THE IMPLEMENTATION OF THE ISISEKO SOKOMOLEZA HIV/AIDS PROGRAMME IN THE DIOCESE OF FALSE BAY: A CRITICAL THEOLOGICAL INVESTIGATION

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Dissertation submitted in fulfilment of the requirements
for the degree of D. Phil in the
Department of Religion and Theology
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Date: May 2019

ABSTRACT

The multidimensional nature of the AIDS pandemic continues to pose challenges within all spheres of society, for example health and religion, human rights, social development politics, economics, human sexuality, and Christian theologies - in particular, the pastoral and caring ministries, as well as the educational ministries. Its multidimensional nature is further exacerbated by factors of, stigma, gender power-relations, poverty, and violence against women and children.

The Anglican Church of Southern Africa, in particular the Diocese of False Bay, has responded to the challenges relating to stigma reduction through many programmes, campaigns and workshops. Despite the implementation of the Isiseko Sokomoleza HIV/AIDS Programme in the Diocese of False Bay, it has had a limited impact on reducing the stigma associated with HIV/AIDS. As such, stigma remains a critical challenge in the pastoral response of the Church.

In light of this observation, the question pertinent to this research project is; "What are the most significant reasons for the limited impact of the Isiseko Sokomoleza HIV/AIDS Programme in the Diocese of False Bay?" The framework of Practical Theology, with special emphasis on pastoral care and counselling, will be used as the theological framework to explore the reasons for the limited impact. In order to achieve this goal, the Primary Healthcare Model (2012) introduced in Brazil and Cuba was utilised. This does not imply that HIV/AIDS is only a medical problem, on the contrary, this medical model of implementation assists the pastoral model of the Church to analyse the reasons for the limited impact of the Isiseko Sokomoleza programme.

Through a combination of both quantitative and qualitative strategies, the study focuses on the some of the most critical reasons for the limited impact of the Isiseko Sokomoleza HIV/AIDS programme. The data from the questionnaires and interviews conducted in the Diocese of False Bay, the findings of this study was analysed through the Primary Healthcare Model (Brazil and Cuba) and the pastoral model (Louw). Despite the implementation of the Isiseko Sokomoleza HIV/AIDS programme to reduce stigma, my observation is that it has a limited impact. The findings also identified the need for a theologically centred pastoral response (praxis), not only to the AIDS pandemic, but also to all future ministries in the Diocese of False Bay. The pastoral intervention being proposed is particularly to educate congregants and community who are the

perpetrators of stigma. Some recommendations, informed by the findings, are presented for the Church to implement pastorally driven ministries that will reflect its identity, mission and witness. The Church will therefore continue to fulfil its calling to be an agent of care and healing to its members as it is well placed to implement pastorally driven ministries that are theologically well researched. Ultimately, this research endeavours to broaden the knowledge base in the theological discourse, for an effective, efficient and affordable/ sustainable pastoral care model. To this end, the context and relevance for this study is offered, stating the problem statement, hypothesis and methodology. A descriptive overview of the structures of ACSA, in particular the Diocese of False Bay, is provided. The implementation of the Isiseko Sokomoleza Programme, as well as its flaws and challenges are explored. The reasons for the limited impact are investigated through interviews and questionnaires, analysed through the Primary Healthcare Model (Brazil & Cuba), and the data interpreted through the theological discipline of Practical Theology (Pastoral Care and Counselling).

KEY WORDS/ PHRASES

ACSA response

Health and Religion

Isiseko Sokomoleza HIV/AIDS programme

Limited impact

Pastoral care and support

Primary Healthcare Model

Stigma

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DECLARATION

I hereby declare that *The implementation of the Isiseko Sokomoleza HIV/AIDS Programme in the Diocese of the False Bay: Critical theological investigation* is my own work, that it has not been submitted before for any degree or assessment at any other university, and that all the sources I have used and quoted, have been indicated and acknowledged by means of complete references.

