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REPORT PREPARED FOR THE WORLD COUNCIL OF CHURCHES ECUMENICAL HIV/AIDS INITIATIVE IN AFRICA

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Mapping Study

RESPONSES OF THE CHURCHES TO HIV and AIDS IN SOUTH AFRICA

**REPORT PREPARED FOR
THE WORLD COUNCIL OF CHURCHES
ECUMENICAL HIV/AIDS INITIATIVE IN AFRICA**

DR. SUE PARRY

January 2005

RESPONSES OF THE CHURCHES TO HIV AND AIDS IN SOUTH AFRICA

Introduction

South Africa is a vast, beautiful country of 45 million people. It is divided into nine Provinces, each as diverse as the other and, as such, is like nine different countries in one. First world and third world live alongside each other. It is a land with a turbulent political history and its resources are immense.

The purpose of this study, initiated by the World Council of Churches Ecumenical HIV/AIDS Initiative in Africa, is to review the responses of the Churches to HIV and AIDS in South Africa, within the context of the country and its peoples.

The study was carried out over the Christmas period of 2004 and in early January 2005. The time limitation meant that the usual data collection techniques could not be applied and the information was thus derived from literature reviews, Internet searches, and in- depth consultations with key stakeholders throughout the country.

It was not possible to meet with representatives from *all* the denominations and faith-based organisations, nor to be able to describe all the many and varied programmes that are in existence and operational in so many different circumstances. Many of the initiators of these projects and programmes did not wait for funding in order to begin, they just responded. This is humbling, and a reflection of true compassion and love in the face of suffering.

The long history of oppression and suppression has left its scars on the nation and, just when the country was emerging into a new democracy, it was 'ambushed' by the arrival of HIV and AIDS: a new challenge which has seemed too much on top of everything else that had gone before. It is as though the nation has said: 'No!' and this denial has delayed action by many years. The seroprevalence is very high: South Africa has the most infected population in the world, but it also has more resources and capability to deal with it than most other countries in Africa.

Churches have credibility and the respect of the people of South Africa, particularly because of their often-heroic stand against apartheid, and are well placed to deal with so many of the complexities presented by HIV and AIDS in this society. It will however take extraordinary commitment, strong leadership and courageous vision to make the leap from the current piecemeal approaches to AIDS to the dynamic coordinated requirements of a truly effective response, which will curtail and mitigate against HIV and AIDS, and its devastating impact on the lives of individuals, families, communities and the nation as a whole.

Whilst every attempt was made, within the time constraint of this study, to ensure the accuracy of the information reflected, any errors or inadequate representation of Churches, or their programmes, is sincerely regretted.

Dr. Sue Parry
January 2005

Mapping study:

RESPONSES OF CHURCHES TO HIV/AIDS
in
SOUTH AFRICA

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Responses of Churches to HIV and AIDS in South Africa

'AIDS is an extraordinary kind of crisis. To stand any chance of effectively responding to the epidemic we have to treat it as both an emergency and a long-term development issue. The AIDS epidemic is exceptional; it requires an exceptional response that remains flexible, creative, energetic and vigilant.'
2004 Report on the Global AIDS epidemic UNAIDS.

1. GENERAL AND EPIDEMIOLOGICAL DATA

1.1 General data on South Africa:

1.1.1 South Africa – Country Profile

South Africa is a country of stunning variety and has been aptly described as 'A World in One Country.' It is the tenth largest country in Africa covering an area over a million square kilometres. It borders Namibia, Botswana, Zimbabwe, Mozambique and both Swaziland and Lesotho are entirely surrounded by South Africa. In addition, it has a very long costal line with both the Indian Ocean and the Atlantic Ocean.

The country is divided into nine administrative Provinces: the Northern Province; Mpumalanga, Gauteng; North West; Free State; KwaZulu-Natal; Eastern Cape; Northern Cape and Western Cape.

The capital city is Pretoria and the largest cities are Johannesburg, Cape Town, Durban, Pretoria, Bloemfontein and Port Elizabeth. Johannesburg is the world's largest city which was not built alongside a river course or the sea. It grew in response to the find of gold and diamonds.

1.1.2 People

South Africa has an official population of over 45 million people (45,214,000) (UNPOP 2004) with an annual population growth rate of 1.5%. 56.7% of the population are in urban areas.

The population is made up of a mixture of races. 75% are black; 13% are whites; 3% are of Asian origin; and others of mixed racial heritage account for about 9%.¹

There are 11 official languages in South Africa, including English, Zulu, Xhosa and Afrikaans, and many dialects.

1.1.3 Background: History of South Africa

1488 ...Portuguese ships first rounded Africa.

1652....1st European Settlement.

1815....Cape colonised by Britain. Northern movement of Voortrekkers.

1839....Natal taken over by Britain.

¹ Steve Berry Sept. 2004

1886....Discovery of Gold in Transvaal
 1889....Outbreak of Anglo\Boer war : Britain razed Boer farms and detained Boers in concentration camps where measles, dysentery and starvation claimed the lives of 30000 Boers and 15000 Africans.
 1902....Boers surrendered and Transvaal and OFS fell under British colonial rule.
 1910....Union of South Africa formed
 1920....ANC formed
 1945....United Party talked about limited integration. Nationalist Party reacted with the philosophy of 'separateness'.
 1948....N.P. elected and government passed a series of bills enforcing apartheid.
 1955....ANC. adopted the Freedom Charter.
 1959 ...PAC, radical Africanist group split from ANC.
 21st March 1960... Sharpville protest....69 killed. State of emergency declared
 ANC and PAC banned. Start of violent resistance campaign.
 1963....Mandela and others sentenced to life imprisonment.
 16th June 1976 start of Soweto riots.
 1977...death of Black Consciousness leader ,Steve Biko.
 1983...Conservative Party split from NP. Period of intense tactics to destabilize black resistance –house -arrests , bannings , censorship ,political detentions and excessive violence.
 1989...F.W.de Klerk elected NP leader.
 1990...de Klerk broke decisively from the past. He lifted bans on ANC, PAC and 20 other organisations and unconditionally released Nelson Mandela. Atmosphere of growing political and criminal violence. Negotiations between NP, ANC and Inkatha Freedom Party.
 1993 ...ANC and NP agree on 5 year Govt. of national unity.
 Chris Hani assassinated.
 Civil war was an ever- present threat.
 1994 ...first all party elections. ANC won 62%; NP 20% and Inkatha 10%.
 Nelson Mandela elected as 1st Black President of South Africa.
 de Klerk: Vice president.

TRUTH and RECONCILIATION COMMISSION....
 THE RAINBOW NATION....
 THE ERA OF HIV and AIDS....

South Africa has little desire to learn from the experience of others, especially in Africa

It has an excellent Constitution developed through a most participatory process. The absence of an effective opposition party, however, is not a healthy state of affairs in any democracy.

1.1.4 Economy

The strengthened Rand is giving financial problems to NGOs who are funded in USA dollars. There has been a drop in value by 30%, in real terms, during the last 2 years. This has a negative impact on the budget of NGOs and thus their ability to deliver services as planned.

1.1.5 Profile of Human Development:

1.1.5.1 Health

Life expectancy at birth: 50.7 years (WHO Report 2004)

Mortality rates:

Infant (0-1) per 1000 live births:	52	(UNICEF 2004)
Under 5 years per 1000 live births:	65	(UNICEF 2004)
Maternal per 100,000 live births:	239	(UNFPA 2003)

Health expenditure (US\$ per capita) 663 (UNDP 2003)

Physicians per 100,000 people 443 (UNDP 2003)

%Births attended by skilled health staff 84% (UNDP 2003)

Malaria cases per 100 000 143 (UNDP 2003)

Prevalence of malnutrition (ages 0-5) 12% (UNICEF 2004)

Access to essential drugs 80 – 94% (UNDP 2003)

Immunization rates % 78 – 82 (UNICEF 2004)

1.1.5.2 Education

86% of the population is considered to be literate.

1.1.6 Uniqueness of South Africa, the Churches and HIV/AIDS

South Africa has a first world nation coexisting within a third world and this is reflected in the extremes of development and wealth of the nation. Historically the population was divided along racial lines. The economic divide reinforced the separation. The nation had a very long struggle against the rigidly enforced apartheid system and the scars will take a long time to heal.

The churches of South Africa also had congregations separated along racial lines, which was enforced by State laws during apartheid. Churches which challenged the State became beacons of hope to a people whose options of confrontation were severely limited. They also at times became places of refuge, for example: St. George's Cathedral in Cape Town frequently 'hosted' demonstrations on their steps and the demonstrators took refuge within the Cathedral when State security agents intervened or sought to break up the demonstrations.

Within Church leadership there were some courageous giants such as Bishop Desmond Tutu, Beers Naude and many others, who stood with the people, were arrested for their actions and even died for their principles. Yet even within the Church, there was a great divide for example: the Calvinists were a branch of the Sinyale Reformed Church who, early on in the apartheid days, wanted to confront the State system. The Sinyale, who represented the people of mixed race, were not ready for the changes suggested by the Calvinists. The Calvinists were considered to

be ‘communists,’ ostracised from their Mother Church and suffered ‘as communists’ under apartheid (at risk of being arrested when more than 5 were present at a communion service).

The end of apartheid came in 1994 and a large number of Church leadership, who had played a significant role in confronting apartheid, found placements within the new Government system. This left many Churches bereft of key leadership, academia and direction.

For the first 5 years of democracy (1994 – 1999) the focus of the new Government was on:

- *Truth and national reconciliation:* the Truth and Reconciliation Commission process ‘was an amazing sacrament of hope and reconciliation. It left it to the South Africans to take the next steps in the journey.’²
- *Unity:* the symbolism of the ‘Rainbow Nation’ became an important crutch in the process of acceptance and the initiation of building community
- *Reconstruction and turning the tide of poverty.*

HIV/AIDS was not considered a priority.

During the next 5 years (1999 – 2004) there was a strong denial over HIV and AIDS. This was manifested in the challenging of scientific theories, facts, evidence and the ‘poverty’ theory. Much time and valuable resources were lost during this time and levels of HIV seroprevalence soared largely unabated.

It was largely the result of the concerted action of a coalition of civil society activists, who led legal challenges against the government’s inertia in the face of HIV/AIDS, that public awareness was raised and the government was forced to respond more actively.

South Africa has now embarked on the largest comprehensive HIV/AIDS care, management and treatment plan ever attempted.

At the same time, churches were slow to respond, initially viewing HIV/AIDS as a medical problem and then as a moral and an ethical dilemma. It failed to recognise the impending magnitude of the epidemic and the cross cutting issues whereby HIV and AIDS became issues of justice requiring an appropriate response beyond acts of ‘charity.’ In the process, in many instances, the Church contributed to stigma, driving HIV/AIDS issues ‘underground’ and silencing both the infected and the affected, whereby Churches failed to become places of refuge and solace but places of exclusion to those ‘out there’ suffering the consequences of their sins.

² TEASA News July & August 2004

1.2 Epidemiological Data

1.2.1 The HIV/AIDS Epidemic in South Africa

Chronology

1982

The first reported cases of AIDS in South Africa were of two homosexual men in Johannesburg who died of the disease in 1983. The largest impact was initially seen in minority groups such as the IV drug users, prostitutes and gay men.

In the mid-80s, several migrant workers tested HIV positive. By 1989 it was clear that the AIDS epidemic was mainly heterosexually transmitted in South Africa.

1985: an AIDS Advisory Group was appointed.

1990: By 1990 there were more than 600 reported cases of AIDS, 270 reported AIDS related deaths and 0.76% of pregnant women confirmed to be HIV+.

In **1991** the number of heterosexually contracted infections equalled the number homosexually contracted. It is thought that the main transport routes of Africa were responsible for bringing the virus through the liaisons between truck drivers and commercial sex workers along the routes.

1992: Nelson Mandela addressed the newly formed National AIDS Convention of South Africa (NACOSA), this represented the first government response to HIV/AIDS.

In **1993** the National Health Department reported a 60% increase in recorded HIV infections over the previous 2 years

However, these figures went largely unnoticed, as all attention seemed focused on the political landscape at the time.

In **1994**, the year of South Africa's first democratic election, the number of HIV+ people was estimated to be between 300 000 and 750 000 which equated to 7.5% of the adult population being infected.

In **1996** the prevalence rate was now estimated to be 14.2% based on antenatal tests. The International Conference for People living with HIV and AIDS was held for the first time in Africa.

1997, when the prevalence rate at antenatal testing sites was 17%, a national review of South Africa's response found there was need for political leadership.³

In **1998** the prevalence rate was now 22.8% (antenatal testing). A pressure group of civil society activists, called Treatment Action Campaign (TAC), was formed to

³ HIV&AIDS in South Africa Steve Berry Avert.org

advocate for the rights of people living with HIV and AIDS and to demand a national treatment plan for those infected.

Thabo Mbeki, the Vice-President, launched the 'Partnership Against AIDS,' calling for an end to the discrimination against people living with HIV/AIDS. He also admitted that 1500 infections were occurring every day.

Gugu Dlamini, a health worker and AIDS activist, made her HIV status public on World AIDS Day, and was stoned to death by a mob, which included her own neighbours.

1999 'loveLife' campaign was launched: a national media campaign targeting 12 – 17 year olds was launched.

2000: Justice Edwin Cameron of the South African Courts announced his HIV+ status.

By the year **2000** AIDS had become the biggest single cause of death in South Africa.

Based on antenatal surveys, the seroprevalence was 24.5%. At the International AIDS Conference in Durban, President Thabo Mbeki declared that AIDS was a disease caused by poverty, not by HIV. He established a group who were charged with solving the country's AIDS problems. This group included controversial HIV thinkers who purport that anti-AIDS drugs, such as AZT, actually cause AIDS, and that lifestyle choices such as homosexuality or drug addiction can cause AIDS.⁴ Valuable time was lost whilst studies were undertaken to establish the cause of AIDS.

2001, with a prevalence rate of 24.8%, largely as the result of pressure and court cases led by TAC, South Africa's High Court ordered the government to make Nevirapine available to pregnant mothers to prevent HIV transmission to the babies.. Despite international drug companies offering free or cheap drugs, the Ministry of Health still refused to provide these drugs on a large scale.

In **2003** overall prevalence rates among pregnant women was 27.9%.

TAC activists embarked on a campaign of civil disobedience and demonstrations to try to expose the government's failure to act. Charges of culpable homicide were pressed against the Minister of Health and the Minister of Trade and Industry, accusing them of the responsibility of the deaths of 600 HIV+ people per day in South Africa denied access to antiretroviral drugs.

By the end of 2003, an estimated 5.3 million (4.5 – 6.2 million) people were living with HIV, 2.9 million of them women: these figures represent the country with the highest number of people living with HIV in the world to-date.

Analysis of South Africa's death registration data shows a rise in the total number of adult deaths in the past 6 years – an increase of more than 40% and, in the case of women aged 20-49years, an increase of more than 150% once population growth

⁴ Steve Berry, September 2004

and possible improvement in death registrations are taken into account (Bradshaw 2004).⁵

South Africa

1999: approximately one-sixth of all infected Sub Saharan people were South African (4.7 million)

2002: number infected in South Africa risen to 5.3 million

2012: anticipated number of infections: 6 – 7.5 million

1500 – 2000 new infections every day

More than 600 AIDS related deaths every day

One third of all adult deaths are attributed to AIDS

8000 babies are born to infected mothers every month

If nothing changes before 2010, it is estimated that 50% of all current 15 year olds will not live to see their 25th birthday

Prevalence of HIV/AIDS

Estimated number of PLWHA (Adults & children end 2003): 5,300,000

Adults aged 15 – 49 : 5,100,000

Women 15 – 49 : 2,900,000

Children 0 – 14 : 230,000

Orphans 0 – 17 living end 2003 : 1,100,000

HIV prevalence % in young pregnant women (15 – 24) : 24%

By race:

Black South Africans are the most affected. Infection rate among white and people of colour are very similar whilst the lowest infection rate is amongst South African Indians and Asians.

By Gender and Age:

In South Africa, women (15 – 49 years) have the highest incidence of HIV/AIDS: 17.7% compared to 12.8% men.

Women are the most vulnerable to infection, regardless of race.

In the age group 15 – 19 years:

- 16% of Black girls are HIV+ compared to 6% of Black boys
- 1% of White girls are infected compared to 0.3% of boys
- 2% of Indian girls are HIV+ compared to 0.3% of Indian boys (Dr Lebo Moletsane 2003)

⁵ Bradshaw D et al (2004). Unabated rise in number of adult deaths in South Africa. *South African Medical Journal*, 94(2):125-130

There is an alarming increase in HIV incidence among children aged 0 –14 years (Mandela Foundation/HSRC 2003). As only 25% of these cases can be seen as related to Mother to Child transmission, and excluding possible health service acquired infections, it raises serious concerns as to the increase in the levels of sexual abuse towards children and premature sexual activity.

By Province:

Based on HIV antenatal prevalence (2000):

Western Cape	8.7%
Eastern Cape	20.2%
Northern Cape	11.2%
Free State	27.9%
KwaZulu-Natal	36.2%
Gauteng	29.4%
Mpumalanga	29.7%
Northern Province	13.2%
North-West Province	22.9%
South Africa (2000)	24.5%

Of the 9 Provinces in South Africa, KwaZulu Natal has the highest incidence: 36.2%. Possible contributing factors are:

- The highest population density of all the Provinces
- Durban represents a major shipping port in the country
- Large migrant labour population
- The second poorest Province
- A major transport thoroughfare
- Possibly the epidemic is more mature in this Province

1.2.2 Determinants to the Spread of HIV/AIDS

• Morality of Family and Society

‘The conventional morality relating to the family, piously upheld by the state, by its religious institutions, by its laws and its code of ethics, remains largely unrelated to the reality of many families who are homeless, jobless and without any opportunity for advancement. This has led to such phenomenon as children living on the streets, rampant crime, teenage pregnancy, alcohol and substance abuse, dissolution of marriages and relationships, as well as mental health related problems (depression, suicide, family murders) as members of families collapse under the effort to survive. These effects are not exclusive to one cultural or racial group.’

B. Mbambo & R.Phiyega *Home Truths we must all face. Children First Vol. 8 No 58 2004.*

• Tuberculosis and HIV/AIDS

Closely linked to the HIV/AIDS epidemic is a tuberculosis epidemic which is fuelled by HIV infection, and which is also the most frequent cause of death

amongst people living with HIV. 40-50% of TB patients are also infected with HIV. In some hospitals in South Africa, the HIV prevalence in TB patients has been recorded as over 70%.⁶

- **Sexually Transmitted Diseases**

There are approximately 11 million STD episodes treated annually in South Africa, with approximately 5million of these managed by private practitioners.

Wilkinson et al (1999) estimated that 25% of women on rural KwaZulu-Natal have at least episode of an STD. According to the South African Demographic and Health Survey 1999, about 12% of men reported having suffered an STD in the previous three months.

Levels of STD treatment, particularly for women, are low.

There is compelling evidence of the importance of STDs as a major determinant of HIV transmission.

- **Poverty and Inequality**

Some 70% of South African children are classified as living in poverty, according to household income indicators.

Inequality is tied to access to services and although progress has been made, the country is pervaded by enormous inequities.

- **Culture and Gender**

Virginity testing has re-emerged in many areas of the country.

Women and girls are particularly vulnerable to HIV/AIDS. Their vulnerability is due to:

- Biologically the risk of HIV-infection during unprotected vaginal intercourse is 2-4 times higher in women than men, and more so in younger females.
- The presence of an STI may not be evident in women, until it is very severe, and thus may remain untreated. STI facilitates the possibility of contracting HIV infection.
- A common practice is 'dry-sex' frequently demanded by men: this may make women more susceptible to vaginal trauma.
- Gender scripting that inculcates a subservient and subordinate role for girls and women to their male counterparts. Boys are raised believing in their dominant role over women. This creates an unbalanced power relationship. These cultural roles are formidably defended and the response: 'there is nothing I can do?' is very common from women.
- Women tend to have a lower educational status
- Economic dependence on men
- Widespread discrimination and inequalities.
- Difficulty in refusing or negotiating for safer sex can result in domestic violence and marital rape.
- Married women are said to be the group MOST vulnerable to HIV infection, contracting it within their marriage.

⁶ HIV/AIDS/ STD Strategic Plan for South Africa 2000-2005

- Society implicitly (and sometimes explicitly) condones the subordination of women, thus limiting their options to desperation measures such as prostitution as an economic survival strategy, particularly single women, and widows, with children to support.
- In many countries, including South Africa, there is the belief that having sex with a virgin (girl child) will cleanse an infected man of HIV/AIDS.
- There are increasing cases of cross-generational sex: the 'sugar-daddy syndrome.' At times this is perpetuated by the older man in the belief that young girls are unlikely to be HIV infected and thus pose no threat, and by the younger girl, for economic gain.
- Many African Independent Churches, Syncretic and traditional religions, which command a large adherence, do not have a clear stand on cultural practices, still widely practiced, that expose people to infection such as widow inheritance, sexual cleansing, genital mutilation and polygamy.
- Women frequently lack information, have insufficient access to HIV prevention services and there are a lack of female controlled HIV prevention methods, such as microbicides.

For boys:

- Initiation rites are widespread. These initiation rites are usually carried out in secret. The secrecy has increased as the number of casualties has drawn attention to the rites, leading to interference from law agencies to protect the children. Frequently the same circumcision knife is re-used, un-sterilized, on several clients.

'JOHANNESBURG, 25 January 2005 (PLUSNEWS) - South African authorities are considering the introduction of new courts in an effort to stamp out the practice of illegal ritual circumcisions that can leave young men dead, mutilated or at risk of HIV infection.

Reuters quoted health department spokesman Sizwe Kupelo as saying: "It [illegal circumcision] also contributes to HIV/AIDS. We had one man who had done 161 boys with the same instrument. By setting up these courts, we want to tackle traditional circumcision offenders head-on. We are talking to the justice department to see if it is possible."

Offenders who break the law could face up to 15 years in prison, but of the 60 arrested since 2002, only 25 have been convicted and some are still awaiting trial.

According to the Eastern Cape health department, more than 6,000 initiates have been admitted to provincial hospitals since 1995, with over 30 dying and 70 having to have their genitals amputated after complications or infections.'

[ENDS]

Men:

'One group of South Africans has been singled out over the years as both the perpetrators and the victims of the 'crimes' against the family – men. They are kept away from their families by migrant labour, they are despised for being absent fathers, condemned for being abusive when they are present- and largely ignored when it comes to seeking solutions.' Deborah Ewing

It is a neglected area of response.

- **Violence in the Society:**

In the recent years, much political emphasis has been placed on the rights of women, and the need for gender equality. However, South Africa remains a largely patriarchal society, in which women are vulnerable to sexual abuse. In 1998 South Africa had the highest per capita rate of reported rape in the world (116 for every 100.000 of the population), which are assumed to be only one tenth of the actual cases occurring but not reported. Rape Crisis Cape Town 2001 assumes that there are close to one million rape cases per year.

