen it through:

- Identifying role models – either living at present, or saints - and we can draw inspiration from that.
- Highlighting the preciousness of the body as the temple of the Lord as created in His image.
- Inculcating self-esteem and self-image so they can appreciate and know others.
- Motivating for behaviour change from within, using values as a guideline.
- Encouraging youth to develop, see, judge and act appropriately. This can be done by Education for Life, Leadership Skills, Life Teen (some work is currently being done) and parish and school outreach visits to poor areas and hospices for exposure.

For adolescents, we need to look at catechism and provide education at their level around theology of the body – created by Pope John Paul – looking at theological significance of the body.

Virginity testing has had some good feedback. There are girls saying they want it so that boys can respect them. So we need to do something similar for boys, teaching them respect for the body.

Priests, deacons and pastors have already been surveyed and this revealed a lot. Some were very aware and others had weird ideas. For example, one said that it was punishment from God. We need to expose students to principles of community development with prevention strategies as a component of this. In this way they can respond appropriately in dealing with community.

We must encourage parish priests to run workshops on how to access resources for projects.

With bishops and leadership we need to:

- ensure the Catholic Archdiocese of Durban AIDS Care Commission (CADACC) keeps in touch with projects.
- ensure they keep themselves informed in order to give direction and support.

Question from the floor in response to the Roman Catholic input

Q: If there is a strategy to look at the family from a new perspective, what about those that don't conform to the idea of a normal family?

A: We believe, when talking about families, we are including those that don't fit. Whilst unmarried mothers cannot participate fully in the life of the church, we have to find a way of including families that are divorced, maybe through their children. We would want it to be open to all.

Methodist Church of Southern Africa

Revival
We have a structure and are talking about reviving what is there - the youth. They feel that parents don't talk to them about sex and so we want to work on this.

We commit to ensuring that:

- Clergy are informed and inspired.
- Promoting the alternative family as a loving relationship regardless of who makes up that family.
- Reviving the heritage of John Wesley who started this - redefining youth (some youth meetings are dictated by people over 30) and creating space for those between 14 and 25.

So the question is how do we do this?

The Plan
Having programmes according to age groups
Target: District retreat in August (annual event)
Youth in September
Youth Synod that includes all cultures
Mixed group – local society
Gender groups
Children

Men are involved in community and are even taking leadership, and we need to get involved here where men are in leadership positions

African Methodist Episcopal Church

HIV and AIDS should be dealt with by auxiliaries in churches, for example Women's Missionary Society - and young people's programmes. These departments must be given a chance and a listening ear because they are the future mothers and fathers and leaders of the church.

The church must take a stand in leading its people to the right 'balm'. People should be given the correct information concerning HIV and AIDS and care of the sick. The church must take its position as the church and not be led by government.

We must be a listening church and be willing to render a service to the people of God with

compassion. As the church we should accommodate cultural practices which are helpful and forget those which destroy people's beliefs. As a Xhosa man, I have my tradition; as a Tswana man you have yours, etc. We shouldn't do away with that but the church should work side by side with that in a selective manner. We should promote helpful cultural practices and do away with unhelpful ones.

United Presbyterian Church of South Africa

We have several documents that deal with our approach, but they make assumptions not stated in them, and we need to address this. The bottom line is maturity in Christ - discipleship. We must build families in Christ to address issues of sexuality and morality; and the information must go down and up and be spread and shared.

We need to do capacity building around our structures and how we arrange ourselves. This includes economic empowerment, awareness campaigns, treatment, care and prevention.

What we are taking from this summit into our strategies:

- Recognise the powerful synergy of scriptural truth, scientific research and experience of community (good/bad) but we must be careful to pull from the good.
- Leadership development (and we realise that our fellow Zimbabweans and Zambians are not here, so we need to come together at a forum outside of the General Assembly so we can present it to the wider church.
- Networking/partnership
- Resource mobilisation

Anglican Church

We have programmes on HIV and AIDS. One of them is called *'Siyafundisa'* which involves peer education and life skills. It is run throughout Southern Africa, with a fieldworker in each Diocese. We have a life skills and peer education programme. We target ten parishes with each parish selecting two supervisors (young adults). We train them and they go back to their parishes and then select peer educators. From each parish we have minimum of nine peer educators – the big number is to ensure that, if they have to leave for schooling or any other reason, the programme continues.

We also have an Orphan and Vulnerable Children programme and an HIV and AIDS programme with an HIV coordinator in each diocese. The programmes are expected to work together and support each other.

As the Anglican Church we need to have a summit from time to time or else we are working in isolation.

United Apostolic Church

There is nothing happening in the church so this summit has been of huge benefit as we will go home and meet with leaders, and will have to start training youth, not working on our own, but using other churches and DCofC for support.

We also realise the importance of peer education.

