Churches’ Responses to AIDS in Two Communities in KwaZulu-Natal, South Africa

Thesis submitted in partial fulfillment of the requirements for the Degree of Master of Philosophy in Development Studies

by

Mark Krakauer

INTERNATIONAL DEVELOPMENT CENTRE
QUEEN ELIZABETH HOUSE
OXFORD UNIVERSITY

ST. ANTONY’S COLLEGE
APRIL 2004
I hereby certify that this thesis is the result of my own work except where otherwise indicated and due acknowledgement is given

SIGNED                  DATE
ACKNOWLEDGEMENTS

Thank you first and foremost to all the respondents—families, church leaders, government officials, and NGO officials. Thank you for being patient and allowing outsiders into your homes and offices. I hope that this work accurately highlights your efforts and needs, and that it will improve knowledge about the current state of resource provision in your areas.

In the planning stages, thank you to those who shared their knowledge and experiences with me: Proochista Ariana, Ralph Austen, Monique Boivin, Rob Blunt, Janette Davies, Paula Heinonen, Simonne Horwitz, Lynne Jones, Ben Knighton, Rebekah Lee, Sloan Mahone, Mona Moore, Chizuko Sato, Fiona Scorgie, Jasmine Waddell, and Saul Weiner.

In South Africa, thank you to those who helped me to make contacts and provided valuable information: Tracey Semple and Thuli Thabethe at the Diakonia Council of Churches; Zanele Buthelezi, Farshid Meidany, Thuli Ngidi, David Patterson, and Thembilithle Zulu at Medical Care Development International; and Philippe Denis and Edwina Ward at the University of Natal, Pietermaritzburg.

For financial and material support, thank you to the Carr Fund at St. Antony’s College, the student research fund at Queen Elizabeth House, Medical Care Development International, and most especially, the Jack Kent Cooke Foundation.

Thank you to my research partners, Thulebona Khoza and Jodie Newbery.

For valuable comments, critique, and encouragement, thank you to my supervisor, William Beinart, and my father, Henry Krakauer.

In all phases of support, thank you to my family—mom, dad, Ruth, Pryor, and Eliana.
# TABLE OF CONTENTS

**MAPS**  __________________________________________________________ 6  

**CHAPTER 1. CHURCHES IN A SOCIAL CONTEXT**  ______________________ 8  
   A. THE CONTROVERSY  ______________________________________________ 8  
   B. CASE STUDY: APARTHEID  _________________________________________ 11  
   C. EXISTING LITERATURE  __________________________________________ 19  

**CHAPTER 2. RESOURCES IN THE TWO COMMUNITIES**  ________________ 26  
   A. BACKGROUND  ___________________________________________________ 26  
   B. MLANDALENI, NDWEDWE  _________________________________________ 28  
   C. MAGWAVENI, TONGAAT  ___________________________________________ 32  
   D. STATE HEALTH SERVICES  _________________________________________ 37  
   E. FAITH-BASED MOBILIZATION IN NDWEDWE  ____________________________ 38  
   F. HOME-BASED CARE  _____________________________________________ 42  
   G. CONCLUSION  __________________________________________________ 48  

**CHAPTER 3. THE ROMAN CATHOLIC CHURCH**  ________________________ 50  
   A. CHURCH HIERARCHY  _____________________________________________ 50  
   B. UPPER TONGAAT PARISH  _________________________________________ 56  
   C. TONGAAT PARISH  _______________________________________________ 59  
   D. KEY CONCERNS  _________________________________________________ 60  
   E. SICK FAMILIES  _________________________________________________ 64  
   F. CONCLUSION  __________________________________________________ 69  

**CHAPTER 4. THE NAZARETH BAPTIST (SHEMBE) CHURCH**  ____________ 72  
   A. CHURCH ORIGINS AND HIERARCHY  _________________________________ 72  
   B. SERVICES  _____________________________________________________ 76  
   C. DEALING WITH AIDS  ____________________________________________ 81  
   D. CONCLUSION  __________________________________________________ 85  

**CHAPTER 5. THE ZIONIST CHURCH**  ________________________________ 87  
   A. MLANDALENI AND MAGWAVENI CHURCHES  ___________________________ 87  
   B. DEALING WITH THE SICK  ________________________________________ 91  
   C. SERVICES  _____________________________________________________ 93  
   D. FAMILY INTERVIEWS  ____________________________________________ 99  
   E. CONCLUSION  __________________________________________________ 101  

**CHAPTER 6. DISCUSSION**  ________________________________ ________ 104  
   A. FOUR DETERMINANTS IN RESPONDING TO AIDS  ______________________ 104  
   B. BROAD THEMES  ________________________________________________ 109  

**APPENDIX A: RESEARCH TECHNIQUES**  ____________________________ 113  
   A. CHOICE OF APPROACH: QUALITATIVE CASE-STUDY  ____________________ 113  
   B. CHOICE OF RESEARCH SITE AND CHURCHES  _________________________ 117  
   C. CHOICE OF METHODS  ____________________________________________ 120  
   D. CHALLENGES  __________________________________________________ 125  
   E. EXTENDING THE RESEARCH  ________________________________________ 128
APPENDIX B: PLATES __________________________________________ 131
REFERENCES_____________________________________________________ 135
A. WORKS CITED _________________________________________________ 135
B. INTERVIEWS CITED ____________________________________________ 142
C. RELIGIOUS EVENTS CITED ______________________________________ 144
Map 1.

Source: University of Texas Perry-Castaneda Library Map Collection
http://www.lib.utexas.edu/maps/africa/sfrica_provinces_95.jpg
Map 2. Sub-Districts of KwaZulu-Natal

Map 3. The Two Research Locations

CHAPTER 1. CHURCHES IN A SOCIAL CONTEXT

In this chapter, I examine the role of churches as social agents. I first look at how this issue has been debated in the public sphere with respect to AIDS, and the policy implications of this debate. I then review the literature on how churches responded to apartheid, in order to provide context for the issues surrounding my research topic. Finally, I review the literature on churches and AIDS, and place my research within this body of work.

A. The Controversy

In February 2003, South African Catholic institutions held a conference in Johannesburg entitled, “Responsibility in a Time of AIDS.” It was an opportunity for the Catholic church to confront the controversy that has surrounded how it has dealt with AIDS. Munro, the head of the AIDS office for the Southern African Catholic Bishops’ Conference, spoke about how churches had been lambasted for the way they portray the disease and those who have it. “We have contributed both actively and passively to the spread of the virus. Our difficulty in addressing issues of sex has often made it painful for us to engage in a realistic way with issues of sex education. Our tendency to exclude others, our interpretation of the Scriptures and our theology of sin have all combined to promote the stigmatization, exclusion, and suffering of people with HIV” (Global Consultation Preamble qtd. in Munro 2003:
49). Other speakers pointed to the good works of the church, providing examples of social service programs in various communities. Ryan, a parish priest in Durban, contended that the Catholic Church is doing more in southern Africa than any non-governmental organisation (2003: 12).

In mainstream media, the same poles of church influence are described—the church is alternately praised as a service provider, and chastised for its messages on sexual morality. Kristof, a newspaper columnist writes: “The Vatican is increasingly out of touch and exerts a reactionary—even, in this world of AIDS, deadly—influence on health policy in the developing world” (2003). By refusing to advocate the use of condoms, the church is preaching a dangerous message. Yet at the local level (in this case, a town in El Salvador), Kristof observed a different church, led by pragmatic clergy who are vital service providers. “The irony is that no organization does more to help AIDS victims and their orphans than the Catholic Church.”

Another newspaper column highlights the important role the church played in prevention efforts in Uganda. “In particular, [Africa’s] faith community—which in many countries already provides most of the care and comfort for the sick and dying as well as the orphans and vulnerable children—has a significant role to play in contextualizing and implementing [U.S. President George W.] Bush’s plan [to provide $15 billion over five years towards AIDS efforts]” (Green and Mlay 2003).

The social and cultural antecedents of AIDS are well-known. They include gender inequality (Varga 1997), migrant labour networks (Lurie et al. 1997), and poor health care and education. The church’s versatility as a social actor allows it to
play, at least in principle, an important role in changing these social processes. For instance, in its already recognized role as a service provider, it can economically empower communities, and women in particular, through skills training and income-generating projects. As a communicator of social messages, it can emphasize gender equality and safe sexual practices, and in the process, decrease stigmatisation. The church has the institutional advantages of an established, loyal following; an existing infrastructure to reach people; a centralized structure to coordinate a consistent response; access to resources beyond the local church; and volunteerism/altruism as a core value. With respect to AIDS in particular, religion deals with the causes of disease (especially in African religions, Kiernan 1990B: 24), sexual morality, and how to cope with illness and death.

The ability of churches to take advantage of these opportunities has very real policy implications. For example, the U.S. Agency for International Development has a centre for faith-based and community initiatives that is intended to assist faith-based organizations in applying for grants. The centre was established in 2001 as part of a presidential initiative to make government grants accessible to faith-based institutions. President Bush touted religious groups as effective “social entrepreneurs” (2003). A 2000 World Bank conference with religious leaders is another example of the prevalence of faith-based organizations in development work. Religious organizations were seen to be “close to the poor and among their most trusted representatives…spiritual ties are often the strongest in societies otherwise rent by ethnic discrimination, conflict over resources, and violence”
As evidenced by the attention it has received at the highest levels of government, churches are in the business of development. The debate about the role of the church as a development agency in AIDS efforts has drawn the attention of academics, government officials, and the mainstream media alike. Yet AIDS is just the most recent controversy that the church has encountered. It has had an ambiguous role in Africa from the start—missionaries provided education and health services, while spreading Western values and the colonial system. They “often, consciously or unconsciously, acted as agents of the colonial authority” (Saayman 1990: 34). More recently, the church played a controversial role during apartheid in South Africa. Volumes have been devoted to the subject—my intention is to highlight the themes relevant to my own research.

B. Case Study: Apartheid

Researchers have generally pursued two strands of inquiry regarding the church and apartheid. The first strand, dominated by historians and theologians, tends to look at churches as political institutions, focusing on high-level debate in the mainline churches. The second strand, dominated by anthropologists, tends to look at churches as social institutions, focusing on what they meant to people on the ground, usually in independent African churches. As we will see, the research has taken this form due to historical circumstance. Mainline churches, until the 1980s,
were usually not engaged in community-level mobilization. Independent churches, which enjoyed a massive following amongst the poor, were not engaged in high-level, political debate.

Apartheid became official state policy in South Africa in 1948. Borer argues that mainline churches, as institutions, did not become involved in challenging the state until the 1980s. Before then, their resistance to the state was limited to defending human rights and voicing sympathy with anti-apartheid activists, rather than overtly challenging state legitimacy (1998: 4). Even within their churches they were not progressive social agents of equality, “There had been no serious efforts by the multi-racial churches to overcome the ethnic division of parish life” (Walshe 1983: 88). Black activists in the late 70s were fed up with the “pathetically ineffective” (ibid.) declarations of church principle. In 1980, black church leaders issued an ultimatum through the progressive South African Council of Churches that if mainline churches did not “purge the church of racism,” (qtd. in de Gruchy 1997: 167) they would form a breakaway church.¹

Mainline churches were not greater forces for social change for three reasons: the composition of their membership, the threat of political repression, and the pace of activism in greater society. Churches can only be as progressive as their constituents and leaders. For instance, the Dutch Reformed Church, whose leadership and members were predominantly Afrikaners, defended apartheid (de ¹It did not come into being because mainline churches increasingly promoted black church leaders, and because of denominational differences.
Gruchy 1997: 160). In the ‘80s, white lay members formed the South African Catholic Defence League in order to criticize the Southern African Catholic Bishops’ Conference’s criticism of the state (Brain 1997: 205). Mainline churches’ leadership was mostly white, and they were not prepared to take a more activist role.

Churches had to be pragmatic in calculating the consequences of opposition to the state. The 1953 Bantu Education Act showed early on that the Nationalist Party was not afraid to pass legislation unpopular and detrimental to churches. The Act ended state subsidies to mission schools (de Gruchy 1997: 161). The Native Laws Amendment Bill of 1957 made it difficult for black people to attend worship in white areas. Progressive bodies, such as the Christian Institute, were banned and shuttered. The state perpetrated atrocities against progressive leaders.

Finally, churches are reflections of the societies in which they operate. Direct opposition to the state did not become widespread until the 1980s, so it was no coincidence that it was at this time that mainline churches became more active. Borer argues that the two key developments in the 80s were the intensification of opposition to the state, which made opposition more acceptable to churches, and an increase in repression by the state, which made accommodation less acceptable (1998: 16). By the late 80s, most mainline churches were “fully embedded” (ibid.: 78) in the anti-apartheid movement—the Catholic Bishops’ Conference, for instance, called for economic sanctions and the removal of the state from power.

Churches, however, are not monolithic. There were progressive, activist forces within mainline churches, but because of the intransigence of the head offices,
activists operated through surrogates. The two most influential bodies were the
Christian Institute, formed in 1963 by disenchanted white members of the Dutch
Reformed and English-speaking churches, and the South African Council of
Churches, formed in 1934 by the missionary churches, but which only became
known for activism in the 70s. Activist black church leaders articulated a new
mainline church theology in the 1970s—Black Theology gave voice to black pride
and the black experience of exploitation (Walshe 1983: 161). Such movements and
organizations, led by mainline church leaders, gave an outlet to the activists within
the mainline churches. The official church bodies did not have to worry about state
recrimination, because the surrogates were breakaway and ecumenical, and did not
speak for the official church.

Thus, while mainline churches, as institutions, were not progressive social
forces, sections of the churches were. Its response to the apartheid state led
Cochrane to write, “The churches can only be expected to lag after popular
resistance, and the role of those who keep up with such resistance, or even enter into
the avant-garde, will likely never be anything but peripheral to the institutional
churches” (1987: 95). The ambiguous role of the church during apartheid leads onto
a broader debate about the role of the church in relation to the state. Historically,
churches have been conservative forces, legitimating even despotic and tyrannical
regimes. Houtart’s analysis of various revolutions in world history leads him to
conclude that the church “almost always identifies itself with the forces of
oppression… because it sees that system as one which provides it with the
possibility of communicating the messages it believes to be essential to human beings” (qtd. in Cochrane 1990: 98). The conservative tendency is essentially a survival mechanism—its voice may be threatened by a revolutionary regime, so it is safer to stay which it knows and has a voice. Villa-Vicencio, himself an activist Methodist minister in South Africa during apartheid, traces a conservative tendency, where “the dominant tradition of the churches vis-à-vis political life tends to maintaining the status quo, while a contradictory tradition of ‘restless subversion which disturbs complacency in every social order’ is also present” (ibid.: 95).

Churches, themselves, change. The Roman Catholic Church, one of the churches covered in my study, shifted towards a more subversive role with the Second Vatican Council in 1962-5. “It allowed the church to potentially free itself from identification with existing structures” (Borer 1998: 12). The status quo could be questioned and improved upon, even through resistance. “Action towards change was necessary and legitimate” (ibid.). Its role as a social agent in traditional community services, such as poverty alleviation, correspondingly changed: “Charity was no longer considered a sufficient or sole means of alleviation. Instead, the structures causing poverty had to change, and this was considered a matter of power and political action” (ibid.). As the terms of acceptable citizenship and social agency changed, new theological movements emerged.2

---

2 As evidence of the new flexibility, theology took different forms in different contexts: liberation theology in Latin America, contextual theology and Black Theology in South Africa. These evolving theologies shaped the form of protests in diverse religious organizations, including the South African Council of Churches and the South African Catholic Bishops’ Conference.
Walshe argues that the inaction of mainline churches during apartheid contributed to the growth in popularity in independent African Churches (1983: 88). These churches’ origins were as vehicles of black empowerment: “the ‘Separatist’ church is, on the part of the African, his logical reply to the Whites’ policy of segregation and separation” (Sundkler 1961: 295). The first AICs were formed in the 1880s by black members of mission churches frustrated by a colour bar in their churches. In the 1890s the first cohesive independent church movement, Ethiopianism, emerged with a vision of black pride and pan-Africanism. As offshoots of mission churches, Ethiopian churches retained mainline theology, practice, and organizational structure (ibid.: 54), but were led by Africans. The movement for church independence and self-leadership naturally dovetailed with a nascent nationalist movement; some of the original leaders of the African National Congress were also Ethiopian church leaders. The rise of overtly political movements, such as the ANC and the Industrial and Commercial Workers’ Union, “contributed to the waning influence of the Ethiopian movement” through the twentieth century (Pretorius and Jafta 1997: 215).

Ethiopianism represented “a revolt on the part of an emergent educated middle-class” (Kiernan 1990A: 22). Zionism, by contrast, was a movement of the poor. It had its start in the first decade of the twentieth century as an import of American Zionism, but quickly sprung into a diverse array of independent churches. Zionism was syncretic, while Ethiopianism was not: “These elements of African religion—invocation of the holy spirit, causing of affliction by malicious demonic
spirits, dependence on prophetic interpretation and speaking in tongues, the performance of sacrifice and the therapeutic use of water are all grounded in Christian Scripture” (ibid.). Zionist churches have the largest following of any denomination in South Africa today, thanks to its appeal to the poor. “What Zionism holds out to the poor and despised is self-respect, economic and social support, a healing service and a general sense of security” (ibid.).

Although independent African churches were a reaction to white domination, they were not mouthpieces for political mobilization. Political organizations failed to recruit them to the anti-apartheid cause; perhaps the most telling evidence of their abstinence from politics is the state’s tolerance for them (Pretorius and Jafta 1997: 225).

Numerous anthropologists studied these churches in the twentieth century (Comaroff 1985, Kiernan 1990B, Sundkler 1976, West 1975). From her anthropological research on the Tshidi Zionists, Comaroff argues that Zionism should still be considered a resistance movement, because resistance was embedded in its very existence—in its rituals and cosmology. “In the domains of everyday practice that escape direct control, a protest is mounted that acts upon the implications of neo-colonial wage labor in its apartheid form…such resistance, then, while it might not confront the concentrated forces of domination, defies the penetration of the hegemonic system into the structures of the ‘natural’ world” (1985: 261).
This discussion on churches and apartheid serves several purposes. Firstly, it gives historical and social context for my study in South Africa, on the churches and AIDS. The three churches I looked at—the Roman Catholic Church and two Zionist churches—were introduced in the course of the preceding discussion above.

Secondly, the preceding discussion presented the debate on churches as social agents. There are two battling forces within the church—the conservative that sides with tyranny at times, and the progressive that speaks for the poor. These forces are borne out in the churches’ experience with apartheid. The mainline churches were not at the forefront of socio-political mobilization, although individuals within the church were. Independent churches constituted a progressive social movement, first for the middle-class with Ethiopianism, and then for the poor with Zionism. Though apolitical, Zionism represented a subterranean revolt for the poor against an oppressive order.

A final point is that the literature can be broadly grouped into the historical, which analysed the politics of mainline churches, and the anthropological, which analysed the social aspects of African independent churches. An interdisciplinary perspective would enrich the discussion of the churches’ responses to apartheid. The existing literature is wanting for interdisciplinary studies that combine the anthropological approach of in-depth, community-based, cultural analysis, with the historical approach of cross-denominational, organizational analysis focused on a specific issue—in this case apartheid. My study aspires to this analytical approach—
it is a community-based study that compares how three denominations have responded to the specific issue of AIDS.  

C. Existing Literature

The literature on the topic of churches and AIDS is far thinner than the literature on churches and apartheid. I will begin my literature review on churches and AIDS by looking at Uganda, which has received the most scholarly attention due to its being regarded as a success story. In Uganda, the church has been viewed as an integral part of the country’s success in decreasing prevalence rates. Surveys of pregnant women show a decrease in prevalence from a peak of 15% in 1991 to 5% in 2001 (Green et al. 2002: 2). Uganda’s success is primarily attributed to the early steps the government took to publicize the disease. In 1986, President Yoweri Museveni established an AIDS control programme, one of the first in Africa (Parkhurst 2001: 73). In contrast, successive South African governments, and most notably, President Thabo Mbeki’s, have been roundly criticized for not initiating an adequate response. Amongst his most visible failures, Mbeki disputed that HIV causes AIDS, and did not take advantage of pharmaceutical discounts on antiretroviral medicines in May 2000 (Barnett and Whiteside 2002: 298, Patel 2001: 82). In Uganda, Museveni went beyond encouraging action by the government; he

---

3 My study is interdisciplinary in scope, rather than methodology. In terms of methodology, my approach was qualitative, and I cannot claim to have utilized distinctly anthropological or historical techniques (Appendix A).
used a multi-sectoral approach that coordinated and mobilized other social institutions—industry, NGOs, religious bodies, student groups, etc.