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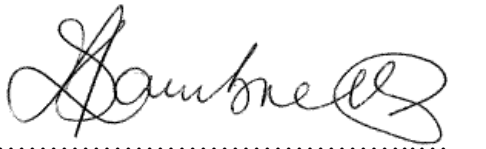

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ACKNOWLEDGEMENTS & DEDICATION

"To God be the Glory, great things he has done."

This journey was made possible through the many people who supported and encouraged me to complete this research project. This acknowledgement is a token of my deep appreciation and gratitude for their unselfish support.

To Dr Miranda Pillay, who has acted as my supervisor during this project and believed in my ability to take on this challenge, I offer my heartfelt thanks and gratitude for her professionalism, guidance, leadership, and encouragement throughout this study.

At the same time I thank Prof. Ernst Conradie, who stretched my vision and scope of this research far beyond my own understanding of what was required of me. Your academic excellence and willingness to assist is highly appreciated. A word of thanks is also expressed to the other academic staff of the Faculty of Theology and Religion for their motivation and encouragement throughout this process.

I wish to thank Mr Eddi Londt for his willingness to edit my document and for his most professional way and manner in which he engaged me during the process. His motivation and encouragement was indeed most helpful.

A special word of thanks to Dr Manitza Kotze for her assistance with the final editing of the document. My sincere thanks to my colleague Dr Sipho Mahokoto who assisted me with the bibliography.

I would like to convey my thanks and appreciation to Archbishop Thabo Makgoba for your personal interest in this research project, for allowing me to finish this research project. My colleagues at Bishopscourt, your prayers and support are greatly appreciated.

I wish to express my thanks to Bishop Margaret Vertue, Bishop of the Diocese of False Bay, for granting me the opportunity to do the research in the diocese and for your prayers and support. My thanks include the various care and support groups in the diocese, for their

willingness to participate in the dialogues and filling in the questionnaires, as well as the staff from the Department of Social Development (Diocese of False Bay), for coordinating and facilitating the groups.

To my dear brother-in-law, Pastor Trevor Herbert, thank you for willingness for your assistance in the capturing of the data, especially the many hours you have personally given to this task.

Thanks and appreciation also to my brother-in-law Edward Jeptha, for his technical assistance in the presentation of the graphs.

I wish to express my sincere thanks to Mr. Romeo de Lange for the professional manner in which he has assisted me with the data analysis and the presentation of it.

I would like to express my thanks to Dr. Renier Koegelenberg and staff at NRASD (National Religious Association for Social Development), for the time you allowed me to undertake this research project and for understanding the importance thereof.

To my colleague Dr. Sipho Mahokoto, thank you for your support and assistance especially with the bibliography.

I owe a special thanks to my wife, Geraldine, I am forever indebted to you for your unconditional commitment, love and support in embarking on this project with me and your many hours of burning the midnight candle. Words cannot express my love and appreciation for you. You have been my co-supervisor and counsellor throughout this endeavour. Without you, I would not have seen the end of this journey. To our children Simonay, Trudy-Lauren, Timothy and his wife Lynette, as well as my adorable granddaughter, Rebekah, throughout this project your personal interest, motivation, humour and prayers carried me through to the finishing line. All of you have given me the courage to carry on. I am also thankful to all family members, friends and colleagues for their prayers and support.

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CHAPTER ONE

INTRODUCTION

1. Background and outline of the argument

This chapter will offer an overview of the research project. The background to the study is presented and its context and relevance is explored. The statement of the research problem, the research question, aims, objectives and significance of the study will be addressed, as well as the main research hypothesis, theoretical framework, and research procedure. The focus on Stigma reduction will be central to this study. In conclusion, a structural overview of the chapters in this thesis is provided.