SANERELA so far has focused on religious leaders, but sees the need to look at the issue of orphans: sometimes a parent dies and children don't only need information; they need to be taken care of. As churches we need to tackle it together. We need to come together more often and should be working closely with community-based and non-governmental organisations.

Another question we discussed is, 'Is the church doing enough about disabled people?' The disabled are neglected. People who are deaf, for example, can't come to such institutions. They need information, and are we accommodating them? Many are infected and some have many children. How do we involve them as the church?

United Congregational Church of Southern Africa

The United Congregation Church of Southern Africa spans five countries, including South Africa. For this process I am standing alone and this is indicative, perhaps, of the position I find myself in. Five others were invited and for the deliberations today, I am left alone. And I'm here to report on my own. At four o'clock this afternoon I will report to our Mission Council for the KZN region. As convener for the HIV desk in KZN, for four years I have been doing my work and presenting reports, and even there I find myself alone. No other clergy attend our Mission Council meetings. I am the only one. Month after month, the work carries on. And it is good work, not necessarily because of me, but because of the lay people doing the work. But there is neither criticism nor support from the clergy. I am uncomfortable standing here as I am not a member of the UCCSA. I am only sent to serve them.

And I think my action plan is simple. Starting at four today, and as long as I continue to serve the Congregational Church, will be to beg for leadership. And this is something we can all do. That is to beg for leadership. There is a lack in government, in churches, and at parish levels.

When I look at strategies, I have to deal with the weakness in the polity of our churches. There are many strengths but also weaknesses. And HIV hits the Congregationalists hardest in our polity – in that we don't have a hierarchy or authority within which to work. So I must question my church's polity and seek ways to maximise the strengths and exclude the weaknesses. The problem with HIV and AIDS is that leadership is needed and the polity in my church does not allow for leadership.

And I will also ask that we go against my church's polity and ask that training for every one of the ordained ministers is compulsory. I also want to talk with Sinikithemba and McCord's Hospital, about HBC training which includes medical and psychosocial training. And then I will pray that from that, leadership will emerge

Comments

I wish to express our support for Revd Couper in his plea. One of the strengths we can develop is networking where we can mutually support each other around our strengths.

I want you to know I commit you to my prayers and hope that with your report you will touch someone and make a difference.

United Methodist Church

We will:

- Go back home and form support groups as we have nothing about HIV and AIDS in our church.
- Run workshops to educate our church leaders and community (pastors, lay leaders, Women's Manyano, Men's Guild, Sunday School and youth).
- We will seek information and supply it.
- We have to train people for counseling so that work can be easier.
- We will seek incorporation of constitutional amendments for the incorporation of an HIV and AIDS committee.
- We will organise special events around HIV.

The HIV and AIDS Summit banner and theme

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INFORMATION: Art For Humanity

Fern Girdlestone from Art for Humanity was given an opportunity to speak to the Summit delegates about the organisation. Various art works were on display around the issue of HIV and AIDS.

In 1988 Art for Humanity had its origins as an ad hoc committee named Artists for Human Rights. The main objective was to promote a culture of human rights through art. It was a time in South African history dominated by growing isolation from the global community. It was a divided and violent society in the grip of a state of emergency. No one could foresee the momentous changes that would affect the cultural and political landscape during the 1990's as South Africa moved towards democracy.

Art for Humanity (AFH) advocates and promotes human rights through art. HIV and AIDS are emotional and personal topics and AFH uses art as a springboard for discussion. Artists donate their material and AFH packages these into educational material.
It is based at the Durban University of Technology (DUT) at the Durban City Campus.

AFH has many international organisations as partners. They believe that where there is a strong culture of art/fine arts, people are less likely to use violence. They welcome collaboration with other organisations and individuals. Contact Fern at 084 500 4091.

INFORMATION: Centre for HIV/AIDS Networking (HIVAN)

Debbie Heustice shared the following information:

She runs a program called HIV 911. They are committed to providing information on where HIV services are around the country. Information is provided for all – from government to churches, to organisations and individuals who can help people connect with one another. People can use this information to connect, to support each other, to check if someone else is doing the same thing etc.

Delegates could access this information through hardcopy directories, copies of which could be found in conference bags

HIVAN runs forums – mainly in Durban – that are free of charge and bring people together to share, learn and network, and to unpack research and good practice.

She suggested people start libraries in their churches using what was in the conference bags as a starting point. Material could be requested free of charge as well.

She also suggested people start coffee clubs in their churches and invite people to sit and talk, if they wanted, about HIV and AIDS.

Around the issue of HIV being notifiable, she shared the following: Statistics go on a monthly basis to the Department of Health. These don't say who the person is and Government is constantly looking at ways to improve this. The challenge is for people like us to get that information because it is not always readily available.

Further information on HIVAN can be obtained through the website: www.hiv911.org.za or calling 0860448911 (HIV911).