For their part, religious leaders in Uganda stressed the prevention slogans of Abstinence, Be faithful (monogamy), and Condoms—the ABCs of AIDS prevention (Liebowitz 2002: 26, Parkhurst 2001: 78). Green and Mlay attribute the decrease in prevalence to A (abstinence) and B (monogamy, 2003). Survey results in 2000-1 showed that 5-9% of Ugandans reported one or more non-regular partners, down from 20-25% in 1990 (Green 2002). Delay of first intercourse increased, from 31% in 1989 to 56% in 1995 amongst males aged 15-19, and from 26% in 1989 to 46% in 1995 amongst females in the same age group (World Bank cited in Green 2002). 4 This could indicate that it was the religious community’s message that was registering an impact on behaviour.

Parkhurst notes that Uganda’s multi-sectoral approach to AIDS was embodied in its prevention campaign, where different organizations promoted different methods of prevention. “The government of Uganda did not push for condoms very strongly, instead pursuing a ‘quiet promotion of condoms’, and inviting religious leaders to take part in discussions of condoms as a state policy” (2001: 78). While different sectors promoted different modes of prevention, they did not snipe at each other, and thus presented a united front in AIDS education (Liebowitz 2002: 26).

4 Okiror’s 1995 study cited in Green 1999: 177 lends further support to this trend.
In Uganda, the church is praised both at the leadership level and at the grassroots level. Catholic and Anglican bishops have chaired the Uganda AIDS Commission (Green et al. 2002: 7). Gifford describes a Catholic education program that organizes youth clubs to publicize anti-AIDS messages. He also describes a Baptist program that goes to schools to educate students about AIDS. Dube shows how the church has helped in Uganda, through the YWCA’s house-to-house education program (2002: 174). Liebowitz reports that the Anglican church offers counselling and testing (2002: 22).

These piecemeal accounts support the respective writer’s generalizations that the church has contributed positively to AIDS work in Uganda. However, their accounts do not constitute systematic research. Researchers seem to be content to describe national level efforts by a few mainline churches or to highlight local “success stories,” but the analysis is superficial. Reading the literature on Uganda, one does not have a feel for how churches operate within the community, which is ironic, since the churches are said to be most effective at the local level. How did national level programs operate at the local level? Did local clergy talk about AIDS to their congregations? Did this match what the national leadership was saying? How did their messages, and the impact of those messages, differ across denominations?

This discussion on Uganda’s success reveals some weaknesses of the literature on AIDS. Even as the church is recognized to have an important role, researchers have noted the dearth of academic literature on the subject (Garner 2000,
Takyi attributes it to the preference of Western researchers for biomedical-type data, and a Western, secular bias (2002: 4). One segment of literature, focuses on a socio-medical, quantitative analysis. For instance the effect of religious affiliation on sexual behaviour and AIDS-knowledge has been explored. In Ghana, Addai found that religion is a significant predictor of condom use and that women who belonged to more liberal religious groups (Protestant and Catholic) were more likely to report premarital sexual activity than conservative religious groups (1999, 2000 cited in Takyi 2003: 1222). Addai does not explore how this process actually works—what the “liberal” religious groups are saying and doing that is different from “conservative” religious groups, and how their respective messages are being absorbed by members of those religions.

Takyi analysed what influences women’s sexual behaviour and AIDS-knowledge in Ghana, using results from a national health survey. She found that Christian women had higher levels of AIDS knowledge than non-Christian women (Muslim, traditional, no religion). Yet knowledge did not translate to safer sexual behaviour. Women who reported a religious affiliation (Christian or Muslim) were less likely to use condoms than women with no religious affiliation (no religion or traditional), and religion did not have a significant effect on monogamous behaviour. Like Addai, Takyi does not address potential mechanisms by which religion affects sexual behaviour.

Besides the socio-medical literature, the existing literature on the church and AIDS is generally of three types: the “gray” literature of NGOs and government
agencies (e.g. MCDI 2000, Oxfam 2002); the theological literature consisting of debate amongst theologians about the proper stance of the church on divisive issues, such as condom promotion and stigma (e.g. Bate 2003); and finally, broad, national level analysis that deals with policy issues (e.g. Liebowitz 2002). Success stories of exemplary church programs are often used to illustrate the positive potential of the church and to lend a realistic feel to the writing (examples in Guest 2001: 78, Catholic Relief Services 2004), but in the process of selecting a success story, they are taking their example out of context.

In South African literature, there has been some progress with the community-based approach. Garner’s study (2000) marries quantitative and qualitative methodologies to produce a more meaningful conclusion about the relationship between behaviour and religious affiliation. In a former township of Pietermaritzburg, a city in the KwaZulu-Natal province in South Africa, Garner interviewed 78 people belonging to five religious categories. The respondents were not randomly selected; he does not compute the statistical significance of his results; and his results do not control for intervening variables. The consequence of an unsophisticated approach is questionable result validity, but he substantiates his conclusions with qualitative data—semi-structured interviews and focus groups. He finds that mainline, Zionist, and Apostolic church members and those with no church affiliation all reported similar levels of extra- and pre-marital sexual activity. Pentecostal church members were unique in reporting lower levels of extra- and pre-marital sexual activity. From interviews and investigations into church teachings
and practice, he explained his results by noting what made the Pentecostal churches different from the other churches. He hypothesizes that Pentecostal church members had lower levels of extra- and pre-marital sexual activity because the Pentecostal denomination has a higher level of ideological power over members than the other denominations. He defines ideological power as being composed of indoctrination, exclusion, socialisation, and religious experience. Thus Garner’s study presents an observed pattern, as well as a mechanism to explain the pattern.

Ntsimane (2000) conducted interviews with two ministers in a rural area of KwaZulu-Natal to compare their knowledge of AIDS. He spoke to a Zionist minister and a Nazareth Baptist (Shembe) minister, two of the denominations I chose in my study. Both ministers knew that AIDS was a deadly sexually transmitted disease. Neither knew anybody in their congregations with AIDS and neither spoke to their congregations about AIDS. The Shembe minister believed that the leader of his church could cure all diseases, including AIDS. Ntsimane’s results are limited to this information culled from a limited set of interviews.

My research extends Garner and Ntsimane’s work. Like theirs, mine is a community-based study, comparing church approaches to AIDS across denominations. Unlike Garner, I am not trying to measure the church’s effect on sexual behaviour. Like Ntsimane, I am interested in the attitudes and approaches of the church leaders, but have a wider range of examples. My study is based in two communities near Durban. I used several layers of research to answer the question: how have churches’ in two communities responded to the challenge of AIDS? I
conducted interviews at three levels—with local ministers, with congregants, and with community leaders, including political leaders, senior church leaders, and other NGOs. I compared the churches’ programs and messages regarding AIDS across three denominations: Roman Catholic, Shembe, and Zionist, and then analysed their messages in the context of other resources in the community at large. I also explored how congregants related to their churches as resource providers and social institutions. This is a qualitative approach. The inherent weakness of community-centric research is its limited generalisability. I cannot attest to its relevance in a different time or place. But it can yield a concrete, real-life picture, with important policy implications and insights into how churches function in these areas.
CHAPTER 2. RESOURCES IN THE TWO COMMUNITIES

This chapter describes the areas in which we conducted our research—the people there and the resources available to them. The urban-rural divide emerges as a significant obstacle for both the government and NGOs. I analyse the successes and failures of government and NGO initiatives, with a focus at the end on two faith-based projects.

A. Background

KwaZulu-Natal is the most populous province of South Africa and, by most estimates, has the highest HIV prevalence rates: it has been called, “the epicentre of HIV/AIDS in South Africa” (Varga 1997: 46). The most recently published data, from 2002, show that 36.5% of antenatal clinic attendees in KwaZulu-Natal tested HIV+ (South Africa DoH 2003). Comparatively, the Western Cape had the lowest rate, at 12.4%, and the national figure was 26.5%.\(^1\) A host of social factors are thought to be

\(^1\) A recent study contradicts these findings. The antenatal clinic data in South Africa are collected by the Department of Health, and used by such authorities as the World Health Organization (WHO 2002). The problems of extrapolation to the general population from antenatal clinic data are well-known. Antenatal clinic attendees are sexually active and do not use contraceptives effectively, causing an overestimation. On the other hand, HIV reduces fertility, causing an underestimation (Shisana 20: 2002). The advantages of antenatal clinic data are that it is relatively straightforward to obtain and that it is the historical, international standard. The alternative method—household surveys—has its own problems of sampling bias. A 2001 national survey in Zambia yielded similar figures to those collected through antenatal clinics, which “confirmed the assumption that HIV prevalence among pregnant women is roughly equivalent to the prevalence among the adult population, in both urban and rural areas” (UNAIDS/WHO 2003: 10). A 2002 national survey in
responsible for the enormous disparities in prevalence across regions. KwaZulu-
Natal has a high-quality road network and is home to the Southern Hemisphere’s
busiest port, in Durban. There are high rates of migration, the “result of decades of
legislation aimed at restricting the movements of the majority of the population and
providing a steady flow of cheap black labour” (Lurie et al. 1997: 17). Violent
political conflict up through the 1990s caused social upheaval. Finally, there is the
politically sensitive issue of race, and the perception that AIDS is “an African
problem/disease.”

The Western Cape has a greater predominance of whites, coloured people, and Muslims; it is 27% African, while KwaZulu-Natal is 85% African (Statistics South Africa 2003). AIDS is one of many things that
disproportionately burdens the African population in South Africa—there is also
poverty, unemployment, gender inequality, and poor education, making for a
complex web of social causes and effects (Manning 12: 2002). Extensive social
research has examined cultural patterns of sexual decision-making that affect the

South Africa using oral HIV tests found prevalence rates that differed greatly from the antenatal clinic
data: 11.4% nationally; 11.7% in KZN; and 10.7% in Western Cape (Shisana 14: 2002). The confidence
intervals for the provincial rates overlap, so the ranking is not definite. Yet the results generally
contradict long-accepted patterns based on antenatal clinic data. The survey also calls into question
the data on who is most susceptible to HIV—it found that the poor and the poorly educated are not
any more likely to be HIV-positive (Shisana 31: 2002).

President Mbeki’s wariness of the racial stigmatisation of AIDS motivates his controversial
reluctance to implement a more vigorous national AIDS plan. In a July 2000 speech to the
International AIDS Conference, he mockingly said, “Perhaps, in thinking that your Conference will
help us to overcome our problems as Africans, we overestimate what the 13th International AIDS
Conference can do” (2000). He has continually stressed that poverty is the key cause of the disease—
ence his push for broader social programs such as primary health care, rather than health programs
that address AIDS specifically, such as antiretroviral therapy (Epstein 2000).
We conducted research in two communities in KwaZulu-Natal—Magwaveni and Mlandaleni—over a seven-week period in the summer of 2003. Magwaveni is an informal settlement in Tongaat, a small city 70 km north of Durban (Map 3). Tongaat is in eThekwini (Durban) Municipality. It is part of a coastal corridor stretching from Durban northwards to another major port city, Richard’s Bay. Along the coastal highway are large sugar plantations. West of Tongaat, however, the development pattern is very different. Ndwenwe is a separate municipality, under a dual local and traditional administration. The second community we looked at, Mlandaleni, was in this rural municipality. The research team consisted of myself, an intern from the NGO Medical Care Development International, and an interpreter. A full discussion of the rationale for our site location and methodology can be found in the Research Techniques Appendix.

B. Mlandaleni, Ndwenwe

Mlandaleni is classified as rural due to its settlement pattern, local governance, and development infrastructure. Homesteads consist of two to three dried-mud buildings, either circular, straw-roofed huts or rectangular, metal-roofed houses. Homesteads are widely spaced, on parcels of land about .25 km². The greater municipality of Ndwenwe, is split into 19 wards, with each ward represented by a councillor. A traditional system of government is also in place, a

---

3 I use “we” when speaking of what we did, and “I” when speaking of my own inferences and analysis.
remnant of apartheid’s policy of separate, internal administration of homeland areas by traditional leaders. Mlandaleni is one of 23 Traditional Areas in Ndwedwe; it is governed by the Qadi Traditional Authority. The Traditional Area boundaries do not coincide with the ward boundaries. The traditional system’s relationship to the state is currently in flux. In terms of government services (schools, clinic), the area is referred to as Molokohlo; to be consistent with its traditional designation, I will refer to the area as Mlandaleni.

Each traditional authority has an inkosi (chief) who assigns responsibility for traditional areas like Mlandaleni to an induna (deputy). Besides Mlandaleni, the Qadi inkosi administers four other traditional areas in other parts of KwaZulu-Natal. Land is administered by the traditional authority and allocated to residents by the induna (Reader 1966: 245). In legal matters, the induna settles property disputes, while the government handles criminal matters. The induna did not provide a precise figure, but by my estimation there are about 400 households in Mlandaleni.

Mlandaleni lies between the two paved roads, about 8 km from each, that laterally bisect Ndwedwe. Homesteads are typically set off a few hundred meters from the unpaved road. Homesteads do not have electricity or running water. There are no industries or businesses in Ndwedwe. Large-scale farming is difficult because of the hilly terrain. There are some plots of sugar farmland, but the typical homestead has enough land to support only a few livestock and small-scale cultivation. Those who had jobs worked in the city, and tended to live there as well due to transportation costs, but would return on weekends. As a result, there are
many children, pensioners, and single mothers in Ndwedwe. Most households that we interviewed reported that government grants and gardens were their sole sources of income.

A 2000 household survey (N=600) by a local NGO helps to further characterize Ndwedwe. 51% of the population was under 15 years old (MCDI 2000). The mother was residing in 79% of the households, while only 43% of fathers were. 73% of mothers (N=374) did not work outside of the house for money; those who did typically sold handicrafts or food that they had produced. 7 of the 11 families we interviewed received at least one state grant.

1. Health Services

In 1997, the Department of Health (DoH) implemented a community health program in rural areas to overcome the coordination difficulties involved with long distances and poor infrastructure. Community health committees consist of volunteers selected by the induna to identify community health priorities, which they communicate to a community health facilitator. Community health workers are members of the community who go door-to-door to teach households about health issues. In 2002, they received training in home-based care as well. They are selected by the induna and the community health committee. They are paid R1700/month by the DoH, and are supervised by the community health facilitator, also a paid employee of the DoH. There are two facilitators for all of Ndwedwe and three workers for Mlandaleni. Another component of the community health system is the
home-based care volunteer. 89 volunteers have been trained in eight Traditional Areas, but none in Mlandaleni. One of the community members told us that the induna would not allow people to be trained if they were not paid for the services they provided.

At the provincial and national levels, the DoH also established the Faith Organisations in HIV/AIDS Partnership, in order to coordinate the DoH’s AIDS efforts with religious leaders’. This initiative seems to emulate the Ugandan government’s highly-touted “multi-sectoral response” that stimulated mobilisation by various sectors of society (Chapter One). Rev. Dumisani Thango is the coordinator for KwaZulu-Natal, a paid employee of the DoH. He meets with provincial-level, as well as local religious leaders, although he has yet to meet with any from Ndwedwe. He also plans to establish 5 church-based voluntary counselling and testing sites across the province, although none were planned for Ndwedwe, given its rural location. Thango developed this program because he thought that people may feel more comfortable being tested in their church than in a clinic. People may not go to their clinic for fear of being stigmatised, whereas going to church is not as likely to arouse questions and suspicion.

The most important program to Thango is the training of home-based care volunteers. He wanted to take advantage of the altruism characteristic of churchgoers (15.8.03). Four “master-trainers” from Ndwedwe completed their training in August 2003. They are supposed to train 40 more church volunteers from their areas in home-based care. Thango, however, does not seem to be aware of
earlier, failed attempts by the Department of Health and non-governmental organizations to establish home-based care networks in Ndwedwe. These experiences will be discussed later in the chapter. Another flaw in the program is that the program does not take advantage of, or even communicate, with the community health committee. This seems to be a failed opportunity to synchronize both with past and current DoH programs.

Several NGOs run AIDS programs elsewhere in Ndwedwe, but most are involved with prevention education rather than care, and they are not involved with churches. Medical Care Development International (MCDI) is the exception, and its experiences will also be discussed later in the chapter. In Mlandaleni specifically, MCDI is the only NGO providing any type of service, health-related or otherwise. Its Ndwedwe project is funded by the U.S. federal development agency, USAID.

C. Magwaveni, Tongaat

East of Ndwedwe lies the more developed coastal corridor. Tongaat is a full-service town, with a linen factory and a sugar mill. The informal settlement of Magwaveni is three kilometres from the city centre, off a main road (Plates 3 and 4 are aerial photos of the settlement). It dates back to the 1970s—it is not a temporary camp, and most of the residents have lived there for years. There seemed to be more families with the father present, but it was not clear whether the fathers were also supporting families in rural areas that they would return to on the weekends. Large
extended families did not live together as in Ndwedwe, if only because of space constraints, although many families had a pensioner (grandparent). More households had at least one employed person, in contrast to Ndwedwe, although unemployment was still very high, especially amongst women. 14 of the 17 families we interviewed received at least one state grant.

Houses are small (under 50 m$^2$), made from dried mud with metal roofs. Half of the settlement is legal—the government recently bought the property—while the other half belongs to a local Indian farmer. Adjacent to the settlement, the government is building low-cost housing, which is expected to accommodate all of the households of Magwaveni. Construction is expected to be complete by 2005. There are about 600 households in Magwaveni. There are communal taps and toilets, but no electricity.

The settlement has been under the leadership of Albert Nthuli since 1977, when he was elected at a community meeting. There have been no subsequent elections for the post, but people seemed to submit to and respect Nthuli’s authority. In 1999, he was elected as a ward councillor to the Tongaat local council. He ran as an Inkatha Freedom Party candidate. He lost the 2001 elections to a candidate from the African National Congress, yet this did not affect his status as de-facto leader of Magwaveni. Nthuli’s post is like that of an induna in a rural area. He allocates property and resolves property disputes. He is not paid, but he is affluent by local standards—he has an income of R7000/month from the only store in in the settlement, drives an old Mercedes, and has a larger house than most. He has an
office in which residents can meet with him to discuss their concerns. He organizes community meetings. Unlike an induna, he is not selected by an inkosi, but neither is the system more representative, as there are no regular elections. Because of the close quarters of the informal settlement, he is arguably more relevant to residents’ lives than the induna. There are more disputes to settle, greater interaction with public officials, and more people moving in and out. He credits himself with bringing services to Magwaveni—communal toilets and taps, building a creche (from funds raised from the community), and organizing a soup kitchen for the elderly (9.9.03).

1. Resources

Magwaveni has seven community health workers, compared to three in Mlandaleni. Unlike the workers in Ndwedwe, they are only trained in health education, not home-based care. Nthuli oversees their work, ensuring that they see a minimum number of households per day. None of the families that we interviewed in Mlandaleni had been visited by community health workers, while most of the families in Magwaveni had been. The difference is due to the sharp oversight of Nthuli and the density of the informal settlement. The nearby Tongaat clinic started a support group in August 2003 for people living with HIV/AIDS. The Department of Health has not trained any home-based care volunteers in Magwaveni, either in conjunction with the community health committee or as part of Rev. Thango’s program.
There are four NGOs and two faith-based organisations working in Magwaveni. Utho Lwethu Rural Development gives rice weekly to about 40 households. It has held three one-week beadwork and sewing training sessions for unemployed women in Magwaveni. It is funded by Eskom, the public utility, and the provincial arts council. The rice is donated by a Pentecostal church in Durban.

The head of Utho Lwethu complained that Nthuli has politicised their community efforts by deciding who gets rice (IFP supporters) and not publicizing the training sessions (Zondi 3.9.03). Nthuli is a member of the IFP; Utho Lwethu is apolitical, but its managers have ANC connnections.

Tongaat Child and Family Welfare does social work in Tongaat, mainly arranging foster care placements. It is a large NGO, with 18 offices around Durban and Pietermaritzburg. Its Tongaat branch is essentially subcontracted by the Department of Social Development, which pays 75% of social workers’ salaries.

There are also two AIDS support groups in Magwaveni. The Hambanathi AIDS Organisation is based in Hambanathi, a nearby black township. According to its founder, the support group has 11 members from Magwaveni. These members learned of the group through the organisation’s home-based care volunteers.

Though its support group has existed for longer, it is not likely to be as successful as the clinic’s support group, which has better access to people living with HIV/AIDS. It is funded by the AIDS Foundation of South Africa, which is itself mostly funded by international donors, including 15% from Norwegian Church Aid (AIDS Foundation 2003: 29).
Sinosizo is a Catholic organization that trains home-based care volunteers. It is fully discussed in Section F. Since 1999, Missions Ablaze has donated food for the soup kitchen for the elderly and the crèche, and clothing for the community. It is an independent Pentecostal organization founded by an American and funded by private donations. Missions Ablaze and Tongaat Child and Family Welfare have had the biggest impact on the community, although the latter is mainly funded by the government. The health care organizations (Sinosizo and the Hambanathi Support Group) have had a minimal impact, although their programs are new and still-developing.