Marital rape is particularly under-reported, with many relationships characterised by violence and sexual abuse. Vundule et al (2001) found, in a study of black teenagers attending antenatal clinics in Cape Town, that 72% of girls reported having been forced to have sex at some stage, and 11% reported having been raped. The South African National Youth Survey (Kaiser Family Foundation 2001) also reported that 39% of sexually experienced girls have been forced to have sex, and 33% reported being afraid to say no to sex.

In many cases therefore, women have limited control over their sexual activity and are thus more vulnerable to HIV infection.⁷

Between April 2003 and March 2004, 15 857 cases of child rape (under 18 years) were reported.

43 children are raped *everyday*.

More than 700 children were murdered during 2003, the majority from KwaZulu Natal.

Less than 58% of cases were referred to the courts and a paltry 4.5% of rape cases resulted in successful convictions. Murder conviction rate is also only 13%. There is a huge backlog of cases awaiting hearings.

(Govt. Statistics reported in The Mercury 7/12/04)

“As much as there have been policy shifts, this shows that police and judiciary management simply have no control over the situation.” Sam Waterhouse: advocacy coordinator at Rape Crisis.

Migrant Labour

It is an accepted and well-known fact that migration, for whatever reason, increases the extent of sexual networking and thus facilitates the spread of HIV/AIDS. South Africa has a long history of various forms of migration, and more recently, has become the recipient of migrants and refugees from countries all over Africa.

In addition, under the new dispensation, with the abolishment of the notorious pass-laws, which restricted movement of people within the country, freedom of movement and association has become a reality. South Africa's road, railways and

⁷ AIDS, Public Policy and Child Well-Being: edited by Giovanni Andrea Cornia 2002

public transport system are of a high standard and this facilitates ease of movement to every part of the country.

- **Migration for employment in the mines**

South Africa's economy is principally based on its mineral reserves and it has some of the largest gold, diamond and platinum mines in the world, in addition to many other precious and semi-precious stones and minerals. The mines employ large numbers of workers from all over South Africa and, for many decades, from the surrounding countries: principally Zimbabwe, Mozambique, Zambia, Malawi and other countries further North. Renumeration on the Mines was higher than in most other manual labour-type jobs and hence attracted the necessary large labour force.

- **Economic migration**

Migrant labour has been the basis of a cheap labour system that has left deep scars. Part of the appeal of migrant labour, to both employers and the State, was that workers' families remained in rural areas. While men sent home some of their wages, their families also depended heavily on local resources for housing and subsistence. Many migrants who viewed urban areas as uncivilized, disease-ridden and dangerous places also saw migrancy as 'a necessary evil which had to be undertaken not only in order to pay taxes but also to secure the resources to marry, build a homestead, accumulate cattle and ultimately to allow for rural retirement.' (Delius 1996)⁸

The system of migrant labour was characterised by poor working conditions, occupational health risks, and over-crowded and unhygienic accommodation. The hostels were single sex hostels for men and the separation of families, economic vulnerability and bleak living conditions created an environment where sexually transmitted infections were commonplace.

South African draconian legislation ensured a state of permanent mobility through strict control of urban migration with influx-control laws.

- **Forced population migration** – historical political reality

The destabilisation of African families through migrancy, impoverishment and the destruction of communities, profoundly impacting on the integrity and resilience of households, must have seriously contributed to the spread of HIV/AIDS.

- **Political migration**

South Africa has experienced high levels of political and economic migration both within the country and into neighbouring States.

- **Migrant labour from elsewhere**

Migrant labourers from other states have been subject to the same conditions as their South African counterparts. Many of them come from regions with an already high HIV seroprevalence and may have either contributed or contracted HIV in the process.

Housing Crisis

⁸ Waiting to Happen: HIV/AIDS in South Africa: Walker, Reid & Cornell

In 1986, with the end of influx-control laws, informal settlements mushroomed around main towns. By the early 1990s, it was estimated that seven million people were living in these informal settlements. This rapid urbanisation did not lead to improved living conditions in cities. It was instead characterised by a period of intensified violence and social dislocation.⁹

Unemployment

Unemployment levels are high, in excess of 30% across the country.

Huge coastline and principle trade routes

South Africa has large a large shipping industry and its excellent infrastructure at its ports make it the transit country for trade from the rest of the world through South Africa to the rest of Africa. The presence of ports brings with it a thriving commercial sex-trade.

In addition, the rolling - stock (trains) and trucking industry is substantial, moving goods from Cape Town to as far a field as the Democratic Republic of the Congo and other countries in Africa. Long distance truck drivers are identified as high-risk groups.

Silence

There is still a strong denial about the existence of HIV/AIDS, and the beliefs that this disease is associated with witchcraft, Western plots, punishment for aberrant sexual behaviour and other similar notions.

Many Churches have kept quiet on issues of HIV/AIDS, perceiving it to be 'someone else's problem' and not their core responsibility or calling.

Stigma

Stigma is rife and, despite numerous protectionist laws now in place, being HIV+ can still very negatively affect employment and housing opportunities. Communities may not be supportive and in some cases, very hostile. The case of Gugu Dlamini bears testimony to this issue when she was beaten to death for revealing her status.

The African cultural notion of 'Ubuntu' is based on the understanding that: "I am because you are." This cultural precept underlies most of the relationship responses between people and extends to cultural obligations towards each other. Of interest is the fact that there is no real Zulu translation for the word 'stigma'; the closest is 'outsider.' Ubuntu does not apply to the 'outsider.'¹⁰

Refugees

South Africa is home to many refugees and illegal migrants, over 2 million from Zimbabwe and many from areas of conflict and war: the Democratic Republic of Congo, Rwanda, Burundi and other parts of Africa. Many of these are countries of high HIV positive seroprevalence.

⁹ as above

¹⁰ based on discussions with Daniela Grennrich: PACSA

Drugs and other substance abuse

Drugs, alcohol and other substance abuse are said to be on the increase in South Africa. This is a situation particularly worrisome for youth.

Post-independence problems:

Many citizens of countries in Africa, that were supportive of the South African's struggle against apartheid, now appear to have ready access to South Africa. This has resulted in large populations of Nigerians, Chinese, Liberians and other nations appearing in South Africa. Many have been associated with emerging crime problems such as drug trafficking, human (especially child) trafficking and the sex slave trade.

1.2.3 Impact of HIV/AIDS in South Africa

1.2.3.1 Social and Economic Impact of HIV/AIDS

Data on the extent of HIV/AIDS and its impact on the economy vary yet analysts agree that government and business need to take urgent action.

HIV/AIDS is estimated to be reducing South African growth rate by a minimum of 0.3 – 0.4% per annum. There is evidence that the economy will be impacted but by how much is difficult to quantify. APT Associates analysts reckon that AIDS will reduce the country's gross domestic product (GDP) by 17% by 2010 at an economic loss of US\$22 billion, whilst ABSA Bank financial analysts estimate the shrinkage will be 9.6% by 2015.

The country's labour surplus replacing lost workers conceals the impact, and drop in productivity is not all that noticeable – at this stage but in time, accumulated loss of GDP per capita will be large.

Gavin George, research fellow Health Economics and AIDS Research Division KZN: *'We will see a ripple effect:'*

Loss of young adults will result in a weakened tax base and this will lead to increased pressure on national finances. Government's ability to finance public expenditure, education and health, will be compromised and there will in addition be strains on the ability to provide social grants.

Food security

At the household level, in HIV infected households, food security is affected by reduced income and increased expenditure on health care, leaving little money available to purchase nutritious food.

At the national level, South Africa has a more mechanised agricultural system. Loss of labour has a ripple effect in terms of loss of expertise. For small-scale farmers, HIV impacts both on the health of the labourer and his capital reserves, which progressively diminish as he seeks medical cures. With progression of the illness, the spouse and family's time is taken up in administering care, leaving little time

and little resources for necessary agricultural activities and inputs, hence a change in type of crops grown and size of production.

Health Care costs: **Old Mutual** estimates that the additional health care costs of HIV/AIDS could reach \$3.8 billion by 2009.

Within **the Private Sector**, AIDS will cause significant cost to this sector from the increase in absenteeism due to employee illness, domestic illness, and funerals. In addition, there will of necessity be increased expenditure on medical schemes, on pension benefits, disrupted production and loss of skilled manpower, and the costs involved in training/re-training and recruitment processes.

Education Sector

Though literacy levels are considered to be high, HIV is having a profound impact on the education sector. Teacher training institutions will have to greatly increase the intake numbers in order to keep pace with the morbidity and mortality faced in this sector as a result of HIV/AIDS. The loss of capacity, specialist skills and experience may compromise the quality of education offered in time. Schools are increasingly being identified, on the global agenda for OVC, as places that can influence positive behaviour change, be places of safety, and offer many of the services needed to mitigate against the impact of HIV/AIDS on OVC. These prospects may be seriously prejudiced and compromised.

In addition, the incidence of HIV+ in the home can be expected to reduce access to education for the children of the household. This is due to increased economic hardships, family care, children having to assume domestic duties and care of younger siblings, and all the other trauma associated with grief, stress and added responsibilities.

The Mining Sector is said to be the worst hit with HIV/AIDS prevalence rates of up to 25% of the workforce.

Within **the Manufacturing sector**, the seroprevalence is estimated to be approximately 19% of the workforce.

The Construction Industry, Retail and Wholesaler sector are considered to be medium to low risk sectors.

The impact in the various sectors is very dependent on location. In the KwaZulu Natal and Gauteng areas, approximately 40% of firms have indicated that HIV/AIDS is having a negative impact on their profits. In the Western Cape it is estimated to be 25% and the Eastern Cape it is 27%

Business Risk factors for South Africa are rated in the following order:¹¹

1. **HIV/AIDS**
2. Asset security
3. Crime

¹¹ IRIN News: South Africa 2004

4. Exchange rate volatility
5. Political environment
6. Infrastructure risk.

2. NATIONAL HIV/AIDS INFECTION CONTROL PROGRAMME

2.1 The National Response:

Some of the major achievements documented over the past 10 years are included in the following:

1992: the National AIDS Convention of South Africa (NACOSA) marked South Africa's first meaningful response to AIDS. Oct.1992 a national conference, 'South Africa United Against AIDS, ' addressed by Nelson Mandela led to the launch of the process to develop a national AIDS strategy and subsequently an implementation plan.

1994 Oct: the Minister of Health accepted the NACOSA Plan as the blueprint for the Govt. AIDS programme.

The response to HIV/AIDS, STIs and TB was fairly limited before 1994 and focused predominantly on limited information, education and communication initiative and the provision of condoms.

With an increase in fund allocation, the government was able to respond and launch in

1995 the NACOSA strategy, to address HIV/AIDS, STI and TB.

The five main strategies included:

- Life skills programmes targeted at youth, using mass media to popularise key prevention concepts
- STD treatment
- Increased access to condoms
- Promotion of care and support

The National HIV/AIDS and STD Programme was operationalised by the National Directorate, mainly concerned with Policy, and the nine Provincial HIV/AIDS Programmes, which were mainly concerned with programme delivery. A number of NGOs were either funded or sub-contracted to run projects or to provide services.

The programme, in addition, was committed to challenging prejudice and discrimination wherever it occurs.

1998: Partnership Against AIDS: to provide for greater multi-sectoral collaboration.

Education Campaigns:

Government introduced basic HIV education awareness campaigns. This was followed by the 'Beyond Awareness Campaign,' which ran from 1998 – 2000. This campaign was initiated to take people beyond the information received through the mass media campaigns and hopefully into behaviour change. This multi-medium campaign, targeted at young people, produced and supplied resource materials to

organisations to use in different contexts. It also promoted the free National AIDS help line, which had initially been started in 1992.

In 1994, another radio – print-and television-media campaign, aimed at the wider audience, was launched. This was called ‘Soul City’ and aimed to educate and empower people to make better personal health choices. Their materials have been widely used and broadcast to other parts of Africa and the wider world.

Government has been a major contributor to the ‘loveLife’ media Campaign, the ‘Khomani’ Campaign as well as life skills and HIV/AIDS education programmes for schools.

2000: HIV/AIDS and STI Strategic Plan for South Africa 2000-2005.

This document, followed an extensive consultative process that started in 1999, and provides the framework for a coordinated response to HIV/AIDS, STIs and other opportunistic infections. The strategy addresses 4 key areas: Prevention; Treatment, Care and Support; Legal and Human rights; and Research, Monitoring and Surveillance.

2000: The South African National AIDS Council (SANAC) established to formalise multi-sectoral collaboration. The Council has 16 Civil Society sectors represented, 14 Ministries and 2 representatives from Parliament. SANAC was to ensure that sectors outside of government have a clear understanding of the National Strategic Plan and their specific roles and responsibilities in implementation. Subsequently all provinces established Provincial AIDS Councils, and there are also District AIDS Councils in the majority of Districts.

2001: The development of the National Integrated Plan for Children and Youth Infected and Affected by HIV/AIDS. This would be to allow for a major scaling up of key interventions and a shift towards more care and support. Prior to 2001, there was no coordinated programme to address issues of community home-based care, voluntary counselling and testing and prevention of mother to child transmission.

The goal was to be achieved through 4 main programmes:

1. Community-based care and support: developing strategies of care of orphans and community based models of care for PLWHA, focusing on policy development and piloting of approaches
2. Strengthening VCT initiatives
3. Life-skills and HIV/AIDS education in primary and secondary schools.
4. Community outreach and mobilisation.

Thus community based HIV/AIDS awareness programmes would link and promote the other initiatives

2002: Thorough review of **SANAC** and the decision to appoint a small dedicated Secretariat with technical and administrative skills, and advertising for nominations of members to SANAC. The Secretariat was moved to the Office of the Deputy President. Sector representatives were requested to establish a fair and open

nomination process within their sector to ensure continuation of sector representation. Sector participation is crucial to the implementation of the Strategic plan.

National Budget Allocation to HIV/AIDS Programmes

South Africa has the largest economy of the SADC countries accounting for 66% of the regional GDP. The degree of commitment to tackle the epidemic in SA is high. The South African government fulfils the 2001 Abuja commitment to allocate 15% of government expenditure to health. Civil society and the private sector engagement in shaping, influencing and implementing policies and programme interventions is dynamic and robust. This is in large measure due to South Africa's open and progressive constitutional democracy.¹²

In 2002 the total allocation to HIV/AIDS at the national level is a small proportion of the overall total health budget (3,5%) which in total is R6,611 billion. The estimate is R236 million for 2001/2 and by 2004 should have been R423.5 million.

South Africa has spent more on HIV/AIDS, as a proportion of its overall budget, than most other countries in Africa. However, it is still considerably less than the amount spent on the Military/Defence budget.

2.2 Voluntary Counselling and Testing

VCT is an essential element in the strategic plan as it provides an important entry point into other health interventions such as TB and STI treatment. Sites have been established throughout the country, including sites where PMTCT is available.

2.3 Prevention of Mother-to-Child transmission (PMTCT)

In 2001 the Dept of Health launched a limited programme on PMTCT to serve as research sites that would inform a broader implementation strategy. This schedule was changed following a Constitutional Court judgement that instructed a more rapid rollout of the programme.

Thus approximately 600 facilities commenced offering VCT and the PMTCT programme that includes the provision of Nevirapine to mother and infant, and formula feed to mothers who chose to exclusively formula feed. The plan was to have all Provinces embarked on a rollout by the end of 2003. The progress has however been much slower.

2.4 Anti-Retroviral Programme

'No doubt that history will record our response and it would be a greater crime to let people die whilst effective medications are available.' Joep Lange

¹² UNAIDS at Country Level. Progress Report 2003

Of the approximately 5 million people in South Africa who are HIV positive, it is estimated that 600 000 are in need of anti-retroviral drugs (this includes those having a CD4 count of less than 200, or being in WHO Stage 3 or 4 of the disease).

In the government HIV/AIDS Strategic Plan for South Africa 2000 – 2005 Goal 11: 'Investigate Care and Treatment Options,' the following were the outlined objectives and selected strategies:

- Review and revise policy on anti-retroviral use for reducing mother-to-child transmission
- Conduct research on the cost-effectiveness of other forms of non-retroviral treatment and prophylaxis
- Conduct research on the effectiveness of traditional medicines

Nowhere was there mention of investigating or rolling out the provision of anti-retroviral therapy.

Events have since over taken the government, in the form of the Treatment Action Campaign advocacy, and Court challenges, as well as international pressure. The funding of the preparation and purchasing of generic drugs in South Africa by the Bush Administration has finally further opened up the gateway for the provision of anti-retrovirals to South Africans in need of therapy.

In November 2003, the government approved the Operational Plan for Comprehensive Care and Treatment for people living with HIV and AIDS.

South Africa launched what is likely to be the world's largest comprehensive AIDS treatment plan. The roll-out of anti-retroviral treatment in the country's public health sector will involve a massive training and structure overhaul and will cost approximately R12 billion over the next 3 years.

In 2004 the National Dept. of Health started an ARV rollout. However, take-up is slow, and logistical complications make it impossible for the government to reach everyone.

National Seroprevalence: 21.5% (UNAIDS end-2003)

Estimated number of adults (15 – 49) with advanced HIV infection in need of treatment in 2003: 750 000 (Source: WHO/UNAIDS)

Number of adults (15 – 49) with advanced HIV infection receiving ARV therapy as of June 2004: 20,000 (Source WHO /UNAIDS)

Problems associated with the government ARV roll-out programme identified by Churches:

- The Nutritional component is under emphasised
- Government requires the patient to have a CD4 count of 200 or less. A patient with a CD4 count of less than 200 is eligible for a disability grant of ZAR7000.00. Once a patient is on ARVs and his CD4 count improves, concern is raised as to whether or not he/she will lose that grant.
- Concern about sufficient sites for VCT.

2.5 HIV/AIDS Vaccine Initiative:

The South African AIDS Vaccine Initiative (SAAVI) was established in 1999 to develop and test an effective, affordable and locally relevant vaccine for South Africa within 10 years.

According to Dr. Simnikiwe Mayaphi of the Perinatal HIV Vaccine Trial Research Unit at Baragwanath Hospital, the very first person to offer himself as a volunteer for the vaccine initiative was a Catholic priest: Fr Kieran from Pretoria. His motivation was from a heartfelt desire that something be done to stem the tide of infections that are devastating the communities that he serves. If a vaccine would provide that response, and they needed people prepared to risk themselves to make this vaccine becomes a reality, then he was prepared to volunteer himself.

Almost all the volunteers on the programme are from faith communities.

2.6 South African National AIDS Council (SANAC)

SANAC is equivalent to the Country Coordinating mechanism. Deputy President Zuma is the Chairperson. It is an organisation that is very dominated by political/government membership and the presence of civil society, including faith-based organisations, is seen as token. Their presence is more for a sense of inclusiveness than to actually contribute on equal terms to the debate.

On behalf of the SACC, the AIDS Unit actively lobbied the Deputy President for greater Christian participation on the Council. In September 2002, a delegation from SACC met with him to discuss these issues. This delegation was comprised of the President of the SACC, the HIV/AIDS Coordinator of the Anglican Church and the Director of Justice Ministries. The outcome was the appointment of a representative from SACC on the SANAC. Through this representation, SACC is able to participate and influence the broader decision-making processes related to HIV/AIDS at a national level.

3. HIV / AIDS and YOUTH

3.1 The Importance of Youth in South Africa¹³

Youth has played a crucial role in South Africa for the past six decades, particularly in shaping the struggle against apartheid. In the 1940s, ANC youth transformed a passive liberation movement into a mass resistance organisation. With the progressive process of banning political parties and exiling leaders, youth movements again led the struggle. During the 1976 student riots, 'youth faced the might and viciousness of the apartheid regime with a willingness to sacrifice their lives in the struggle.' By the 1980s, youth were fighting the system on all fronts, playing a key role in giving direction to popular resistance.

¹³ South Africa YMCA: Youth Engagement, Mobilization and Development Strategy Concept Paper 2004

The sacrifice was enormous. Years of interrupted schooling left them without sufficient skills. A declining economy left them with few prospects for employment. A study produced by the Community Agency for Social Enquiry (CASE), “Growing up Tough” identified that unemployment, crime, drugs and other problems placed a *majority* of youth at risk of being marginalized. With the new South Africa, the new generation of youth are experiencing an increasingly integrated society where individualism and materialism have become more important than political consciousness. But in addition to economic limitations, they face the life-threatening challenge of HIV/AIDS.

Since the CASE study, youth development organisations intensified efforts to improve employable skills and provide opportunities for small business enterprises. Post-apartheid, development initiatives have shifted to address HIV/AIDS. Churches launched values based life-skills training in schools and within communities in response to the crisis. By 1994 and motivated by the CASE study, the new government held forums to discuss, for the first time, a strategy for youth development. This would become the basis for a comprehensive approach to serving young people. The National Youth Commission (NYC) was established to monitor the impact of programmes and policies on young people. The South Africa Youth Council (SAYC) was also formed to serve as a civil society forum that advocates for youth.

Both these organisations seem to have limited success. So a consortium of seven NGOs formed the Youth Development Network (YDN), playing a critical role in raising youth work to a more professional level, encouraging best practice in youth development and building the capacity of member organisations.

Despite all these efforts, the future for South African youth remains bleak¹⁴:

- 36% of the population are youth under 35 years of age
- Almost two-thirds of all able-bodied youth remain unemployed
- The number of young people aged 18-20 serving prison time has increased by 33%
- Youth between 20 –34 years represent the majority of people living with HIV/AIDS.
- Pregnancy and lack of money remain the two biggest reasons why young people stop their education

3.2 Definitions (which are consistent with South African usage of terms)¹⁵

A child: is a person under 18 years of age, unless a law majority is attained at an earlier age (Convention on the Rights of the Child)

Youth: The Youth Commission Act defines *youth* as anyone between the ages of 16 –35.

The White Paper on Social Welfare (1997) defines a young person as between 16 –

¹⁴ as above

¹⁵ Children Living with HIV/AIDS in South Africa – A Rapid Appraisal : R. Smart for the Interim National HIV/AIDS Care and Support Task Team

30 years.

An Orphan: is a child under the age of 15 years who has lost his or her mother. (this narrow definition will exclude large numbers of orphans, between 15-18 years, and it excludes those who have lost their father).

Age of consent: at 14 years a child is deemed to be competent to decide about medical treatment, but the parent or guardian retains the right to give consent, except in the case of choice on termination of pregnancy where a 14 year old female may give consent to the procedure.

Child labour: the minimum age of employment of children is 15 years

Compulsory schooling: 15 years, or the completion of grade 9, is school-leaving age. There is provision for compulsory education between ages 7 – 15 years.