1.1 The context and relevance of the study given the HIV/AIDS pandemic

The context and relevance of the study must be viewed in the light of the fact that the multi-dimensional challenges posed by the HIV/AIDS pandemic have not yet ceased to exist.
Since 2005 South Africa became one of the countries identified by donor agencies and foreign governments as having a greater responsibility to respond to the HIV/AIDS pandemic. According to Bate and Munro (2014:30), donor agencies have established new geographical and thematical priorities for themselves where Europe and South Africa were considered to be middle-income countries. This change in guidelines caused a domino-effect on funding of programmes globally, including the South African context. Church-related HIV/AIDS responses, in particular those of ACSA, experienced a direct detrimental impact, resulting in the decline and end of many initiatives in the Diocese of False Bay (Siyakha 2009). Another major threat experienced was that the focus and enthusiasm with which Churches, and in particular ACSA, had initially responded to the challenges posed by the HIV/AIDS pandemic, was losing momentum. In the Church, the gravity and vibrancy of former responses have faded, if not completely dissipated (Anglican Church of Southern Africa [ACSA] 2009b).[1]

[1] This is true of most, if not all, programmes initiated by the ACSA Provincial (Southern Africa), which included programmes such as Isiseko (building the foundation), funded by the Department for International Development (DFID) UK; Vana Veto, a programme for orphaned and vulnerable children, funded by the Presidents Emergency Programme for AIDS Response (PEPFAR), and also the Siyafundisa (we are building) youth programme.

This was not only true for the Church, but also for other sectors of society (Yawa 2016). The vibrancy of the initial response to HIV/AIDS from government, private sector, and other institutions has turned into calm scientific discovery of innovative funding by policy makers and researchers (Bate and Munro 2014:21). It would appear that HIV/AIDS was no longer considered as a priority disease. In an article, "Post, Post-AIDS: Have we really forgotten the epidemic?" Gewirtz (2011:1) argues that, while for many American students, knowledge about HIV/AIDS is of an unconscious value, it is imperative to maintain the promulgation of this knowledge, in order to understand the forces that continue to shape international society. The same may be true for South African students, who are reportedly experiencing "AIDS fatigue".[2] To emphasise this point, at the visioning process of the Diocese of False Bay during 2014, a young person stated that HIV/AIDS was no longer a major issue, and that topics such as violence against women, gender-related issues, poverty, and substance abuse should enjoy priority instead.[3]

Statistically, already in 2014 it was estimated that 330 000 new infections were reported in South Africa, which was a significant increase since 2008. However, in recent years, globally, there has been a decline in new HIV/AIDS infections among adults, with the estimated annual new infections remaining nearly static at about 2.1 million in 2015. The largest reduction in new adult HIV/AIDS infections occurred in the Eastern and Southern Africa. There were about 40 000 fewer new adult infections in the region in 2015 than in 2010, a 4% decline. The 2015 number of new infections has elevated the global total to 36.7 million people living with AIDS (UNAIDS 2016). Various complex social and structural dynamics within countries account for the uneven geographical distribution of HIV in those countries (UNAIDS 2016). Harmful gender norms and inequalities, insufficient access to education and sexual reproductive health services, poverty, food insecurity, and violence are at the root of the increased HIV risk, especially for young women and adolescent girls, aged 15-24 years. Globally, they accounted

Although the historical overview will reflect on the responses and programmes of ACSA, the focus of this research will concentrate on the diocese of False Bay, and not the entire ACSA.

[2] By AIDS fatigue, I refer to the overdose of information on AIDS, as well as the enormous emotional, psychological, economic and social consequences and strain, not only on the person who is HIV-positive, but also on the families and the caregivers.

[3] See "Profile of the Diocese of False Bay 2012" – Statement made by one of the group members at the strategic planning workshop of the Diocese of False Bay". Produced by the Department of Social Development. Diocese of False Bay, Cape Town.

for 20% of new HIV infections among adults in 2015, despite accounting for just 11% of the adult population. In geographical areas with higher HIV prevalence, the gender imbalance is more pronounced.