Table 1. Resources in Magwaveni

<table>
<thead>
<tr>
<th>Organization</th>
<th>Patron</th>
<th>Services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>DoH</td>
<td>Government</td>
<td>Hospital, clinic, mobile clinic, community health facilitator, community health worker, AIDS support group</td>
</tr>
<tr>
<td>DoSD</td>
<td>Government</td>
<td>Grant</td>
</tr>
<tr>
<td>Utho Lwethu Rural Development</td>
<td>Eskom, KZN Arts Cultural Council, Pentecostal church</td>
<td>Skills training, food donations</td>
</tr>
<tr>
<td>Sinosizo Home-Based Care</td>
<td>Catholic Relief Services</td>
<td>Trains and supervises hbcv’s</td>
</tr>
<tr>
<td>Missions Ablaze</td>
<td>Pentecostal church</td>
<td>Food donations</td>
</tr>
<tr>
<td>Tongaat Child and Family Welfare</td>
<td>DoSD, private donations</td>
<td>Social work—orphan placements</td>
</tr>
<tr>
<td>Hambanathi Support Group</td>
<td>South Africa AIDS Foundation</td>
<td>AIDS support group</td>
</tr>
</tbody>
</table>

Catholic Relief Services is a United States charity. In 2002, the largest source of revenue was private donations, but the U.S. government was the largest single contributor, at $86 billion, 22% of revenue (Catholic Relief Services 2003: 19)
D. State Health Services

The government is the main service provider in both Magwaveni and Mlandaleni. The Department of Social Development gives grants to impoverished households. The most common are the old age and child support grants. They also offer a disability grant (covering clinically-certified AIDS) and a foster care grant for orphans. According to the 2001 census, there were 152,495 people living in Ndwedwe, 8,480 people over 65, and 17,161 aged 0 to 4 years (Statistics South Africa 2003). From the numbers of grant recipients in August 2003 quoted by a DoSD administrator in Ndwedwe (Table 2), the old age grant is heavily used, while the child support grant is not. Many respondents reported not having birth certificates for their children, which may explain why old-age grants are more common than child-support grants, despite their being many more children in the area.

Table 2. Common DoSD Grants in Ndwedwe*

<table>
<thead>
<tr>
<th>Name</th>
<th>Amount (R/month)</th>
<th>Criteria</th>
<th>Frequency, Aug 2003</th>
<th>Relative frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Old age</td>
<td>700</td>
<td>Male&gt;64, female&gt;59</td>
<td>8207</td>
<td>49.3</td>
</tr>
<tr>
<td>Child support</td>
<td>160</td>
<td>Child&lt;9</td>
<td>5374</td>
<td>32.3</td>
</tr>
<tr>
<td>Disability</td>
<td>700</td>
<td>Medical confirmation</td>
<td>2564</td>
<td>15.4</td>
</tr>
<tr>
<td>Foster child</td>
<td>500</td>
<td>Court confirmation</td>
<td>251</td>
<td>1.5</td>
</tr>
<tr>
<td>Care dependency</td>
<td>700</td>
<td>Child age 1-18 with disability</td>
<td>246</td>
<td>1.5</td>
</tr>
</tbody>
</table>

*All grants are means-tested. Does not include war veterans, special distress grants (N<24).
The Department of Health operates clinics in Tongaat and Mlandaleni. The Tongaat clinic conducts HIV testing and provides nevirapine for prevention of mother-to-child transmission. The Mlandaleni clinic does not, although its patients can go to Osindisweni Hospital for these services. The hospital is 8 km from Mlandaleni and 12 km from Magwaveni. Anti-retroviral therapy for AIDS is not offered at either clinic. Under public pressure, the government announced in August 2003 that it would start providing anti-retroviral medicines, but did not offer a timeline. There is a mobile clinic that visits Magwaveni twice a month. Services and medications through these providers are free (the hospital charges a R50 admission fee).

E. Faith-based mobilization in Ndwedwe

In 2001, Medical Care Development International (MCDI) and the ecumenical Diakonia Council of Churches jointly began working with churches in Ndwedwe. MCDI is an international NGO with a small (5-employee) branch in Durban that works with the Department of Health on maternal and child health issues. It has worked in Ndwedwe since 1997, mainly training community health workers and home-based care volunteers. Diakonia is based in Durban; most of its member churches are mainline, such as Anglican, Methodist, Presbyterian, and Roman Catholic. In 1994 it started an AIDS program helps churches start AIDS programs (Diakonia 2003).
In Diakonia’s experience, many churches do AIDS work in isolation from each other. It developed a model whereby an introductory workshop with religious and community leaders is used to assess the needs and existing resources of the community. Though Diakonia’s member churches are mostly mainline, churches of all denominations are invited. Various media, such as personal invitations, fliers, and word-of-mouth, are used to ensure diverse participation. Follow-up workshops are then held, where the religious leaders are taught about HIV/AIDS. They select volunteers from their churches to sit on a faith-based AIDS task team. The volunteers are usually people who are already volunteering for programs within their respective churches. The task team is taught about AIDS and how to start and coordinate AIDS initiatives.

As in the case of Rev. Thango’s home-based care program, the assumption is that the church has a pool of ready volunteers. Churches are either already running programs, or are prepared to establish community projects. Diakonia was only a consultant to “capacitate,” in the words of Thuli Thabethe (15.9.03), its AIDS director—to encourage and teach organizational principles. After the initial workshops, the task teams would be self-sufficient. They would serve as a conduit through which Diakonia could pass information and monitor the faith-based programs in the community. Diakonia judges this model to be a success based on its implementation in numerous communities in Durban.

Together with MCDI, Diakonia brought its program to six communities in Ndwedwe, including Mlandaleni. However, according to Thabethe, “the
methodology of the urban setting was not fully functional in the rural setting.” It was Diakonia’s first experience in a rural area, and several features made the work there more difficult. In the first workshop, Ms. Thabethe saw that, “In Ndwedwe nothing was happening, which was something we had never experienced before. Even amongst the mainline churches there was nothing happening. For example, the Anglican and Methodist churches reported at a very senior level what they were doing, but the churches based in Ndwedwe were not doing anything.”

Even when Diakonia and MCDI tried to institute their program—to educate volunteers forwarded by church leaders and have them set up task teams—the communities were not interested. When they held a follow-up meeting to the first workshop with religious leaders, they saw a large drop in attendance—in central Ndwedwe, from 40 at the first meeting to less than ten at the second. As Thabethe said, “In the follow-up meeting, you felt like you were pushing yourself into their lives. You didn’t feel needed. In other communities you’re like a loaf of bread—everyone wants you.” Diakonia’s previous efforts were also in impoverished communities, but the poverty in Ndwedwe was even more widespread. “We discovered for the first time a high level of poverty. As a result, participants, though they could recognize the impact of AIDS on society, maintained that poverty alleviation was the priority.” People lost interest because they did not see AIDS as a priority. They came to the initial meeting with employment prospects: “When they hear that two organisations are coming from the city centre, people think there will be jobs.” In this context, Thabethe asserted, you cannot separate AIDS work from
poverty relief. An AIDS program that relies on volunteer efforts will not work. It needs to provide jobs. “In my view if you want to empower the ministers to help the community you can’t avoid a financial commitment—you must also pour in financial aid,” something that MCDI and Diakonia were not prepared to do.

Another barrier was education. The participants did not have the organizational skills necessary to conduct meetings independently. Thabethe said that when an attendance register was circulated at the meetings, it came back nearly blank, due to a combination of apathy and illiteracy. In four of the six areas, MCDI tried to continue with further meetings and in setting up a task team. Chris Mohatsela, the MCDI faith-based coordinator, found that the task teams were not self-sufficient. They did not meet unless he organized and attended the meeting. Thabethe said, “The main challenge with the task team is the need for a self-driven person, somebody with a vision that you can help with more skills and information. But in Ndwedwe the people are too dependent on Chris.” Mohatsela said, “It is difficult to hold a meeting if someone does not know how to take minutes” (4.9.03).

In addition to the education barrier, poverty, and apathy, Ndwedwe did not logistically lend itself to meetings. It was hard to organize events because of the long distances involved. Diakonia holds regular events for its task team leaders in and around Durban, too far to expect someone from Ndwedwe to attend.

In some areas, there has not been a meeting since the establishment of a task team in spring 2002. The program has not had a big impact in Mlandaleni; the only person that mentioned that there was a workshop was the catechist from the
Catholic Church, and he did not actually attend it. MCDI was also to blame for its unreliability in planning community meetings.

F. Home-based Care

Another faith-based project, using women’s church groups, is currently being attempted in Magwaveni. It was built on many of the same assumptions as the Diakonia/MCDI plan in Ndwedwe—that the church has the advantage of being an already-existing local institution, with an eager pool of volunteers. This program looked even more promising because it used an already-existing social group.

Women’s groups are a common and historical feature of black South African churches. Gaitskell and Brandel-Syrier attribute their origin to meetings organized by white missionary women as early as the 1830s (Gaitskell 1997: 255). Africans adopted the groups and called them manyanos, the Xhosa word for unite (Brandel-Syrier 1962: 15), although in this area, people referred to them as “class.” The character and activities of the groups are almost identical, even across denominations that have very different origins and practices. According to Gaitskell, their practices, even in mission churches, are syncretic (1997: 261).

The women’s group is chiefly for collective worship (Brandel-Syrier 1962: 91). It is composed mostly of older women. For members, an essential component of group prayer is praying for the sick. Classes meet on Thursday mornings, usually at

---

6 Volunteer training began in May 2003, so it is too early to judge the success of the program. Sinosizo came to Magwaveni at the request of a Councillor from Hambanathi.
the house of a sick person in the community. Members of the class dress in uniform, which they also wear to Sunday services. The tone and format of the services were similar. The women read from the Bible, sing prayers, and give individual testimonies, usually about God and healing. Classes will visit sick people from other congregations as well, even uninvited or unannounced. Invariably they are welcomed by the sick family. I fully describe the class experience of each denomination in subsequent chapters.

Sinosizo is an internationally recognized program, held up as a model of self-help for under-resourced communities. Its program has been successful in urban, as well as rural areas in the Durban region. When Sinosizo was founded in 1995 to provide home-based care training, it thought that the class was a logical place to start. The class already visited sick people, so if the class members were trained in home-based care, they could provide a valuable health service at the same time. Retention and organization would not be obstacles. Being a Catholic NGO, Sinosizo started with the Roman Catholic classes, known as the Sacred Heart Society. To the surprise of Cathy Madden, the training manager at Sinosizo, “we found out very quickly that the women were happy enough to pray, but were not interested in providing health care” (10.9.03). Sinosizo changed course, and started recruiting its volunteers from the community at large, rather than specifically through the church. This permitted it to engage and then intensively train persons whose orientation was consistent with the objective of providing home care; it has maintained this approach, to great success.
Two interesting questions emerge from Sinosizo’s experience. Firstly, why were the classes not receptive to training? And secondly, what has made its program successful, while MCDI has been frustrated in its efforts to cultivate home-based care volunteers in Ndwedwe? On the first question, the class serves a very specific purpose for its members and the community. It is a social group and a spiritual group for the women; it is not a social service agency. Visiting the sick is one of their most vital duties, but the purpose of the visit is to provide spiritual care (Brandel-Syrier 1962: 78). Visiting the sick makes them feel useful to society and fulfils their own beliefs of the healing power of religion. “It becomes a social outing in which great numbers take part” (ibid.). It also provides a real service to the community, by comforting the sick. From our interviews, all of the families who had been visited by the class welcomed them.

These insights are based on observation, interviews, and historical precedent. Indeed, Sinosizo’s experience is not surprising in light of how classes responded to similar situations in the past. Brandel-Syrier relates the attempts of several white missionaries to teach the manyanos productive skills, such as sewing, “but by and large the women are not willing to allow practical issues to interfere with what they consider their religion” (ibid.: 90). During her fieldwork in 1953, Brandel-Syrier saw the Anglican missionaries trying to transform the manyanos to resemble the white women’s groups. They wanted to introduce educational and practical training, but the reaction of the African women was to stop participating. “They do not come to meetings, they do not resign, and they do not give any explanations…” It won’t
work,’ the minister’s wife summed up for me. ‘Our African women want to pray as they feel. They are very religious. It’s a waste of time’” (ibid.: 96).

Sinosizo’s program was not as interventionist; it did not try to change the way the group was conducted. It tried to teach a skill that overlapped with the group’s regular activities. But the women were not interested. Ironically, one class member was also a member of the community health committee in Mlandaleni. So it is not that class members are reluctant to engage themselves in community activities: “The women themselves might be willing as individuals to do their share, but then in another organizational context” (Brandel-Syrier 1962: 104). Rather, the class has a certain purpose for its members, which does not include “practical” activities. Their very withdrawal from social concerns is part of their identity—it is critical to them that they not be engaged in social or political concerns. Yet that is not a slight on their social value. It is this self-centeredness that allows them to be the type of resource that they are for their members: “It is in the Manyano that the women have first recognized their own value, and in which they regularly re-affirm their strength” (ibid.).

Sinosizo’s successful experiences also yield important insights. MCDI has been frustrated in its attempts to train home-based care volunteers in Ndwedwe. In has trained 89 volunteers, but suspects that most of the volunteers are not actually making home visits. As with their experience with Diakonia in organizing AIDS tasks teams through churches, the main issue is money. The induna in Mlandaleni made it a straightforward issue by not allowing volunteers to be trained unless they
were paid. The volunteers that were trained in other areas undertook the training in the hopes that they could then get employment as DoH community health workers. Since there are no plans to significantly augment the current working force of 80 community health workers in Ndwedwe, their expectations will not be met. The volunteers are envious and bitter. It is a pity that the volunteers have been trained, but sit idle, considering that the community health workers do not reach many homes due to the long distances and poor oversight.

To improve home-based care in Ndwedwe, the DoH must first focus on improving the service provided by its community health workers. They should set clear and reasonable goals for the workers. Currently, each worker is expected to see 100 households/month, an unrealistic target given the long distances. It is also unreasonable to expect two community health facilitators to oversee the 80 workers while also completing other tasks such as working with the community health committees. The DoH should simplify the facilitator’s job to supervising the workers. Checklists could be given to the workers to be completed with each household that they see, which would improve communication with the household, clarify what is expected of them, and facilitate oversight. The workers could also work with the Department of Social Development to provide information to families about grants. While most families received at least one grant, many were not taking advantage of all of the grants for which they were qualified.

To improve home-based care provided by volunteers, MCDI and Rev. Thango could emulate Sinosizo. According to its training supervisor, Sinosizo has successful
programs operating in ten communities, including rural areas similar to Ndwedwe. MCDI estimates that in only four of the eight areas in which it has trained volunteers are they actually working. After their two-week training session, MCDI meets monthly with each group of volunteers to address their concerns and check on their progress; Rev. Thango’s volunteers have no supervision after training. Sinosizo’s system is more comprehensive. After two weeks of training, volunteers must individually complete six months of practical work. There is a high dropout rate. In Magwaveni, eleven began the apprenticeship in January 2003, and only six completed it. The volunteers are typically middle-aged women who have finished raising their children, and younger women who do not have jobs and are looking to build their skills.

The most important distinction between MCDI’s and Rev. Thango’s programs, and Sinosizo’s, is in their support mechanisms. Sinosizo expressly tries to promote a corporate identity by giving their volunteers uniforms. It does not pay volunteers and is careful not to fan expectations of future employment. Instead, volunteers find reward in their work and in belonging to a group. The volunteers organize regular meetings. Sinosizo helps to pay the school fees of volunteers’ children, gives twice-yearly gifts, and reimburses for travel expenses. This compensation is by no means adequate to cover the work done by the volunteers, but is meant as a symbolic gesture of appreciation.
G. Conclusion

Overwhelmingly, the state is the main service provider to the residents of Magwaveni and Mlandaleni. In fact, most residents were dependent on the state. Health care is free and accessible, and most families receive state grants. In Mlandaleni, far from the economic opportunities of the city, most respondents had no income other than state grants. The under-development of the rural area was an obstacle to residents in need of jobs, and to the government’s service provision. The community health system was designed to cope with the difficulties of the rural setting, but its performance has been disappointing. The system can be improved with better management and clearer directives to the health workers and facilitators—a major funding boost is not necessary. The DoH has also made an effort to reach out to religious leaders on the issue of AIDS, but its initiative, with insignificant funding, is not likely to permeate to individual communities, although it has sparked dialogue at higher levels of religious leadership.

The urban-rural divide is also apparent in NGO provision. There are a few NGOs with modest programs in Magwaveni, while there is no significant NGO presence in Mlandaleni. NGOs did not seem to be any more capable or efficient in program implementation. MCDI attempted two programs in Mlandaleni; both were frustrated by the paralysing poverty of the area. In terms of faith-based work, the MCDI/Diakonia program in Ndwedwe and Sinosizo’s original efforts with women’s church groups both failed. These experiences raise doubts in the, perhaps unfair,
expectations that the church is a nest and source of volunteers. MCDI/Diakonia
could not recruit volunteers through the churches—people needed jobs and were not
interested in AIDS volunteer work. Sinosizo found that the women’s groups were
social groups, not social service groups. The latter experience also serves as a
cautionary tale—that working through an existing social group will not necessarily
be successful.
CHAPTER 3. THE ROMAN CATHOLIC CHURCH

The resources and organizational structure of the Catholic Church have enabled the Church to develop dynamic, successful programs in some areas. These programs were exclusively in the domain of care, not prevention. Yet its record in the localities of Magwaveni and Mlandaleni is much less clear. The way the priests have dealt with AIDS in these areas is a function of past experiences with the issue, and their priorities as religious leaders. Another topic of this chapter is stigma, and the thorny issue of how religious institutions may contribute to it.

A. Church Hierarchy

The smallest unit of organization in the Roman Catholic Church is the parish. Each parish is in the charge of an ordained priest. Mlandaleni’s church is one of twelve within Upper Tongaat parish. Magwaveni is two km from the main Tongaat parish church; there are two smaller outstation churches in the parish. Parishes are further organized geographically into deaneries, with about seven parishes in each deanery. The deanery does not have formal administrative duties, but serves primarily to provide fellowship amongst priests from the same area. The Archdiocese of Durban is composed of seven deaneries. The head of the Archdiocese, the Archbishop, has administrative responsibility for the parishes. He is in regular contact with the parish priests and holds semi-annual training days for
priests and pastoral assistants. The Archbishop of Durban is one of 28 bishops in the Southern Africa Catholic Bishops’ Conference (SACBC), which like the deanery, is a consultative body. The Archdiocese is responsible to the Vatican, headed, of course, by the Pope.

The Archdiocese has a variety of sources for its income. The Vatican makes a yearly worldwide collection in its churches for poorer dioceses, and then distributes the money to them. It also receives donations from church communities abroad—private individuals and Catholic organizations (charities, bishops’ conferences, dioceses). Finally, the Archdiocese receives a percentage of the donations collected in richer parishes. It uses this income for its own operating costs and programs, as well as the operating costs of poorer parishes in the Archdiocese (Stirton 3.9.03). In this sense, the Church redistributes wealth, from the richer church communities, to the poorer.

The SACBC has an AIDS office that supports AIDS prevention and care projects in under-resourced communities. Requests for grants of R70,000 to R300,000 are received at the diocesan level, and are not restricted to Catholic organizations. The AIDS office is headed by a nun, and has six paid employees. No projects in Ndwedwe or Tongaat are currently funded by the SACBC AIDS office. It is funded by the U.S. charity Catholic Relief Services.

The Archdiocese of Durban established an AIDS Care Commission in 1987. It is in the process of organizing twice-yearly meetings in each deanery to discuss AIDS programming at the parish level. It advises that each parish set up an AIDS
committee, which Upper Tongaat and Tongaat have not yet done. Though no financial support is available through the Archdiocese, the Commission offers to help local churches find funding. Sinosizo falls under the Commission, but is run independently of the Archdiocese, on funds from Catholic Relief Services.

In December 2001, the Archdiocese issued, “Guidelines for responding to poverty, unemployment, and AIDS.” One of the two study days for priests and pastoral assistants in 2000 was devoted to these issues. A pastoral letter from Cardinal Archbishop Napier was read in all parishes on Advent (December 7) 2001 to mark the release of the guidelines. In twenty pages, the guidelines lay out Christian values, how to teach about AIDS and sexuality, suggestions for church programs, and links to outside resources. The guidelines emphasize marital fidelity and abstinence as methods of prevention. The document does not discuss condoms, although it says, “Life is to be protected in all its forms. From the vulnerable extremes of birth and old age to the daily living of ordinary men and women” (Catholic Archdiocese 2001: 7). For programming, the Archdiocese asks parishes to train congregants in home-based care, pastoral counselling, and to “address the prejudice and silence that surrounds the AIDS status of people.” The Archdiocese encourages churches to provide “strong moral, and even material, support for families” (ibid.: 10) who foster AIDS orphans. Churches are referred to the SACBC AIDS office’s funding program.