3.3 Overview

The National HSCR Study of 2004 identified three components of child vulnerability to HIV infection:

1. *Risk environments:*
Levels of poverty and exposure to alcohol and drugs are high for South African children.
2. *Care and Protection:*
Care and protection of children in both homes and schools are not adequate. Frequently children are left unprotected or sent out alone on errands. Children are at risk for sexual abuse and possible HIV transmission in both situations.
3. *Correct knowledge and communication about sex and HIV/AIDS:*
Correct knowledge is still deficient and communication between youth and primary caregivers is inadequate. Parental communication with boys is significantly lower than with girls on sex, sexual abuse and HIV/AIDS. There is thus need for specific interventions to focus on parental communication with boys.

In South Africa the peak incidence of HIV/AIDS is occurring amongst 15 – 24 year olds.

Based on UNAIDS estimates, over 20% of adult South Africans (15 – 45 years) are HIV+. However, over the past four consecutive years, the rate of HIV infection among young people below the age of 20 has remained stable.

HIV disproportionately affects young women.

Among the 10% of South African youth who are infected, 77% are women.

Nearly 1 in 4 women aged 20 – 24 are HIV positive compared to 1 in 14 men of the same age.

The highest HIV prevalence is in KwaZulu-Natal Province (14.1%) and the lowest in the Limpopo province (4.8%). In terms of geographic area, youth living in urban

informal settlements have the highest HIV seroprevalence (17.4%); followed by rural formal areas (13.5%); urban formal areas (9.8%) and rural informal area (8.7%). (*HIV and Sexual Behaviour among Young South Africans: A national survey of 15-24 year olds*. Pettifor, A.E. 2004).

3.4 Sexual Experience

Two studies have reported that the average age at first intercourse to be 13 years for males and 15 years for females among the rural youth, and 14 years for males and 16 years for females among the urban youth (Buga, Amoko & Ncayiyana 1996; Richter, 1996, 1997).

The 'loveLife' South African National Youth Survey (2000) reported 31% of youth 17 years and younger have had sexual intercourse. Of this sexually experienced group, 31% have had this experience before the age of 14 years. The Demographic and Health survey 1998 suggest that, by age 14 years, about 3% of young people have had sex.

Cases of sexual assault and rape are another source of information on the risk of exposure to HIV infection of children. Large numbers of cases go unreported. Nevertheless, according to detailed statistics provided by the Family Violence, Child Protection and Sexual Offences Unit in Johannesburg, 24% of raped children are infants, toddlers and primary school children (Neethling & Higson-Smith 2003).

A recent national survey¹⁶ on sexual behaviour amongst youth in South Africa reported that 67% of young people aged 15 – 24 years reported having had sexual intercourse. Amongst 15 – 19 year olds 48% are active compared to 89% of 20 – 24 year olds. Amongst those youth who were sexually experienced, abstaining from sex in the past 12 months was not associated with an active choice to protect oneself against HIV/AIDS, but rather due to lack of opportunity to have sex or not having a sexual partner.

The median age of sexual debut amongst those reported as sexually experienced was 17 years. 8% reported having sex at age 14 or younger. 6% reported having being forced into their first experience (10% females and 2% males). 30% of sexually active females reported really wanting their first sexual experience compared to 83% of sexually experienced males.

24% stated they had sex whilst under the influence of alcohol.

1 in 10 youth reported using drugs, more commonly amongst males (18% vs. 3%).

Data on pregnancy rates from Census 1996 indicate that, of all women aged 13 – 25 who have given birth to at least one child, 0.7% have given birth at age 12 years, 1% at 13, 1.3% at 14 and 3% at 15 years of age.

Condom use:

¹⁶ *HIV and Sexual Behaviour among Young South African: A national survey of 15-24 year olds*. Pettifor, A.E. 2004

In the same study, among sexually experienced youth, 52% reported using a condom at last sex. Overall, among youth who reported having sex in the last 12-month period, females were significantly less likely than males to report condom usage (28% vs. 39% respectively).

The majority of youth (87%) felt that they were able to access condoms when they needed them.

Amongst the faith-based organisations, there remains a widespread resistance to the use of condoms and especially the promotion of the use of condoms.

The Catholics have been consistent in their messages concerning the use of condoms.

Many Charismatic churches and African Independent Churches are vehemently against condom use believing that promotion of condom use equates with the promotion of promiscuity.

As one Church leader pointed out: “Abstinence messages are used as threats to the Congregation. A single girl who is found to be pregnant is thus ‘marked’ (though not the boy). The ‘pill’ succeeded in concealing sins. Then when HIV/AIDS came on the scene, sins again became visible. We say ‘no!’ to the condom because the condom will conceal from us who are the sinners that we can blame.”

HIV Knowledge, Communications and Perceived Risk among youth

Awareness campaigns are very evident in most of the major cities in South Africa. Media campaigns are active and huge advertising billboards with HIV and AIDS messages are visible all over South Africa. Television Newscasters all wear the AIDS ribbon on TV whilst broadcasting. TV news and chat shows on HIV and AIDS issues are frequent and the ‘LoveLife’ programme is well known and very visible.

Condom promotion is obvious, again in media campaigns and condoms are readily available in most public toilets, bars, transport lounges and other places well frequented by the public.

The national level of awareness on HIV/AIDS is generally high but the gap is wide between awareness and internalisation of the messages that would result in effective changes in the norms of society.

The Treatment Action Campaign (TAC) has mobilized civil society, mounted legal challenges to the government and kept the public spot-light on the need for equitable access to treatment, including antiretroviral therapy.

3.4 Sex Education in South Africa

Communication is an important weapon in the battle against HIV transmission.

In a recent study¹⁷, caregivers of children aged 2 – 11 years of age and children 12 – 18 years were asked about communication about sex, sexual abuse and HIV/AIDS.

¹⁷ ‘Communication about sex, sexual abuse and HIV/AIDS in homes’ National Household HIV Prevalence and Risk Survey of South African children 2004.

Caregivers were shown to be more likely to communicate with girls than with boys. Also two thirds of the caregivers said they were comfortable to discuss these issues with the children. However, only two-fifths of the children aged 12 – 14 years say that their parents have actually talked with them about sex and HIV/AIDS.

Of particular note is that **82.3% of 12 – 14 year olds felt strongly that parents should discuss these topics with them.**

Sources of information about sex, sexual abuse and HIV/AIDS

12 – 14 year old children list schools as the most important source of information on HIV/AIDS (85.9%), followed by parents / caregivers (39.9%) **and faith-based organisations (25.5%)**. Peer groups and the media are the next most important sources of information on sex.

It would be extremely interesting to compare the content of the information disseminated by the different groups.

Apparently, there is a general lack of motivation amongst teachers: under the new laws of the country, pregnant school girls may remain in school and the teachers have to act as nurses to these girls. With the religious plurality in schools, even school prayer requires the permission of parents. Poverty is a real factor in the lives of the pupils and teachers complain that some children collapse in class from a lack of food and there is insufficient information as to how they can access bursaries.

Teachers also wish to be included in programmes. The Dept. of Education has stated that every school needs a resident counsellor who is not a teacher. Both teachers and students are dealing with high stress issues, some youth are dealing with overwhelming challenges. Churches could do much to assist with the provision of such counsellors, even one per three schools could make a big difference to the coping strategies of so many.

3.5 Response to HIV/AIDS and Youth

The SA Schools Act No.84 of 1996 regulates and provides protection for learners infected with HIV. The National Education Policy on HIV/AIDS, Govt. Notice 1926 of 1998 covers the management of HIV/AIDS in schools, based on the principle of non-discrimination, confidentiality, education and management of HIV/AIDS within the school environment.

In 1997, 840 Master Trainers and 9034 secondary school teachers were trained in life skills and HIV/AIDS. This was initiated by the Dept. of Health and only recently taken over by the Dept. of Education. In 1999, piloting of the life schools programme was initiated in selective schools, focusing on the ages 10 – 12 years. In conjunction with the life-skills programme, a youth programme called **the South African AIDS Youth Programme (SAYP)** was established to target youth through social mechanisms and youth programmes.

Many interviewees stated that the life-skills programme is not taken very seriously. It is not a mandated part of the school curriculum but still remains an optional extra. There have been no large-scale rollouts of any of these programmes to date.

PACSA has developed a schools' project that focuses on relationships and decision making, with ample discussions on the types of relationships that are desirable. Some primary schools have even approached PACSA to run a similar programme for their youth and an Anglican priest has requested assistance to integrate such a programme, and one that incorporates sexuality as a discussion topic.

3.5.1 'loveLife' Campaign

LoveLife is the largest youth focused intervention aimed at HIV prevention in South Africa and has become recognised as the largest campaign aimed at HIV prevention in the world. Launched in 1999, it is a joint national initiative of unprecedented scale between government, Foundations, NGOs and academic institutions that aims to reduce HIV; other sexually transmitted infections and unwanted pregnancy among South African youth. It combines a sustained multi-media awareness and education campaign with comprehensive youth friendly sexual health services in public clinics nationwide, and offers countrywide outreach and support programmes. Through the multi-media blitz, its aim is to become a household name, stimulate debate and, in the process, promote sexual responsibility. Lovelife aims to delay first sex, reduce the number of partners people have and encourage the practice of safer sex. It offers a network of telephone help-lines, youth friendly clinics; youth centres and recreational and sexual health facilities. There is also an outreach service to youth in remote areas, who may be without access to the usual educational materials and resources.

3.5.2 Khomanani

In 2001, a campaign called 'Khomanani' ('caring together') was launched using a newly formed AIDS Communication Team (ACT) comprised of a number of different organisations including Soul City. This media campaign aims, through its multi-language materials, to educate people, particularly youth, on the dangers of HIV.

The broad aim of the Khomananai campaign is to move the nation to act, so that individuals see themselves as part of a caring community, proactively addressing the HIV/AIDS, STI and TB epidemics.

4. CARE OF CHILDREN ORPHANED AND MADE VULNERABLE BY HIV/AIDS

4.1 Poverty and Children

Using a poverty line of R215.00 per month, 53.4% of children across South Africa are ultra-poor (Woolard) which represents some 9.7 million children under 17 years of age are in deep poverty. Child poverty rates are highest in the Eastern Cape (72%), Limpopo (69%) and KwaZulu-Natal (60%). (E. Coetzee, J. Streak *Monitoring Child Socio-Economic Rights in South Africa: Achievements and Challenges 2004*)

AIDS related deaths have a destabilizing effect on the lives of the orphaned children. Life circumstances deteriorate, they are emotionally traumatised and the losses experienced are very often multiple in nature. AIDS intensifies poverty.

4.2 Government Welfare Policies for Children

The greatest burden of care for children made vulnerable by HIV/AIDS has been left to the families, individuals and communities. Outside of cash grants, acting as poverty alleviation schemes, there has been very little programme development to assist in the welfare of children. Currently the Social Assistance Act 59 of 1992 makes three grants available to children: the child support grant; the care dependency grant and the foster grants. These are accessed from the provincial social development departments. All of these grants are subject to a stringent means test for the applicant. Children are only eligible for one grant in any period.

1. The Child Support Grant: R110.00 per child per month

To access the grant, the caregiver must have a limited income, as stipulated by the Department of Social Welfare, and must present a bar-coded birth certificate of the child and ID document of the caregiver before the application can be processed. Lack of documentation, which is reported to be fairly common, precludes these children from accessing support.

Only children aged 0 –6 receive the grant, but the system does not address the situation of OVC above 6 years age.

2. Foster Grant: R410.00 per child per month

Again there is a stringent means test based on the combined income of the foster parents. Only children who have been placed in the care of foster parents by a court of law are eligible for the grant. This precludes the vast numbers of children who have been absorbed into their extended families, without the intervention of the Courts, and who may represent an additional economic burden on already impoverished families. The maximum number of children who can be fostered and receive grants are six.

The system creates a perverse incentive for families in poor communities to place their child in foster care so that the larger foster care grant can be accessed than the smaller child support grant.

3. The Care Dependency Grant: R570.00 per child per month.

This grant is also dependent on a means test and is for children with severe mental or physical disabilities and who require permanent home care. There is no specific provision for children with chronic illnesses like HIV/AIDS.

Only children under 11 years age are eligible. From April 2005 it will extend to children under 14 years of age.

About 750 000 children receive the Child Support Grant, approximately only 18% of the some 4 million children living below the poverty line.

Some of the problems identified, which preclude those in need from accessing their entitlement, include:

- Lack of transport and finance to access the relevant offices
- Denial of grant because the surname of the child, on the Road-to-Health Card, differs from that of the caregiver; a common situation when the primary caregiver is the grandmother
- Lack of birth certificates and identity documents
- Lack of information concerning the availability of grants.

All these are areas in great need of advocacy.

South Africa has a high rate of crime, abuse and murder. Children, whose parent/s are in correctional services, should also be classified as vulnerable or as children in especially difficult circumstances. The stigma attached to their circumstances as well as possible abusive home circumstances make them very vulnerable. They need to be able to access the care, protection and other services provided by the State to children in especially difficult circumstances. FBOs working in prison services could bring up these issues as advocacy issues.

4.3 Orphans in South Africa

Orphan care is undoubtedly one of the largest challenges facing the country as a whole and the Churches in particular. The magnitude of what is to come has yet to be realised and proactively responded to. The functional extended family, whereby children are absorbed into extended families, without the intervention of external agencies, means that the magnitude of the crisis is concealed from the general populace. It is only when these children fall through the traditional and time-honoured safety net of the extended family; beginning to appear in large numbers on the streets and as child headed households; and when the demand for social grants exceeds the nations capacity to deliver, will the full seriousness of the situation be acknowledged.

Estimated number of orphans (0 – 17) living in 2003 : 1,100,000 (UNAIDS Global Report 2004)

13% of children aged 2 – 14 years have lost a mother, father or both parents.
About 3% of all households are headed by children aged 12 – 18 years.

By 2005 South Africa will have over 1 million orphans. This figure is expected to rise to 2 million by 2010.

4.4 Options of Care for Orphaned Children

Government policy, with regard to the care of orphans is to concentrate on 'empowering the community to take care of orphans' (Deputy Director of HIV/AIDS in the Dept. of Social Services and Population).

The Government has placed a moratorium on the establishment of new institutions, and the registration of such institutions, and is concentrating on foster care. Institutional care may meet immediate short-term needs but also creates long term negative implications for the welfare of the child. In addition, given the scale of the pandemic, there will never be sufficient to cope with the demand, and alternative forms of care must be investigated and supported. In spite of this, new institutions continue to appear, supported by church groups, NGOs and the private sector. Over 90% of institutional places for children have been closed, but there has not been a proportional shift in funding to support foster care nor community based models of care.

The South African government has committed line ministries to providing a continuum of care for vulnerable children, integrating care and support across sectors. However, there is little coordination at national or provincial level and at grassroots level, there is fragmentation at best, and non-delivery, at worst.¹⁸

The CINDI Programme for Children and the Thandanani Children' Foundation (Pietermaritzburg) are very good examples of comprehensive support for children.

5. NON-GOVERNMENTAL RESPONSES TO HIV/AIDS

5.1 UN Agencies

In 2002, it was found that where UNAIDS had invested resources in countries, national responses were more quickly mobilized, the UN as a whole worked more effectively to address AIDS, and a greater number of partners were supported and engaged. For most countries this held true: support, support, support. For South Africa, a country of vastly superior resources, the need has instead been identified as 'capacity build, capacity build, capacity build.'

As already mentioned, South Africa has embarked on the largest comprehensive HIV and AIDS care, management and treatment programme ever attempted. The UNAIDS has stated that programme management and coordination of this initiative is one of the cardinal challenges requiring urgent attention. The other challenges identified include inadequate human capacity for service delivery; weak infrastructure, tackling stigma to facilitate programme uptake and adherence to treatment; monitoring of programme implementation; and building of partnerships with the community and civil society to support the programme, as well as ensuring that prevention remains on top of the agenda.

To this end, UNAIDS focus is on national leadership, technical assistance for strategic areas for implementation, and for monitoring and evaluation, and advocating for government-led partnerships.

¹⁸ The Current & Future impact of the HIV/AIDS epidemic on S.A.'s children: Chris Desmond and Jeff Gow

UNAIDS in South Africa has expressed an interest in more contact with FBOs. They are interested in following up on 'best practices' but information concerning these is not readily available.

5.2 International Organisations

Médecins Sans Frontières (MSF) Doctors without Borders

This international medical aid network offers HIV prevention and treatment services. With the support of the South African government, MSF works to reduce mother-to-child transmission providing antiretroviral treatment to thousands of HIV-infected individuals in the Western Cape.

The Clinton Foundation brokered a deal with four generic companies to provide triple therapy to governments in the developing world at the cost of less than US\$140 per patient per year.

The United States Congress approved US\$40 million for South Africa.

United States PEPFAR Fund: In 2004 South Africa received US\$65.4 million to support a comprehensive treatment, prevention and care programme.

5.3 Civil Society:

Treatment Action Campaign (TAC)

Treatment Action Campaign (TAC) is a pressure organisation involving civil society to promote public awareness on the availability, affordability and use of HIV treatments. It was started in 1998 by Zachie Achmet in response to the unwillingness or claims of inability by the South African government to provide antiretroviral treatment to PLWHA. TAC has played a major role in advocating for access to ARVs and in highlighting inequalities in access to treatment. They have successfully taken the South African government to court over a number of issues including provision of Nevirapine to pregnant HIV-positive women and universal access to anti-retroviral medication. Zachie Achmet drew much publicity to the situation by refusing to take antiretrovirals himself until it was available to all South Africans.

In March 2003, TAC laid criminal charges against the Ministers of Health and Trade and Industry for failing to provide access to a known medication that could save the lives of over 600 HIV+ people per day. In August 2003 the government ordered the Health department to develop an operational plan for the rollout of antiretroviral drugs to PLWHA.

5.4 Private Sector Response

Response to HIV/AIDS from the Private Sector has been slow. Only about one quarter of the country's businesses, mainly the large corporations, have workplace policies in place.

Small to medium sized firms are said to lack the human and financial resources necessary to implement an AIDS plan.

The South African government has failed to provide “real leadership” to business and need to implement a comprehensive strategy for business firms nationwide. Government needs to consider incentives for businesses as well, such as tax relief for firms providing ARVs to the workforce.

Daimler-Chrysler was one of the first businesses to implement a comprehensive, holistic programme to combat HIV/AIDS for both employees and their families. This package includes: free health care, HIV/AIDS training and education; voluntary counselling and testing; antiretroviral therapy and a community AIDS programme.¹⁹

It represents an example of a ‘Best Practice.’

5.4 Traditional Healers and Culture

Traditional healers have a crucial role to play in strengthening and supporting the national response to HIV/AIDS.

There are an estimated 150 000 – 200 000 traditional healers in South Africa. It is believed that as many as 80% of African people consult traditional healers instead of or in addition to Western medical personnel. All illnesses are attribute to some social cause, either caused by the person himself or herself or visited upon them by others, including ancestors.

‘Traditional healers usually take a holistic approach, dealing with all aspects of the patient’s life, social context and psychological state. They provide culturally familiar ways of explaining the cause and timing of ill health and its relationship to the social and supernatural worlds.’²⁰

There are two broad types of African healers: faith healers and traditional healers, with several subsets.

The *sangoma* enters a trance and is possessed by spirits and then divines causes and treatment.

The *inyanga* or herbalist is a person knowledgeable about African medicinal herbs, the knowledge sometimes being acquired through dreams and ancestral passing on of knowledge. Frequently there is a combination of elements in their work, both emphasis a spiritual dimension to the illness.

Many HIV+ people spend large sums of money seeking a cure from these traditional healers. It was from some traditional healers that the notion arose that one could be cleansed of HIV by having sex with a virgin.

Traditional healers command respect, sometimes fear, and credibility amongst the population they serve.

Traditional healers have a role to play and it is practical to consider them in the overall response to HIV/AIDS and ‘to maximise the potential contribution that can be made toward meeting the magnitude of needs for care, support and prevention.’(UNAIDS)

¹⁹ Newspaper and Equinox Cuttings; Dr Clifford Panter 2004

²⁰ Waiting to Happen. HIV/AIDS in South Africa. Liz Walker, Graeme Reid & Morna Cornell

The South African government is engaging them in the discourse on HIV/AIDS and recommending research into their many remedies.

6. POSITION and INVOLVEMENT of CHURCHES in ADDRESSING HIV/AIDS

*Despite numerous difficulties, many organisations throughout Southern Africa have risen to the challenge, attempting to mitigate and address some of the worst effects of .. HIV/AIDS as well as prevent its further spread. **The Church has played a critical role in supporting and developing these small, localised initiatives, which currently form the backbone of the indigenous response to the epidemic of HIV/AIDS.***²¹

‘For many in South Africa, their Church is still the main source of information and education, especially in largely illiterate communities’ (Saayman 1992).

‘It remains a crucial agency for interpretation of events and for raising consciousness, and is trusted as “honest purveyors of information.”’ (Nicholson 1995).

6.1 Religious Adherence in South Africa

Percentage of Christian Observation: +/- 65%

Percentage of Non- Catholic: +/- 57%

Percentage of Catholic: +/- 8%

Moslems: 1.1%

Traditional religions and others: approximately 40%

6.2 Categories of Churches:

- **Mainline Churches:**

For example: Catholic, Anglican, Methodist, Presbyterian, Congregationalist, Dutch Reformed, Salvation Army

- **Evangelical and Pentecostal Churches:**

E.g. Baptist

- **Charismatic Churches:**

E.g.: International Federation of Christian Churches (IFCC) (Rhema based); Assemblies of God, Apostolic Faith Mission

Many PLWHA say they feel ‘safer’ in these churches than in the mainline churches. They feel more welcomed. These churches too have a strong emphasis on divine healing and healing is frequently a strong part of their services.

- **Other Christian Churches**

E.g.: Seventh Day Adventists; Church of Jesus Christ and Latter Day Saints

²¹ Evaluation of CMMB/SACBC HIV/AIDS Projects 2003

- **African Independent Churches:** predominantly rooted in African traditional religion.

Includes the African Instituted Churches; Zionists and small independent Churches.

6.3 Perceptions of HIV/AIDS by the Churches

From the numerous interviews, the following perceptions emerged:

Positive perceptions and responses: (details below under individual denominational responses)

- Several denominations, such as the Anglican Church of the Province of South Africa, the Lutheran World Federation, Methodists, Roman Catholics and others have already developed denominational policies concerning HIV and AIDS which form the basis of their responses.
- Signs are visible outside some community churches reading: “This is an HIV friendly Church.”
- Responses are very varied and mostly centre around care issues. Some churches, such as the Catholics, are offering the whole continuum of care.
- Networks have been formed around issues of HIV and AIDS involving different denominations for greater impact.
- Best / Good Practices exist but they are not readily shared.
- Many initiatives have originally started in Churches and have gone on to become independent NGOs.
- Virtually every Protestant denomination interviewed stated: ‘The Catholics are doing a lot’

Negative perceptions and responses:

- Churches generally seem to be some 10 years behind in response.
- Large numbers still do not see HIV/AIDS as an issue for the Church to be concerned about. It is still very much ‘out there.’
- In addition, large numbers believe that contracting HIV is ‘a choice’ and is the result of personal sexual sin. This attitude is particularly prominent within Charismatic churches.
- Fear
- Generally, whilst there is willingness to respond to HIV and AIDS, there is also ignorance on how to deal with it.
- Concern was expressed about confusion in their messages to congregations: on one hand, sermons focus on sexual purity and marriage values. On the other hand, they are supposed to be welcoming to PLWHA, who seemingly have ‘obviously’ disregarded these messages.
- Concern was expressed that the more the pastor spoke about the subject of HIV and AIDS, the more likely he could be branded as ‘one of them.’
- Of particular note, was the concern expressed that if the church started getting involved in issues of HIV and AIDS and, in particular, if the church had a welcoming attitude towards PLWHA, they might be totally overwhelmed.