The latest estimates (Abdulla and Ndaki 2016:36) determined that there were 6.8 million people living with HIVAIDS in South Africa. According to Dr Fareed Abdulla, Chief Executive Officer for the National Aids Council in SA, there are two schools of thought in response to this data. The first school of thought believes in the provision of a pill, as a preventative treatment programme, while the second school of thought upholds that no amount of pill consumption, gel insertion, or medical male circumcision is going to result in a rapid reduction in new infections (Abdulla and Ndaki 2016). It has been reported that huge strides in combatting HIV/AIDS have been made by various countries, particularly Southern Africa. "In sub-Saharan Africa, adolescent girls and young women account for 25% of new infections among adults, while women account for 56% of new HIV infections among adults" (UNAIDS 2016:6). At a United Nations General Assembly, held on 8-10 June 2016, the central focus was: 'How to end AIDS within the sustainable development goals' (UNAIDS 2016).

Since the global treatment was set in 2003, the latest statistics on HIV/AIDS reported by UNAIDS are as follows: Annual AIDS related deaths have decreased by 43%. In Eastern and Southern Africa – the most affected region – the number of people on treatment has more than doubled since 2010, reaching nearly 10.3 million people. AIDS related deaths in the region have decreased by 365 since 2010 (UNAIDS 2016:3). The scale up of antiretroviral therapy is on a fast track trajectory that has surpassed expectations and reached a global coverage of 46% in 2015 (UNAIDS 2016:3). South Africa has the largest and most vibrant HIV treatment programmes in the world, with more than 3.1 million people on antiretroviral therapy (Abdullah and Ndaki 2016:36). According to the latest UNAIDS Report (2016), South Africa has averted 1.3 million deaths through antiretroviral intervention over the last decade (UNAIDS 2016:36).

Despite these enormous gains in the decline of HIV infections, challenges such as social drivers, as alluded to by Pillay (2003) and re-emphasised by Abdullah and Ndaki (2016), continue to impact on the status quo of HIV/AIDS (UNAIDS 2016:2-7). The arrival of ARV has greatly influenced the tide of the AIDS pandemic. According to the Strategic Plan for HIV/AIDS (National Strategic plan for HIV, STI's and TB, 2012-2016), more than 3 million South Africans are on antiretroviral treatment, mostly in the public sector, which makes the largest treatment campaign in the world 15 million, of which 20% live in South Africa.

However, at a workshop for religious leaders in Johannesburg, Sue Parry, regional co-ordinator of the World Council of Churches, stated in her opening remarks that although UNAIDS (United Nations programmes on HIV/AIDS) refers to the "end of AIDS", in reality it does not represent the end of AIDS for many years to come (Parry 2014:1).

This statement of Parry was re-emphasised in March 2016, when researchers at the Harvard University, School of Public Health and Cambridge, Massachusetts, estimated that the funding needed to treat people form 2015-2050 poses a major challenge to the donor world. Professor Rifat Atom (Global Health Systems), at Harvard University, stated, "This epidemic is far from being over. The magnitude of funding needed to sustain the HIV fight is very challenging and the consequences of complacency is even larger" (Kurian 2016). Venter (2016:11) reflects on the International AIDS conference held in Durban, which endorsed the fact that the "The end of AIDS" is premature and dangerous.

Over the past 30 years, HIV/AIDS has unlocked responses from various stakeholders; for example, the South African government was initially characterised by a state of denialism by the presidency (Mbeki-era), and developed to South Africa hosting the world's largest anti-retro viral programme (Bate and Munro 2012:127). Due to the complexities of HIV/AIDS, a multisectoral response was required from the South African Government, South African National Aids Council (SANAC), political sphere, health sector, and all 18 sectors of civil society, which represent the broad spectrum of institutions ranging from education to religion. Religious institutions have utilised the vehicle of education as a medium of engagement and sharing of information on HIV, sex, and health as key components in their training workshops. This resulted in a broad spectrum of education on HIV/AIDS material being produced by religious organisations, through acceptable religious language, anecdotes and theological statements as a "catalyst for interpretation" (Haddad 2011:360; Pick 2003; Genrich 2004). According to the UNAIDS report (2010), South Africa has become the single largest population with AIDS.