The Archdiocese does not run any AIDS programs, and neither do Tongaat or Upper Tongaat parishes. Yet several other parishes in the Archdiocese are
independently running AIDS programs. Father Massimo Biancalani, the parish priest of an affluent neighbourhood in Durban, started the Right to Live Campaign, which has three AIDS hospices in the Durban area. There are a total of 46 beds, with each hospice staffed by two nuns from the Montebello convent and several volunteers. The Campaign is funded by donations from Biancalani’s church, as well as a yearly collection at parishes throughout the Archdiocese. The British consulate provided funding for training the volunteers. With its current funding and management resources, the Right to Live Campaign is developing a seventh home, but no more beyond that (Robinson 17.10.03).

Montebello parish, 20 km east of Mlandaleni, has a home for the chronically sick, a primary school, a crèche, and a home for orphans and destitute children. These are staffed mainly with nuns from the Dominican convent along with a few paid employees. The children’s home has 50 beds, half are for orphans. The children are referred by social workers from the Department of Social Development, which is the home’s principal patron, through the institutional foster care grant (R1100/month per child, Sister Ethel 9.9.03).

The hospital at Montebello was originally a mission hospital, but since the 1970s it has been run by the state. In 1999, the parish priest started a community resource centre to teach skills for small enterprises (sewing, beadwork, etc.) and to provide legal advice for domestic violence cases and grant registration. The priest guided management of the resource centre over to the community, so that is now community run and independently funded (by an international paralegals’
association), although it remains on church grounds. Its services have suffered due to the unreliability of its three paid (R500/month) staff members, who were recruited from the local community (Stirton 3.9.03).

Ekukhanyeni parish, 20 km south of Mlandaleni, has a primary school, a crèche, clinic, and an AIDS hospice. These are also run by nuns, from the Dominican convent at Oakford parish. The clinic is mainly government funded. There are 11 beds at the hospice. The workers at the hospice were trained by Sinosizo. People are routinely turned away due to lack of capacity. The matron estimates that 15 applicants per month are turned away due to lack of capacity (Sister Michaele 9.9.03). The hospice is supported by donations from Catholic churches in Germany.
Table 1. Catholic AIDS outreach

<table>
<thead>
<tr>
<th>Organization</th>
<th>Patron</th>
<th>Services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>South African Catholic Bishops’ Conference</td>
<td>Catholic Relief Services</td>
<td>Funds for AIDS projects (open to any religious organization)</td>
</tr>
<tr>
<td>Archdiocese of Durban</td>
<td>DoSD</td>
<td>Funds for poverty alleviation projects</td>
</tr>
<tr>
<td>AIDS Care Commission</td>
<td>Archdiocese of Durban</td>
<td>Consultation for parish AIDS projects</td>
</tr>
<tr>
<td>Diakonia Council of Churches</td>
<td>Member churches</td>
<td>Consultation for AIDS projects</td>
</tr>
<tr>
<td>Sinosizo Home-based Care</td>
<td>Catholic Relief Services</td>
<td>Trains and supervises hbcv’s</td>
</tr>
<tr>
<td>Right to Live Campaign</td>
<td>Private donations,</td>
<td>3 AIDS hospices in Durban area (46 beds total)</td>
</tr>
<tr>
<td>Montebello Children’s Home</td>
<td>Archdiocese of Durban</td>
<td></td>
</tr>
<tr>
<td>Montebello Community Resource Centre</td>
<td>DoSD, Dominican convent</td>
<td>Takes care of orphans, abused children (50 child-capacity)</td>
</tr>
<tr>
<td></td>
<td>International paralegals’</td>
<td>Skills-building, information on grant registration</td>
</tr>
<tr>
<td></td>
<td>association</td>
<td></td>
</tr>
<tr>
<td>Ekukhanyeni AIDS Hospice</td>
<td>Donations from Catholic Churches in Germany, Dominican convent</td>
<td>Hospice at Ekukhanyeni parish (11 beds)</td>
</tr>
</tbody>
</table>

The variety and number of AIDS programs run by the Catholic Church attest to the extensive resources available within a mainline church. The Archdiocese encourages programming through its AIDS Care Commission, but it does not directly run or fund any programs. That is left to the parish level. Where services exist, they are the work of an exceptional priest or of nuns from convents in those parishes. They found financial support through the expansive church network.
Their programs are local resources of modest size, and are constantly full. People are referred by government social workers and word-of-mouth; religious affiliation is not a factor in admissions decisions. However, none were close enough to Mlandalen or Magwaveni to serve those communities.

B. Upper Tongaat Parish

Upper Tongaat Parish was established in 1927, but the Catholic Church’s presence in Ndwedwe dates back to the 1880s. It operated churches, schools, and hospitals in the area. There are 12 outstation churches and 4000 parishoners, according to the most recent parish census, in 1990. The parish priest, Father Mbongwa Xaba, manages the outstations through eight catechists. They are laymen who lead services when Xaba is not present, help prepare the youth for their confirmation, and inform the priest of people with special needs, such as the sick. Xaba leads services in each church once a month. There are services every Sunday and the class meets every other Thursday. Each outstation church has a council with three to five members. The councils meet individually, and collectively as a parish council.

Xaba was appointed to the parish in April 2003 following his ordination earlier that year. He lives next to the Tongaat church because there is no priest’s residence in his own parish. His predecessor was an old priest from France who built many of the churches in the parish with donations he himself raised in France.
Xaba is originally from Pietermaritzburg, KwaZulu-Natal and received his theological training there.

Without international connections, Xaba does not have the external funding that his predecessor did. The Archdiocese provides R2250/month for operating costs. Members are asked to pledge R50/month if employed or R10/month if not. The church council collects the pledges and collection plate proceeds, and gives them to Xaba. The pledges generate R4000/month. The R6250 in monthly revenue is exhausted on operating costs (petrol, priest’s maintenance). The parish council and Xaba decide how to spend the money, although they do not have any money left over after operating costs. The Archdiocese recently started a relief fund to provide necessities for families in distress. Recipients do not have to be Catholic.

The catechist led services on the morning that we attended services. The catechist at Mlandaleni is affluent; he owns the only local store. The chapel was simple and in good condition, with seating for 100. It is the only purpose-built church in Mlandaleni.¹ Children sat in the first two rows, but the rest of the seating was mixed. The service followed the order of the prayer-book: opening prayers, weekly readings, sermon, prayer for the sick, collection plate, communion, closing prayers, and announcements. We were asked to introduce ourselves to the congregation after the sermon, which we did through our interpreter, Khoza. Most people did not have prayer books, but knew the prayers from memory. Most

¹ Zionists pray in the minister’s house; Shembites pray in outdoor temples; members of other mainline churches go to services elsewhere in Ndwedwe, outside of Mlandaleni. The Catholic Church in Mlandaleni serves people from neighbouring areas as well.
prayers were sung, in Zulu, but with less emotion and “charisma” than at the Zionists’ services (and there were no drums or horns).

Table 2. Attendance figures for Mlandaleni Roman Catholic Church

<table>
<thead>
<tr>
<th></th>
<th>10 y.o. and under</th>
<th>11-25</th>
<th>26+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>12</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Female</td>
<td>13</td>
<td>20</td>
<td>20</td>
</tr>
</tbody>
</table>

The catechist was expecting us at services. He did not talk about AIDS. He gave a sermon for 10 minutes about the week’s readings that had been given to him by Xaba. After he finished reading the sermon, he briefly spoke about God’s power to cure diseases. “God only will cure us from diseases. There is no one else who will cure us. We must not rely or believe in things that we are told by people of this world. We must use what God tells us. We must only believe in God, and not other things because if we believe in them and forget about God, we will be lost.” His point is vague to the point of being incomprehensible. He did not say anything further. In context, he seemed to be speaking for our benefit, but he did not mention AIDS. Indeed, in our preceding interview, he said that he leaves the topic of AIDS to Xaba, but that he does talk about the appropriate way to behave (and was similarly vague about that). He had previously showed concern about doing or saying something inappropriate—he consented to the interview only after receiving permission from Xaba, and he did not attend an MCDI training session on AIDS.

---

2 In this and subsequent attendance tables, age groupings were formed arbitrarily, and ages were not verified.
because he did not have the express permission of the priest. His statement was a good example of observer effect (Appendix A). But his cautious behaviour was an exception—most of the other ministers were more forthright and reflective. This is perhaps to be expected, given his role as an assistant to the priest.

C. Tongaat Parish

Tongaat parish was founded in 1973. It is an urban parish, while Upper Tongaat is in a rural area. Magwaveni is 2 km from the parish church. 1400 parishioners were counted at the last census, in 2000—25% Indian and white and 75% African. Father Julian Davey lives next to the parish church. A white South African, he received his theological training in South Africa. Davey manages his parish through twelve ward leaders. He receives R4000/month from the Archdiocese, plus donations and pledges. As a reflection of the demographics of their respective areas, Tongaat parish is wealthier than Upper Tongaat. It can afford more activities and a charity fund. Davey plans to collect donations to build a school. Unlike the Mlandaleni outstation church, there is a monthly collection for the needy, of which Davey is informed through the ward leaders. They also notify him of sick people so that he can visit them.

A parish council meets monthly. Ward leaders meet every two months, and within their wards, every two weeks. The class and Sunday school meet weekly. Junior and senior youth groups meet monthly. There are two Sunday services: one
in English and one in Zulu. Since there are only four families from Magwaveni who are active in the church, the only church event that we attended was the Zulu Sunday service.

It was the same format and duration (two hours) as the Mass in Mlandaleni (7.9.03). The chapel had seating for 300. It was in good condition, with electricity. The chapel was full, and the audience was almost entirely African (there was one white teenager). Men were outnumbered by women, but not to the extent in the Mlandaleni church. This is a reflection of the demographics of the two areas: In the Tongaat church, there were more two-parent families in attendance, because there were middle- and upper-class families. Even amongst the poor families of Magwaveni, we saw that the family unit was more likely to be intact in the city.

Davey read a prepared, 15-minute sermon in Zulu. He was not expecting us. He spoke about the weekly readings—how Jesus cured the “deafness” of the Israelites by opening their ears to God. He did not mention AIDS.

D. Key Concerns

The Upper Tongaat and Tongaat parishes have not responded to the encouragement of the church hierarchy (the Archdiocese and SACBC), nor matched the programs of other parishes. The hospice and children’s home in Ekukhanyeni and Montebello parishes are the work of the Dominican nuns in those parishes, not
the parishes themselves, and Upper Tongaat and Tongaat parishes do not have convents. The Archdiocese had it right when it chose poverty and unemployment as focus issues in 2001—the families that we interviewed always listed them as their top concerns. But nobody mentioned its third focus issue—AIDS. A few mentioned sickness. When directly asked whether AIDS was a concern for them, people would respond that they did not know anybody with AIDS. This is not due to ignorance, but rather stigma. In MCDI’s 2000 survey of mothers in Ndwedwe (N=374), 94% had heard of AIDS. Most respondents we spoke to knew of AIDS and that it was a fatal, sexually-transmitted disease.

Davey and Xaba agreed that poverty, unemployment, and AIDS were the key concerns in their communities. They were aware of the Archdiocese’s guidelines and encouragement, as well as the services provided in nearby parishes. Yet neither had programs in any of the three areas.

This was due to several factors. Firstly, Davey’s previous efforts had been met with indifference. He had tried to start a group of unemployed people, “But people didn’t respond,” he said. “They didn’t want to be seen as a needy group. They didn’t want to meet together” (10.9.03). “For AIDS, I haven’t even tried anything because the response would be even worse,” because of the stigma attached to it. Secondly, the priests minister to large parishes, and they see themselves primarily as religious leaders. “We’re not the government,” Xaba said. The catechist in Mlandaleni said that if the church had extra money, he would want to use it to renovate the church. Davey was going to start a school-construction
fund. The priests’ reluctance to do more social work has to do with their own priorities, as well as economic reality. Their relief funds gave away material donations, but generally not money. Otherwise they would be besieged by requests, “and we wouldn’t be able to cope,” Davey said.

Davey and Xaba said that AIDS was having an effect on their communities. “In most of the funerals, the person died of AIDS,” Davey said. “But it is not stated openly, because they would have to live down the stigma. They don’t want to be identified as such. I don’t refer to AIDS in the funeral sermon, because I don’t want to hurt them.” Officiating at funerals and administering the Sacrament of the Sick (formerly known as the Last Rites) are essential duties for the priest. Xaba said, “I’ve tried to let it be known that I’d like to be informed even before people get seriously sick” (22.8.03). Yet the widespread stigma has had an effect on their duties. “People don’t tell me if they’re sick—I only know two sick people in Mlandaleni and both are old,” Xaba said (14.9.03).

It is possible that the Catholic Church’s message on AIDS has undercut their relationship with those affected by AIDS. People do not want the general community to know, but they also may be embarrassed to tell their priest, given the church’s moral position on premarital sex. To be sure we did not hear of any instances of browbeating about sinful sexual behaviour or that AIDS was a punishment from God. “Almost every week I preach about AIDS, especially to the youth, and even during funerals,” Xaba said. “We [Zulus] have got other beliefs—someone was bewitched. I say that you should come out if you are HIV-positive,
you should give support to each other. I preach about the way people should behave, to try to make them change their behaviour, and become more responsible” (22.8.03). Yet even positive messages about proper behaviour and care for people living with AIDS, when preached from the pulpit, can contribute to stigma. The pulpit gives the prevention message a moral-religious dimension—a person who does not follow the sexual norms is sinful and endangers his health and that of the community.

This is the central, insoluble paradox of prevention advocated through churches. On the one hand, the strength of the church in AIDS prevention is its appeal to morality. Long before AIDS, abstinence and fidelity were church doctrines. Perhaps moral and religious conviction will lead to behaviour change. On the other hand, by emphasizing the links between sin, unsafe sex, and AIDS, the church could be branding people with AIDS as sinners, which is unfair to those who contracted the disease through no fault of their own (children, faithful spouses whose partners are not), and possibly alienates those who did contract the disease through unsafe sex.

Davey said that he did not talk as often about AIDS anymore, “because there is no effect,” he said. “I do youth meetings once a week. I talk as much as I can about AIDS, but they say, ‘We know that, Father. We’re tired of hearing about it.’ It’s not for lack of knowledge…Some are just not prepared to postpone sex for the proper time.” Neither of the priests nor the catechists advocated condoms, for two reasons. The first is because of moral principle—as the catechist from Mlandaleni
said, “To preach about condoms is a sin” (22.8.03). Secondly, they did not think that preaching about condoms would be any more effective: “condoms are not the solution,” Xaba said (22.8.03).

The Catholic families that we spoke to in both communities said that the priests spoke about AIDS. Davey was right—the message was getting across, and people knew the church line on abstinence and fidelity. As Davey said, it is a matter of behaviour change. In the meantime, the downside of church involvement—stigma—is ubiquitous. To dampen stigma, Davey preaches that those in the church, “Still love everyone, even if you’ve failed—to hate the sin, but love the sinner...We must be careful not to state that people with AIDS must be loved and that we all make mistakes.” This is a subtle, difficult-to-convey message.

E. Sick Families

In Magwaveni, we interviewed Eric Mkhize. He was not a member of any church, but his sister was an active in the Tongaat Catholic church. The Shembe lay preacher’s wife referred him to us, and he praised her for helping the family from time to time. He was thirty years old and suffered from tuberculosis. Mkhize was previously a taxi driver, but had not worked in over a year. There were nine people in the family, seven over the age of 18, but only his mother had a job, at a sewing factory. Her monthly salary of R1500 supported the family.
He had been tested for HIV, but did not disclose the results to us. He would only tell his family if he were HIV-positive, because, “People don’t look at you nicely. If you have AIDS, they speak badly about you” (7.9.03). The Shembe class had visited him, because he was neighbours with the Shembe lay preacher. His sister had not told the priest or ward leader of her brother’s illness.

In Mlandaleni, we visited four sick Roman Catholic families. In one family, which we visited with the class, the husband told us that he, his wife, and two of his children were HIV-positive. He did not tell the class or the catechist because “people would laugh and discriminate” (Anonymous C 28.8.03). In another family, the Ngidis, there were two sick brothers (4.9.03). They were in their thirties, and were small-scale farmers. One suffered from a variety of illnesses and the other had tuberculosis, for which he received treatment at the clinic. They were part of a large extended family (nineteen people) that lived in a cluster of six small houses. The household income was R1600/month, including three child support grants. One brother had a child who lived with him, while the mother lived in Tongaat and sent back money from her job at a latex factory. The other brother had a child who lived with the mother in another area of Ndwedwe, and was supported by a child support grant. Both were Catholic, although only one of them attended church, infrequently. Their aunt was a member of the Catholic class, and had brought the class to visit. But they would not tell the priest or anyone in the community if they were HIV-positive, because they feared discrimination.
One had been tested, but had not returned for the results. Most people we spoke to did not know their status. “TB is not like AIDS. People are afraid to even check about AIDS because they don’t want to know. It would kill themselves to know that they had it,” said Olga Gumede, the ward leader from Magwaveni (11.9.03). “I asked my daughters to get tested, but they said, “No. If I have it I’d keep thinking that I’ll die, that it is killing me.’” The psychological burden of knowing, combined with discrimination against people living with AIDS are powerful deterrents to testing.

To make testing routine, it will be necessary to reverse discrimination and halt the perception of AIDS as a death sentence. People who know they have HIV would then hopefully take steps to ensure they do not transmit the disease to others. To decrease stigma, it is instructive to look at a disease that people are generally open about having—tuberculosis. The differences in perception could be due to the fact that tuberculosis is transmitted differently than AIDS—it does not carry the guilt and moral stigma attached to a sexually transmitted infection that is preventable. Another important difference is that TB is treatable. Treatment is provided for TB at both local clinics, and the respondents who said they had TB, attended the clinic. This demonstrates the importance, and feasibility, of making AIDS medicines available in these communities. A common explanation for why antiretrovirals are not available in many developing countries is that even if they were available, there is not adequate capacity to deliver them. In Magwaveni and Mlandaleni, there were accessible, widely-used clinics. The provision of antiretroviral therapy would
change the perception of AIDS as a death sentence, removing a barrier to testing. And as people sought treatment, they may be more open about their status, as they are with TB.

1. Class Visit

We attended a Thursday visit by the Sacred Heart Group (the Catholic class) to a sick man’s house. Twelve women from the church participated. Most were older (40+) and wore a black and purple uniform; the younger women were not full members of the class. Everyone had a prayer book. The class formed a circle in the sick man’s living room. Each of the members of the class gave a testimony. Each testimony was followed by the singing of a prayer. The atmosphere and procedure was more like that of a Zionist service than a Catholic service. The mood was not joyous, but intense, with people dancing in place to the songs. In the testimonies the women told the sick man that they were there to help him pray and urged him to have faith that Jesus will heal him.

The women in the group told us that the man was suffering from seizures and visions. The man’s family—his mother, father, and wife—was present, and they also testified. No one mentioned any specific illnesses. After the testimonies, the women surrounded the sick man and touched him on the head with their rosaries. The leader of the class then took a leaf, dipped it in a cup of water, and sprinkled it over the sick man and his bedroom. Holy water is a common feature of Zulu and Catholic rituals. After the ceremony, muffins and soda were served.
There were several aspects of the visit that support the idea of the previous chapter that the class has a social, rather than social service, function. A collection plate was passed around, and the R15 was given to the sick man. However, he was affluent, the owner of a local store. He had a television and nice furniture. One of the younger women who was present at the visit, but not a member of the class, told us that the class tended to visit richer families, because they will be in a more comfortable house and get refreshments (Mgeyane 4.9.03). The ward leader in Magwaveni said that the Tongaat Sacred Heart Society did not visit the informal settlement, although she did not say whether it was because they were busy in other wards or because it was a poor community.

Even if there are no sick families to visit, the women gather on Thursday at the church to pray. They are visible leaders in the church—Davey in Tongaat called them “the backbone of the parish.” They consistently attend services, to which they wear their uniforms, and they help organize church events. In this case, the class was invited to come by the sick man. They lived a few kilometres outside of Mlandaleni, but his wife was raised Catholic and regularly attends services; he attended infrequently.

The class had visited the man several times before. He said that they “help me to relieve my heart” (28.8.03). However, they do not have medical training. In fact, the man feared that they harboured discrimination against people with HIV. He told us during our interview that he, his wife, and two of his three sons were HIV-positive. But he did not tell the women from the group because, “they would
be afraid to bring me a cup of water. They think that they could catch the disease by talking to me.” He has not told anyone in the church, only a friend of his who is a nurse.