- Prevention messages tend to simplistically focus on abstinence. What is lacking are comprehensive strategies to address poverty, social ills, inequalities in relationships, in access to services and the many other issues that underlie the issues.
- Many of the interviewed pastors used very stigmatising language, unknowingly and unwittingly, when they discussed issues of HIV, AIDS, PLWH and A and orphans.

6.4 Theological Institutions

There are many such training institutions in South Africa, especially as SA remains the Headquarters for many of the Protestant denominations in Southern Africa. In addition, tertiary training institutions including Universities are very numerous. UNISA is the largest Correspondence or Distance Learning Education Institution in Africa, and is amongst the largest in the world.

- Some Institutions are working towards integrating HIVAIDS into their curriculum.
- UNISA offers a Masters' degree in HIV/AIDS.
- The University of the Western Cape focuses on training in Counselling.
- The University of KwaZulu Natal has a compulsory module on HIV/AIDS for all theological students.
- There is a National Board of Christian Educators who, are involved in ensuring that HIV/AIDS is taught in the institutions.

6.5 The South African Council of Churches (SACC)

The Overall Mission: "As a National Council of Churches and Institutions, the SACC, acting on behalf of its member Churches, is called by the Triune God to work for moral reconstruction in South Africa, focusing on issues of justice, reconciliation, integrity of creation and the eradication of poverty and contributing towards the empowerment of all who are spiritually, socially and economically marginalized."

The SACC has 27 member churches. Unlike other Councils, it also involves the African Independent Churches (African Instituted Churches started by Beers Naude) and the Council of African Independent Churches, as well as the Charismatic Churches (IFCC). In addition, the Catholic Church is a full member of the Council.

SACC has 5 Key Programme Areas (KPA):

1. Poverty Eradication
2. Health and HIV/AIDS
3. Justice (democracy, land, youth)
4. Emergency relief; Ministry of Uprooted People
5. Peace building; anti-racism and reconciliation.

All have their own directorates.

Provincial Councils are required to undertake 3 out of the 5 issues but HIV/AIDS is mandatory. The Council has a clear position on issues related to HIV and AIDS. It has made an uncompromising stand to show its intention to embrace those living with HIV.

Treatment literacy will be included in 2005.

Western Cape: focuses on counselling

Eastern Cape: focuses on nutrition and awareness raising

Freestate: focus is on ARV roll-out and advocacy

Mpumalanga: Home based care

Gauteng: Awareness raising, Home based care, counselling.

Kwa Zulu Natal: everything!

Justice is a major programme

The HIV/AIDS programme is wide because of many networks with other organisations and church leaders.

KZN-CN: Coalition on HIV/AIDS.

Collaboration:

The SACC has entered into a partnership with the Nelson Mandela Foundation and 'loveLife' (an extensive media campaign aimed at raising awareness amongst youth) to develop resource material on sex and sexuality for the churches. The aim of this project is to get churches to reflect theologically on these issues and through it enable them to communicate effectively with their constituencies. The project focuses on clergy, youth leaders and parents. The Foundation is developing and producing the material, the SACC coordinates the training events for church leadership and facilitates engagement between 'loveLife' and Church youth.

In 2003 SACC, in partnership with Youth for Christ, commissioned a CD and video entitled: "Fulfilling your sexual dream," which aims to address issues of sexuality with teenagers.

SACC AIDS Unit is represented on the Executive Committee of Treatment Action Campaign. In this capacity it can participate in discussions and the decision making process as well as acting as a conduit for relevant information from TAC to member churches.

In Feb 2003 SACC sought to establish and play a coordinating role in a **Membership Network**, to get an overview of the various member churches' responses to HIV/AIDS and to discuss the Christian community's participation on SANAC. SACC was requested to collate information on these responses as a resource to its members.

Interview with HIV/AIDS Coordinator

Q: *What is the SACC view on the Church and HIV?*

A: SACC has adopted a theme: "Combating HIV/AIDS".

A preamble to this theme is to develop a "Theology of Life"- to look at issues from God's view-how do we view humankind? It is a study of life and HIV needs to be

accepted as a disease, which is with us and within us. The current 'Theology of hope' is a post-crisis response. There is need for a pre-crisis theology of hope.

Addressing issues of stigma alone, and providing anti-retrovirals, will not solve the under-lying problems that HIV/AIDS high-lights. Failure to address issues such as poverty, homelessness, illiteracy, gender inequalities will mean that the church has failed in her response to HIV and AIDS.

To date, the Church in South Africa has responded but not universally. Leadership is struggling to convince itself and its constituencies of the necessity for response and is being reminded by secular organisations, Govt. and NGOs, of its responsibility. The Church has been dragging its feet and has been left behind. The Church is trying to be parallel to the world but hasn't caught up. Critical issues have been debated, such as doctrinal beliefs, condoms, diet, abortion, gays and lesbians, and in the process the Church loses focus and there is thus stalemated response. There has been much stereotyping. Though many secular organisations are speaking the truth, it is not necessarily accepted because it is coming from those who are 'outside the Church.'

During apartheid days politicians often confronted the Church, wanting the church to promote and articulate some of their issues, rather than the politicians themselves as they recognised the credibility that the church held with the people. Perhaps this might be a way of promoting dissemination of more accurate information as people 'buy' issues promoted by the church. The role of the Church in South Africa is essential in this war against HIV/AIDS.

Already the church is experiencing the uniting of denominations around HIV/AIDS. People are angry – they want this disease OUT.

Q: Is the leadership equal to the task?

A: Very variable. Leadership has been sleepy, undecided, dragging its feet. Bishops do not know who is who in the struggle. When Government calls a meeting to discuss these health issues, the church leadership is not there. Yet people are dying and everyone needs to be committed. The Church leadership is good about preaching 'sacrifice' but not good about doing it in terms of sacrificing time and resources to the struggle. It has made big noble and sweeping statements but these are not really translating into action.

Q: How can this be addressed?

A: Church needs to pursue these issues more rigorously, sharing information, taking the realities of life more seriously, and to come up with a theology on AIDS that is acceptable to all – not a compromise but a commitment. There is need to create a situation where every Christian would agree with out any hindrance. St Paul talked of 'One Body One Cross' can we not put our doctrines aside and be with the people, journeying with them and not restrict ourselves to statements from platforms?

6.6 Anglican Church: Church of the Province of South Africa (CPSA)

The Church of the Province of South Africa is the oldest Anglican Communion in Africa extending back to 1806. It represents 23 Diocese in 6 countries, 902 Parishes

and 874 Clergy. The Primate is the Most Reverend Njongonkulu Winston Hugh Ndungane based in Cape Town.

“ As faith communities we are guardians of moral and spiritual values. It’s part of our task to be involved in a way that seeks to address the pandemic. Our job is to have a generation in Africa without AIDS, and I would like the church to have a particular focus on young girls and on children.” Archbishop Njongonkulu Ndungane of Cape Town, head of the Provinces of the Anglican Communion in Southern Africa

Both the Archbishop and the Synod of Bishops have addressed the issue of HIV/AIDS for several years. Individuals across CPSA have been responding for over a decade to the real crisis and the tragedies posed. In Dec. 2000, the Archbishop met with international faith leaders in Washington DC, and requested support for a new initiative in the CPSA. He was given the promise of support through USAID to develop the capacity within the Province to coordinate and fund AIDS ministries.

In Aug. 2001, an All Africa Anglican Conference on HIV/AIDS was held in Boksburg, RSA. The participants came from 12 African Anglican provinces and more than 33 African nations, several archbishop from across Africa, Anglican Communion leadership from the worldwide Communion plus a host of donors and observers from numerous agencies.

The principal outcome of this meeting was a Vision Statement and a Strategic Planning Process that could be used throughout Africa, and would be available for use across the worldwide Anglican Communion, and formulated policies that would guide the worldwide Anglican’s response to the HIV/AIDS pandemic.

The CPSA programme focus:

1. There is a comprehensive focus on stigma eradication via programmes of care, prevention and impact mitigation: HBC, OVC, wellness and healing.

This component is funded with a three-year grant from Christian AID and DIFID:

the largest single amount of money ever received by an NGO in South Africa; ZAR260 million. The money is being used to finance training, addressing stigma and developing the necessary resources for the Church to address HIV/AIDS effectively.

Running parallel is the second focus:

2. Abstinence programme, prevention efforts including Voluntary Counselling and Testing and Anti-retroviral treatment support, funded by PEPFAR at ZAR1 million per month for 5 years. The focal person is Bishop David Beetge: Bishop of the Diocese of Highveld.

Stigma is considered to be the key factor which is under-mining all the efforts to deal with HIV and AIDS. Churches have, since the onset of HIV, contributed to this stigma, knowingly and unknowingly, and thus should be part of the solution. Stigma

is real within the church itself and this undermines the ability and capacity of the Church to effectively deal with HIV/AIDS.

Every Diocese is supposed to have developed strategic plans around HIV/AIDS. In fact since mid-November 2001, nearly every diocese has participated in planning activities, setting and adopting its own strategic plan for meeting the challenge of the HIV/AIDS pandemic. In August 2002, a Provincial Strategic Plan was sent to each diocese for consideration. The Plan addresses Provincial –wide concerns, leaving each diocese the freedom to determine what aspects of its diocesan plan will be implemented, and what support might be expected from the Province.

Yet there is an uneven ‘buy-in’ and levels of cooperation giving an overall very uneven picture. There are just plans, and then there are plans that are actually being implemented in different diocese. For example, the Diocese of the Highveld has had a home-based care programme for more than 10 years. It is often not necessarily due to a lack of will on the part of the Diocese but because of a lack of basic skills in what is needed. In addition, they frequently lack the capacity to deal with the problem and to manage large funds. Most churches seem to lack proper financial administrators.

6.7 Roman Catholic

The South African Catholic Bishops Conference AIDS Office was established in mid-1999 by the Catholic Health Association (CATHCA), the Catholic Development and Welfare Agency (DWA) and the Catholic Institute of Education (CIE) who collectively represent the associate bodies of the bishops’ conference dealing with health , development and education.

In 2000 it opened as the umbrella body, co-ordinating the response of the Catholic Church to the HIV/AIDS pandemic in five Southern African countries: South Africa, Swaziland, Botswana, Lesotho and Namibia. As such it has only been operating for the last 5 years.

By 2004, the Catholic Church was recognised as a major provider of care, treatment and support to infected and affected people. Currently it is coordinating some 200 initiatives which are largely resourced locally and from the SACBC.

The Church’s response is disproportionate to its membership numbers, which are less than 10% of the total Christian community in South Africa. Thus the outreach is to people of all faiths.

Given theological and doctrinal differences among people of different faiths, this practical outreach is a major social and spiritual movement, unprecedented in recent history.²²

Commitment to the response of the Catholic Church to AIDS comes from all levels. Bishops who take a hands-on approach inspire the laity to take seriously the call to serve God in their brothers and sisters. ‘When clergy, as gatekeepers, open the gates to various initiatives of their parishioners, much good work ensues.’ Even when

²² Belated, but powerful: the response of the Catholic Church to HIV/AIDS in five southern African countries. A. Munro SACBC AIDS Office, Pretoria, RSA

clergy are obstacles to various ventures, many of the laity find innovative ways to offer their own response as local church.

The SACBC AIDS Office assists the Catholic Church to:

- Coordinate its response in the region
- Fund raise
- Facilitate training and exchange possibilities
- Scale-up existing programmes
- Establish new programmes in poorly resourced areas
- Provide monitoring and evaluation support
- Facilitate the sharing of best practice models for prevention and care
- Respond to the needs of PLWHA and their families
- Address the increasing needs of OVC
- Do advocacy, especially in the areas of access to treatment, children's issues, budget reform.

With the endorsement of the Bishops, who have been very supportive, every diocese has an HIV/AIDS coordinator in place. Some dioceses have both coordinators and supporting committees that are very active. Some operate with less structure. The SACBC AIDS Office seeks to bring all these initiatives together in order to streamline the process, build local capacity and build on the interaction between the diocese and the local congregation. Further, it helps to break barriers that exist between the National and the local level and helps get management to the local level.

In three Provinces, they have concentrated on capacity building, food and nutrition and youth.

In addition, generally, there has been a focus on project management and enhanced financial management.

There are areas where very little is happening, by comparison with other areas. These areas include parts of the Eastern Cape and what were called the Homelands. Historically and politically, they were under-resourced and that has hampered a lot of efforts.

In addition, some of the older Bishops lack the capacity needed to deal with these larger issues of HIV/AIDS.

HIV/AIDS is very linked to food security and in order to address this important issue, SACBC has linked development programmes with welfare programmes.

A Sister-to-Sister Conference has been established, linking religious sisters from different orders together around issues of HIV/AIDS. Action plans are currently being developed to carry this concept into different countries as well, and share through feedback consultations.

A new decision has been passed to establish a Brother-to-Brother chapter as well. This will include religious persons from the time of Religious formation- training through to Bishop level.

Through the Catholic Institute of Education (CIE), some 300 individual and private schools have introduced life-skills programmes for their youth.

In the Free State Province, they have started working in farm schools as well.

Prevention Programmes: These are funded and implemented in all diocese and parishes.

‘ABCD’ programme is used at Tertiary level in the Universities and Technikons with the Chaplains.

‘Education for Life,’ and ‘True Love Waits’ programme is for High School pupils.

Awareness raising and education programmes, targeted at youth, adults and clergy try to promote values based approach to life.

Life-skills programmes for children, students, and out-of-school-youth complement similar government and NGO programmes.

Teachers in Catholic schools attend workshops to empower them to work with children and students.’ Permissive and irresponsible behaviour has consequences and must be addressed if impact is to be made on the spread of HIV/AIDS. Programmes do not promote condom usage.’

However, condom usage by discordant couples was upheld in the SACBC statement on AIDS in July 2001, “A Message of Hope.” There is a difference between preventing life through contraception and preserving life in the case of HIV in discordant couples.

The CIE has also developed a ‘**Circle of Care.**’ This Circle is developed locally through a workshop involving the Police, Department of Health, Social Welfare, Counsellors and numerous other local agencies/responsible authorities. A Poster is developed giving contact details of all the above and the poster is prominently displayed, informing people who to turn to when in need of assistance/help: for example in the case of a rape case.

SACBC have led a Social Grants Campaign, which is an advocacy programme under Justice and Peace. This involves getting mobile units to register children for social grants, especially orphaned children entitled to foster care grants.

Care: This is the area where the Church has been in the forefront, offering care to chronically ill and their families. There are hospices for the dying; opportunities for respite care for people who may still be able to spend time with their families when they have regained some strength; home and family care within communities; spiritual counselling and support to the dying, to their families, to the carers.

Home Base care (HBC)

Catholics have rediscovered their role in health care, not through hospitals –which were mostly nationalised many years ago- but through their home based care programmes. They have 2 hospitals and 33 clinics left. Increasing numbers of sick

people led them to recognise that their main focus had to be on home based care, which had to be holistic i.e. responding to the whole person in the totality of their home situation, whatever that might be. This requires not only health care, counselling, assisting in the sustainable access of nutritious food; spiritual care and accompaniment; and an inclusive response to the needs of all members in the household.

Nationally, there are currently 66 home-based care programmes.

Orphan care is an integral component of almost all Catholic home-based care programmes as well as the training of increasing numbers of volunteers.

Necessity in some circumstances has demanded that even small children be trained, enabled and supported to care for their own terminally ill parents or guardians.

Orphans and Vulnerable Children (OVC):

After the death of the ill person on Home Based Care, many of the children left behind have no one to turn to except the home based carers. Thus orphan care is a component in almost all the Catholic HBC programmes, and in the training and enabling of increasing numbers of volunteers to fulfil that ministry: e.g. St. Kizito programme at parish level.

Some orphan care is provided in institutional facilities; however, institutions cannot cope with the sheer numbers of orphans. Catholic institutions are moving towards alternative models such as houses. Some children are fostered or adopted by family or community members, some live together with other children, with adult house-fathers and mothers to emphasise the family, cultural and community dimensions. The Church is working hard to circumvent the tragedy of child-headed households.

Some of the interventions include:

- Day-care centres to which children are brought from homes during the day and provided with a place of safety, food, medical care and basic education.
- Groupings of foster homes where people communally grow food both for nutrition and for greater economic self-reliance.
- Memory boxes: these are boxes the purpose of which is to hold what HIV+ parents wish to leave their children after their death: special personal memories, information, advice and above all a sense of personal love and care which will endure.

The Church is increasingly seeing the need to challenge communities to accept all children as ‘our children’ needing to be fostered by ‘all.’²³

The poverty of many communities inhibits or almost entirely prevents adequate care being given to orphans.

Large-scale provision of antiretroviral treatment, including prevention from mother to child transmission, paediatric care and supplementary nutritional programmes is a

²³ Bishop Kevin Dowling November 2003

preventative strategy to the orphan situation by prolonging the parent-to-child relationship.

In addition, there is the concerted effort to give HIV+ orphaned children a chance at a healthy life and education and thus the possibility of being able to provide for themselves and those for whom they are responsible.

Counselling: Lack of adequate infrastructure, trained personnel and other resources often constrains to provision of adequate counselling services.

Training is a feature of all programmes: preventative work amongst youth, home-based-care, counselling etc. On the basis of the acquired skills, there is a constant loss of trained volunteers who find formal employment with NGOs or government where they receive remuneration for what previously was done voluntarily. This is both an expense and a loss that the Church can ill-afford. However, the training becomes an asset in another setting, and the Church's impact is more widely felt.

Some training is done in inter-faith settings, and committees have taken initiatives further, frequently using the infrastructure of the Catholic Church as a home base.

In Church projects, the role of training and capacity building in leadership and management skills should not be underestimated.

A coordinator is vital to HIV/AIDS programmes with an ongoing skills transfer.

6.7.1 The Anti-Retroviral Treatment Programme (ART) of the SACBC

At the end of January 2005, the Bishops will be launching their national ARV programme in Soweto, commemorating and coinciding with the launch of the 'Year of the Eucharist.'

*Much attention is given here to this programme, as it is an example of what **the Church can do, what is being done** and what **could be implemented elsewhere**. If the Church is really going to be relevant in the era of HIV/AIDS, it cannot turn away from any possibilities of showing holistic care and support to communities, especially the poorest of the poor and the most marginalized. Many churches do not believe they have a responsibility to be involved in issues such as ARV treatment, and they consider that it is solely the domain of the Ministry of Health. The following, however, highlights many of the underlying issues that are driving the HIV pandemic, to which attention must be paid, if our responses are to be pro-active rather than just reactive. The site-selection also indicates the potential for outreach to communities in need.*

It also opens up the doors to the greatest possibility for outreach that the church has had in many decades.

The ARV programme of the Catholic Church is quite unique and is an example of what is possible, irrespective of resource settings. Most of the ARV treatment rollout is home-based care driven.

In February 2004, the church started rolling out its programme to provide HAART at 22 of its facilities. By January all 22 sites were operational. This success was not without much bureaucratic difficulties with the government to obtain permission for the process.

Plans for the implementation of ART in Catholic facilities started in 2003. 22 Sites were selected, using the John Snow International tool, and funding proposals were submitted to various donors. The first donor to respond was Cordaid and the first wave of sites could be started in February 2004. Except for starting off these sites (by paying for staff salaries, laboratory tests and drugs), Cordaid funding paid for the training of doctors and nurses from all sites (through the Foundation for Professional Development). PEPFAR funding finally started to come through in the middle of the year. The process has been delayed by the requirement of the US government that letters of agreement had to be obtained from each provincial Department of Health, before the funding for the sites in the specific province could be released. This requirement is due to the fact that PEPFAR funding is part of a bi-lateral agreement between the South African and US governments.

All SACBC sites use the government's treatment protocols and treatment regimens. It was agreed to also use the government's patient tracking forms. An efficient system has been developed: each site employs a doctor, a professional nurse and a project co-ordinator. Before commencing with the programme, the staff undergoes government-accredited training by the Foundation for Professional Development. The doctor and nurse draw blood from patients on site, which is then sent by courier service to Toga Laboratories in Johannesburg, to be tested for CD4, Viral Load and Full Blood Count (where necessary, liver function tests are also performed). The site is informed of the results by e-mail. Patients with CD4 counts below 200 are put on treatment. The site doctor orders drugs electronically from Motswedi Pharmaceuticals in Johannesburg. They are pre-packaged individually for each patient, and are delivered to the site, where they are given to the patients. Each patient has to undergo adherence training before commencing with treatment. A member of their families undergoes training with them, to act as treatment supporters. Each site has a home-based care network. Caregivers are also trained to act as adherence monitors.²⁴

Currently there are 22 operational sites and all, except one, are non-hospital based. The uniqueness of this programme is demonstrated in the rollout sites and method. For example:

St Mary's Hospital

St Mary's Hospital is situated at Mariannhill, on the western outskirts of Durban. It is one of only two remaining mission hospitals in South Africa, and as such is the flagship of Catholic healthcare in this country. It serves an area with a population of close to 750 000, consisting mostly of very poor, mostly unemployed people living in informal settlements.

²⁴ The SACBC ARV Roll out: A narrative report 22 Sept. 2004 Johan Viljoen

St Mary's also serves a community that, together with the Hlabisa Magisterial District, has the highest HIV infection rate in the country. The Hospital has been in the forefront of providing care to people with AIDS through their ART programme, started a number of years ago, known as the iThemba Clinic – a Zulu word meaning 'Hope'. In 2002, Catholic Medical Mission Board (CMMB) started a PMTCT programme at the Hospital, known as 'St Anne's Clinic'. Both of these functioned as vertical programmes. Both programmes were extraordinarily successful. IThemba Clinic reported an adherence rate of 99,6% - something almost unheard of elsewhere. St Anne's Clinic reported an almost unbelievable HIV infection rate of over 50% of all pregnant mothers attending antenatal services at the Hospital – an indication of the massive problem faced by St Mary's.

In order to maintain the target of 750 patients on ART by Feb.2005, an additional 100 patients are enrolled each month, and commence with adherence training. It has been named as a 'Centre of Excellence' under the PEPFAR funded AIDS relief programme. It continues to provide technical support; human resources and training to many of the SACBC's ARV roll out sites in KwaZulu/Natal.