However, almost three decades since the Church's initial response to the aggravating challenges caused by the HIV/AIDS pandemic, the number of people dying or becoming infected place even greater demands on the educational-, liturgical-, and mostly the pastoral role of the Church. Greater trauma is caused by the realisation that out of the 5.6 million people who lived with HIV in 2010, 300,000 were newly infected children under the age of 15

(UNAIDS Report 2010). At the National Religious and Public Health Conference in 2010, Anglican Archbishop Thabo Makgoba highlighted that care and compassion towards those in need, including the sick and suffering, has been a touchstone of most faiths since ancient times (Makgoba 2010). What the Archbishop Makgoba alluded to then, is still very relevant at present.

In my opinion, the plight of orphans could be regarded as the most tragic long-term legacy of the HIV/AIDS pandemic. Caring for the orphans is one of the greatest challenges that the AIDS pandemic could ever have posed to the Church. The risk factors for orphans and vulnerable children are that often, many of them either grow up on the streets or stay with grandparents, and in most instances, are traumatised by the illness and death of their parents and the separation of siblings. Due to emotional instability, orphans are more prone to exposure, abuse, and becoming infected. Some becomes sex workers and enter into high risk relationships. Their trauma is often aggravated by the stigma they experience in the community and extended families, further exacerbated by secrecy around HIV/AIDS.

Moreover, women are bearing the brunt of the impact and challenges of HIV/AIDS. The conditions of women affected by HIV are more compromised due to their financial dependency, harmful cultural practices, and in particular, the threat of physical force. This makes it difficult for women to protect themselves and their families from infection (Vana Vetu Report 2009). Therefore, although many in South Africa may want to wish HIV/AIDS away, the multi-dimensional nature of the disease continues to affect, whether directly or indirectly, every aspect of daily human life. Given the continued tragic impact of HIV/AIDS on individuals, families, and communities, the Church in particular, is challenged to respond in ways that are congruent with its identity, mission and witness – to be a compassionate, caring and supportive community (Conradie 2014:30). The devastating impact of the HIV/AIDS requires more than just a biomedical and political response.

Why a pastoral response? With reference to the aforementioned daunting challenges posed by the HIV/AIDS pandemic, especially in South Africa, the Church is in my opinion generally confronted with the biggest pastoral dilemma in history, namely mitigation of stigma. One is tempted to say that HIV/AIDS became the new apartheid for South Africa, by marginalising a section of the population and tearing families apart. The burden of care and counselling puts huge responsibilities on the shoulders of various faith traditions and congregations. For many clergy and congregations, the reality of HIV/AIDS has become a daily occurrence, where the

Church has to respond pastorally to the overwhelming grief in communities. My argument is that in order to have a more sustainable impact on the pandemic, a more comprehensive approach is required. The Church has a prominent role to play in that the HIV/AIDS pandemic, which continues to challenge matters affecting life and death, and therefor demands a vigorous pastoral response from the Church. In order to address the current challenges of HIV/AIDS, which continues to be an extraordinary pandemic in need of extraordinary counter-measures, the Church therefore continues to be challenged to provide effective and efficient pastoral care and support. The context is calling for a pastoral response at all levels of society – ecumenically and through interfaith collaboration. The provision of care, addressing and challenging stigma and denial surrounding HIV/AIDS, moved the Church into greater partnerships between faith-based (FBO's), and non-governmental organisations, (NGO's).

Many of the mainline Churches (for example, the Roman Catholic Church or Methodist Church) were amongst the faith formations in South Africa which responded to the call to address the daunting challenges caused by HIV/AIDS. The Anglican Church of Southern Africa in particular, responded through the launch the of the Isiseko Sokomoleza HIV/AIDS programme, which main aim was to reduce stigma. The World Council of Churches in many ways spearheaded the call to Churches to address the urgent challenges caused by HIV/AIDS. Churches were particularly called upon to address specific pastoral needs through education, prevention, and the diaconal ministries with special emphasis on pastoral care and counselling. Most of these interventions were geared towards addressing stigma. A survey of ecumenical responses from within the Christian tradition will be offered in chapter two. The response within ACSA will be further developed in chapter three. The particular response of the Diocese of False Bay, namely the introduction of the Isiseko Sokomoleza HIV/AIDS programme, will then be developed in chapter four.