In the event of his death, his brother-in-law would take care of his family. He has been unemployed for the past seven years, since before he became sick. He had previously worked, and lived, in Durban as a civil engineer. The R2000/month income from the shop supports his family of seven (including his parents). He does not know how he contracted the virus, but suspects that it was passed to his children when they shared a razor blade in a ceremony conducted by a sangoma (diviner).

F. Conclusion

The work of the Catholic Church in these communities with regards to AIDS does not lend itself to simple characterization. It is a complicated story full of paradoxes. Thanks to the initiative of individual priests and nuns, there are several successful, dynamic AIDS resources in the Durban area. These individuals took advantage of resources available in richer Catholic communities to fund their programs. Their programs were largely independent of the superstructure, although without an international, expansive Catholic Church, they would not have had access to their funding. As we will see with the Shembe and Zionist churches, having churches in rich communities makes a big difference in access to resources.
The Archdiocese and the SACBC have given significant attention to AIDS, offering technical and financial support for AIDS initiatives in parishes. Yet the Upper Tongaat and Tongaat parishes did not have any programs. Davey’s attempts to speak about AIDS and start other initiatives were met with indifference in his congregation. From the functions of the class and the priorities of the priests, it was also clear social service provision was not the top priority. In all the talk of social service provision, it must be remembered that the church is a religious institution first and foremost.

Besides resources and organizational structure, another major theme of this chapter was the stigma around AIDS. There is a trade-off in the church being involved in prevention. Since the AIDS awareness level was high, providing information was less essential, but the church’s voice can perhaps stimulate behaviour change. In Uganda, churches, even those that advocated only abstinence and fidelity, were regarded as one of the social actors that successfully stimulated behaviour change (Green 2002: 5). In fact, Green argues the multitude of prevention strategies and messages was essential in the campaign for safe sex—that the church’s relatively conservative voice was an asset in the campaign. We observed firsthand the silence in these communities. The key questions are in the end insoluble: should the church be “encouraged” to talk about AIDS, should the church promote condoms, is it contributing to stigma, is it contributing to behaviour change? Rather than asking the church to do one thing or another, there is still a more direct solution on the table—to provide antiretroviral therapy. While it may not answer the tough
questions about the appropriate stance on prevention, perhaps once therapy is available, stigma will be a thing of the past.
CHAPTER 4. THE NAZARETH BAPTIST (SHEMBE) CHURCH

The Shembe Church has a large following amongst the poor in KwaZulu-Natal, especially in rural areas. It has a remarkably vigorous hierarchy that ensures conformity through church ranks. If it so desired, it could disseminate a social message or implement a social program with efficiency and thoroughness. Unfortunately, although the Church is aggressive in its guidance regarding sexual behaviour, that guidance is stigmatising, and it denies that AIDS is a problem. Thus, the Church has failed to capitalize on its discipline and strong organization in its treatment of AIDS.

A. Church Origins and Hierarchy

The Zionist movement started in South Africa in the first decade of the twentieth century. It was strongly influenced by John Alexander Dowie’s Christian Catholic Apostolic Church in Zion from Zion City, Illinois. It is remarkable that its many branches can be traced back to a single group of 27 Africans baptized by an American missionary from Dowie’s Church in Johannesburg in 1904 (Sundkler 1961: 48). In South Africa, the Zionist model offered a less orthodox, more syncretic option for the local population, compared to the first independent church
movement, the Ethiopian church. The Ethiopian church was an African enterprise, but retained the theology, practice, and organizational structure of mainline churches. The Zionist movement was a wholly different entity in all of these respects. Dowie’s church differed from mainline churches in its emphasis on the prophetic voice of the church leadership, healing, and the creation of a utopian society. Furthermore, the Dowie model provided a loose, fluid theology that in the South African context, became infused with indigenous customs, such as ritual sacrifice, divination, and dress. Zionism is now the most popular church in South Africa—in MCDI’s 2000 survey, 61% of respondents were Zionist (37% in Zionist churches, 24% in the Shembe Church, 2000: 34). “What Zionism holds out to the poor and despised is self-respect, economic and social support, a healing service and a general sense of security” (Kiernan 1990A: 22).

A wide array of Zionist churches were established by charismatic ministers who claimed prophetic and healing powers. One category of distinction is between Book- and Spirit-type churches. The latter live and die with the charismatic leader. They rely on “prophet manipulation of fervor and enthusiasm” (Kiernan 1990B: 9). Book-type churches are those in which the founder has canonized his teachings, thus securing a legacy for himself. He remains the central figure even after his passing. These churches therefore tend to be older, larger, more centralized, and more orthodox. The Shembe Church has made the transition from Spirit- to Book-type church (Sundkler 1976). Spirit-type Zionist churches are the subject of the next chapter.
The Nazareth Baptist Church, as it is officially called, was founded by Isaiah Shembe in Natal in 1911. Shembe’s intention was to create a church for the Zulu people, in order to respond to the breakdown of the Zulu social structure in the face of colonialism and urbanization (Vilakazi 1986: 22). “Shembe’s mission was to restore the dignity of Zulus” (Kau 1999: 82). He incorporated Zulu dance, leadership structure, and cosmology into the religion. The retention of Zulu traditions made the church especially appealing to the rural poor. Its Zulu nationalist identity survives today. Several respondents were not religious and did not belong to a church, but nevertheless said they “supported” the Shembe Church. It has one of the largest followings of any Zionist church in South Africa, but its popularity is, predictably, limited to KwaZulu-Natal. The Church has several settlements, including its headquarters in Ebuhleni.

The fidelity of Isaiah Shembe’s vision is ensured 70 years after his passing thanks to his writings (Gunner 1988: 205). He passed on the mantle of leadership to his family line—his gifts as a prophet and healer are believed to pass down through his family. The current head of the church is Bishop Mvumbeni V. Shembe, his grandson. Its strict hierarchy is patterned after the Zulu system of rank (Kau 1999: 75). Under the Bishop are successive layers of bureaucratic control: priests,

---

1 The respondents who said this were male; I would hypothesize that this identification is a view more likely to be held by males. The male: female ratio in the Shembe Church was higher than in the Catholic and Zionist churches (Vilakazi 1986: 53, own attendance figures). It may be that the Shembe Church’s distinctive political-nationalist identity is what draws males to the Church.

2 Its attempt to establish utopian settlements puts it in the Zion-City sub-type of Zionist churches (Pretorius 1997: 220).

3 Other sources (e.g. Gunner 1988, Vilakazi 1986) refer to the city as Ekuphakameni, but the city of Durban street signs identified it as Ebuhle ni. It is located in Inanda, a former township of Durban.
evangelists, lay preachers, and group leaders. This chain of command ensures order and uniformity within the church: “This structure was created to curb maladministration, corruption, and divisions within the church,” (6.9.03) said Sipho Ngubane, the lay preacher from Magwaveni. Lay preachers are ordained—they have certificates from the church stating their status, though they do not undergo formal religious training. Leaders are promoted through the ranks based on administrative and religious competence. The local church, headed by the lay preacher, is also divided into sub-units: there are separate groups for men, married and non-virgin women, and virgin women, each with its own leader. Church leaders from the various levels have meetings during the general church pilgrimages in January and July. The Bishop also has a set of advisors, one of whom represents the church on the Department of Health’s Provincial AIDS Religious Executive Committee. I spoke with another of his advisors, Chauncey Sibisi, the executive-secretary of the church. Sibisi’s job is to assist lay preachers and review project proposals submitted by people within and outside the church.

The sheer size and bureaucracy of the church put a distance between the individual and the Bishop. He is accessible, at times, to the masses: in January and July, he hosts massive pilgrimages to Ebuhleni. Though smaller, Ebuhleni is similar to the informal settlement of Magwaveni; its inhabitants live in small, densely spaced mud-brick houses without electricity or running water. The Bishop and his family live in several large brick houses in a closed-off, inner compound at the centre of the settlement. Pilgrims enter this inner compound, make a small donation, and
then are blessed collectively. Because of the number of pilgrims, it is unlikely that he blesses people individually. Sick people also come to receive his blessing.

According to Sibisi, the church does not conduct any social programs, because of a lack of funding. His office does not have a budget to implement any programs. The Bishop has said that the church is supposed to support widows/widowers and orphans, but does not have a welfare fund. Sibisi said this was “because the church is made up of poor people and they cannot contribute so that there are funds for such people” (10.8.03). Sibisi said that he wanted to start programs, but had no specific plans. He had not discussed any specific project with the government or outside organizations. His priorities are, in decreasing importance, a self-help farming scheme, old-age homes, and orphanages. Any program proposals from local churches have to go through the hierarchy, up to Sibisi’s office and then on to the Bishop for approval. The Magwaveni and Mlandaleni congregations do not have any programs. In contrast, although the local Catholic parishes do not have any programs either, neighbouring parishes do. The Catholic system actively encourages parish priests to be entrepreneurial, at least in regards to AIDS programming, whereas the Shembe system does not.

B. Services

Shembe temples are outdoors and are demarcated by a circle of white stones. There is a morning and an afternoon service on Saturday. An individual is required
to pray four times daily and five times on Saturday. There is a class of older women who visit the sick on Thursdays. The three groups within the church—married and non-virgin women, virgin women, and men—have separate overnight services once a month. According to the lay preachers, it is at these ceremonies that the church’s doctrines, particularly regarding sexual behaviour, are emphasised to members.

The lay preachers in Mlandaleni and Magwaveni are in their fifties and head large households (nine and eight family members, respectively). Both are dependent on government grants. The lay preacher from Mlandaleni has an income of R1560/month from one child support and two old-age grants, supplemented by R60 from his small farm. Ngubane has an income of R860/month from a disability and a child support grant, supplemented by R600 from his son’s temporary job. They receive no funds from the Church, for themselves or for their congregations. The local church’s only income are the inconsequential sums raised at Saturday services. These are sent up the church ladder; the local church has no money at its disposal.

In contrast, the Archdiocese in the Catholic Church sent poor parishes a monthly subsidy, and the parishes kept the money from their collections, allocating it through the parish council. There are no maintenance costs for the outdoor temples or any other aspect of the local church. Occasionally, there are special collections for

---

4 We do not know the budget or income of the Bishop’s office. The Bishop lives in a palatial home and drives fancy cars. We were told that the Shembe family was independently wealthy, and that one of the current Bishop’s achievements was to separate the finances of his family from that of the Church (Xthlathla Shembe 22.9.03).
families in need. When asked what they would do with extra funds, the lay
preachers responded that they would build temples for when it rains.

We attended a Saturday afternoon service at the Mlandaleni temple, from 1-3
p.m (23.8.03). All congregants wore white gowns; non-virgin women wore
traditional Zulu hats; virgin women covered their faces with white cloths; and men
wore animal skin headbands and necklaces. Congregants sat in their respective
groups, on straw mats. Most had the Shembe hymn-book and a Bible. About 65
people attended services, with women in the majority, although not as
disproportionately as at the Catholic service (Table 1). The order of the service was
set out in the hymn-book: opening prayers, sermon, closing prayers, and a closing
sermon. After the first sermon, we were asked to introduce ourselves, which we did
through Khoza, our interpreter. The entire service was in Zulu. There was no
dancing accompanying drums and horns, or testimonials, as there are at Zionist
services.

Table 1. Attendance figures for Zionist churches

<table>
<thead>
<tr>
<th></th>
<th>10 y.o. and under</th>
<th>11-25(^5)</th>
<th>26+</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mlandaleni Saturday p.m. Service</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>12</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Female</td>
<td>13</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td><strong>Magwaveni Saturday a.m. service</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
<td>3</td>
<td>20</td>
</tr>
</tbody>
</table>

\(^5\) The Church divided virgin females from non-virgin females, in dress and seating section. The 11-25
category refers to the female virgin group, and the 26+ category refers to the female non-virgin group.
The sermon was delivered by the lay preacher from Magwaveni, who was visiting for his niece’s wedding. As at the service conducted by Davey in Tongaat, we did not have the opportunity to introduce ourselves to him before the service. But in contrast to Davey’s sermon, the visiting preacher’s was extemporaneous, and he took note of us amongst the congregation. Upon later review of a translation of the sermon, it seemed to have been addressed to us, as visitors—it was an introduction to the customs and beliefs of the church. He did not mention AIDS.

At the end of the service, the host preacher also delivered a sermon. He informed the congregation that we had spoken with him about disease prevention:

I said that we do not emphasize talking about disease because Shembe gave us ways to influence our children, so that they stay free from these diseases. It is so difficult for us as a Church to tell our children to carry condoms. If we tell them to carry, what will we tell them to carry them for? That will mean we are sending them to use them. What we only do is to teach Jehovah’s way, Shembe’s principles, which is the only way to keep them prevented and preserved. In such a way these diseases will pass side by side without touching them. Only the one who will not heed Jehovah’s principles will get affected.

This is a good example of how the church can stigmatise AIDS. Though he did not specifically mention AIDS, the lay preacher said that only sinners get sexually transmitted diseases. We did not get a chance to hear the Catholic priests talk about AIDS, but what they told us they said was less stigmatising. They said that they talked about compassion for people living with AIDS, and were careful not to label people living with AIDS as sinners.

We attended Saturday morning and afternoon services at the outdoor temple in Magwaveni (6.9.03). There were about the same number of women as men (Table
1). The leader of the men’s group gave a sermon about how Shembe cured his illness when he was a child. At the end of his speech, he said, “Shembe is a place where kids should be since there is a sickness like AIDS. Under him, the youth will not get affected.” The lay preacher had probably told him about us.

There were about half as many people at the afternoon service. The order was similar to the other services, except that there were two sermons (by the men’s group leader and the lay preacher), a ceremony for the sick after the sermons, and private prayers following the closing prayers. Neither sermon addressed AIDS or sexual behaviour. The preachers spoke about Shembe and the Sabbath, and told stories of how Shembe affected their lives. In the prayer for the sick, four married women, one boy, and one middle-aged man knelt at the centre of the circle. The lay preacher and the men’s leader repeatedly waved a sheet over the heads of the congregants. The men’s leader shouted for the demons and sickness to come out of the people. At the same time, the congregants were singing a prayer that asked for God to help with sickness. At the end of the service, people with special concerns knelt before the preacher, made a small donation, and asked the preacher to pray for them. Their concerns, which could be heard by other congregants, consisted of misbehaved children, illnesses (non-specific), and other hardships.

There were about 15, mostly older women in the Shembe class in Mlandaleni (19.9.03). They were visiting a family whose daughter, a woman in her late thirties, had died recently. They did not talk about what she died from. As in the case of the Roman Catholic class, the format of the ceremony was an alternating series of
testimonies and prayer-songs. The testimonials paid tribute to the daughter. During the ceremony, three Zionist women joined the class, because the daughter had been a member of their church prior to her conversion to the Shembe Church. At the end, the leader of the class gave a speech, telling the women that their primary duties are to take care of their husbands and their families and to teach their children respect and responsibility. The women donated R30 to the family.  

C. Dealing with AIDS

Healing and sexual morality have been central issues for the church since its founding. The founder was believed to have healing powers, which have been passed down the line of succession of the church. Sick people go to the Bishop for blessings during the twice-yearly pilgrimages and buy blessed Vaseline and water for their curative effects. The prohibition of pre-marital sex is one of the central tenets of the church. Vilakazi traces Shembe’s opposition to pre-marital sex to three factors: messages he received from God telling him to cease his own pre-marital sex activities; the prohibition in the Bible, stressed by missionaries; and finally, his observation that colonialism and urbanization were breaking down the Zulu family structure, leading to many illegitimate children (1986: 32).

In the eyes of the church leaders, the prohibition against pre-marital sex obviates the need for the church to directly address AIDS or develop any AIDS

---

6 We did not have a chance to interview the family afterwards.
programs. “Generally speaking, we don’t have AIDS in our congregation simply because the teachings of Shembe, the founder, are so strict,” said executive-secretary Sibisi. “We don’t even talk about it [AIDS] because so far as we are concerned we are taught that we must abstain.” The Church does not promote condoms, because doing so would promote promiscuity. As in the Catholic church, the linking of premarital sex to disease and sin may be contributing to the stigma of AIDS. Sibisi said, “If there is someone who gets affected or contracts AIDS, it will mean that one has gone out of the principles and teachings of the church.”

These principles were repeated with remarkable consistency in interviews at all levels of the hierarchy, from the Bishop (22.9.03) to the lay preachers to the class leaders—a testament to the conformity within church ranks. These principles were conveyed to the congregation in the sermons that we heard, although the lay preachers said that they more typically talk about them during the monthly group meetings, which have higher youth attendance than Saturday services. The structure of the church is conducive to the dissemination of a uniform message, especially one on sexual behaviour. Men are separated from women, and virgin women from non-virgin women, at services and in dress.\(^7\)

AIDS, in fact, is seen as a justification for the behavioural dictates of the church, which in addition to forbidding premarital sex, prohibit drinking, smoking, eating pork, and shaving. In this line of thinking, the church norms directly protect

---

\(^7\)One female Shembite told us that some girls lie about being a virgin, which would indicate that virgin-testing was not practiced, although we did not inquire with the church leaders.
the individual from AIDS, since sexual intercourse is the dominant mode of
transmission. But more generally, church norms are a conscious means of exclusion.
They build a barrier against the moral and physical corruption of the rest of society.
As the lay preacher from Mlandaleni said, “People separate themselves by not
drinking alcohol and not going to places for entertainment. A Nazarite is not
allowed to go such places which cause a person to enjoy oneself to the extent that he
exposes himself to danger or getting disease” (22.8.03). This exclusivity achieved
through behavioural restrictions was a feature noted by Kiernan in his study of
Zionists in KwaMashu, a former township near Durban, in the late 1960s: “Zionists
are primarily engaged in erecting a barrier between themselves and fellow Africans,
upheld in ritual symbol and moral code” (1990: 33B).

The benefits of these restrictions were evident to church leaders and members
in the church’s success against AIDS. Church leaders denied that AIDS was a
problem for members. As Sibisi maintained, “I have not seen one Nazarite who is
affected by AIDS.” This is troubling since the church’s following is largely the rural
poor, a particularly at-risk demographic group. Sibisi admitted that it was possible
that some church members had AIDS: “Out of a hundred, you’ll get one, two, three,
up to ten who will be a square peg in a round hole.” His comments differ from the
Catholic priests’, who said that AIDS was a problem for the community, including
their congregants. Davey expressed doubt that his message was getting across to
young people, but the Shembe Church leaders were confident that their guidance
was being followed.
Like Sibisi, the preachers did not know any church members with AIDS, because of their insistence that the Church’s principles protected its members, not because of stigma. They also did not know anyone in the broader community with AIDS, but this they attributed to stigma. In Magwaveni, the lay preacher knew of two families in his congregation that had experienced the loss or sickness of a family member. In Mandeleni, the lay preacher and his wife, the head of the Shembe class, knew of five families with AIDS, but only one were Shembites. The Shembe families that we interviewed reported that they went to their church and to clinics in case of illness, but not to traditional healers—sangomas (diviners) or inyangas (herbalists), because the church prohibits seeing them.

We interviewed the matriarch of the Ngubane family in Mlandaleni (2.9.03). She was the sister of the lay preacher from Magwaveni. She was the leader of the class, and her recently deceased husband had been the lay preacher. In her sixties, she was the head of a household of 13, including seven under the age of 18. The household’s income was R1020/month, from an old-age grant and two child support grants. One of her daughters had passed away after a protracted illness whose symptoms were stomach- and headaches. She had sought treatment at the clinic and hospital, as well from the church. When this daughter became ill, the family lost her income from dressmaking. She was survived by two children, now in Ngubane’s care; the father was also deceased. Another daughter was ill with tuberculosis. She did not live with the family, but her two children did, although she occasionally stayed there. The father did not provide any support, nor did she.
Mrs. Ngubane did not know anyone in the church or the community with AIDS. “In the Shembe Church, no one has been found with AIDS. People wonder why Shembe followers do not get it. It’s because they follow the words of Shembe,” she said. “The preachers tell the women to take care of the children, to teach them to behave. If they don’t behave, they’ll end up with disease.”

D. Conclusion

The Shembe Church lacks the access to rich communities, and hence resources, which the Catholic Church enjoys. Money is less of an object in the Shembe Church, partly because its membership base is predominantly the rural-poor, but also because such was Isaiah Shembe’s original intent. Temples are outdoors, lay preachers are not paid, and there are no membership dues. But the main reason why there are no social programs in the Church is not the lack of resources, but rather the lack of interest on the part of its leaders. The executive-secretary, who guides all programming, had no programs in development. Unlike the Catholic Church’s leadership hierarchy, conformity, rather than entrepreneurship, is valued. To be sure, the Catholic priests said similar things about AIDS and sexual behaviour. But they were actively encouraged to start new programs. The Shembe lay preachers had to navigate the Church’s bureaucracy to develop programs. Despite these differences in organizational values, the congregation leaders from both denominations accorded the highest priority to the
use funds on church construction. Yet, the conformity of the church means that the church has the ability, if it so desired, to vigorously and faithfully implement top-down social messages and programs.