Tapologo

Tapologo is the programme of the Diocese of Rustenburg. Rustenburg is the world's largest source of platinum – numerous mines dot the landscape in an arc-stretching north-west to north-east of the town, and is the fastest growing town in South Africa. Traditionally, the mining industry has always made use of migrant labour, and mineworkers come from as far away as Malawi and Mozambique, and live in single-sex hostels close to the mineshafts. Following in their wake, large numbers of desperate women came, setting up informal settlements close to the gates of the hostels, practicing prostitution and selling home-brewed liquor. Retrenched mine workers erected shacks in these settlements as well, hoping to find employment again if they stayed close to the mines. And so, shack settlements have grown up around the hostel gates, accommodating poor, desperate, uprooted people: an ideal environment for the spread of HIV/AIDS. The problems are exacerbated by the inability of the local authority to provide services – all of these settlements are on Bafokeng tribal land – the tribe does not want them there, and therefore does nothing to provide services or security of tenure.

Sister Georgina Boswell stepped into this void, and started providing primary health care services through the Freedom Park Clinic. Housed in converted shipping containers, the clinic provides curative services, home based care, adult education and child day care facilities. Due to overwhelming demand, services quickly spread to all the surrounding squatter settlements. Currently Tapologo has a network of home based caregivers running a programme that is financially supported by the platinum mines, providing services to all of these communities. Tapologo is currently constructing an administrative centre and a hospice on the grounds of St Joseph's Mission in Rustenburg.

With its well-trained and well-motivated staff, and its extensive network of caregivers who would be responsible for adherence monitoring, Tapologo is well placed to function as an ARV site. This was initially obstructed by the provincial Health Department, as they had identified Rustenburg as a site for their own roll out,

and wanted donors to fund an ARV roll out in another area – the remote Bophirima district, on the edges of the Kalahari Desert

In March 2004, SACBC made funding available to Tapologo to initiate the process. By September, Tapologo had 66 patients on treatment.

The programme is extremely cost effective, providing services to people in a large number of villages. Sister Georgina runs the ARV programme, quite literally, out of the boot of her car. The programme has also been extremely successful in terms of adherence. Viral load tests done on the 48 patients on treatment at the beginning of August showed that the viral loads of all of them had dropped to undetectable levels. Tapologo currently has nine little satellite clinics, operating out of tin shacks; from where the ARV programme is run in the different communities it serves.

Tapologo has paid particular attention to treating families as units. The strength of the programme lies in the way family members of patients are trained and utilised as treatment supporters, reinforced by home based caregivers. *In one particularly touching case, a nine-year-old boy acts as treatment supporter and adherence monitor for his mother and father. He does not want to loose them, so he makes absolutely sure that they take their treatment.*

At the end of October, the Hospice was opened on the premises of St Joseph's Mission and was immediately filled to capacity. All of the patients were in such an advanced state of emaciation, that none of them could walk. The Hospice plays a vital role in the ARV programme – it offers place for patients where they can stabilise on their ARVs and gain strength before returning home.

The spiritual force behind Tapologo has been the Catholic Bishop of Rustenburg - Bishop Kevin Dowling –a ceaseless advocate for those suffering from AIDS.

St Joseph Care Centre, Sizanani

Sizanani, in Bronkhorstspuit, is a large Centre, with home for mentally handicapped children, a conference centre, a crafts workshop, training centres and a hospice. A former nun and professional nurse, in response to the plight of dying people who were dropped at Sizanani's doorstep by relatives from the surrounding rural villages, who were unable to care for them, started the hospice. It currently is also the base of a well trained and well-organised home- based care organization. *Its services are so widely recognised, that it was named as one of the country's top five models of best practice for home based care and palliative care by the Department of Health.* St Joseph's also provides voluntary counselling and testing, and runs a number of support groups for people in the surrounding communities. The Centre operates a number of day care centres for orphans, providing food, clothing and medical care.

When Sizanani initiated the programme, word was sent out to the support groups requiring those, who wished to be considered for treatment, to come with proof of their HIV+ status. There was concern that the numbers might be small because of fear of stigma. Over 120 people arrived; ***clearly demonstrating that stigma disappears when people have the prospect of accessing treatment.***

Sizananani has since been identified by the Department of Health to be a site for field-testing a computerised patient tracking system.

Nazareth House

Nazareth House is situated in Yeoville, serving the inner city of Johannesburg, an area with extremely high rates of crime, substance abuse and prostitution, and a highly transient population (including a very high percentage of refugees and economic migrants from all over Africa). It houses mentally disabled people, frail old people and terminally ill people. It also has a home for HIV positive abandoned children.

Nazareth House was one of the first sites where SACBC started its ARV roll out with Cordaid funding. Since the beginning of the year, the project has been funded by PEPFAR. It has the services of a paediatrician and a doctor for adults as well as an out-patient clinic. Counselling and adherence monitoring is done by Rophe, a local home based care organization based at the nearby Yeoville Clinic.

Discussions were recently held between Nazareth House, SACBC, CRS, Dr Francois Venter (of the Johannesburg General Hospital ARV Clinic) and Laurie Bruns (UNHCR) to discuss ways of collaborating. The Johannesburg General Hospital currently provides treatment to 750 patients. However, two problem areas were identified:

- The Hospital has a very long waiting list. Patients needing ARVs can only be given appointments at the ARV Clinic in six months' time. Many patients could be dead by then.
- In terms of the government's protocol, the Hospital cannot provide treatment to non-South African citizens. This is problematic, as a very high percentage of the catchment area of both the Hospital and Nazareth House (Central Johannesburg, Hillbrow, Berea and Yeoville) are foreigners.

It was resolved to solve the first problem, by Nazareth House putting South African patients on treatment who have CD4 counts below 200. They will stay on treatment there until they get appointments at the Hospital, after which they would become government patients. The second problem would be solved by the Hospital referring all its foreign patients who require treatment to Nazareth House. UNHCR would support the programme, by providing Nazareth House with French and Portuguese speaking counsellors.

St Francis Care Centre

St Francis, one of the oldest, and largest, Catholic hospices in the country, is situated in Boksburg – a grim mining and industrial area east of Johannesburg. It was started over ten years ago by Fr Stan Brennan – a Franciscan priest. It offers palliative care and has a residential facility for orphans. It also provides home-based care in two areas – Vosloorus (the former black township of Boksburg), and Reiger Park (the former Coloured township of Boksburg). St. Francis operates as an independent site providing ARVs and is expected to scale-up quickly. An ARV clinic has already been built.

St Francis is receiving numerous enquiries from potential patients in the Boksburg-Vosloorus-Reiger Park area.

Bethulie

Bethulie is in the middle of nowhere. Situated on the banks of the Orange River, between the Southern Free State and the Karoo, it is surrounded on all sides by arid semi-desert, and is more than 200 km away from the nearest significant population centre and hospital – Bloemfontein. Four years ago, Fr Peter Surdel founded the Good Samaritan Hospice in the town, as a residential facility with six beds, staffed by a husband-wife medical team. The Hospice also has a home-based care network, with more than twenty volunteers, and an orphan care programme for 100 orphans.

Bethulie started testing blood for CD4 counts in August. By the end of September, Bethulie had 31 patients on treatment.

Bethulie is only the second site providing ART in the whole of the Free State Province.

Mtubatuba

Mtubatuba and Hlabisa, in the Zulu heartland, are the two largest towns in the Hlabisa Magisterial District. They have a combined population of over 200 000. The area has one hospital – at Hlabisa and because it has the dubious distinction of being the place with the highest HIV infection rate in the country, it attracts large numbers of researchers who leave after their research is done leaving nothing behind. One is struck by the fact that there are almost no services on the ground to those suffering from the disease.

In 2000, the Catholic parish at Mtubatuba formed the Unkulunkulu Unathi Home Based Care programme – a Zulu term meaning ‘God is with us’. This was done in response to the large number of its members that were becoming sick and dying. Two years later the patient numbers had become so large, that a second home-based care organization was formed: Melusi Omuhle (meaning ‘The Good Shepherd’) at Hlabisa. Training for volunteers was provided by the matron of Hlabisa Hospital.

Extensive negotiations between Unkulunkulu Unathi, Melusi Omuhle and Hlabisa Hospital preceded the starting of the ART programme. The Hospital was unable to provide ART, as it had failed the government’s accreditation criteria. It was decided that the two organizations would bring their patients to the Hospital, that they would be tested for CD4 counts by the hospital doctor, the tests would be sent to Toga Laboratories (paid for by SACBC), and that the drugs would be ordered from Motswedi Pharmaceuticals (also paid for by SACBC). It was expected that no more than 30 patients would come forward to be tested. In stead, 129 came. In the meantime, the provincial Department of Health accredited the Hospital as an ARV site – possibly because it heard that the Hospital had already started testing patients for CD4 counts, with the assistance of SACBC

To avoid congestion at the Hospital, the site has employed a professional nurse. She will go to the various villages in the area, draw blood, send it to Toga Laboratories

for tests, and identify those patients with CD4 counts below 200. She will then take them to the Hospital, to start off with ART under the supervision of the Hospital doctors. The services of Motswedi Pharmaceuticals will be retained as a backup, due to the unreliability of supplies at the Hlabisa Hospital.

The site has already attracted the interest of other donors, with Ford Foundation expressing an interest in putting more patients on treatment there.

Holy Cross Home

Holy Cross is situated in Pretoria. It used to be a hospital and maternity home serving Pretoria's former black township of Lady Selborne. When the black population was removed under the Apartheid government's policy of forced removals to Ga Rankuwa (40 km away), Holy Cross became a frail care centre. Five years ago it opened a Hospice with ten beds. In 2001 it was named in a survey by the *Pretoria News*, as the institution providing the best quality of care in the Pretoria area. It trains health carers. The standard of training offered is so high, that credit is given to students from Holy Cross who go to nursing colleges. The Home also has an outreach and home-based care service in the nearby informal settlement of Plastic View – a dismal place, so called because its residents live under sheets of plastic.

In March, Holy Cross started putting its patients on treatment, with Cordaid funding. Results were immediate and dramatic. One female patient, who was so weak that she could not sit up in her bed, and had to be carried to the bathroom, recovered so fast, that within a week she was able to climb the stairs without assistance to the chapel on the first floor. Another male patient, who had been paralysed in the left part of his body, regained full mobility. Holy Cross has been given a target of 50 patients on treatment before February 2005.

Sister Emmanuel Nyeka, the matron of the Home, says that the introduction of ART has “turned the way in which the Home functions around.” Instead of patients coming to die, they now come to get better and be discharged. In past years, a sombre service of remembrance was held each year on World AIDS Day. In 2004 instead, a “Mass of Celebration and Thanksgiving” was celebrated, to which the Archbishop of Pretoria was invited as well as former patients where they had the opportunity to tell their stories. One of the patients, who went to Holy Cross to die and who recovered fully from the ARVs provided at Holy Cross, is now in full time service with Treatment Action Campaign, running ‘Access to Treatment’ and ‘Treatment Literacy’ workshops all over the country.

Sinosizo

Sinosizo is the home-based care organization of the Archdiocese of Durban. It provides a standard of training that has made it one of the foremost training organizations in South Africa. It also has a large network of caregivers, providing care to the terminally sick in all parts of the city.

Sinosizo started off as an SACBC ART site in February 2004, by first getting policies in place and formalising referral arrangements with the local hospital. It has served as a model for all the other SACBC ART sites as it faces a formidable

challenge, being the first roll out site that is **only** a home-based care organisation, not linked to a clinic, hospice or hospital. It has also provided valuable service to other SACBC sites, providing them with training in adherence monitoring and drug literacy.

Blessed Gerard Care Centre

Blessed Gerard Care Centre is situated at Mandini, in Zululand, approximately 100 km north of Durban. It is the service organisation of the South African branch of the Knights of Malta. The Centre has a large and well-equipped hospice, a home for abandoned Aids orphans, and a home based care organization.

Winterveldt

Winterveldt is an impoverished peri-urban area with a population of about 240 000, situated 45 km north west of Pretoria. Under the Apartheid government it was made a part of the Bophuthatswana homeland. As such, it was used as a dumping ground for people who were forcibly removed from areas that were declared 'white'. It has no infrastructure, no running water, sanitation or electricity. With the exception of three government clinics, a network of six Catholic Church clinics provides health care. These clinics provide curative services and home-based care. The Winterveldt clinics are also PMTCT sites.

Again, it was assumed that fear of disclosure and stigma would keep patients away but that has not proved to be true.

Botshabelo

The Siyathokoza Clinic in Botshabelo is a collaboration between the Holy Cross Sisters and the Holy Family Sisters. Botshabelo itself was started as a resettlement area during the apartheid era, for people who were removed from their homes in areas that were declared 'white'. It presently has a population of more than 400 000, making it the largest township in the Free State. Like most other resettlement areas, provision of basic services was neglected for many years. Today the Sisters provide an invaluable service, and also have a home-based care network that looks after many patients in their homes. The commitment of the Sisters to their patients causes many Botshabelo residents to bypass the government clinics, to seek treatment at Siyathokoza. Sr Alicia Hogan, already well into her seventies, is a familiar sight, cycling along the gravel roads on a mountain bike with her backpack on her back, to visit her patients.

Siyathokoza started testing HIV positive patients for their CD4 counts at the beginning of October and 70 patients underwent adherence training for the rest of the month.

Siyathokoza Clinic well illustrates the plight of Catholic health facilities in resource-poor settings. Laboratory results are e-mailed by Toga Laboratories to each site. Siyathokoza has got neither a fax machine nor a computer. Sister Adeline Lesaoana has to drive 60 km to Bloemfontein to get the results – that is where the nearest

computer with an e-mail modem is. Obtaining the results was further delayed, because no computer could be found in Bloemfontein to download the lab results.

Centocow

Centocow is situated in the Diocese of Umzimkulu. It is a very rural area, taking in the southern parts of KwaZulu/Natal, and parts of Griqualand East (which falls under the Eastern Cape). The Mariannhill Fathers built the mission at the turn of the century. Its historical buildings and beautiful natural surroundings (nestling in the foothills of the Drakensberg Mountains, close to the Ukahlamba World Heritage site, make it ideally placed for tourism development. On the mission's premises is the St Appolinaris Hospital, which used to be church owned, but has since been taken over by the KwaZulu/Natal Department of Health. HIV infection rates are very high. To serve the needs of the sick and the orphans, the Izandla Zothando Home based care project was started (a Zulu word meaning 'The Hands of Love'). Caregivers travel long distances on foot to provide care to villagers living in huts high in the mountains.

Centocow has excellent relationships with St Appolinaris Hospital. The ARV programme is a joint collaboration between the Hospital and Izandla Zothando. Izandla Zothando operates out of a mobile caravan, on the hospital grounds, where they are seen by the doctor and the nurse. All laboratory tests are done through the hospital, and drugs are also procured through the hospital. The patients are then followed up and their adherence is monitored by Izandla Zothando's caregivers, in the various communities.

Newcastle

Newcastle is the third largest urban centre in KwaZulu/Natal – with the townships of Madadeni, Osizweni and Blaauwbosch it has a population of approximately 400 000. The area's main source of employment is its collieries, and the Iscor steel foundry. It therefore attracts a large number of job seekers from all over the province.

The parishes in Osizweni, Madadeni and Blaauwbosch are run by the Consolata Fathers. Each one of these parishes has its own home-based care organization. The ARV programme is a collaboration between these three home-based care organizations. Each one has a counsellor and a number of adherence monitors. The programme makes use of the services of a doctor in the town, Dr Musa Ngubane. It also employs a full time professional nurse. There is a considerable amount of expertise locally concerning ARVs. The clinic of the Dominican Sisters at Blaauwbosch is a site of CMMB's PMTCT programme. In addition, Dr Ngubane has been treating more than 200 patients with ARVs for a number of years. About half of these patients are unemployed, do not have medical aid and cannot afford to continue with the treatment. They will be placed on this programme, and will be monitored by the home-based caregivers in their communities. Furthermore, the three home based care organizations refer HIV positive patients to Dr Ngubane, who then does the necessary blood tests, and places them on church –funded treatment.

Bela Bela

Bela Bela, formerly known as Warmbaths, is situated 100km north of Pretoria, in Limpopo Province. The project is situated on the grounds of the local clinic, and for numerous years has been providing counselling and home-based care to people with AIDS. The site has also been providing ARVs to a small number of people, with private funds. Because of its proximity to the clinic, the project has an excellent referral system with the local hospital.

Kurisanani

Kurisanani is the AIDS ministry of the Diocese of Tzaneen. It serves a poor, very rural area in the northern parts of Limpopo Province, along South Africa's border with Zimbabwe. It has been providing home based care for a number of years, and also has an extensive care and support programme for orphans.

The ARV programme will be based at the former St Joseph's Clinic, near Thohoyandou. The clinic has been refurbished, and a congregation of nuns, all of whom are nurses, have moved into the convent on the premises, to run the programme. The home for HIV positive orphans at Ofcolaco is a satellite of this programme, with treatment being provided to those orphans who need it.

6.8 The Methodist Church of South Africa

The Theology of the Methodist Church includes the belief that the proclamation of 'the Good News' in Jesus Christ requires that Christians openly embrace those infected by HIV/AIDS, in self-sacrificing love and care for those who are suffering and calls on all Methodists to act with love and compassion towards those infected and affected.

The Methodist Church of Southern Africa developed a Strategy and implementation plan to respond, as a denomination, to HIV and AIDS.

The Plan entails an integrated response to HIV/AIDS and is comprised of eight key elements:

1. Mobilisation
2. Training
3. Education and prevention
4. Health care
5. Counselling
6. Welfare and support
7. Project development
8. Funding.

The plan is guided by the pursuit of four overriding objectives:

1. Preventing the spread of HIV/AIDS
2. Care for those infected and affected by HIV/AIDS
3. Reducing the personal and social impact of HIV and AIDS
4. Mobilizing national, international and local resources.

The Methodist Connexional Task Force on HIV/AIDS encourages the development of projects that make a direct impact on people living with AIDS and the families

affected by it. This means that the projects should be directed to making a significant impact on the 'quality of life' of the affected.

The Methodist Churches have wonderful functioning programmes yet, according to the programme implementers and HIV coordinators, there is a sense that these programmes very often are uncoordinated, under-resourced and under documented. Their networking facilitation is lacking.

These programmes are sometimes:

- Directly run by the Church
- Are ecumenically based
- As a result of an initiative, originally started in the Methodist Church, which has now become an independent NGO
- An NGO that has 'piggy-backed' onto Church initiatives.

In reviewing the Central District AIDS database listing the activities of 22 Methodist initiatives, I noted the following:

- 70% are involved in counselling and spiritual direction;
- All but one are offering home-based care and training for carers;
- A quarter of them offer debriefing sessions and supervision of the carers;
- Nearly half are involved in prevention activities and sex education;
- 20 out of 22 have some form of de-stigmatisation programme;
- Only 4 ran education for positive living initiatives whilst three quarters facilitated support groups, even more offered some form of care to orphans and child-headed households;
- Similarly there were large numbers of soup kitchens, food parcels with some income generating and therapy projects.
- Almost all had some form of liaison with health clinics and other NGOs. Four were in partnership programmes.

Some of the outstanding programmes include the following examples:

The Methodist 'Love Box.' (Cost approximately ZAR250.00 each)

HIV/AIDS is a chronic condition requiring continuity of care. Current health systems are frequently inadequate to provide medical care for HIV+ people. The MethCare 'Love Box' contains medical supplies for the treatment of opportunistic infections associated with HIV/AIDS: pneumonia; cough; diarrhoea; thrush; fever; bronchitis; herpes; retinitis and skin infections.

The medicinal supply is used alongside medical treatment and AIDS drugs. The Love Box medicinal support is accompanied by a guide for caregivers on 'How to administer the medication' in home-based care. It is care outreach focused on alleviating suffering.

Alberton Methodist Care:

This started as a shelter for battered women and children. It now has 26 ministries, including HIV/AIDS and economic empowerment programmes.

Hillcrest AIDS Centre KwaZulu Natal:

Director: Julia Hornby. This Centre operates on a daily basis Monday to Friday. It started as a Methodist project and is now a stand-alone NGO. The Centre, chaired by Methodist Bishops, offers HIV/AIDS information, education, counselling, HIV testing, support and care. It also runs very innovative programmes such as 'Renate' – the making of fuel conservative stoves.

Carryou Ministry:

Director: Sr. Pam Jameson. Carryou Ministry focuses on home based care and orphan support in under-resourced communities with 'make-do' skills and adaptive skills.

Food Gardens Foundation

This project focuses on nutrition and is based on the 'deep trench' plan. Permaculture training courses are run for the 'common good' and are open to all, not just members of the Church. The training costs R300.00 /3days course and includes seeds and other resources.

It is operational in the Eastern Cape, Hillcrest (KZN), Mooiplaas and East London.

There are several other similar nutrition projects, of note being Net Care Hospital, the Mustard Seed Foundation (Rev. Joh Tooke) in Franschoek and Tikkum Helping Transformation.

Phakamisa

Focal person: Glenda Howieson.

This programme started with pre-schools in the church and the provision of training. There are now 200 satellites with over 800 children in care and involving some 220 teachers, 8500 children under 5 years; 5940 orphans, 990 care givers and 165 groups working in this field.

Ethelbert Children's Home

Sparrow Ministries: AIDS Settlement

HIVES

Focuses on HIV education, support and sustainability. It is a multi-church programme.

AIDS Mission Outreach: Lebore House Care Centre

God's Golden Acre:

Focal person: Heather Reynolds

God's Golden Acre is a non-profit organisation providing support to children infected and affected by HIV/AIDS and violence in KwaZulu-Natal. The project has two focuses: a residential cluster foster care centre for 91 orphans in Khayelihle; and an outreach programme to 4000 children in the rural areas.

Methodist 'Women's Manyano' (Women's League)

This association is for married women within the Church and the 'Young Women's Manyoro' is for unmarried women.

Nationally there are 140 000 such leagues. Every church has a comparable grouping.

If these women were properly HIV/AIDS trained, equipped, motivated and resourced, they could become a huge resource to the Church in the struggle against HIV/AIDS.

They are an untapped resource in all churches.

Treatment Literacy Programme

At the Helen Joseph Hospital (adults) and Coronationville Hospital (paediatrics), Prof. Keith Bollting, a Methodist, together with a Muslim doctor, convened a FBO training programme, involving 50 – 60 people per course, which runs for 5-6 weeks part-time. The objective is to get people from the wider church community involved and informed on ARVs, the side –effects, compliance, adherence, and nutritional issues and monitoring. The intention is to get people from the faith communities to ‘buddy’ with patients on treatment and then ensure compliance and adherence.

6.9 The Evangelical Alliance of South Africa (TEASA)

The Evangelical Alliance South Africa (TEASA) is a result of a merger of two previously existing organisations namely Evangelical Fellowship of South Africa (EFSA) and Concerned Evangelicals (CE). These two organisations, representing different experiences and racial divisions of the apartheid era, ceased to exist at the end of 1995, and gave way to the higher expression of evangelical unity in a post-apartheid society with the launch in Nov 1995 of TEASA.