1.2 The Immediate Motivation for this Study

The more immediate background to this study relates to the slogan "This Church is HIV/AIDS Friendly" (Appendix 1), that confronted me and piqued my interest as it was displayed on the wall of the Anglican Church in Somerset West in the Western Cape. Having been a priest for thirty-five years in the Anglican Church of Southern Africa (ACSA), I have served in different types of communities at various levels. My exposure at the South African National Aids Council (SANAC) as a representative of the Religious Sector acutely highlighted the continued

devastating impact of the HIV/AIDS pandemic on the lives of many inside, as well as outside, the Anglican Church. Therefore, the poster triggered some pertinent questions for me, such as, "Surely, taking care, as the Church of God, requires much more than a colourful poster on the wall, or yet another programme?" "Surely taking care, as the Church of God calls for care and support that mirrors the identity, mission and witness of the Church?" While contemplating these questions, it became apparent to me that there was a need for a theological investigation into the implementation of HIV/AIDS programmes of ACSA.

In my opinion, this study is important and relevant, not only to the Church's ministries, as it seeks to respond to a specific societal challenge, but also as a contribution towards increasing the knowledge-base of the impact of intervention programmes in general, and in particular the Isiseko Sokomoleza Programme implemented by ACSA in the False Bay Diocese. Therefore, while the thesis purports to be a scholarly document, my personal context influenced the motivation for this research project. It has long been noted that the multi-dimensional nature of the HIV/AIDS pandemic continues to pose challenges to all spheres of society, including faith communities. This reality has prompted 'partner-responses'. In its response to the AIDS pandemic, the Christian Church is challenged in a number of ways. It challenges the Church's pastoral caring ministries (action and compassion), educational and outreach ministries of the Church and, simultaneously, the theological discourses around HIV/AIDS (Pillay 2003:17). The Christian Church, in particular, has become an important partner because of its grassroots capacity to reach individuals and communities.[4]

In her address to religious leaders, Dr. Asha-Rose Migiro, Deputy Secretary General of the United Nations, states that religious leaders were "natural activists, who can change attitudes".[5] However, most, if not all, Church HIV/AIDS programmes, in particular the Isiseko Sokomoleza Programme, depended on donor funding. In this regard, the Church also served the agenda of foreign donor agencies, since donor funding was on the decline, and existing awareness and support programmes were ending, AIDS support programmes have ceased to

[4] South African systemic theologian, Dirkie Smit (1996:119-129; 1996b:190-204), wrote extensively on the six manifestations of the church in society, namely: a worshipping community; a local congregation; denomination - institutional church; ecumenical church - representing different denominations; volunteer organizations; civil initiatives, namely community based organizations; faith based organizations; and individual members living their daily lives, according to the values of Christianity (cf. Pillay, 2008:173).

[5] See http://www.e-alliance.ch/en/s/hivaids/accountability/ungass/. Dr Asha-Rose Migiro, Deputy Secretary General of the United Nations addressed religious leaders in 2011. Her key message was that the church is a natural fit for addressing and influencing behavioural change.

function in many parishes in ACSA. In order to respond appropriately to the question below, there are a number of 'sub questions' that will have to be answered. These sub-questions are stated as follows: What is the actual problem? This relates to a further question of how the ecumenical Church responded to the HIV/AIDS. Influenced by the global and regional challenges, how did Anglican Church of Southern Africa (ACSA) (Diocese of False Bay) respond through the implementation of the Isiseko Sokomoleza HIV/AIDS (IS) Programme? The observation was made that the Isiseko Sokomoleza Programme had limited impact. Why would that be the case? In order to answer this question, I had to consider what appropriate research instrument could be employed in order to assess the reasons for such perceived limited impact. In addition, what constructive recommendations based on these could lead to appropriate strategies in future responses to HIV/AIDS?