The Church demanded a high level of discipline of its members through behavioural restrictions, which deliberately served as a barrier between the Church and greater society. Diseases such as AIDS justified the need for exclusion from an impure society. The mainline and Zionist churches did not operate in the same exclusive manner. The varying levels of discipline across churches may be reflected in the attitudes of the congregation leaders—the Catholic priests were frustrated by the perceived or expressed lack of regard for the church’s norm of abstinence, while the Shembe lay preachers seemed confident that their message was being heeded. They could be right, or their confidence may be misplaced. They also were convinced that no one in their church had AIDS, which is clearly not possible.

Discipline cuts both ways though—it may result in compliance, but it also excludes. There were not many young people at general services. They may be turned off by the discipline expected of members. The Roman Catholic Church does not have many young members either, but Zionist churches did, for reasons to be discussed in the next chapter.
CHAPTER 5. THE ZIONIST CHURCH

In this chapter, I explain the particular appeal of the Zionist Church to youths, and how the Church is viewed as a health resource. These characteristics represent promising opportunities for an effective campaign against AIDS. I will show, though, that the opportunities have been squandered through stigmatising, vague rhetoric about sexual behaviour, and a lack of programs.

A. Mlandaleni and Magwaveni Churches

While the Shembe Church has evolved into a Book-type church and has no overt connection to the Zionist movement, Spirit-type churches retain their connections to the original movement of the early twentieth century (Kiernan 1990B: 21). Indeed, the ordination certificate of Rev. Mtholeni Gumede, a Zionist minister in Magwaveni, cited the Christian Catholic Church in Zion, in Zion, Illinois as its head office. It further stated that Rev. John Alexander Dowie founded the church, on February 22, 1896. The Spirit-type churches have received scholarly attention in numerous works (Comaroff 1985, Kiernan 1990B, West 1975, Sundkler 1976). They are characterized by their autonomy and individuality, yet paradoxically their rituals and beliefs are fairly consistent, even across ethnic boundaries. Analytically, healing can be seen as the central, commonly held organizing principle of the church. To
varying degrees across churches, water, sacrifices, traditional medicines, and the
prophet are believed to have the ability to heal. The healing service is distinctive to
these churches, over and above what the Shembe or mainline churches offer. “The
[missionary] church is particularly wanting in the area of health, always a major
concern for the poor, in that it lacks an appreciation of the connection between
religious observance and physical and social well-being which is presupposed
among Africans. Zionists not only acknowledge this connection, but service it”
(Kiernan 1990A: 23).

Despite his ordination certificate, Gumede had no administrative connection
to the U.S. church. His church in Magwaveni was of typical Zionist organizational
structure. He had founded his branch, one of forty churches in his particular
denomination. All were essentially independent of the church superstructure, in
that they received no financial or theological support from the head church. In fact,
the superstructure wholly consisted of the Bishop, the minister of the head church in
Stanger, a city north of Tongaat. One reason for the proliferation of Zionist
denominations is that the minister is the heart of the congregation. He is a
prophet/healer, and it is his magnetism that determines the popularity of the church.
A man who feels called to the pulpit can start his own church. Whether motivated
by spirituality, an internal dispute, or personal ambition, he may alternately choose
to break away from his own church entirely, or to expand the existing church by
opening another branch.
M. Gumede founded his branch of the Ukuthula Christian Catholic Church in Zion in 1996. He paid R150 per year to the head church in Stanger for a license. Petros Mdletshe’s Uhkanya Christian Catholic Church in Zion broke away from M. Gumede’s church in 2000. Mdletshe’s congregation was smaller—30 members compared to 150. He ran his congregation from his home, while M. Gumede had a purpose-built church in Magwaveni. Many members of Mdletshe’s church also attended services at M. Gumede’s church. The third Zionist church that we looked at, in Mlandaleni, was Rev. Philip Gumede’s Inkanyezi Church of Christ in Zion. It was one of ten churches in his denomination, under a Bishop Ngcobo.

The advantage of belonging to a denomination is the network that it provides. Conferences between sister churches are a staple of Zionist churches’ programming. Churches come together to hold overnight services as frequently as once a month. Belonging to such an organization provides fledgling churches like Mdletshe’s with legitimacy—members see that they are part of a larger movement. M. Gumede’s church was larger and more established, consequently, he did not participate in as many conferences as Mdletshe. From the popularity of his congregation and his increasing independence from other churches, M. Gumede’s seems like a probable candidate for secession from his denomination. He did not need the name or the connections that came with his license fee. He told us that he had established branches in other communities.

At the conferences, there are choir competitions. The choir is a key element of the Zionist churches’ appeal to adolescents, who form the core of their membership.
Choir practice, called “composing,” is held weekly. Our interpreter, Khoza, compared the popularity and spirit of choir competitions to the weekly community soccer matches, except that there were more females in Zionist choirs, which in turn, was luring more males to the churches. Just as the class serves as a social group for older women, the choir serves as a social group for the youth. It gives them an opportunity to meet together and travel to other areas.

All three priests were ordained by the bishops of their churches, although they did not receive any formal theological training. They held day jobs and were not paid by the church. Their jobs were fairly typical for where they lived. In Mlandaleni, P. Gumede earned 800R/month from temporary work. In Magwaveni, Mdletshe and M. Gumede earned 2500R and 2000R/month respectively, working for municipal agencies. Gumede supported a family of seven. He also received a R700 old-age grant for his mother. Mdletshe and his wife had one son, but had also taken in five orphans. They received a R500 foster child grant for one of the orphans.

The revenues of the three churches were small. There were 25 paying members (R10/year) in P. Gumede’s church and 80 (R3.50/year) in M. Gumede’s, while Mdletshe did not charge membership fees. People were not refused if they did not pay their fees. The dues were sent to the head office and were used to cover operating costs, to pay for the license fee in M. Gumede’s case, and, in P. Gumede’s case, to pay for the costs of conferences. There was a collection plate for the needy in Mdletshe’s church, and ad hoc collections were made for dire cases in all three churches, but the sums were insubstantial. At M. Gumede’s Sunday service,
donations were solicited for a single mother who had recently died and for a congregant’s whose house had burned down.

The Zionist churches had more programming than the Shembe or Catholic churches. In addition to a weekly service and class on Thursdays, they had twice-weekly composing (choir rehearsal), which the youth attended. M. Gumede had a youth service instead of composing, because he did not want to encourage the youths’ socializing.

The Zionist ministers, like their Catholic and Shembe counterparts, identified poverty and unemployment as the chief concerns of the community. Also like their counterparts, Mdletshe and P. Gumede said that if they had funding, they would use it for church buildings, but they added that they would like to start programs for orphans and the sick. M. Gumede, who had a building for his church already, said he would use funding for a burial scheme for the congregation.

B. Dealing with the Sick

The Zionist ministers knew more sick families than the Catholic and Shembe ministers; M. Gumede and P. Gumede each said they knew at least 20 sick families in their congregations, many of whom they suspected had AIDS, compared to the 2-5 families that the Catholic and Shembe leaders said they knew. M. Gumede was a licensed inyanga; over the course of an hour-long interview one evening, two sick

---

1 The class in M. Gumede’s church did not visit the sick; he personally visited sick members.
persons visited him for medicines. Mdletshe supported five orphans. M. Gumede and P. Gumede agreed to organize focus groups for us, but unexpected conflicts intervened at the last minute in both cases.

The Zionist ministers' greater contact with the sick is due to the youthfulness of their membership (an age group coincident with high rates of HIV/AIDS) and the central role of healing in the church. As P. Gumede said, “I think the church is popular because it is a healing church. People get interested in the church by seeing its powers in prayers and healing” (23.8.03). To compare, Bishop Shembe also has healing powers, but because of the size and bureaucracy of his church, there is limited access to him. The healing ceremony was not as much of a focus in the weekly Shembe service as it was in the Zionist service. The Catholic priest Xaba remarked that sick people did not come to him. None of the Catholic families we talked to had asked the priest to visit them. Because of the size of their parishes, Xaba and Davey were dependent on lay leaders in the administration of their parishes. The prayer for the sick was a relatively small part of the Sunday service.

Of all the ministers with whom we spoke, Mdletshe and P. Gumede were the only ones to whom persons living with AIDS had confided their secret. The Zionist ministers suspected that a number of families in their churches had AIDS, but for the most part, people did not tell them. The Shembe lay preachers denied that anyone in their church had AIDS. The Roman Catholic priests thought it was likely that some members had AIDS, but did not specifically know any whom they thought had

---

2 M. Gumede made an additional R300/month from his work as an inyanga.
AIDS. Despite the Zionist ministers' concerns over AIDS, they had not initiated any AIDS programs within their churches. This may be due to resources, because compared to their counterparts, they expressed an eagerness to start programs.

All three ministers said that they preach about AIDS. They warn about the risks of getting infected, but are not specific about the methods of abstinence they promote. P. Gumede said, “We tell them [the youth] that if they misbehave and are careless it is easy for the disease [AIDS] to attack and affect them.” Likewise, M. Gumede and Mdletshe said that they warn the youth to behave properly. This was confirmed by the families that we interviewed. The ministers said that they promote condoms, but this was not substantiated by the families or in their sermons. They were not attached to any one component of sexual behaviour in the way that abstinence was a central tenet of the Shembe Church and Catholic Churches. Certainly the lack of a uniform guideline is due to the lack of organizational cohesiveness amongst the Zionist churches. The lack of a clear and closely-held guideline on sexual behaviour, be it condoms or abstinence or fidelity, raises doubts about the efficacy of their prevention message, as well as their commitment to regulating sexual behaviour within their churches.

C. Services

We attended Sunday services at each of the congregations, as well as a sick prayer service by P. Gumede and a youth service by M. Gumede. Again, females
outnumbered males (Table 1), but more young adults attended services than in the other denominations. As in the Shembe Church, members sat according to age and gender, although virgin women were not distinguished as a group.

Table 1. Attendance figures for Zionist churches

<table>
<thead>
<tr>
<th></th>
<th>10 y.o. and under</th>
<th>11-25</th>
<th>26+</th>
</tr>
</thead>
<tbody>
<tr>
<td>P. Gumede (Mlandaleni)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sunday service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>10</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>Mdletshe Sunday service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Female</td>
<td>9</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>M. Gumede Sunday service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>10</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Female</td>
<td>10</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>P. Gumede overnight/sick service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>M. Gumede youth service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>9</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>Female</td>
<td>8</td>
<td>30</td>
<td>15</td>
</tr>
</tbody>
</table>

Most members wore the Zionist uniform—a blue or green dress with white shirt for women and a blue or green robe and pants with white shirt for men; many of the men also carried staffs. Sunday services lasted about two and a half hours.

Nobody used prayer-books, and only a few had Bibles. The format was the same at the three churches—opening prayers, sermon, testimonies, healing ceremony. We

---

3 M. Gumede had the largest congregation. His purpose-built church, adjoined to his house, could accommodate 150 people. Due to rain, attendance was less than usual on the Sunday we attended.
were asked to introduce ourselves, which we did through Khoza. All prayers were sung as a congregation, to the accompaniment of drums and horns. The congregants clapped to the prayers and danced in place. The service was far more participatory and emotive than the Shembe and Catholic services.4

In their sermons, the ministers mostly talked about the glory of God and the church, periodically calling on congregants to read selected passages from the Bible. M. Gumede did not discuss AIDS during the service. P. Gumede, in Mlandaleni, spoke most extensively about AIDS. He said:

In order to go straight to God, you must behave correctly, which will also prevent AIDS, as it is prevalent these days. To survive, you must behave correctly. If you have respected your home, your leader, and the place where you are today, indeed you are protected and disease is prevented. Diseases have finished the people. We bury everyday, there is crying and children are left alone. You find that they are left without anyone to look after them and not knowing what to eat. If you get killed by AIDS it is you who expose yourself to it. To do or go as you like, is to expose yourself to it. You are warned by this and this side but you do not learn. AIDS then gets you. Once you are affected, you start to affect the whole community. Maybe it is only you who is affected but you will end up destroying the whole community. (24.8.03)

Mdletshe also spoke about AIDS: “The word of God saves the young person. Let us work for God because you will be saved from AIDS. Should you appreciate worldly things, you will get AIDS. These are hard times we live in. we live in days of cruel diseases such as AIDS, but if we live for the Lord, we are safe from the diseases. Should you live a worldly life, not heavenly, definitely you will die” (7.9.03).

4 Garner’s study in a nearby area ranked the churches’ “religious experience,” that is, “the level of participation in meetings, opportunities for self-expression, and emotional involvement” (2000: 63). Mainline churches were ranked as low, Shembe as medium, and Zionist as high.
As was evident from my interviews with ministers and families, the ministers talk about AIDS in their services, but vaguely. They said that AIDS is dangerous and that the youth should behave. But they did not say, “Do not have premarital sex,” or “Use condoms,” and people may not have understood, “Behave correctly,” to mean those things. By being so general, they associated the disease with sin, but may not have been effective at conveying specific messages of prevention. Also, the ministers did not speak about compassion for people living with AIDS, which could have blunted their stigmatisation of the disease.

After the sermon, congregants took turns testifying—in the two smaller congregations everyone testified. The people giving testimony became very emotional, with some crying. In the testimonies, people would usually cite a Biblical verse and praise God and the congregation. Some said that having white people visit was a blessing from God. The older members would generally echo the preacher, exhorting the congregants to behave properly. The younger members would generally thank God for bringing them there. Only one person mentioned AIDS in their testimony—at P. Gumede’s church, one young woman said that she prays that of all the diseases, she should not die of AIDS. In Mdletshe’s congregation, the two persons who had told us that they were HIV-positive did not mention AIDS or sickness in their testimony. This part of the service took about an hour.

The healing ceremony, the final part of the service, took 45 minutes. Sick people stood as a group in the middle of the room and the remaining congregants
circled them. The minister and a few older congregants entered the circle, and put their hands on the heads of the sick people. They shouted that the spirits should leave them, threw them to the ground, and hit them on the back. Male congregants would take their staffs and touch the sick people. They were trying to shake the bad spirits out of the sick people. The minister or a senior congregant would diagnose the sick person. He, or she, put their hands on each person, and listed a variety of possible ailments—headache, stomach ache, running stomach, sweats, etc. P. Gumede sat down next to one man and, holding his head, told him that he had contracted a disease from his girlfriend, and it is eating him inside. He asked where was the girlfriend, and told the young man to come back to see him because something bad was going to happen to him. M. Gumede focused on one young woman, and listed a variety of illnesses that she might suffer from. Then one senior woman screamed for the animal to come out of the woman, and advised her to see a sangoma or inyanga for help. Khoza said that this is what sangomas do. M. Gumede burned some herbs next to her.

The healing ceremony at Mdletshe’s church was less demonstrative. First, a group of people came forward and knelt at the front of the church. Each one gave a small donation and said what troubled them: bad dreams, personal relationships, employment. This was similar to the ceremony at the end of the Shembe service, where people knelt and told their concerns to the preacher. The woman who had told us that she was HIV-positive prayed for her young son to be more obedient.
Then, the sick gathered at the front, and Mdletshe put his hand on each person’s head and said a prayer; the HIV-positive woman did not come forward.

M. Gumede’s youth service followed the same format as the Sunday service, except that he did not give a sermon, nor did he single people out for healing. Many young women attended. The mood was more joyous; for one prayer-song, the congregants spun around in a circle. Even though Gumede did not have composing, his church was very popular amongst the youth.

We attended a service at a sick man’s house. It took place on a Sunday: P. Gumede and his congregants had been walking back to his house/church after an overnight service at another church. On the way back, they were summoned to the house of a young woman from his congregation. Her brother was gravely sick and bedridden. He was in his twenties and had been working in Durban, but then became ill. As his health deteriorated, he moved back home to Ndwedwe so that his family could take care of him. He was very thin; the minister said he had suffered a stroke. When we arrived, the congregants were singing prayers in the living room of the small house. They sat according to age and gender, as at normal services, but there were no drums or horns. There were 25 people there, including the sick man’s family and visiting friends. The congregants were mostly young adults. The minister went back and forth between singing prayers with the congregation and attending to the sick man. He burned herbs in the sick man’s room, and said prayers next to his bed. He gave the man a cup of water into which he had dipped his

---

5 We did not have time to attend a Zionist class.
finger. The sick man’s mother said that the reverend was helping him, because before he could not even drink. The minister rubbed the man’s chest. He told the mother that he thought the man would survive, but that if she takes him to the doctor and they give him an injection, he will die.

An hour and a half after we arrived, the sick man had a seizure. The minister then started to pray and a senior congregant took the man’s hand and slapped it repeatedly. The mother thought that he needed oxygen, so she announced that she was taking him to the hospital. The minister then agreed—he said that he cannot help if the sick man is lacking oxygen. The congregation left, continuing onto P. Gumede’s house/church.

P. Gumede claimed that he could cure some illnesses; AIDS was not one of them, nor did any of the other Zionist ministers claim that they could cure AIDS. P. Gumede said, “I tell a person to go to the doctor if the person is dehydrated or lacking oxygen and for other things I cannot help with. I can cure headaches, stomach aches, body pains, and other things” (31.8.03).

D. Family Interviews

We interviewed the matriarch of the Mfeka family in Mlandaleni (31.8.03). Her brother had died the week before from AIDS; his wife and young son had also died from AIDS, several months before. They were survived by six children, four under the age of 18. Mrs. Mfeka and her husband, who themselves had eight
children, took care of her brother’s children. Mr. Mfeka could only find temporary employment, which earned R200/month. Though qualified for them, the family had not applied for any grants. The deceased brother had children with four other women; during the interview one of these women came to get a copy of his death certificate, so that she could get a government grant. She had four children by him; they lived with her in Durban, where she had a job at a factory.

The deceased brother had told his family and the minister that he was HIV-positive. Mrs. Mfeka said, “People don’t want to say that they suffer from AIDS. They only say that they suffer from TB, because people laugh at the person with AIDS and discriminate against them.” They did not know anyone else in the community with AIDS. His 19 year-old son had not been tested, he said, because it was no use knowing if he was going to die.

The family were members of P. Gumede’s church. Mrs. Mfeka said that Gumede talks about AIDS. “He says that we should be aware of sexual activities because they can kill,” she said. The congregation held services at their house on several occasions. “My brother loved them because he felt free when they were praying for him. They came with solutions—water that the Reverend blesses. He used that and it helped him—it slowed the disease down,” she said.

Two of the six families whom we interviewed from Mdletshe’s church told us they were HIV-positive. One family—a grandmother, mother, and her four children—had an income of R900/month, from the grandmother’s old-age grant and from renting out two rooms of their house. She attended both Mdletshe’s and M.
Gumede’s services. She had only told her family that she was HIV-positive. She had already arranged with the social worker in Magwaveni for foster placements for her children upon her death (Anonymous D 9.9.03).

In the other family, the woman had told Mdletshe that she was HIV-positive. Her 14-year old daughter lived with her mother in Ndwedwe. Her two sons lived with her—the youngest, six years old, was HIV-positive. They were supported by a child-support grant and money from her boyfriend. She moved from Ndwedwe seven years ago to find a job in the city. She joined the church a year ago because she felt alone and helpless. She is a member of the class. Mdletshe helped her from time to time with small donations. She had told him that she was HIV-positive because, “I don’t want people to think that I was poisoned or bewitched—I want him to tell the truth at my funeral” (Anonymous E 9.9.03).

E. Conclusion

In some respects, Zionist churches hold great potential in the prevention and care of AIDS because people go to them for healing and because of their popularity. Healing was an integral part of the identity of Zionist churches, more so than the Catholic and Shembe churches. As P. Gumede told us, the success of his church was due to his success as a healer. The healing ceremony was the focal part of every service. In contrast to the Catholic church, people actively sought out their church leaders for healing. The only respondents who had told their ministers that they
were HIV-positive were Zionist congregants. In contrast to the Shembe church, the church leaders said that AIDS was affecting their congregations. They spoke more openly about AIDS, albeit they were vague in their prevention messages and did not talk about care for those with AIDS at all.

Zionist churches’ appeal, particularly to the youth, can be attributed to several factors. Services are lively, with singing, dancing in place, and the musical accompaniment of drums and horns. There are frequent overnight services, which gives young people the opportunity to travel and meet young people from other areas. Young people form the choirs that represent the church in competitions. M. Gumede was wary of choir practice because he thought the youth used it as an excuse to meet and socialize. These elements are related to the level of discipline in the church. In a sense, the church allows, and encourages, young people to have fun. The Shembe Church’s services were more austere; youth meetings were held separately for each gender; dating is forbidden. Extensive rules govern a Shembite’s life. The Catholic Church had a lower discipline level, but it did not have the choir, lively services, or healers—it was not something one could identify strongly with.