An estimated 3 million Evangelicals, including Pentecostal and Charismatic Christians work together through the alliance in their denominations, mission agencies and Para-church organisations.

Evangelicals, after African Independent Churches, represent the fastest growing network of Churches and are growing at an annual average rate of 4.3%.

Denominations and Church Networks include:

Alliance Church of South Africa; Apostolic Faith Mission; Assemblies of God; Assemblies of God Fellowship; Association of Vineyard Churches South Africa; Baptist Convention of SA; Baptist Union of SA; Christ Ambassadors Church; Christelike Gereformeerde Kerk; Church of England in South Africa; Church of Nazarene; Ebenezer Evangelical Church; Ethiopian Charismatic Church; Evangelical Bible Church; Evangelical Church; Evangelical Churches in South Africa; Faithways Community Church; Foursquare Gospel Church of SA; Free Baptist Church; Free Methodist Church; Full Gospel Church of God in Southern Africa; Holiness Union Church of SA; International Assemblies of God; International Fellowship of Christian Churches; Kingdom Ministries International; Pentecostal Assemblies of God; Pentecostal Holiness Church; Salvation Army; Transvaal Independent Baptist Church; Wesleyan Church.

Theological Institutions include:

Africa School of Missions; Cornerstone Christian College; Baptist College of South Africa Cape Town; Bible Institute of South Africa; Evangelical Bible Seminary of Southern Africa; Evangelical/Theological House of Studies; Petra College for Children’s Ministries; Rosebank Bible College; Teologiese Kweekskool Kuratorium

National Service Agencies include:

ACATSA; AFNET; Africa Evangelical Fellowship; Africa Inland Mission; African Ministry Resources; African Enterprise; Africa Services; Bible Band; Campus Crusade for Christ; Cape Town City Mission; Christ is the Answer for Africa; Christian Camping International; Christian Foundation; Christian Gospel Outreach; Christian Literacy for Africa; Dawn Ministries; Evangelism Explosion III; FEBA Radio SA; Focus on the Family; Free Methodist Mission; Helping Hand Christian Woman's Club; Jews for Jesus; Light from Africa (LIFA); Middle East Christian Outreach; Natal Teachers Christian Fellowship; Netcare of Woman in Ministries; Oasis Ministries; Operation Mobilisation; ORA International; Overseas Missionary Fellowship Int. (SA); Pentecostal Assemblies of Canada; SANSSA Christian Education Ministries; Scripture Union of SA; SIA Southern Africa; Students' Christian Organisation; Student Union for Christian Organisation; Student Union for Christian Action; The Evangelical Alliance Mission; Today Magazine; Trans World Radio SA; Walk thru the Bible; WEC International; World Outreach Ministries; World Sending Service; Young Woman's Christian Association of Southern Africa; Youth for Christ (SA); Youth with a Mission (YWAM)

The Pentecostal and Charismatic World Conference was held in South Africa, for the first time, in September 2004, hosted by 26 of South Africa's largest denominations within the Pentecostal family of Churches. Over 8000 delegates, including 3500 church leaders from over 100 countries attended this 4th yearly event.

The message focused on spiritual and moral regeneration, and issues of transformation, poverty, HIV/AIDS and family values were high on the agenda.

TEASA has a comprehensive range of programmes, some of the key activities, within those programmes which influence HIV/AIDS response include the following:

World Missions: TEASA is mobilizing churches for increased involvement in World Missions activities.

National Discipleship Programme: aims to move away from the patterns of apartheid in which racism, divisions, and rivalries hindered the maturation of the body of Christ.

Evangelism and Church Planting: there is an annual church planting conference.

Democracy, Education and Advocacy: this programme provides education and training aimed at building the institutional capacity of member churches to fulfil responsibilities of Christian citizenship at local and national levels.

Reconciliation: the fund enables care and healing work amongst survivors and victims of gross human rights violations, and micro-finance to start micro-businesses.

HIV/AIDS: TEASA runs a resource hub for churches providing HIV/AIDS training and education material. The project also offers programme development services for member churches and ministries who wish to develop HIV/AIDS interventions. In partnership with the SACC, the main focus is on High schools, peer education and counselling. They also target post matric students either in tertiary education or already in employment. The emphasis is on abstinence programmes.

Almost all the member churches and affiliated agencies have their own programmes specifically targeted at some form of HIV/AIDS response, whether in impact mitigation or in awareness raising and preventative education. Generally, TEASA felt that the majority of its members were not doing very much to address HIV/AIDS effectively. HIV/AIDS is still perceived as an issue that is peripheral to the Churches' calling – it is not part of the core function. Few have any specific policy on HIV/AIDS. For those who are involved, the concentration seems to be on home-based care, with a commendable spirit of volunteerism.

The major problem seems to lie with the Pastors, who lack a theological perspective on HIV and AIDS, as they concentrate their efforts on evangelism. Many still believe that HIV/AIDS is retribution for sins committed. It is acknowledged that Pastors can play a critical role in changing people's perspectives, and need to be well engaged and positively interactive with PLWHA.

Though there are many theological and Bible colleges, there are few well accredited colleges and seminaries with degree courses. Others are not even registered at all. Rhema Church has its own theological training institution.

On-going training is lacking. TEASA occasionally runs seminars for pastors.

Lay Training Seminars are not really a popular concept with the Evangelicals, who prefer to run the occasional seminar from the Church.

The Charismatics are part of the International Federation of Charismatic Christians (IFCC). Currently the Presidency is with the Rhema Church.

Baptists have their own Boards. Apostolic Faith Mission has both local and regional structures as well as a national welfare structure.

Many people are called Pastors but have no theological training at all. It is a challenge how to engage these people without undermining them and the obvious authority they exert and the popularity they enjoy.

HIV/AIDS training within these institutions is very variable. At the Auckland Park Theological Seminary (for Pentecostals and Charismatics) the module on HIV/AIDS is compulsory. Others receive only a one-day course on HIV/AIDS.

Affluent Churches tend to do more, not only because of the additional resources but because they have the supportive infrastructure.

There are few support groups for PLWHA.

6.10 African Methodist Episcopal Church (AME)

(Based on discussions with Rev. Klaas of AME and SACC)

The African Methodist Episcopal Church has no official policy on HIV/AIDS but they do have 'A Statement on HIV/AIDS' issued by the Bishops and thus is

applicable and the Churches are required to develop policies. It is a 'connectional denomination.'

The Mother Church is in America and the South African membership is approximately one million. The congregations are collected under the banner of Conferences. One Conference in Gauteng, for example, has over 60 congregations. Some of the congregations are huge.

In 2001, an area survey was conducted on congregations' responses and attitudes towards HIV/AIDS. In 2002, a convocation was held at which the findings were discussed.

The survey indicated that there was an appreciable level of awareness but a gap in terms of Church involvement in creating *more* access to awareness. Churches indicated a sense of *responsibility* towards the infected and the affected but were unsure how to respond. There was a lack of direction how to address these problems as well as difficulty in 'creating awareness' from the pulpit. Though there was acknowledgement of need, practical follow-up was lacking. In addition, there was the complaint that there is no continuity with Church leadership as the Bishops come and go every 4 years. The Bishop who initiated this study has now gone too.

During the General Conference in July 2004 Africa was raising questions on resources, partnerships between the States and Africa. A resolution was passed which sought to expand and intensify the involvement in health issues in Africa.

In February 2005 the plan of Action is to be released.

In the last 5 years, the Bishop has mobilised resources to encourage local churches to respond to HIV/AIDS. An example of such a response is a Centre called: 'Patching the House'. This is a place offering counselling and testing and home-based care using the services of volunteers. In Soweto, there were plans to establish a Hospice but instead, there will be a Day Care Centre. HIV/AIDS coordinators are to be found, not at Conference level but at local congregation level through social action directorates. These coordinators, and their activities, are not structured in any way.

6.11 Evangelical Lutheran Church of Southern Africa (ELCSA)

Discussions with Bishop Dr. N.P. Phaswana (ELCSA Central Diocese)

The Evangelical Lutheran Church has 5 Diocese in South Africa, one on Botswana and One in Swaziland and collectively represents approximately 500 congregations served by 430 pastors.

There are also two German Lutheran congregations, which are still separated along racial lines. LUCSA collectively represents all SADAC countries.

Membership is estimated at 1.2 million members (by Govt. assessment) and about 750 000 from their own assessments.

The Lutheran Theological College is based in Pietermaritzburg and is the only one operational. In the senior classes, HIV/AIDS is a compulsory module and includes

practical theology and pastoral care. Refresher courses are offered annually and HIV/AIDS tops the agenda.

The Lutheran World Federation developed a policy on HIV and AIDS, which has been adopted by all the Lutheran Branches. The Plan of Action is left to the member churches to develop and operationalise.

Within the Central Diocese in Gauteng, for example, the member church has established a Day-Care Centre for HIV infected and affected. A pastor, as a full-time coordinator, and an administrator, runs it. In addition volunteers come from the USA on 2-year rotations to work with the Church.

This Centre offers training in life-skills, management skills, business skills and parenting skills necessary in the midst of the HIV/AIDS crisis, which is ravaging 'the mind' not just the body. People come to the centre twice a week and there are over 100 members.

Food parcels are distributed once a month.

The Centre offers HIV testing twice a week. Once the clients have received their results, they can register at the Centre.

The Centre is open to the wider community including Anglicans, Methodists and non-Church goers as well. They are non-discriminatory in their provision of services.

Other denominations run similar Centres. The Rhema Church has a more advanced Centre, which offers residential care, and a Hospice.

There is an agreement between the Catholic and Lutherans whereby the Lutherans can refer their patients for terminal care in Catholic hospices. *This represents practical ecumenism.*

KwaZulu/Natal South Eastern Diocese has also assigned a pastor as coordinator of the programme. They have a hospital and have been encouraged to use it specifically for HIV/AIDS and other health delivery services.

The Eastern Diocese is located in Swaziland where they have similar programmes scattered all over. The Head Office is in Mbabane.

In Petersburg the Church runs a Health and information Centre.

The ELCSA Natal / Transvaal Church (German Lutheran) runs a project in the Hillbrow congregation called the 'Peace Church.' It is involved in information dissemination.

Youth programmes: wherever there are youth meetings HIV/AIDS tops the agenda of the meeting. The Church encourages parents to talk about sexuality with youth. In addition, each congregation leader or pastor to set aside a minimum of 15 minutes each Sunday to talk about HIV/AIDS.

HIV/AIDS Coordinators:

HIV/AIDS Coordinators are attached at every level, cascading down from Diocese level to Circuit level to Parish level and finally at parish level. Each circuit has volunteers leading the health committees.

6.12 United Congregational Church of South Africa (UCCSA)

In February 2003, the UCCSA developed a 'Policy Statement on HIV/AIDS.'

The Vision is for the South Africa Synod of UCCSA to be a community where all people, infected with and affected by HIV/AIDS, are embraced unconditionally.

The next step is to turn the Vision into coordinated action, and in Oct.2004 a Convenor was appointed to manage the Vision. In 2005 there is a workshop planned with the synod teams to turn the Vision into reality.

It is difficult to coordinate things in South Africa because of the distance between the eleven Church regions. Each region has signed the HIV/AIDS statement and has an HIV/AIDS coordinator. The South African Council of Churches, in a TOT training workshop on 'Education and Care,' has trained one person per region. These people are supposed to work with a regional committee. At synod level, coordinators meet, share from their experiences and undergo follow-up training.

There are three groups: Ministry (which includes an HIV/AIDS ministry); Means (financial); and Mission; which are coordinated by the Mission Council.

There are wonderful examples of work being undertaken in local churches and within the region.

As a synod they feel that they are doing too little about HIV/AIDS. There is appreciation for all the small local initiatives that had been developed out of compassion. Funds are not the critical issue for involvement, it is important for Churches to start where the greatest need is and to start with what they already have. People are well motivated to respond.

There are plans to develop a UCCSA Directory of Activities. The document should be ready by August 2005. Some other activities include the following:

Ministry: Prevention & Education Initiatives

Regional AIDS training teams conduct HIV education workshops for clergy, interns and students. Prevention workshops are held for youths and young adults, and after school clubs focus on abstinence.

An HIV/AIDS Resource Centre has been established to provide educational materials to churches.

Ministry: Care

Hospice care e.g. in the Eastern Cape. The Hospice service is supposed to be supported by the government hospital, but this isn't always the case. The current model involves the Church, providing material and spiritual support, in an 'end-of-life' ministry. The intention is to build on what is already in the community.

Adopt-a-Hospice Ministry provides visits, blankets and food for hospice patients.

Day Care Programmes operate for small children who have lost parents.

There is a Centre to support girls who have, because of their circumstances, become 'street children.'

The Milk Fund: This represents a creative form of practical support to orphaned babies: on the birthday of one of the members of this group, the member donates to the Milk Fund the equivalent, in finance, to the years they are celebrating. One of the Members then organises the milk for the babies at the hospitals.

Outdoor Ministry: Orphans and Vulnerable Children:

Using sites owned by the Church, this Ministry runs weekend camps, one per month, for affected youth aged 7 – 14 years.

The youth receive training in issues related to HIV/AIDS and they have a chance to escape from their circumstances, have time to play and be able to express themselves in a fun environment.

This programme needs to be sustained. How to sustain any of these programmes presents challenges to the Church: one suggestion was to encourage other churches, donors, private sectors etc to 'adopt a ministry.'

Support Groups: Soweto Church plans to open up the church building so that it can be used for support groups for PLWHA and for Home Based care, using the services of retired nurses.

Treatment Ministry in KwaZulu/Natal: Partnering with a local HIV/AIDS Government clinic, the Church is supplementing care, which the government clinic cannot provide: the clinic provides medical care, including anti-retrovirals, which are paid for by the Church.

In addition, they have a vegetable garden and they cook for the clients on clinic day.

Means Ministry: One of the projects is a beading collective: women patients sell beaded cutlery for money. This programme is linked with Lydia's House: making craft items as an income-generating programme.

The church is developing a curriculum on training in 'Business and Marketing Skills' for income generating projects, in order to offer it to those running income generating projects, such as the craft people. In Eastern Cape and Ianda, women are more likely to be able to join a co-operative if they have received such training. The training has been taking place on an informal basis but now, with the curriculum, it will be more formalised.

Critical challenges identified by UCCSA:

1. There is need to develop a holistic model, if there is to be any serious impact on HIV/AIDS by the church. An example that comes near this ideal is the programme run by the Church in Groutville, which offers medical care, counselling, food and employment prospects.
2. Issues of economics: unemployment and poverty need to be addressed. If there is no economic basis to the programme, these initiatives are unsustainable. Income generating programmes are necessary to get people engaged and they need

transport assistance to come. All these considerations involve finance, which is not currently being adequately factored into the design and implementation of the church programmes.

3. Stigma: still remains a huge challenge.
4. Indifference: many members still ignore the pandemic, and leadership is not supportive in some areas.
5. Lack of trained people.

6.13 The Uniting Presbyterian Church of Southern Africa (UPCSA)

The UPCSA consists of 18 Presbys (Regions) each with their own committees. This denomination has been concentrating on 'union' of the different sections of the church for the past four or more years. UPSCA brings together two churches that were distinctly racially different, with separate white and black congregations. The Church has become a microcosm of the macrocosm, especially with regards to poverty and unemployment. 'Our social countenance is beginning to threaten us, not because of violence etc but the HIV/AIDS pandemic coupled with poverty induces a sense of urgency on a daily basis: there is actual starvation.' UPCSA HIV/AIDS Coordinator

They would like to envision a church that is 'one' and for that there is need to develop an agenda relevant to the challenges. The questions being asked are: 'How can we be one and celebrate our diversity? How do we narrow the gap between rich and poor?'

It has been suggested that they could bring to public life a model of reconciliation by responding to HIV/AIDS and seriously address the challenge.

The amount of involvement of the church in HIV/AIDS programming is unclear. There are definite sporadic interventions but they tend to lack guidelines and a clear strategy. They are said to be striving for a policy on HIV and AIDS.

At their General Assembly, held in September 2004, the focus was on four areas:

1. Evangelism
2. Preaching the Gospel to the poor
3. Stewardship
4. HIV – it was decided to focus attention on widows and orphans.

All the General Secretaries and Moderators have been challenged to brainstorm these issues, and to ensure there is regional participation and involvement with the AACC as well. Currently the UPCSA is jointly engaging with the Methodist Church in Southern Africa, specifically to access resources from the SA government.

Recently there was a joint meeting between delegates from the Presbyterian Church of USA, the Evangelical Presbyterian Church of Southern Africa and the Uniting Presbyterian Church of Southern Africa in an attempt to develop a joint response to the AIDS pandemic.

Unfortunately, many congregations still believe that HIV/AIDS is only affecting a certain sector of the population and along racial lines. We are the 'helpers.'

All congregations / Presbys have been called upon to identify their responses to HIV/AIDS.

6.14 The Dutch Reformed Church / Uniting Reformed Church of South Africa

The Dutch Reformed Church was historically made up of four arms:

- The White congregation, who met as the 'Dutch Reformed Church'
- The people of Mixed race who met as the 'Sending Mission Church'
- The Black Congregations who met as the 'Dutch Reformed Church in Africa'
- The Indian / Asian Congregants whose Church was called the 'Reformed Church in Africa.'

10 years ago, the Sending Mission Church and the Dutch Reformed Church in Africa united together as the 'Uniting Reformed Church' (called 'Uniting' rather than 'United' because the process is on-going).

The Reformed Church in Africa, the DRC Mother Church and one group of DRC in Africa Church are not yet part of the above unification.

Since the end of Apartheid, the church focus has tended to be on unification not on HIV or AIDS. Overall, it is 'voicing' support but has made no budget provision for HIV/AIDS.

However, there are pockets of groundbreaking programmes at grass-roots level that offer considerable hope in this direction.

6.15 Calvin Church

The Calvin Church, representing approximately 10000 worshippers, was challenged to respond. The Christian AIDS Bureau of South Africa (CABSA) addressed their synod and the Synod has since developed a Vision and a strategy. Facilitators have been sent for training with CABSA and, significantly, the Church has budgeted for HIV and AIDS. They are attempting to seriously deal with the pandemic as it affects them and the communities in which they live and work.

6.16 Baptist Convention of South Africa

The Baptist Convention of South Africa HIV and AIDS desk was launched at the end of 2001. The Desk operates with project leaders, who form the executive committee, which meets monthly and the project implementers meet quarterly. Their motto is 'People who Care' and their Vision is: 'to be the light and hope to the people living with HIV/AIDS by creating a loving and caring environment wherein people of different backgrounds can live together.'

Currently they are operational in three Provinces with plans to extend into the remaining six Provinces in the near future. There are ten functioning projects, most of which have received government funding, that are principally focused on care and support in the form of home based care and orphan care and support. In addition, they have prevention projects in schools and run skills -development training courses.

Their projects are well documented and have a clear strategy. Base line studies were even undertaken before initiating some of the projects.

6.17 South African YMCA

The YMCA²⁵ has more than 160 years experience working with youth worldwide, with associations in more than 120 countries. At its core, the YMCA is grounded and guided by Christian principles. The YMCA considers itself an extension of the Churches and working in partnership with the Church to improve the living conditions of young people and mobilize them to be agents of change in society. Through various programmes and services, which engage the youth themselves in voicing their own opinions and views, YMCA educates youth about societal issues, moral challenges and ways to express their opinions.

In South Africa, the Cape Town YMCA formed in 1865, was the first of what is now a nationwide movement of 32 independent local associations. The International YMCA movement worked with members of the South African Y's national council to denounce the injustice of apartheid. The council positioned the organisation to play a vital, constructive role in post-apartheid society.

The YMCA became an innovative leader in educating youth about HIV/AIDS. It developed a programme called **'The Better Life Option' (BLO)**, one of the first in the country to use peer educators to teach adolescent reproductive health and life-skills in schools and communities. These peer educators are trained to become practitioners to run programmes at local level. They attend **a one-year training course**, broken into three ten- day residential training sessions, assignments and a written and practical examination. KAP surveys are carried out pre-and post-training. The course is certified with the University of South Africa and the successful participant is empowered to become a professional youth worker.

The YMCA works with the SACC and TEASA. They have in addition a contract with the government in the Cape for schools work.

YMCA runs Drop-In Centres and offer counselling to youth. Their programmes network with all the structures in the community who impact on the youth. They also engage with all the clinics, seeking to promote youth friendly attitudes.

The YMCA developed other national programmes such as the **Youth Worker Intern**, which provides training and hands-on leadership experience for aspirant youth practitioners. Local associations started site-specific programmes, such as **environmental education, care support for HIV infected and affected and juvenile rehabilitation**. All of these were designed to develop and empower youth.

The growth of such programmes increased dramatically over the years. This growth spurt created some weaknesses. So during the 2003 National Assembly, youth, adult volunteer leaders and staff created the 'Shared National Agenda and Roadmap'

²⁵ South Africa YMCA: Youth Engagement, Mobilization and Development Strategy Concept Paper 2004

(SNARM), which reiterated the focus on young people, and committed the organisation to provide youth with critical space to shape the direction of the movement.

One of the key tools is the creation of local youth clubs. Under the youth club umbrella, programmes and services are offered to educate and engage youth.

Youth clubs also are key to getting youth involved in their communities and their country. These clubs are run by the youth themselves.

The Youth Worker Intern Programme trains youth to lead their peers in programmes and events. Local programmes include students educating prison members in Cape Town.

The components include Adolescent Sexual Reproductive Health (sexuality, HIV/AIDS, rape, abstinence, contraceptives and STIs); Life-Skills (decision making, conflict resolution, assertiveness, self-esteem and motivational skills); Arts and Culture (drama, dance, music, poetry, crafts, beading); Support Groups (home-based care' care and support, entrepreneurial skills and life-skills); Youth Worker Intern Programme (training linked to all youth programmes, modules in gender, project cycle, organisational dynamics etc.); Work with Juveniles and Prisons; and Advocacy.

The YMCA entire programme, with its many components, is an inspiring testimony to a holistic programme, which believes in the potential and inner resources of youth, given the opportunity to develop and apply these talents to their own good and that of their community. I consider it one of the best practices that I encountered any where in South Africa, and a programme that needs to be well resourced, replicated and emulated, wherever organisations are seeking ways to effectively work with youth.

6.18 DIAKONIA

Diakonia Council of Churches is based in KwaZulu/Natal. It is an inter-church agency, working with churches and church–organisations to promote justice, economic empowerment and development, AIDS prevention and care, democracy in action, and peace, healing and reconciliation: “Partners in Faith and Action.”

It is recognised as one of the ‘giants’ confronting HIV/AIDS in South Africa.

They have a leadership focus to maximize impact and action by supporting, motivating and working with formal church leadership, including women and youth leaders; key influential people in related church organisations and independent and indigenous church leaders.

KwaZulu Natal is the area of South Africa with the highest seroprevalence rates of HIV/AIDS: 32.5% of women attending ante-natal clinics. It also is the area with some of the worst socio-political and economic problems, including highest levels of poverty and unemployment.

Together with other Ministries, Diakonia produced a very practical resource book for the Church called: ***“The Church in an HIV Positive World.”*** The book grew out of a call to provide an information booklet for the South African Christian Leadership Assembly (SACLA) in July 2003. Following SACLA, several requests from Churches and individual Christians revealed the need for a practical handbook.

This book answers that need and is a practical resource material that should be much more widely distributed.

The Methodist Church, following their Mission Congress in December 2004, has adopted this book as a training resource for both the Ministers and the lay persons. It is a resource book that needs far greater circulation because of its practicality and appropriateness to the issues at large.

6.19 WORLD VISION HIV/AIDS HOPE INITIATIVE

The HIV/AIDS Hope Initiative has an overall goal to reduce the global impact of HIV and AIDS through child focused programmes and through partnering with governments, key agencies, organisations, faith and local communities for increased HIV prevention, AIDS care and advocacy.

Their primary partner remains the Church and other faith communities. WV acts through equipping, empowering and engaging them to expand and to sustain their responses.

World Vision has been a key facilitating agent for many faith communities and the collaboration has resulted in the initiation of many programmes. World Vision is one of the key stakeholders in the Faith Based response to HIV/AIDS in South Africa.

6.20 African Independent Churches

African Independent Churches are predominantly rooted in African traditional religion.

The academic background of many of the leaders in this group is frequently lower than that of the other religions and the theological training is very frequently limited or non-existent. Nevertheless, these religions command widespread support and have a considerable influence on their adherents. They are well known for healing services, adherents falling into trances and the casting out of demons.

Lacking formal structures, they are much more difficult to tap into to ascertain their rituals and rights as well as their attitudes towards HIV and AIDS and subsequent responses. Undoubtedly they too are as affected as any other religions and they need engagement.

6.21 Interfaith Collaboration:

6.21.1 Faith Organisations in HIV/AIDS Partnership (FOHAP) (Government– initiated intervention)

The Government AIDS Action Plan, a unit of the SA Dept of Health, spearheaded a national capacity building process for the interfaith sector, in collaboration with the Policy Project. This led, in 2002, to the establishment of an interfaith programme called: 'Faith Organisations in HIV/AIDS Partnership (FOHAP). This initiative is linked to the Policy Project with USAID funding.

Represented within this organisation are Christians, Muslims, Jews, Hindus, Buddhists and African Independent Churches.

The objectives of FOHAP are :

- To critically reflect on the current responses of FBOs to HIV/AIDS and explore key challenges facing this sector
- To provide a platform for sharing ideas and experiences for future planning
- To facilitate networking and collaboration across faiths and with the broader HIV/AIDS initiatives.

Currently FOHAP is active in three Provinces of SA: Limpopo, Western Cape and Gauteng. Structures exist at national, provincial and district level.

Achievements to date:

- As a collective advocating voice for the faith based community, FOHAP has managed to mobilize support for the ARV treatment plan.
- FOHAP provides advice to government interventions that impact on the faith based sector. It is represented at the South African National AIDS Council (SANAC) which plays a key role in influencing policy formulation
- Individual religious groups have sought assistance in developing strategic and advocacy plans. Good practice lessons are being freely shared between different religious groups.

Lessons learned

- Religious groups need to find a common intervention point that does not compromise any religion's doctrine and beliefs.
- Capacity building is needed and the need to build 'working' networks and partnerships with stakeholders outside of the faith sector is crucial. Training in counselling skills is required.
- There is need to promote meaningful involvement of PLWHA into the faith based HIV/AIDS response.

Discussions with some of the key stakeholders indicated some dissatisfaction with the structure, citing concerns that FOHAP seemed to have been founded without much consultation with either the National Church Leaders' Forum nor the National Religious Leaders forum; both of which were already functioning collaborative bodies, involved in social and economic issues of national importance, and annually have an audience with the President. It is felt that FOHAP is too loosely structured and has little alliance.

In addition, there had seemed, initially, to be much emphasis on the distribution of 'paraphernalia' (T-shirts, conference-type bags etc), which was considered to be an unnecessary expense.

6.21.2 The National Religious Association for Social Development (NRASD) is the religious arm for the National Department of Social Development (Welfare Department). It exists to coordinate the religious sector for social developmental issues including HIV and Nutrition, Poverty and HIV etc. It also represents a platform for faith groups to speak with one voice to government over a number of issues

The Secretary General of the Catholic Bishops' Conference is the Chairman of the working group.

It is a more functional association than FOHAP but lacks funding.

6.22 Christian AIDS Bureau of South Africa: CABSA

The closest organisation to a network of Christian responses around the issue of HIV/AIDS is the Christian AIDS Bureau of Southern Africa, established in 2001, located at the Huguenot College in Wellington. It is 'an organisation to assist local Christian churches to become significant role players in the field of HIV/AIDS.'
Logy Murray: Founder

CABSA believes that the major Churches have already initiated activities around HIV/AIDS but the smaller churches need help.

A sub-committee of the National Religious Association for Social Development (NRASD) was formed to focus on HIV/AIDS and a training manual was developed. A resource centre was established where the core function was to offer training and HIV/AIDS resource material. A business plan was also developed.

Eventually this training/resource centre registered as an NGO, 'the Christian AIDS Bureau of South Africa' and became attached to the Huguenot College in Wellington, as an arm of the College. The College is a tertiary institution training social workers and youth.

The Vision and Mission of CABSA is to be a caring Christian community ministering reconciliation and hope to people infected and affected with HIV. They seek to assist churches and faith communities in their response to HIV/AIDS through *sensitising, mobilizing, building capacity* (training) and networking thus empowering pastors, church leaders and church members to demonstrate God's love, compassion and care.

The manual was re-worked: the Anglican Church, together with CABSA, launched this training manual called: 'Churches, Channels of Hope' aiming to train 5000 trainers and facilitators in both understanding the issues of HIV/AIDS and how to effectively communicate and train others in the same. Currently the Anglican Church sponsors the participants. Rev. Christo Greyling is the key facilitator in the programme.

The 'Churches, Channels of Hope' programme is one of the major projects of the Christian AIDS bureau and has become synonymous with CABSA.

The aim of the programme is to empower congregations with knowledge and skills to develop their own unique strategy on HIV and AIDS, based on what is happening in their own communities. It focuses on three levels of mobilization:

1. Church leadership
2. Congregation-based planning teams
3. Facilitators. A mentoring programme supports the trained facilitators.

This programme is widely used in South Africa. The South African Council of Churches entered an agreement with CABSA to use this material in the workshops facilitated by the Council. An evaluation of the programme showed it to be having a remarkable impact on the churches and congregations concerned.²⁶

Examples of on going developments include:

- CABSA is now working with the Anglican Church, co-developing the manual further.
- CABSA has a close working relationship with World Vision.
- The Uniting Reformed Church of SA is committed to the process.
- The Calvin Protestant Church, representing some 10000 members, had facilitators trained, arranged a mentoring programme, and now independently organises all the on-going training within their churches.

The Dutch Reformed College, Huguenot College through CABSA, in partnership with the Church of the Province of South Africa has formed CARIS, based in Randberg, Gauteng. CARIS stands for Christian AIDS Bureau Resource and Information Service and it aims to offer quality, reliable and accessible information and resources to empower Christian initiatives in the fight against AIDS. They have formed a national network of resource centres and are currently developing a resource database. This HIV/AIDS website and database will offer a wide range of HIV/AIDS resource material over the Internet. The website will ultimately offer information on projects and programmes available, addressing pertinent issues around HIV/AIDS. In addition, there will be a regular guideline for sermon material on issues of HIV and AIDS.

Recognising the fact that churches have not had an effective cohesive body, World Vision and CABSA convened a meeting which has led to the plans for a large consultative meeting to be held in 2005 (24/9 – 04/10/05) to bring Christian Churches and bodies together for action to confront HIV/AIDS together, including the Dutch Reformed Church.

This is a remarkable resource service for Churches in South Africa. It is not as widely known as it could and should be. It is also remarkable how much has been achieved on their limited resource base, using staff and collaborators who work on a voluntary or contractual basis.

It is an organisation that deserves considerable more attention and resources than it currently enjoys, given the depth and breadth of the services offered.

²⁶ Hope in the Time of AIDS: CABSA Annual Report 2003

CABSA is currently recognised locally as one of the ‘giants’ effectively confronting HIV/AIDS in South Africa.

6.23 Pietermaritzburg Agency for Christian Social Awareness (PACSA)

Pietermaritzburg Agency for Christian Social Awareness is an independent, ecumenical, NGO committed to the transformation of society, based on principles of freedom, equality, human dignity and mutual respect.

Working within the KwaZulu/Natal Midlands region, PACSA seeks to facilitate the empowerment of marginalized communities –especially women, youth and unemployed-

- By working directly with those groups
- By conscientising the churches and the faith community to various dimensions of the social implications of their faith
- By establishing strategic alliances with other similar agencies concerned with economic justice.

PACSA has six outreach programme areas:

1. Gender
2. Poverty and economic justice
3. Citizenship and conflict transformation
4. Citizenship and participatory democracy
5. Communications
6. The Director’s desk.

HIV/AIDS is systematically integrated into all programmes.

In order to achieve its goals, PACSA works closely with other relevant organisations and groups nationwide such as:

- The ‘Justice and Women’ organisation dealing with maintenance and abuse cases in courts.
- KwaZulu-Natal Churches’ AIDS Network
- KwaZulu-Natal Council of Churches
- Diakonia Council of Churches
- ISB HIV/AIDS Solidarity Project

Training workshops are regular features.

There are five main project areas:

1. Gender-based violence and HIV/AIDS. PACSA has been working to raise awareness on these issues, particularly during the national 16-Day Campaign: ‘No Violence Against Women and Children.’
2. Women’s Theology and Spirituality: This project seeks to engender the theological training of the Theological Cluster in Pietermaritzburg. They are involved in the Circle of Concerned African Women Theologians and the development of gender sensitive publications.
3. Youth in Schools (aged 11 – 13 years): gender, sexuality and HIV/AIDS are the main areas of focus, to empower youth on ‘value-based-relationships’

4. Gender, poverty and HIV/AIDS. This is the gender-based research project to understand how women survive in a rural or semi-rural setting with HIV/AIDS. This is a joint project with the Poverty and Economic Justice Desk.
5. Men and Gender Project. This is a research project to develop a better understanding of how men's attitudes, beliefs, and understanding of their identity contribute to gender inequalities and inequities. Men can catalyse social change and need to be on the agenda.

PACSA was key to the development of the resource handbook: 'The Church in an HIV+ World: a practical handbook.' In addition, there have been several crucial action-orientated research projects run by PACSA, looking at issues such as: 'Gender, Poverty and HIV/AIDS: How do women survive and what support do they need?' and 'Churches and HIV/AIDS: exploring how local churches are integrating HIV/AIDS in the life and ministries of the church and how those most directly affected experience these.' Results gathered from such research serves to inform and data-supported recommendations can be made to key stakeholders how to more effectively minister to their surrounding communities.

PACSA produces a number of topical and excellent publications: newsletters, fact-sheets, liturgies and books, as well as brochures, photographs and displays. HIV/AIDS issues are prominent in these resource materials and are of real value to those who wish to be timeously informed and challenged to respond more effectively and appropriately.

PACSA is an agency that places a key role in meeting people where they are at, and becoming sensitively but practically involved, to make a difference. They empower communities – including, and especially, the faith communities- to respond.

It is undoubtedly one of the programmes that has practical replicability and scale up potential.

6.24 African Religious Health Assets Programme (ARHAP)

The African Religious Health Assets Programme was initiated in 2002 at the University in Cape Town. It is in line with the Global religious health assets mapping initiative. Faith based organization play a significant role in the delivery and promotion of health. This initiative is designed to document the various levels of health care provided focusing on:

- The role of human agency in health (providers and recipients)
- An appreciative enquiry into the capabilities of religious health assets
- A mapping of material assets
- An assessment of their alignment to public health systems and policies.

The ultimate goal is open ended but essentially aims to produce a data base of what is there, to facilitate linkages; to demonstrate capabilities, and to facilitate in the distribution of resources.

7. PEOPLE LIVING WITH HIV and AIDS (PLWHA)

“Before you pray for me, feed me, make me comfortable, and then I’ll listen to your prayer.”

7.1 African Network of Religious Leaders Living With or Personally Affected by HIV and AIDS (ANERELA+)

ANERELA was formed in Uganda in 2002 and registered in South Africa in February 2003. It is a network that has been established to enable religious leaders who are living with and affected by HIV and AIDS to be empowered to live openly as witnesses to hope, and to be forces for change in their congregations and communities.

ANERELA runs national retreats in African countries to help achieve this vision. Themes covered in their retreats include: Basic facts on HIV/AIDS; safe disclosure; attitudinal change; being an agent of change as an HIV+ religious leader; public speaking and communication skills; how to confront silence, stigma and discrimination in a congregational context.

ANERELA+ and the Churches United against HIV and AIDS in Southern and Eastern Africa (CUAHA) are collaborating together on the Ambassador’s of Hope Project. This programme has run media workshops to inform both journalists and clergy on the role that they can play in de-stigmatising HIV/AIDS.

The Global Network of People living with HIV/AIDS (GNP+) and ANERELA+ have initiated a process to form a partnership together.

8. HUMAN RIGHTS AND POVERTY ALLEVIATION

South Africa has experienced democracy for 10 years and has one of the world’s most progressive Constitutions. In addition there are many policies in place to benefit and protect the lives of its citizens. However, for many South Africans information on government resources and means to access support remain at the policy level and the benefit is not felt in their lives. Statistics demonstrate that poverty and unemployment are on the rise.

Churches could play a significant role in raising awareness, offering support and appropriate training and thus empowering people to influence the issues that so negatively impact on their lives.

A number of examples of such responses exist. Many of which are as the result of networks of organisations, foundations and faith based organisations.

Example: The Papillion Foundation

Project Papillion is a registered independent non-denominational body, operating in the poorer south of Johannesburg, and assisted by a network of specialists in the areas of research, planning, structuring and the implementation of a tapestry of projects aimed at societal renewal and transformation.

‘Papillon’ is the French word for Butterfly – a universally accepted symbol of transformation.

Where areas of the country have seen dramatic drops in economic viability, there is a subsequent increase in the numbers of displaced, unemployed and destitute people. The Papillon Foundation was initiated, in 2002, to aid in the economic and social rebirth of the area and to empower communities to meet their own needs.

The network involves WITS University, Black Sash Movement, South African Police Force, UNHCR, Jesuit Refugee Services, Lawyers for Human Rights, Rosebank Union Church, Salvation Army, Dorcas Aid, Lions, St. Paul’s united Church, Methodist Church, the United Sisterhood (Jewish), St. Patrick’s Catholic Church, Human Rights Commission, Wits University Streetlaw Clinic, JHB Child Welfare Society, JHB Muslim Charitable Organisation, Hare Krishna Movement, P.A.A.I.S. Aids movement and other NGOs and Churches.

It is involved in many projects including English Language improvement classes; para-legal training, dealing with Human Rights cases (approximately 360 per month); free legal advice (20-30 cases per month); training projects like computer skills, project management and library services; and much welfare work in the form of distribution of clothing, blankets and food.

9. RESOURCE MOBILIZATION: CASE STUDY

Catholic Relief Services (CRS) Umbrella Funding to the SACBC: One Effective Strategy in the Struggle against HIV/AIDS.²⁷

The purpose and mission of the CRS South Africa HIV/AIDS Programme office is:

“Reaching out in solidarity with partners and people living with HIV/AIDS to promote dignity and justice.”

Supporting small projects, that have been identified, reviewed and approved by the SACBC AIDS Office, is one way that CRS can support transformation in South Africa.

It was decided to give priority to small grants through the SACBC AIDS Office following a recommendation from a joint SACBC/CRS assessment in 2001. The reasons given included the following:

- The SACBC AIDS Office and the Bishops, who know the local needs, are the ones requesting the small project grants in poor rural areas.
- Small projects reach out into communities that would never otherwise qualify and/or receive funding. They are projects most in need of funding but with the least capacity to write proposals acceptable to CRS and other funders.
- Small projects build capacity in poor communities

²⁷ “Umbrella Funding to Faith Based Organisations: One Effective Strategy in the Struggle against HIV/AIDS” Sr. Alison Munro SACBC and Dr Ruth Stark CRS Aug. 2003

- Small projects tend to be “owned” by local communities. They are viewed as South African projects, rather than as American (or donor) projects.
- In small projects, more of the leaders are members of previously disadvantaged groups.
- It is a practical way to support transformation in South Africa.

An independent on-site evaluation was conducted in 65 projects by experienced staff of larger more established projects. The findings were as follows:

- There are projects in all diocese
- The projects are geographically located in areas with high rates of HIV/AIDS and high poverty levels. ***Thus small projects spread the Church’s efforts more evenly among the poor and the needy.***
- Main areas of project focus are education; care-giving; socio-economic upliftment; and community involvement
- Most depend on unpaid volunteers – ordinary people – who are poor (and often infected or affected by HIV/AIDS themselves)
- Although there were many difficulties to overcome, there were very few project “failures”
- Capacity building was significant, through networking and skills training.

Price Water House Coopers conducted a financial audit of over 40 projects funded by the SACBC in 2002. It was gratifying to find that there was no evidence of mismanagement of funds. It was clear that many needed their financial skills strengthened and this was addressed by workshops in financial management to 80 of the projects.

The concluding statement of the evaluation research read:

“The Catholic Church is making a powerful response to the prevention of HIV infection and to care of those infected and affected by the pandemic.” Professor Stuart Bate D.Th.

10. OBSERVATIONS AND RECOMMENDATIONS

‘AIDS is fundamentally changing the fabric and functioning of societies. One way in which the epidemic creates a vicious circle is by striking hardest at those countries with the weakest capacity to implement responses. In many nations, AIDS is now depleting capacity faster than it can be replenished.

Given the deep and lasting effects of the epidemic, the most affected countries need to review and adapt policies and instruments across a wide range of areas to cope with the coming impact. AIDS calls for a complete rethink of how skills will be built, retained and sustained.’ 2004 Report on the Global AIDS epidemic UNAIDS

South Africa is a mixture of first and third world: it has many resources not found in other less developed countries. Many of the responses mirror first world solutions, and are not always the most appropriate, to the crisis in this environment in South

Africa. Sometimes more problems are created than are being solved in the process, where frequently back-up services and monitoring mechanisms are absent. For examples: some children have to be actually separated from their families in order to access some of the poverty alleviation grants. In the case of the elderly: there are numerous stories of people being tyrannized and literally held hostage by youths for their grants, who then use them on various forms of substance abuse.

There is a yawning gap between policy formulation and implementation. This is not only at Government level but also within Churches. Policies take too long to be reached and the time lag before even the initiation of action is of worrying proportions, given the scale of the epidemic.

Lack of appropriate skills

Within most Church projects, especially those involving HIV/AIDS, there seems to be a lack of key competencies, particularly in leadership, management and finance. In addition, there is also a decided lack in networking, documentation, monitoring and evaluation and advocacy skills.

Leadership

South Africa is experiencing an HIV /AIDS 'leadership crisis.' In comparison with many other countries in the region, it is many years behind in an effective response. The difference between South Africa and other countries is that it has both huge potential and vastly superior resources. There are plenty of bright minds and energy but they lack effective political leadership.

South Africa lost valuable time whilst President Mbeki vacillated over the issue as to whether or not HIV actually did cause AIDS, and while he refuted the efficacy of Nevirapine to protect unborn babies.

Many programmes are operating tacitly but would really forge ahead if given sufficient encouragement and mandate from senior Government leadership. When the UN General Assembly Special Session on HIV/AIDS was held in New York 2001, the absence of President Mbeki was notable, especially considering the fact that, numerically, South Africa has the most infected persons in the world.

The first South African National AIDS Conference was held in 2003 building on the International AIDS Conference that took place in Durban in 2000. The theme was "Taking Action," building on the theme of "Breaking the Silence" of the IAC.

Some of the key challenges that emerged were the need for expanded partnerships in response to HIV/AIDS. Responses need to be both local and global. AIDS can threaten the survival of the nation and government leadership is called for to slow the progress and mitigate its effects. It must also allocate sufficient domestic resources and not rely totally on international donor assistance. Responses to HIV/AIDS must be linked into the broader issues, which are exacerbating the epidemic. It requires coordinated, responsible leadership to ensure this happens and to also ensure that tradition, culture and religion should not prevent or hinder effective strategies.

Within all sectors, it will take some extraordinary efforts to make the leap from the current piecemeal approaches to AIDS to the dynamic requirements of an effective, coordinated response, which has a measurable and sustained impact on prevention, mitigation and social relief.

There are large gaps between what is policy and what is practice. There are gaps between what is *perceived* to be happening and what is *actually* happening, and gaps between what needs to happen and what is happening.

The problem of leadership extends also into the Church. For example: Churches may have policies on HIV/AIDS but these policies may not be translated into plans of action and implementation. Church leadership may acknowledge issues related to HIV/AIDS in public forums yet the message from the pulpit may convey quite a different picture.

Pastors may know the biological facts about HIV/AIDS but be completely at a loss as to how to sensitively and appropriately counsel people infected and affected by HIV/AIDS.

‘The prevention strategies of churches should not be simply advocating to ‘abstain from sex,’ but should also provide knowledge about sex and a healthy sexuality. Sex cannot be viewed as a taboo topic. Open and honest discussion about sexual issues needs to be encouraged. The history of silence and negative perceptions about human sexuality has led to contradictory messages and narrow approaches regarding safer sex and HIV prevention. Churches need to be able to talk about relationships, the positive aspects of sex as well as being open to discussing sexual health issues.’²⁸

Leadership deficiencies are evident in families too: parents and caregivers state that they *are* communicating with the youth on issues of sex, sexual abuse and HIV/AIDS and yet very few youth concur with this statement. Over 80% of youth **want** to hear and discuss these issues with their primary caregiver.

Homes and schools should be places of protection and solace for children yet the indications are that children are at risk of sexual abuse and possible HIV transmission in both situations. Leadership is needed to ensure that interventions focus on increasing care and protection for children at home and at school and on making communities safer.

The Church needs to identify these gaps and fill them.

HIV/AIDS Messages

It is not reasonable to assume that religious leaders have all **the information**, or the ability to effectively communicate this information to their wider audience. These leaders themselves need access to accurate information in order to counteract irrational fears and discrimination. Even the most conservative cleric can become an agent for change, when properly informed and involved (plenty of examples exist in Uganda and Senegal). Coupled with this is the need for theologically based

²⁸ Policy Project South Africa: Centre for the study of AIDS.

reflections on HIV/AIDS and appropriate liturgical material. Re-reading the Bible through the eyes of HIV/AIDS today should be facilitated and encouraged. The Bible is all about relationships and is full of examples of the intricacies of relationships as well as suffering, and the call for compassion.