The fluidity and decentralization of Zionist churches was also a source of appeal. There are many distinctive ministers to choose from. In Magwaveni, several of Mdletshe’s congregants also attended M. Gumede’s services. Every congregant has direct and personal access to the church leader. The parishioner-to-priest ratio in the Catholic Church was much higher. The Shembe lay preacher was accessible, but
the Bishop was less so, and the Bishop is very clearly the authority and the one with healing powers.

It is difficult to envision any change in church programming without external assistance, particularly in the form of material resources. These churches are so impoverished that, without external funding, they cannot provide any relief or start any programs, other than voluntary ones. In this sense, the organizational structure of the church works against programming. There is no centralized bureaucracy to work with to implement a wide-ranging intervention. One would have to speak to, support, and monitor every minister, individually.

Likewise, the lax discipline that is appealing to youth is also an impediment to an effective prevention campaign. If a minister were to split the choir by gender, the church would probably be less popular. If the youth like the church for its laxness, making it more strict and scrutinizing will likely impair its popularity.

---

6 M. Gumede could afford not to have choir practices because his church already had such a large following.
CHAPTER 6. DISCUSSION

In analysing AIDS strategies and efforts, there is a natural distinction between prevention and care. While none of the churches that I researched were involved in overt prevention campaigns, they did communicate messages about sexual behaviour as part of routine church discourse. Not surprisingly, their sexual behaviour messages took a moral-religious, rather than medical, approach. The Catholic Church was the only one involved in AIDS care. I propose that the following four characteristics moderate churches’ responses to AIDS: their resources, organizational structure, cultural appeal, and discipline. These four characteristics can be used to explain why churches have responded in the way that they have. In this chapter, I will first explain how these features have dictated church praxis, and then I will conclude by drawing together the broader themes of my research, and revisiting the Chapter 1 debate on the role of churches as a social agents during apartheid.¹

A. Four Determinants in Responding to AIDS

The Catholic Church is the richest of the three churches, and it is the only one to organize any AIDS programs. Clearly, it is difficult to start programs without financial resources. The attempts by MCDI/Diakonia and Sinosizo to establish

¹ Directions for future research are discussed in the Research Techniques Appendix.
volunteer-based programs through the churches were unsuccessful, even through the women's class, a group that seemed so suited to the cause. In the Durban area, priests and nuns had started programs in local communities by taking advantage of their connections to richer Catholic communities. Zionist ministers did not have access to such resources, and did not have any programs in general, although the ministers were used as health resources by their congregants. The Shembe Church's following is also amongst the poor, but since it has a larger following and centralized structure, it has more resources than Zionist churches. Yet it is not developing any programs either.

The Shembe Church had the tightest organizational structure. Its stance on AIDS and prevention is consistent throughout the hierarchy. Such conformity is not surprising, considering that structural conformity allowed the Church to make the transition from one of the many Spirit-type Zionist churches to a large Book-type church. Isaiah Shembe's family is the centre of the Church, instead of individual lay preachers. As the current Bishop has not initiated any programs, it is highly unlikely that lay preachers would do so. If the Bishop changed direction and decided to initiate programs, the Church's top-down structure would be an asset, ensuring compliance across the entire church.

By contrast, the Zionists' independent, loosely-connected structure would be a barrier to the implementation of a comprehensive program across churches. They belong to loose confederations of churches, and receive no guidance from their head offices. Individual church leaders would have to be the vehicle. The problem then is
selecting the right ministers. The Shembe preachers are screened by seniority and
discipline, and the Catholic priests go through rigorous training. The Zionist
ministers succeed because of their charisma, so there is no guarantee of
scrupulousness. The lack of external guidance in the Zionist Church may explain
why the Zionist ministers were so vague in their messages of prevention. They
spoke about AIDS, but urged the youth to “behave,” rather than advocate any
specific method of prevention.

Overall, the Catholic Church’s structure was most conducive to grass-roots
programming—the hierarchy gave guidance from above, and the priests initiated
from below. In some parishes, priests had started their own programs; in the two we
looked at, they had not.

The churches appeal to different demographic groups. Overall, women are
much more involved in churches, as evidenced by the class, as well as general
attendance. The Zionist Church has a much younger following. Their style of
worship and the choirs appear to be an important element in their attraction. The
Shembe Church had a greater proportion of older males than the other
denominations, possibly because of its Zulu nationalist ethos. The Catholic Church
was the least popular of the three, sharing a percentage of the 16% mainline
affiliation reported in a survey by MCDI (2000: 34). This was arguably because the
Church does not have the same cultural affinity as the other two, which, combined,
had 61% affiliation.
A distinctive part of Zionism’s cultural appeal is its healing ministry. The minister is a healer; congregants seek him for help with sicknesses. During services, he diagnoses and cures. Therefore, it is not surprising that they were the most amenable to starting social service programs in their communities. It also makes these churches attractive partners in prospective prevention campaigns.

True to its Zionist origins, healing is also important to Shembe followers, but this power was embodied at the central, rather than local, church. Catholic and Shembe leaders did not know as many sick families—they were less sought after as medical resources. Shembe preachers and Catholic priests were religious leaders first and foremost in their relationships with their congregations, their stated goals for prospective church funds, and the way they described their own duties.

While its healing ministry makes the Zionist church relevant in the daily lives of its members, discipline, in the form of various lifestyle prohibitions, makes the Shembe Church relevant in the daily lives of its members. The Church uses prohibitions to separate members from an impure society. To Shembites, it was no coincidence that the founder had prohibited premarital sex—the rules he made were for their protection. In terms of prevention campaigns, the church leaders were not willing to compromise on their abstinence-only policy, nor were they willing to talk more about AIDS—they reasoned that talking about AIDS was not necessary given the efficacy of the founder’s teachings.

The Zionist preachers were seemingly “looking the other way” when it came to discipline within their churches. M. Gumede and the Shembe preachers said that
choirs were magnets for dating amongst youths, which is why they did not have choirs in their congregations. On the one hand, the Zionist preachers spoke the most directly and extensively about AIDS (although they were vague in promoting any specific method of prevention). On the other hand, they sponsored the choirs. If the discipline level were raised, for instance, by making the choirs single-sex, the popularity of the church would almost certainly suffer, especially since it operates in a competitive atmosphere where members can rather easily join another church. There were not many youths at Shembe services, where the discipline level was higher.

The latter two characteristics—cultural appeal and discipline—make the Zionist and Shembe Churches attractive for prospective prevention campaigns, but the first two characteristics—resources and structure—would make implementation difficult. Overall, the Catholic Church is the best-suited organization to run AIDS care programs, as well as the most likely to develop programs in these communities in the future. Its success in other areas demonstrates its potential in Mlandalen and Magwaveni. While the priests saw themselves primarily as religious leaders, they said that they were not averse to starting programs. Given more external support and money they could capably organize programs for their communities. Even though it had the smallest following of the three churches in the areas I studied, any services it offered would undoubtedly be utilized to their fullest by the community. In other areas, its social services were non-exclusive and in demand. In the area of prevention, education campaigns require captive audiences. Due to its limited
cultural appeal and lax discipline, the Catholic Church would not be the most logical partner for such campaigns.

**B. Broad Themes**

An MCDI survey of mothers put AIDS awareness at 94% (2000: 34). In our interviews, most respondents knew that AIDS was a fatal, sexually-transmitted disease.\(^2\) The key question then is, if people know the dangers of high-risk sexual activity, why do they still engage in it? Why are HIV incidence levels still so high? The answer may lie in the unanimous identification of poverty and unemployment (but not AIDS) as their biggest concerns. Poverty is so intense that it might cause a fatalistic mindset, where people dismiss long-term costs in favour of immediate gratification.

The silence around AIDS caused by stigma may also explain risky behaviour. People are not confronted directly with the reality of AIDS, because the sick hide themselves and do not disclose, or even know, their status. Respondents said that they could not tell whether AIDS was affecting their community, because they personally did not know anyone with AIDS. Stigma hurts people living with AIDS, and it also explains why people do not bother to get tested for HIV. Ignorance of sero-status conceivably leads to more high-risk behaviour.

---

\(^2\) This could be proof of the effectiveness of churches’ messages about AIDS, but high incidence rates then imply low discipline.
In Chapter 3, I argued that making AIDS treatment available would do a lot to reduce stigma. Churches face a trade-off when involving themselves in prevention campaigns. The issue automatically becomes “moralized” in the context of the pulpit. But it is the moral authority of the church that makes it potentially influential in promoting prevention. The Zionist and Shembe Churches were more stigmatising than the Catholic Church. P. Gumede said, “If you get killed by AIDS it is you who expose yourself to it…Maybe it is only you who is affected but you will end up destroying the whole community” (24.8.03). The Shembe Church’s strong rhetoric on the effectiveness of Shembe’s teachings in preventing diseases in general, brands anybody with AIDS as a sinner. While the Catholic priests called premarital sex sinful, they said that they were careful to follow up their prevention message with one preaching compassion for those affected by AIDS. Precisely because the issue of sexual behaviour, to the church leaders, is a matter of moral conviction, it may be pointless to try to convince them to advocate one prevention method or another. Other churches should be encouraged, though, to adopt the Catholics’ message of care and compassion for the sick. Thus, even as the churches’ bring their own moral sensibilities to bear on AIDS, they can also work to fight discrimination.

Overwhelmingly, the government was the most important social service provider in these communities. Most respondents were dependent on the government for their incomes and health care. For this it should be given credit. Its record, though, is marred by President Mbeki’s controversial leadership decisions.

---

Indirectly, since they said they did not generally talk about AIDS.
He has yet to give AIDS the attention that other African presidents have. The government has yet to provide antiretroviral therapy, despite the strong primary health infrastructure in these communities.

Nongovernmental organizations were largely absent from these communities. Chapter 2 discusses the modest projects underway in Magwaveni, and the obstacles of the rural setting to MCDI, the only NGO in Mlandaleni. The Catholic Church compares favourably to its development-agent peers, including the government. Sinosizo has trained home-based care volunteers in Magwaveni, and other parishes have care programs. Its priests promote a message of prevention that is consistent with the Church’s moral principles and is sensitive to the issue of stigmatisation.

The Catholic Church’s efforts on AIDS also compare favourably to its record on apartheid. As discussed in Chapter 1, there were progressive individuals within the Church, but until the 1980s, they were relegated to the fringes of the Church (e.g. Black Theology), or to surrogates of the Church (e.g. the Christian Institute). AIDS is a socio-medical issue that plays more to the Church’s strength in social service provision. Apartheid was a socio-political issue, and the Church had to navigate the inertia of some of its own white membership, as well as the danger of state repression. In neither instance has the Church been a force for large-scale social mobilization, but firstly, it must be compared to its peers, and secondly, it does not have an immense social following.

African Independent Churches do. With both AIDS and apartheid, these churches have done little. However, during apartheid, a little could have meant a
lot—resistance took on apolitical forms. Anthropological research in several areas and times, demonstrates that Zionism (including the Shembe Church) was engaged in a resistance that was rooted in its origins, rituals, and cosmology. The ethnic group that Comaroff researched, the Tshidi, “did not rebel directly against the neocolonial order. In the main [the Tshidi] w[ere] to find expression in resistance at the level of everyday practices, the most cogent form of which occurred within the dissenting discourse of Zionist Christianity” (1985: 12). For the powerless, religious ritual was one of the few “accessible implements” (ibid.: 258) that let them express their dignity, self-expression, and defiance.

Now, as well, Zionism is an important resource for the poor. But apartheid is no longer there to give the Zionist religious experience the validation of being a resistance movement. One can argue that now, as then, Zionism is a creative force against the same oppressive conditions of capitalism and urbanization, only without the added political repression of the state. If one focuses on the issue of AIDS, even considering the social antecedents of the epidemic, the Zionists’ response has not been productive. In fact, it has scarcely responded to the epidemic at all. The Shembe Church denies that AIDS affects its members. Zionist ministers generally denounce the disease and those who have it. As discussed above, the independent churches face numerous obstacles, most notably the lack of resources. They do not have historical experience as service providers. It is hard to be critical under such conditions. Their continuing popularity certainly shows that these churches are valuable institutions for the poor. But ritual is not a sufficient response to AIDS.
In this Appendix, I provide the rationale for my methodological choices. I first place my work in an academic context, by looking at the methodological approaches of other researchers. I then discuss my own choices, and difficulties I encountered. Finally, I present possibilities for extending the research.

A. Choice of Approach: Qualitative Case-Study

In Chapter 1, I argued that there are two distinct strands of academic inquiry into how churches dealt with apartheid: the historical, which mainly looked at the political activity of the mainline churches, and the anthropological, which mainly looked at the cultural significance of independent churches. The divide is largely a result of historical circumstance—mainline churches’ activity was mostly in the political realm, in the form of public statements made by church elites. Progressives in these churches worked through surrogates, both at elite levels and in communities. Meanwhile, the African Independent Churches were intrinsically resistance movements, yet were apolitical due to the threat of political repression, and their own cosmologies. The methodological lesson I gleaned from this research was the potential value of an interdisciplinary approach that is community-based, but focuses on a specific issue, and is comparative across church types.
This is the approach I used in my research on churches and AIDS: I compared how three denominations have responded to AIDS in two communities in the Durban area. Other writers (Takyi 2003, Liebowitz 2002) have noted the paucity of research on the topic of churches and AIDS. In Chapter 1, I argued that the literature can be grouped into three major categories: national-level analysis, the “grey” literature of NGOs, and theological debate. There are a few exceptions, discussed below. Therefore, I felt that a community-based study would be a positive contribution to the field. This approach provides an analysis of what is happening on the ground, which is especially valuable for a topic that seems swamped at times with large-scale statistics and high-level policy debate. Casley and Lury argue that this case-study approach is useful for detailed, micro-level research, because it allows for a variety of data collection methods (Casley and Lury 1987: 64).

A few studies have looked at the issue of churches and AIDS from a socio-medical perspective. These quantitative studies do not start with religion as their focus, but rather some specific outcome, such as sexual behaviour. They test for variables, including religion, that display differences in the outcome across the population (Adegbola and Babatola 1999, Gray et al. 1998). Takyi’s study (2003) is an exception in that she does start with religion as her focus. She explores how AIDS knowledge and sexual behaviour differ across religions, using a large, pre-existing dataset (4593 women) from a national survey in Ghana.

A quantitative approach allows one to control for potentially confounding factors in the relationship between religious affiliation and sexual behaviour. Takyi
observed a positive correlation between being Christian and having both a high level of AIDS knowledge and low-risk sexual behaviour. When she controlled for age, education, exposure to the media, and marital status, she still found that Christian women knew more about AIDS. However, controlling for these variables reversed the trend in sexual behaviour, so that some measures of high-risk behaviour were correlated with being Christian.

These findings demonstrate the strengths and limitations of a quantitative, survey-based approach. Why did Christian women have higher AIDS knowledge, yet report riskier sexual behaviour? Takyi is not able to answer this question because of the limits of her dataset. Without more intensive research amongst the people whose behaviour she was researching, she lacks a theoretical or interpretive framework to explain her results.

Gregson et al. (1999) and Garner (2000) use a combination of qualitative and quantitative techniques to analyse how religion affects sexual behaviour. Gregson et al. conducted a survey (N=136) at an antenatal clinic in rural Zimbabwe and found a negative correlation between Zionist and Apostolic church affiliation and HIV-infection, controlling for age, education, and marital status. They then use qualitative techniques—in-depth interviews and focus group discussions—to construct a behavioural model. They conclude that there are higher levels of discipline in these churches, in sexual behaviour as well as lifestyle rules in general.
(alcohol consumption, etc.). Another limit to the quantitative approach is evident in their research. The ability to generalize survey data across a population depends on the representativeness of the survey sample. Gregson et al. did not take steps to ensure that the antenatal clinic attendees were indeed representative of the general population.

Garner used mostly qualitative data collection methods. He looked at how sexual behaviour varied across four denominations in a former township in KwaZulu-Natal. His interviews were half-survey, half-in-depth interview. He averaged the sexual behaviour responses to his survey questions, and saw that Pentecostal church members tended to engage in safer sexual practices. From the interview portion, as well as focus groups and observation at church services, he proposed a mechanism for this observed trend. Where Gregson et al. saw the major difference between mainline and Spirit-type churches as discipline level, Garner’s qualitative analysis was more nuanced—he distinguished denominations by indoctrination, exclusion, socialisation, and religious experience.

Yet his quantitative analysis is not as sophisticated as Takyi’s or Gregson et al.’s. He does not control for intervening variables, so it is not certain that the observed trend of Pentecostal church members having safer sexual behaviour was

---

1 The researcher must also deal with the ethical issues involved with publicizing these types of conclusions. As Gregson et al. say, “If Spirit-type churches are less affected by HIV, it is conceivable that they will grow in popularity” (192). The Spirit-type churches may seize on this finding as a recruitment tool, and the fallout may be the stigmatisation of the other denominations as those of the HIV-positive.

2 The validity of antenatal clinic data in estimating HIV prevalence in the general population is discussed in Chapter 2.
not in fact due to differences in member characteristics’ between the denominations. When Takyi controlled for these variables, religious affiliation lost its explanatory power for sexual behaviour. Also, his sample size is small—for one denomination he had only ten respondents.

In scope, my study combines the strengths of Garner’s and Gregson et al.’s work. Like Gregson, I looked at two communities, and like Garner, I looked at several denominations. This was an attempt to add breadth to the case-study method. An inherent weakness of the case-study is its lack of generalisability, an issue to which I will return later. I chose a qualitative analysis along the lines of Garner’s study, because I was not looking to observe trends in outcomes such as sexual behaviour or knowledge across religions. Rather, I was interested in the church as a resource: how local churches have responded to AIDS, and how families affected by AIDS use the church as a resource. With community-level inputs, I could ask a whole set of sub-questions: which type of church is most effective, which understands the issues the best, etc. Having described my rationale for a qualitative, case-study approach, I will now go into the particulars of the research process.

B. Choice of Research Site and Churches

I chose to look at a rural and an urban community for the sake of richness of comparison. Chapter 2 describes the differences in geography and demography of these two areas, which have a large effect on access to resources. Mlandaleni, the
rural community, was located in Ndwedwe Local Municipality. I chose to work in Ndwedwe, because the NGO with which I was working had a project there. Within Ndwedwe, I chose Mlandaleni in order to take advantage of my research assistant’s familiarity with the area, as he lived there. While working in Mlandaleni, I was introduced to a Shembe lay preacher from Magwaveni who invited us to visit his congregation in Magwaveni, which thus became the second site of our research.

An undergraduate student from the United States, Jodie Newbery, was also working at MCDI, and joined my research project. She participated in the interviews, and transcribed notes from interviews. The third member of the research team was Thulebona Khoza. He was responsible for arranging the interviews in Mlandaleni and for translation. We were introduced through MCDI—he was a recent graduate of the University of Natal and was looking for temporary employment. I was responsible for Khoza’s salary (R120 per day) and for small gifts of food for respondents. I led most of the interviews, designed the questions and direction of the project, and collected background information. MCDI provided transportation, office space, and technical support from its staff of six. In the past several years, MCDI had been trying to coordinate its community health initiatives with religious leaders in Ndwedwe. Newbery and I each submitted a report on our research, hers on stigma and mine on the present subject, churches and AIDS.

We conducted fieldwork from August 10 to September 22, 2003. This relatively short window of time precluded the possibility of an ethnographic approach. We collected data using a variety of methods, from a variety of social
actors, in a process of triangulation. We interviewed several dozen community
leaders, eleven households who held some leadership role in their local church, and
26 sick families. We attended a weekly service at each church, as well as other
church functions. I used a resource questionnaire with each family that I
interviewed. I was thus able see the issue of what the community was doing about
AIDS from a variety of perspectives, and to corroborate what informants were telling

We looked at three types of churches in each community: Roman Catholic,
Shembe, and Zionist. Implicit in the design of the study was a compromise between
breadth and depth. I could have looked at more communities, or more churches
within each community to get a broader picture; or I could have focused on one type
of church in each community to get more depth. By choosing two communities, I
could look at urban-rural distinctions, and by choosing three churches, I could
compare organizational structures and theological outlooks.

I chose Zionist, Shembe, and mainline churches because they were the three
most popular denominations in Ndwedwe (Table 1). They also exhibited important
differences in resources, structure, cultural appeal, and discipline. Of the mainline
churches, I chose the Roman Catholic Church because of its controversial position
against condoms, and because I had developed contacts in the church in the early
stages of my research. Garner chose the Methodist Church in his study, but he
argues that, “In black South Africa as a whole, the similarities between these
Significantly, I did not have a chance to interview families with no religious affiliation. Garner reported that 14% of the population had no religious affiliation where he was working (2000: 46). I decided to access sick families through ministers, which meant that they mostly referred us to sick families in their congregations.

Table 1. Religious Affiliation in Ndwedwe (MCDI 2000: 34)$^3$

<table>
<thead>
<tr>
<th>Religious Affiliation</th>
<th>Number (N=410)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zionist</td>
<td>153</td>
<td>37.3%</td>
</tr>
<tr>
<td>Shembe</td>
<td>97</td>
<td>23.7%</td>
</tr>
<tr>
<td>Mainline Churches (Roman Catholic, Anglican, etc.)</td>
<td>64</td>
<td>15.6%</td>
</tr>
<tr>
<td>Apostolic</td>
<td>36</td>
<td>8.8%</td>
</tr>
<tr>
<td>African Independent Churches</td>
<td>30</td>
<td>7.3%</td>
</tr>
<tr>
<td>Other (American Churches/Universal Churches)</td>
<td>18</td>
<td>4.4%</td>
</tr>
<tr>
<td>Gospel</td>
<td>11</td>
<td>2.7%</td>
</tr>
<tr>
<td>Muslim</td>
<td>1</td>
<td>.2%</td>
</tr>
</tbody>
</table>

C. Choice of Methods

Triangulation applies to the selection of methods, as well as informants. “Different methods can be used to collect data on the same thing. Each can look at the thing from a different angle” (Denscombe 1998: 84). I used interviews, observation, and questionnaires; Denscombe’s fourth recommended technique, documentary analysis was not possible since documents were not produced within these communities on the subject.

$^3$ The survey used random sampling. Inexplicably, there was no “no religious affiliation” category.
With all respondents, I used semi-structured interviews, because of their flexibility and their ability to collect detailed information. Open-ended questions allow the respondents to express themselves in their own words (Foddy 1993: 129). It was thus important to make the interview process as comfortable as possible. I avoided the most personal questions, because I did not trust my ability as an outsider and stranger to collect this type of information. I found that it helped to use questions on resources as “ice-breakers,” at the beginning of the interview. As the comfort level rose, I asked the more personal questions, and tried to make them as conversational as possible, a technique recommended by Bernard (1994: 208).

Symbolic interactionist theory holds that the characteristics of the interviewer have an affect on the responses of the respondent—people respond differently to different interviewers (ibid.: 19). I thus had to strike a balance between making the interviews as conversational as possible, and standardizing the process in order to minimize the variability between interviews. Nearly all interviews were conducted with all three researchers present, and followed the same general format.

I was aware of my position as an outsider, and that the data that I collected was processed from my point of view. Denscombe argues that this exercise in reflexivity is crucial to the researcher as well as the reader (1998: 57). Social research—the uncovering of social “facts”—is inherently biased. Given the research topic, it is important to note that none of the researchers identified as Christians, personally or in interviews. Other than a few of the ministers, none of the respondents asked what faith we were. We were not proselytised by any of the
ministers. In the analytical process, as well, it is important to note that I view my subject from a secular perspective.

Before every interview Newbery and I introduced ourselves (through Khoza) as university students working with a local health organization, MCDI. As part of informed consent, I stated my research goals (Denscombe 2002: 183). Following the ethics guidance of my department, Queen Elizabeth House, I asked for consent to quote, and offered the option of anonymity. If I used a tape recorder, I asked permission first. I only recorded the ministers’ interviews. Khoza would translate respondents’ answers after each response, which I would write down; this is a common and accepted technique (Devereux and Hoddinott 1992B: 28). We were confident in the fidelity of the process, based on the accuracy of my notes to the translations Khoza would make from the interviews that we did record.

I chose questions from a list that I had prepared beforehand. I would ask follow-up questions and let the interview follow the direction of conversation. However, I did standardize one section of the ministers’ interview. After collecting background information on the minister and his congregation, I began the questions on AIDS. To open this part of the interview, I posed the four key questions to the ministers, without any follow-on questions. I standardized these questions in order

---

4The four questions were: how do you help families cope when they have lost a breadwinner; how does AIDS affect the community around you; what happens when a person falls ill in your community; do you talk about AIDS in your sermons—if so, what do you say? Because of space constraints I was not able to include the ministers’ replies to these questions. They are available upon request. In presenting their answers in their entirety, the only filter between the minister and the reader is the interpreter, Khoza.
to limit my role as researcher in filtering the information. I wanted to give each minister the same opportunity to address the issues that I was presenting to him.

Despite the epidemiological reports of high prevalence in the areas we researched (Ligani 2003), only three of the sick families we interviewed said that a family member was HIV-positive. This was not simply because we were outsiders—only two of the ministers (both Zionist) reported knowing someone with HIV/AIDS. Church leaders and families alike said that stigma was pervasive. We asked the ministers to put us in touch with sick families. We thought this was a more sensitive way to introduce ourselves to the families we were trying to interview—sick families—and would give us greater legitimacy than the other options available. The “snowball” technique of referrals by other interviewees (May 1997: 119) was not appropriate because we did not want to make families feel like the whole community knew that they were sick. We did not work through the antenatal or tuberculosis clinics, because we did not want to infringe upon patients’ privacy.

With families, I began the interview with a brief questionnaire. The information I was after was more factual (resource usage, income) than with the ministers (Foddy 1993: 127). The closed-question format also expedited the interview. Ministers were more engaged and were even eager to share their opinions. Families were more reserved. As I did not have the time or opportunity to develop relationships with families, I realized that my ability to get them to open up to me was limited. I therefore approached the topic of AIDS more generally, rather
than asking a whole series of personal questions. Silverman recommends this

I tried to use focus groups as another method of interview. The Catholic and
Shembe ministers know no more than five sick families each, not enough to hold a
focus group. The Zionist ministers knew many sick families. Two ministers tried to
organize focus groups for us, but were called away at the last minute in both cases.

My third data collection method, observation, consisted of attending a weekly
service at each congregation, women’s group meetings (known as classes), a youth
service, and a congregation’s visit to a sick person’s house. On Spradley’s scale of
participant observation, my participation would be classified as the lowest degree of
involvement—passive (1980: 59). Our goal was not to participate, but to observe. It
was impossible to anonymously attend these events—we often found ourselves
seated at the front of the congregation, being publicly welcomed by the minister, and
asked to introduce ourselves to the congregation.

In this sense, we did participate. We thus had to account for “observer effect”
(Denscombe 1998: 47)—the possibility that people were altering their behaviour
because of our presence. The services we were attending were “typical,” because of
our presence. Anthropologists have written extensively on Zionist services
(Comaroff 1985, Kiernan 1990B). Our main purpose was to hear what the minister
said publicly about AIDS, so the observer effect may have actually benefited our
research. Because the ministers saw us at the service, and knew beforehand that we
were coming, they may have deliberately talked about AIDS, when in a typical
service they may not have. To answer the question of whether the ministers regularly talked about AIDS, we later asked families in our interviews.

Because we could not eliminate observer effect, we tried to standardize it, by going though the same process in each church. Before we went to services, we conducted the interview with the minister, so that they were all aware of our purpose. The Catholic Church near Magwaveni is the one exception.

Since all of the functions were in Zulu, I took notes on what was happening, and Khoza took notes on what was being said. Khoza recorded the key portions of ministers’ sermons and church members’ testimonies (when they talked about sickness), and then translated them afterwards.

D. Challenges

At the end of interviews, we were often asked if I could help in some way. These communities were extremely impoverished. I responded that my research was intended to help a health organization, MCDI, which was bringing services to the community. Hopefully, my research would help bring attention to the needs of these communities. Some ministers thanked us for causing them to think more deeply about the issues we presented. I informed some of the ministers of the grant opportunity available to religious institutions through the Southern African Catholic Bishops’ Conference’s AIDS office. I gave small parcels of food (R30) to all respondents. I tried to keep this as a surprise until the end of the interview, so as not
to create the atmosphere of a quid pro quo transaction. In retrospect, I should have just given the gift at the beginning, because it was a transaction of sorts. Small gifts do not change the inherently one-sided nature of social research, but they are usually at least a socially acceptable token of gratitude and respect (Devereux and Hoddinott 1992A: 21).

The interviews with families were the most challenging part of the project. It was difficult to find families affected by AIDS. Families gave much less expansive responses than the ministers. Ministers were used to public speaking and understood that I was speaking to them as representatives of their churches. Their status as representatives gave us a context for interaction, whereas with families, my only context for interaction was that I had been referred to them by their minister (which was better than no context at all). The barrier of being a stranger and an outsider was insurmountable; to elicit deeper responses I would have had to build long-term relationships with the communities.

The use of an interpreter has the obvious disadvantage of adding another filter between the respondent and the researcher. Some information was certainly lost in translation. Without knowing the language, I could not analyse the words people used for stigma or AIDS. Without a common language, the distance between respondent and researcher is even greater, “Even with the most excellent of interpreters, there is nothing so alienating as to speak another language” (Ellen 1984: 106). On the other hand, Khoza helped me to phrase the questions in a socially palatable way, as only an insider could have done.
There are degrees on the scale between being an insider and being an outsider, and I definitely fell to the extreme of being an outsider, since I had no prior experience with the culture or the community. I was conscious of the many barriers between respondents and myself—national, cultural, racial, educational, socio-economical. One advantage of being an outsider is the outside perspective one has, taking nothing for granted (Spradley 1980: 56).

Khoza’s insider status also had advantages and disadvantages. On the one hand, it was necessary to have an insider to navigate, geographically, a rural area such as Mlandaleni. Devereux and Hoddinott debate the advantages and disadvantages of working through an insider: “Villagers may be more suspicious of an assistant whom they do not know, at least initially, but they also may talk to her or him more freely than they would to a local person” (1993B: 27). Since we worked in a second area with which he was not familiar, I could compare respondents’ reactions to him. I did not notice a difference. Khoza was adept at asking our potentially awkward questions in a delicate and sensitive manner.

It is common for researchers who are strangers to the community to work through a key informant (ibid.). Khoza was at once an interpreter, and a source of information about the community. He, of course, had his opinions about our research and the individuals that we met—so did I. He did not impose these opinions on me, but rather, I often had to ask him what he thought because he was quiet. Mostly, he explained things that we saw together, but his perspective on Zionist choirs, for instance, was crucial, because we would not have known of their
significance independently. We then substantiated that they were magnets for the youth, by asking the ministers.

E. Extending the Research

The biggest constraint on my fieldwork was time. With more time, I would work at building stronger relationships within the community, which would enrich the responses I got. The most disappointing aspect of my fieldwork was the inability to connect with the sick families, and my interviews suffered for it. While the many barriers separating us will always be present, my hope is that I can forge personal relationships with the respondents.

In what context could this be done? I was always conscious of the extractive nature of this research. It helped that I was working with a local NGO, both in justifying my work to myself and to respondents. If I were to continue my research I feel that I would need to sustain a position with a service provider, to ensure that I was contributing to the community beyond the aims of my own research. When the local organization is a service provider, then the bias that is introduced by being a representative of that organization can be beneficial, if people trust that organization. Garner’s research benefited from his long-term experience working for an NGO in the community he studied.

In any case, I hope to one day be a “development practitioner,” so further experience with an NGO would at least be useful towards my own career development. This research was incredibly enriching for me on a personal level, and
served to deepen my commitment to serving these communities. It allowed me to understand the incredible and paralysing obstacle of poverty.

There are several specific promising avenues of inquiry that I did not have a chance to follow-up on due to time constraints. I did not have a chance to interview the women in Magwaveni who were recently trained in home-based care by the Catholic NGO, Sinosizo. I could have used their experiences to better understand what made Sinosizo a widely-regarded success as an organization of volunteers, when MCDI’s efforts in Magwaveni had failed. I would have liked to attend choir practices and Zionist conferences to see how they operated as magnets for the youth.

Thus, as my research gained depth, I could more fully take advantage of anthropological methodologies, such as participant observation. The interdisciplinary nature of the current work was limited by the methods I used, as I mostly relied on interviews. More extensive participant observation would allow for a more traditional ethnography. I would retain the cross-denominational comparison, as well as the focus on the single issue of AIDS. My research convinces me of the value of such research. In my opinion, there is not enough community-based research to inform contemporary debates on whether faith-based institutions are worthy recipients of development dollars, or how poor communities use social institutions to cope with poverty and AIDS.

Theoretically, I would like to expand upon my comparative analysis to include the historical experience of churches as social agents during apartheid. I would like to more fully explore the literature on this topic, particularly in the area
of the transfer of Black Theology from its formulation by theological elites to communities, in the late 1970s through the 80s. This research would allow me to answer more fully the question of whether churches, in their responses to AIDS, have learned from the wide-scale social mobilization against apartheid in the 80s.

Finally, I would like to explore the current role of African Independent Churches. They have massive followings amongst the poor. As discussed in Chapter 1, they constituted a resistance movement for the poor during apartheid. What relevance do they have for the poor in dealing with AIDS? My research shows that they have not creatively responded to AIDS. I would like to see how this fits into sociological and anthropological theories of social groups, since “resistance,” to apartheid at least, is no longer a useful way of viewing these churches.
APPENDIX B: PLATES

Plate 1. Mlandaleni Traditional Authority in Ndwedwe Local Municipality (24.8.03)

Source: Plates 1-2, 5-8 by Mark Krakauer

Plate 2. Roman Catholic Church in Mlandaleni (14.9.03)
Plate 5. Magwaveni informal settlement, looking eastward (14.9.03)

Plate 6. Site of future government housing for residents of Magwaveni, adjacent to Magwaveni (14.9.03)
Plate 7. Bishop M.V. Shembe at his house in Ebuhleni (near Durban, 22.9.03)

Plate 8. Zionist healing ceremony, Rev. M. Gumede’s Sunday service (14.9.03)
A. Works Cited


## B. Interviews Cited

<table>
<thead>
<tr>
<th>Date</th>
<th>Name</th>
<th>Religion</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.8.03</td>
<td>Chauncey Sibisi</td>
<td>Shembe</td>
<td>Executive secretary of Shembe Church</td>
</tr>
<tr>
<td>15.8.03</td>
<td>Dumisani Thango</td>
<td>Full Gospel</td>
<td>DoH Provincial faith-based coordinator</td>
</tr>
<tr>
<td>22.8.03</td>
<td>Anonymous A</td>
<td>Catholic</td>
<td>Catechist, Mlandaleni Catholic church</td>
</tr>
<tr>
<td>22.8.03</td>
<td>Mbongwa Xaba</td>
<td>Catholic</td>
<td>Upper Tongaat parish priest</td>
</tr>
<tr>
<td>23.8.03</td>
<td>Philip Gumede</td>
<td>Zionist</td>
<td>Minister, Inkanyezi Church of Christ in Zion</td>
</tr>
<tr>
<td>23.8.03</td>
<td>Anonymous B</td>
<td>Shembe</td>
<td>Lay preacher, Mlandaleni temple</td>
</tr>
<tr>
<td>28.8.03</td>
<td>Anonymous C</td>
<td>Catholic</td>
<td>Class visit sick person</td>
</tr>
<tr>
<td>31.8.03</td>
<td>Mfeka</td>
<td>Zionist</td>
<td>Family/P. Gumede</td>
</tr>
<tr>
<td>2.9.03</td>
<td>H.E. Ngcobo</td>
<td>Shembe</td>
<td>Induna of Mlandaleni</td>
</tr>
<tr>
<td>2.9.03</td>
<td>Mrs. Ngubane</td>
<td>Shembe</td>
<td>Head of class</td>
</tr>
<tr>
<td>3.9.03</td>
<td>Mr. Buthelezi</td>
<td>Shembe</td>
<td>DoSD administrator</td>
</tr>
<tr>
<td>3.9.03</td>
<td>Justin Stirton</td>
<td>Catholic</td>
<td>Montebello parish priest</td>
</tr>
<tr>
<td>4.9.03</td>
<td>Chris Mohatsela</td>
<td>Catholic</td>
<td>MCDI Interfaith Liaison</td>
</tr>
<tr>
<td>4.9.03</td>
<td>Ngidi</td>
<td>Catholic</td>
<td>Family/Mlandaleni</td>
</tr>
<tr>
<td>4.9.03</td>
<td>Mgeyane</td>
<td>Catholic</td>
<td>Mlandaleni class member</td>
</tr>
<tr>
<td>6.9.03</td>
<td>Sipho Ngubane</td>
<td>Shembe</td>
<td>Lay preacher, Magwaveni Shembe temple</td>
</tr>
<tr>
<td>6.9.03</td>
<td>Petros Mdletshe</td>
<td>Zionist</td>
<td>Minister, Ukhanya Christian Catholic Church of Zion</td>
</tr>
<tr>
<td>6.9.03</td>
<td>Mtholeni Gumede</td>
<td>Zionist</td>
<td>Minister, Ukuthula Christian Catholic Church of Zion</td>
</tr>
<tr>
<td>7.9.03</td>
<td>Eric Mhkize</td>
<td>None</td>
<td>Family/Catholic sister/Magwaveni</td>
</tr>
<tr>
<td>7.9.03</td>
<td>Sister Michaele</td>
<td>Catholic</td>
<td>Ekukanyeni hospice</td>
</tr>
<tr>
<td>9.9.03</td>
<td>Sister Ethel</td>
<td>Catholic</td>
<td>Montebello orphanage</td>
</tr>
<tr>
<td>9.9.03</td>
<td>Albert Nhuli</td>
<td>Magwaveni</td>
<td>informal leader</td>
</tr>
<tr>
<td>9.9.03</td>
<td>Anonymous D</td>
<td>Zionist</td>
<td>Family/Mdletshe</td>
</tr>
<tr>
<td>9.9.03</td>
<td>Anonymous E</td>
<td>Zionist</td>
<td>Family/Mdletshe</td>
</tr>
<tr>
<td>10.9.03</td>
<td>Cathy Madden</td>
<td>Sinosizo</td>
<td>Sinosizo training director</td>
</tr>
<tr>
<td>10.9.03</td>
<td>Gugu Zondi</td>
<td></td>
<td>Utho Lwethu rural development director</td>
</tr>
<tr>
<td>10.9.03</td>
<td>Julian Davey</td>
<td>Catholic</td>
<td>Tongaat parish priest</td>
</tr>
<tr>
<td>11.9.03</td>
<td>Olga Gumede</td>
<td>Catholic</td>
<td>Magwaveni ward leader</td>
</tr>
<tr>
<td>12.9.03</td>
<td>Joe Mabaso</td>
<td>Catholic</td>
<td>Hambanathi support group director</td>
</tr>
<tr>
<td>12.9.03</td>
<td>Pastor Mervin</td>
<td></td>
<td>Haven of rest director</td>
</tr>
<tr>
<td>15.9.03</td>
<td>Thuli Thabethe</td>
<td></td>
<td>Diakonia aids coordinator</td>
</tr>
<tr>
<td>22.9.03</td>
<td>Mvumbeni V. Shembe</td>
<td>Shembe</td>
<td>Bishop</td>
</tr>
</tbody>
</table>

142
<table>
<thead>
<tr>
<th>Date</th>
<th>Person</th>
<th>Religion</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>22.9.03</td>
<td>Xthlathla Shembe</td>
<td>Shembe</td>
<td>Bishop’s son</td>
</tr>
<tr>
<td>17.10.03</td>
<td>Lynn Robinson</td>
<td>Catholic</td>
<td>Right to live campaign treasurer</td>
</tr>
</tbody>
</table>
### C. Religious Events Cited

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Religion</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>23.8.03</td>
<td>1-3</td>
<td>Shembe</td>
<td>Saturday midday services</td>
</tr>
<tr>
<td>24.8.03</td>
<td>8:30-10</td>
<td>Catholic</td>
<td>Sunday Mass</td>
</tr>
<tr>
<td>24.8.03</td>
<td>12-3</td>
<td>Zionist</td>
<td>Sunday services</td>
</tr>
<tr>
<td>28.8.03</td>
<td>10:30-12</td>
<td>Catholic</td>
<td>Class</td>
</tr>
<tr>
<td>31.8.03</td>
<td>10:30-12:30</td>
<td>Zionist</td>
<td>Sick prayer</td>
</tr>
<tr>
<td>6.9.03</td>
<td>9-10:30</td>
<td>Shembe</td>
<td>Saturday morning services</td>
</tr>
<tr>
<td>6.9.03</td>
<td>13-15:00</td>
<td>Shembe</td>
<td>Saturday midday services</td>
</tr>
<tr>
<td>7.9.03</td>
<td>8:30-10:15</td>
<td>Catholic</td>
<td>Sunday Zulu Mass</td>
</tr>
<tr>
<td>7.9.03</td>
<td>11-14</td>
<td>Zionist</td>
<td>Sunday services</td>
</tr>
<tr>
<td>9.9.03</td>
<td>19:30-21:30</td>
<td>Zionist</td>
<td>Tuesday youth services</td>
</tr>
<tr>
<td>14.9.03</td>
<td>13-15</td>
<td>Zionist</td>
<td>Sunday Service</td>
</tr>
<tr>
<td>19.9.03</td>
<td>9-11:15</td>
<td>Shembe</td>
<td>Class</td>
</tr>
</tbody>
</table>