Many agencies and organisations, including the WCC, have invested much time and resources in assisting to develop such theological aids. These need to be accessed, shared and developed further in line with the dynamics of HIV and AIDS.

There is a real need to reappraise the **content of the HIV/AIDS messages**.

Church leaders may have adequate knowledge about HIV/AIDS, though most of this focuses on biological facts and does not adequately take into account the social complexities surrounding the pandemic and how they impact on individuals. This factual knowledge has in many cases not led to a transformation of attitudes, and many church leaders hold judgemental opinions about the main way people become infected.²⁹

PLWHA are hearing judgemental messages in the sermons: sometimes it is frank moral condemnation and other times it is in the stigmatising language used when referring to PLWHA, and finally it is messages ‘in passing.’

In addition the content of the message may be a narrow focus on preaching abstinence and faithfulness, with regard to HIV/AIDS, not acknowledging the many other issues at play in the complexity of the pandemic, and a deafening silence with respect to adult sexuality and condoms. This often makes the PLWHA feel that the church is too hostile an environment in which to disclose and be supported.³⁰

In conveying messages on HIV/AIDS: there is need to base these messages on rational expressions of true-to-life scenarios, not excluding the very real issues of social contexts; socio-economic status, culture, gender relationships, supporting environment and frank poverty.

If messages could be shared, not in a top-down-approach of information transmission, but in an environment that allows for dialogue and debate and negotiation on the issues expressed, perhaps that might better foster a sense of ownership of the messages, by the very communities we are seeking to empower.

Whilst there has been a strong emphasis on the necessity for HIV/AIDS sensitive sermon guidelines and liturgical material, it is also important to recognise that there are churches from non-liturgical traditions who need a different form of assistance.

Many people complain of: an ‘HIV/AIDS saturation;’ of ‘HIV/AIDS constipation’ – meaning they feel ‘over-work-shopped’ on HIV/AIDS. At the same time, there is emerging a call for help with counselling skills in an era of HIV/AIDS. It could be an opportunity to address this expressed need, whilst at the same time focusing on the stigma, which is fuelling HIV/AIDS, and is often left out of ‘information on HIV/AIDS.’

²⁹ PACSA Research Project Churches and HIV/AIDS Dec. 2004

³⁰ PACSA Research Project ‘Churches and HIV/AIDS’ Dec. 2004

Gender Issues

Gender inequalities and injustices are at the root of much of the spread of HIV/AIDS. Even within Churches themselves, there are glaring examples of gender discrimination where women are excluded from decision-making.

Women should not be viewed merely as ‘victims’ and that their vulnerability stems solely from inherent physical or psychological weaknesses. Women have an amazing resilience.

Many of the factors making women vulnerable are external: such as cultures and traditions, laws and practices which regulate and maintain their low and vulnerable status, and in most cases, their infection does not result from high risk behaviour. These injustices need exposure. So long as silence shrouds these injustices, they will be perpetuated. There is need to raise them from silent acceptance and acquiescence to public attention, and to challenge cultural practices and gender discrimination that is harming and killing the women of our society. We have a moral duty and an imperative to do this, and currently, the Church is *not* taking the lead.

There is a mistaken perception that ‘Gender issues’ refer solely to issues concerning women. The current gender –relationships are making *both* sexes vulnerable to HIV/AIDS and men equally need to be included as part of both the problem and the solution.

‘Children suffer the most from the fallout of previous generation’s failure or inability to provide for them. There is much talk of ‘moral regeneration’ but it is often presented as the need for improved behaviour among children and young people. It is evident those children find themselves in a morally ambiguous world and that they are in desperate need of role models. There are positive role models out there and many of them are men.’ Deborah Ewing; Children First Nov/Dec 2004

There is great need to encourage and enable men to take up their roles as fathers, and to provide children with care and protection, particularly in an environment of HIV/AIDS where youth are the most vulnerable.

Society is being ravaged by HIV/AIDS. There is need to look at ways to promote men as ‘Protectors of society,’ to assume the role of ‘responsible fatherhood’ and to plan to deal with many of the negative impacts of the reverse in society.

In addition, children need the care and protection. A man can make all the difference to a child’s life by preventing or stopping abuse perpetrated by other men. Men need to protect children in the home, in the neighbourhood, at school, on public transport systems and anywhere where they are vulnerable. Similarly they can protect women and all vulnerable members of society.

Significantly there are insufficient associations for men, especially within the Church, where these issues could be given adequate space to be addressed. There are plenty of ‘Women’s leagues,’ Mothers’ Unions, Youth Clubs and Children’s Sunday school events but too few activities specifically for men. High rates of unemployment, loss of traditional status and men’s social marginalisation and all the

ensuing psychological issues that accompany these problems are barely addressed within the Church.

‘Create and improve training and education programmes to enhance awareness and knowledge among men and women on their roles as parents, legal guardians and caregivers, and the importance of sharing family responsibilities, and include fathers as well as mothers in programmes that teach infant child care development.’ *Recommendations of UN Commission on the Status of Women. 2004.*

Violence

Recently, during the ‘16 Days Campaign against Violence toward Women and Children,’ President Mbeki blamed whites for stereotyping black masculinity as ‘violent and abusive.’ In so doing, he succeeded in turning the issue into a racial question rather than addressing the seriousness of the situation. This is a very public example of similar reactions to many pressing issues, including HIV and AIDS, that results in side-tracking from the underlying issue and thus never dealing effectively with it.

There *is* a definite increase in violence towards women and children. The responses need to be much more aggressive and involve zero tolerance. The ‘soft approach’ is equated with a condoning of the violence. It is NOT cultural to rape children, one’s own children, and it never was. Zero tolerance will act as a ‘wake-up call’ to perpetrators that it is NOT acceptable and it is a punishable offence. The powerful voice of the Church in advocacy needs to be much more audible. Perpetrators need to be prosecuted, there need to be well known and easily accessible places of safety for victims (there are very few run by the Church) and there should be much more active community support – which will need to be mobilised and again the Church could have a valuable role to play. Where training has taken place of women, and it is said to have led to more violence toward the women, the training should not be stopped but the efforts redoubled as the need is obviously there.³¹

Unfortunately, again, this is a totally under-resourced area.

The question is constantly raised as to *why* South Africa is such a violent society. I believe there is no simple one-answer to this complex situation. Some of the contributory factors may be the following:

- In a society that has been so repressed for so long, there is much suppressed anger and frustration that spill over into violent acts on more vulnerable souls.
- Poor levels of education: The education system for non-whites was always considered to be of lower standards than in the counter-part white schools. There were the laws that insisted on the classes being conducted in the Afrikaans language medium, which was already a second language for the scholars. During the height of the violence, the call was “Freedom now, education later!” Freedom took a long time in coming, by which stage these students were now largely adults and education did not follow. Under the

new dispensations, opportunities knock for those with education and training. An under-educated, unemployed, frustrated population with failed expectations is a dangerous population.

- The inadequacy of the security system and poor conviction rates in the courts. This is aggravated by the inability of the police system to adequately investigate the crimes and present the evidence in a clear-cut manner to the courts. Too many cases are rejected from the courts because of insufficient preparation or poor presentation of the cases. The low conviction rate thus is no deterrent to would-be criminal activity.
- In some areas, local vigilantes resolve issues of crime, as there is little faith in the state system of justice. This in itself is open to many possibilities of violent retribution and ‘an-eye-for-an-eye-justice.’
- There should be ‘zero-tolerance’ for these acts of violence, both by the community and the state, but there is not.

Paucity of documentation

There is a paucity of quality documentation available. Programmes are there but they are not documented. This deficiency compromises the church’s ability to quantify their activities, justify to the donor community the need for support and funding, and to really assess the effectiveness of these programmes.

Some Churches have put a lot of effort into these areas, and they are to be commended. Others also take the trouble to keep a regular flow of information back to supporters, and involved communities, on their activities and programmes. Others have very little on paper – they are the busy ‘doers.’ In a time of great competitiveness for resources, churches need to be professional about their programmes and this includes putting more attention into adequate accurate documentation.

Weak programme monitoring and evaluation

Coupled with the above, monitoring and evaluation does not seem to be regularly included in the development or implementation of programmes. This deficiency may compromise programmes, as the implementers have little idea as to the real effectiveness of all their efforts. Further more, implementers do not know whether or not the programme is the most appropriate to the perceived need.

Human Capacity Challenges

Many programmes have arisen as a response to a need, not because there was a conscious decision to develop such a programme. Care of orphans and vulnerable children is a prime example: home-based care was initiated to support ailing adults but the presence of children in need required some response. Day-care centre, residential care and other forms of care have thus been developed. Many of the caregivers and staff in these programmes have little or no training in the intricacies of such forms of childcare: the basis of early childhood development, the psychological problems of traumatized children and so on. As a consequence, though the children may be well cared for physically, in terms of being fed and

sheltered, there may be serious other issues needing attention for which the staff are not prepared or adequately trained.

Example: South African Council of Churches

The South African Council of Churches enjoys the approval and esteem of local leadership; because of their historical role in addressing the plight of the poor and marginalized. This is a real strength. However the administrative and facilitation role of the SACC AIDS programme is greatly hindered by limited human capacity as well as resources. The increased demand for their intervention and /or participation means that they end up spreading themselves too thinly, resulting in gaps and inability to follow up and to consolidate responses. There is need to encourage and ensure adequate documentation of responses by member churches and opportunities for truly sharing of good/best practices as churches struggle with different issues. There is also a lack of collaboration between various church related initiatives and an unhealthy competition for funding from similar donors.

Given sufficient human resources, the SACC could do a lot more networking and facilitation both between the churches themselves, and between churches and more secular stakeholders, thus making the linkage with expertise, experience, capacity and resources.

It is in situations such as these that churches and organisations need to seriously consider their effectiveness. If their ability to perform could be greatly enhanced by either appropriate training, or the addition of new staff, or the outsourcing of technical expertise, then it is a justified utilization of resources and should be pursued, and supported.

Partnerships / networks:

Many faith-based organisations have initiated partnerships and networks with other faith groups, NGOs and private sector working in the field of HIV/AIDS.

Some of these networks are very effective whilst others can be a source of frustration: such as some of the networks with Government ministries. The latter is usually because of poor arrangements and communications, and last minute scheduling or cancelling of meetings. If FBOs pull out, they are accused of being non-supportive to govt. efforts. Faith Based organisations, and NGOs, have a greater flexibility in their work programmes and ability to respond to needs. The wheels of govt. turn much more slowly, and inflexibly, and that can be another source of frustration.

In spite of these difficulties, it is worth pursuing these networks and partnerships. FBOs need to be seen as equal partners at the table and deserve the same respect. FBOs need the forum to voice issues that affect their constituents, and to have a direct input into policy decisions that will have implications for the communities, and the nation, that they serve.

FBOs must have *appropriate* representation on the Country Coordinating Mechanism: it is their right as well as their responsibility to demand it. In order to do this, there needs to be sufficient coordination and collaboration between the FBOs to ensure consensus is achieved.

Overall, there appears to be a lack in the formation of networks and partnerships:

- With other churches within the same denomination
- Between denominations
- With other sectors and key stakeholders around issues of HIV and AIDS
- With the community in which they are involved
- With PLWHA

Greater collaboration is needed to maximise efforts, coverage, and quality of service delivery, and better utilization of resources, both human and financial.

There are some examples of excellent practices: these need to be shared. Some denominations have maximally utilized their resources, infrastructure and church networks to get the greatest possible coverage, using the least resources, and having the biggest impact. How they have done this needs to be shared and much could be learned from each other. Churches are not partisan service providers. They serve anyone in need in the community, not just those of the same denominational background. There may be denominational differences of theology or interpretation, but HIV/AIDS is a problem that is common to all.

PLWHA

***Support Groups: a litmus test of Church commitment to PLWHA**

Support groups - operating out of the church and as an integral part of church life - are the true 'litmus test' as to whether or not the church has truly accepted people living with HIV and AIDS and has 'embraced' them into the life and community of the church.

Support groups do exist, but they are largely run by NGOs outside of the church, and separate from the church. A PLWHA, attending a church for the first time, is unlikely to be able to establish where to find support from that church.

Church structures are not being fully utilised, even in the face of such need.

This is a sad reflection of how far there is still to go..

*** Insufficient involvement of PLWHA in the life of the Church:**

PLWHA are still kept very much on the fringes, as *recipients* of care and support rather than as valued *contributors* to programmes and policy setting. They have personal experience of HIV/AIDS and understand best how it affects every aspect of their lives: we need to learn from them and demonstrate our acceptance and inclusiveness by truly having them involved in the life of the church.

It is very important that the rights of PLWHA are respected. Whilst it is extremely helpful to have someone with HIV share their testimony with others in the congregation or in our workshops, we must be very careful not to 'exploit' their services. It takes a lot of courage to share at such a deep level, to complete strangers, such personal details of one's life and the impact the disease is having. It is

emotionally taxing and their courage should be respected. The audience should also be asked to respect the dignity of the person, and ensure the questions they ask are the kind of question they themselves would not object to being asked. For those who share their story for the first time, they deserve pre-testimony counselling, so that they can better handle the reactions they are likely to experience during and after their testimony. There may even be need of post-testimony counselling, as the reaction they experience may be very negative and consequently very damaging.

In addition, and most important, is the need to respect the confidentiality of the PLWHA who chooses to share their status with the Pastor or someone else in leadership in the Church. No one has the right to share that information with anyone else, without the explicit permission of the PLWHA. These issues should be discussed and factored into all programmes.

This is a deficient area in most of the churches I encountered.

Stigma

Stigma and discrimination is still very evident in the life of the church, albeit unconsciously in many cases. Language used can be stigmatising and conveys the 'us' and 'them' attitude.

Issues of Stigma and stigma mitigation are not mainstreamed into all the myriad of activities around HIV and AIDS. Without adequately addressing stigma and discrimination, we remain working at the 'tip of the ice-berg.'

Involvement in treatment

PMTCT, ART has been considered the domain of the health system and not the core function of the church. Most Church health facilities were nationalised by the previous government and thus distanced the church from many health issues that previously they were very involved in. With the need to offer care, in particular home- based care, the church is rediscovering her role in health care of her people.

By far the most notable response to the ARV roll out amongst faith-based organisations in South Africa has been that of the Catholic Church. I would seriously consider it as a Best Practice model.

Indeed, the Catholic Church has re-found her health ministry through the strong home- based care models and networks. The church is present in all communities, and can reach patients who live in areas too remote or marginalized to be reached by government.

The Catholic Church has a network of over 140 service programmes for people living with HIV/AIDS in South Africa (hospitals, home based care, PMTCT and orphan care) making it one of the largest service providers in the country after the government.

Church sites have been providing psychosocial support to affected communities for years and now integrating these with HAART ensures holistic care for patients. Furthermore, the strong networks ensure very high compliance rates.

The wonderful examples, demonstrated most visibly by the Catholic Church's response, show clearly the very necessary role that the church can play in the era of HIV/AIDS. HIV and AIDS has led to the opening of new doors into previously closed areas and to marginalized communities. Holistic care, walking with infected and affected communities, sharing, and lifting their burden, advocating, supporting their children and vulnerable members and being the voice –for-the-voiceless- is this not demonstrating God's love and 'being Jesus' to one another?

The rollout of anti-retroviral treatment will only be considered a success if there is close to 100% adherence. In order to achieve this, each person on treatment will require at least one 'buddy' who can support them, encourage them and act as a go-between when problems arise. The Church can fulfil this role, promoting care one for another, being 'my brother's keeper' and friend. Treatment literacy is a programme that must be embarked upon within communities urgently. The failure of the rollout will be everyone's responsibility, as it will affect us all. The emergence of drug resistant opportunistic infections, more virulent strains of HIV, increased mortality of the most productive sector and age group of society, will affect us all. Therefore we have a duty and a responsibility to factor this information into all our programmes. Currently, this is not being done. Some churches are still discussing the possibility of starting 'AIDS awareness' courses – this denial of the urgency required to become an AIDS competent society is very worrying indeed.

Resource Issues

“Often governments do not have the political will to do what it takes to put programmes and funding in place. It is widely believed, and verifiable, that the Church with few financial resources does far more to address AIDS than does the government with more resources at its disposal, often unspent.” Sr. A.Munro: SACBC

There is need to get the necessary resources to communities where the activities are taking place and making a difference. Too often community based organisations access funds along the parameters set by the donors instead of accessing funds for what they are already doing, and doing well.

Working towards sustainability is difficult for any community or faith based organisation programme because of the uncertainties around funding, and the high costs of certain components such as care for OVC.

Local networking and collaboration must happen, more than it already does, with other FBOs, CBOs, NGOs and government to strengthen the impact of a local response. The advantage is that the use of resources goes further, to more people, and there is less duplication within the same area. This should allow for the replication of good practice models elsewhere.

Churches do not budget for HIV/AIDS. This creates a problem as Churches have not taken a committed decision in this regard and thus provide no space for their trainers to carry on with the work they have been trained to do.

In the '2004 Report on the Global AIDS Epidemic by UNAIDS' it was stated that 'the epidemic has placed multiple challenges before the international community, cutting across every sector.' Amongst the challenges listed was 'reorienting situation assessment and early warning systems to 'people focus' with greater attention to household impacts. In addition, the challenge to develop new strategies to deal with the disproportionate impact on women, girls and orphans, including micro credit, school support and food assistance programmes.'

The question remains: how?

I believe there needs to be a whole reorientation of donor funding strategies, particularly with regard to Faith Based programmes. Instead of the heavy emphasis of 'scaling up,' perhaps in conjunction with this should be an emphasis on 'replication' of the small successful interventions that make a difference at household level. These are very often the community-based initiatives, which lack the infrastructure and overheads of the larger initiatives. They are the one-to-one initiatives, the door-to-door, the 'widows in the church' initiative and so on. But all these initiatives lack resources to do better what they are already doing successfully. The carers often lack the skills in project proposal writing and report writing, but they KNOW what is needed and what makes a difference at the interface with HIV/AIDS, and often these are only small grant applications anyway.

Donors are so concerned about accountability, transparency, and capacity of organisations to handle funds, sustainability, population coverage and so on. They keep the financial tap so tightly screwed that support doesn't even drip down to the communities most in need, let alone *flow* to where it can be effectively utilised. It is time to trust the communities. 20% may fail but 80% may not. Should funds be withheld until one can be sure of all 100%?

There is a serious need to consider 'basket funds' for small grant projects, which are controlled by reputable, accountable mother bodies, who can best verify the authenticity of the response and the effectiveness of it. The example of the Catholic 'Umbrella funding,' controlled by the SACBC, clearly has shown the effectiveness of such a fund for small grant projects.

Small projects involve more people and contribute to community capacity building. The funds go to delivering actual services to those most in need. Less is spent on administration and salaries. The small projects provide technical and financial support to ordinary people who want to help their communities respond to the AIDS pandemic and, in particular, these projects initiated by the local church provide a *relevant* response, appropriate to the local situation.

It means that: "*even the remote rural parishes are able to set up projects for those who would otherwise be totally abandoned.*" Cardinal Wilfred Napier, Archbishop of Durban.

The financial audit conducted by Price Water House Coopers of over 40 such funded projects in 2002, showing that there was NO evidence of mismanagement of the funds, clearly demonstrated that given sufficient support, guidance and trust, *it is* possible for such an intervention to be successful.

The other benefits described in the case study only serve to reinforce the seriousness with which such an initiative should be considered.

Clearly this is a 'Best Practice' strategy, which could be further investigated for consideration and replicability amongst other denominations, Christian Councils and Faith Based Co-ordinating bodies.

Orphans and Vulnerable Children

Orphans remain one of the biggest challenges facing South Africa and the magnitude of this impending crisis does not seem to be appreciated either by the State system or the Churches. By 2015, as many as 5,7 million children could be orphaned. This is a disaster in the making and all concerned need far more proactive attention in this area, and there is need for creative, sustainable solutions.

For children to receive adequate care and attention communities must be strengthened and programmes planned on a large scale with a long time frame. There are very few truly holistic responses.

There is a growing number of Child-Headed Households at community level and this constitutes an emergency but generally is being treated as 'business-as-usual.'

In addition, there is the developing norm that grandmothers are being forced by circumstances to care for orphans and vulnerable children. Is this an 'acceptable solution?' They are elderly, over-whelmed by the demands and often impoverished at every level of their being.³²

There is need to look at ways of sustaining and supporting communities who are responding to the needs of OVC. Communities cannot become dumping grounds and expected to not only take up the responsibility but also expected to shoulder the expenses involved alone, especially when they too are reeling under poverty.

'We urgently need to shift our perceptions so that instead of seeing children affected by HIV/AIDS as helpless victims, and a burden on society we see them as a critical resource. If our projects fail to integrate the participation and opinions of children and youth, they will fail to empower the children and youth. They will fail to prevent a second wave of orphans.' *Yvonne Spain Report on the SACBC Conference on OVC 12 Nov 03*

Prophetic Role of the Church

The Church can only exercise her prophetic role from an informed position. Given the amount of information available and the training offered from all sectors, there is truly NO EXCUSE for the church to be *uninformed*.

There is need to overcome lethargy in bridging the gap between formulation of ideas and policies and action if it is to be relevant in the era of HIV and AIDS.

³² Bishop K. Dowling Nov 2003

South Africa is a country of immense potential. It has come through a crucible of fire in establishing democracy and her hard won gains are to be jealously guarded. The energy and passion that was poured out to achieve freedom needs to be redirected and focused into tackling HIV/AIDS, which will tear out the heart of society if it is left unchallenged and unresolved. There is a real urgency necessary to regain lost time and to move proactively forward. The Church has a history of standing with the people in time of need. The need is there, albeit different.

Though 'truth and reconciliation' has been an essential process in the development of democracy in the country, there remains the underlying ocean of traumatised psyche of a nation that suffered such oppression, isolation and abrogation of human rights for so many decades. These traumas may have moulded many of the perceptions of 'self-worth', human dignity and hope in the future. Unfulfilled expectations, lack of employment opportunities, violence, poverty and now HIV/AIDS are a sad mixture of enormously complex proportions. The Church must not overlook these deep issues and pains, when it is frustrated at the 'lack of behaviour change' in spite of all the many AIDS awareness programmes and messages.

The Church has a prophetic role and a role as a healing agent. Sometimes, this healing does not require words; it requires presence, understanding, empathy, acknowledgement, compassion and pure unconditional love.

Churches in South Africa are well placed to relevantly, effectively and sustainably respond to HIV and AIDS. They have the higher mandate of their faith. More than anything what is required is commitment, collaboration, courage and vision.

PARTICIPANTS IN DISCUSSIONS AND COLLECTION OF DATA

The following is a list of participants who facilitated and/or took part in discussions and assisted me with the collection of necessary data, guiding much of my thinking in the process.

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- Reformed Church
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- Methodist
- St. John's Anglican
- Presbyterian
- Scripture Union
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