1.3 Discourse on HIV/AIDS in the context of Practical theology

HIV/AIDS has been discussed in many disciplines, also religious studies and particular religious traditions, including Islam and Christianity. This has also been the case in Christian theology, including Bible studies (on narratives of healing), ethics (sexual ethics, stigma, ethics of care), systematic theology (the theodicy problem on God and suffering, understanding the nature of the Church as embodied), practical theology, with specific reference to youth ministry (HIV prevention), pastoral counselling (dealing with issues of guilt), and ecclesial ministry. In terms of ecclesial ministry, there have been a corpus of literature. This study will contribute to such literature.

Practical theology is the academic discipline that examines and reflects on Christian practises in order to understand the theology that is enacted, and to consider how theological theory and theological practices can be more fully aligned, changed, or improved (Osmer 2008). Practical theology consists of several related sub-fields, such as applied theology (missions, evangelism, and pastoral psychology of religion), Church growth, administration, homiletics, spiritual formation, pastoral theology, spiritual direction, political theology, theology of justice and peace, and other areas. It may also include advocacy theology, such as theologies of liberation (of the oppressed, in general, of the disenfranchised, of women, of immigrants, of children, and Black Theology). Practical theology may also include practices of Christians caring for others, as Christ cared for the poor (Osmer 2008:54). Scholarly contributions to pastoral care and

counselling have contributed greatly to pastoral theology over the past years (Dunlop 2009;[6] Kornfield 2002;[7] Gunderson 1997[8]). The theoretical framework for this study is based on the discipline of practical theology, with specific reference to pastoral care and counselling.

Pastoral care has a hermeneutical task, which is to link stories/narratives of people's lives with the story/narrative of the gospel. In this regard, a pastoral hermeneutic is about an attempt to understand and interpret human beings with their perception and experience of God. In pastoral hermeneutics, the pastor functions as an interpreter of God-images (perceptions and concepts of God). In this regard, a pastoral assessment, or pastoral diagnosis, is about the appropriateness of such God-images – not whether these images reflect the confession of the Church correctly, or incorrectly, but appropriate, in terms of the human quest for meaning, and the struggle of learning to live with human suffering (Louw 2007:30-36). In this regard, the suffering and difficulties brought about by HIV/AIDS provide us with a challenge that calls for immediate attention from both Church and academic theology. How do we deal with the high number of people who are sick and dying, and above all, how do we as Christians theologians justify reasons for our faith, or our belief in God? In other words, we are challenged more than ever before to show that God is indeed the God of life who conquered death through Jesus Christ. Therefore, there is a need to think about the role of pastoral care (theology) contributing to the solution to the HIV/AIDS pandemic.

We need to seek new methods of doing pastoral care and methods of interpreting Scripture that take into consideration people's experiences of life and the dangers posed by social challenges, of which HIV/AIDS is but one of them. I am of the view that such an approach to doing theology will help ACSA and in particular the diocese of False Bay to offer hope, which will generate action through care and support as it, respond to the challenges revealed in the findings of this research study. Furthermore, it assists us to embark on a quest for a pastoral theology of wholeness and healing (liberation) and at the same time, it will highlight the role God has played in creation and continue to play in our struggles against HIV/AIDS, as well as our search for a renewed life. In this instance, the pastoral care model of Osmer will form the guiding

[6] Dunlop (2009:277) states, "…wellbeing is understood holistically and corporately, and includes personal, as well as social structural components."

[7] He states, "Contemporary pastoral caregivers continue seeking to help others lead fruitful lives and possibly even to die a happy death" (Kornfield 2002:273).

[8] He states, "…while historically much pastoral care focussed on the pastor, it is increasingly understood, as a communal responsibility of church members in a model of care for all by all rather than the privilege of the ordained" (Gunderson 1997:275).

principles of this research study, leading it into a theological response towards the end of this study.

Louw (2007) defines practical theology by reflecting on the contributions of Browning (1991:9-10). According to Browning (1991), practical theology deals with the Praxis of God – Gods act of salvation and engagement with human suffering. In the context of theological reflection, it is the human attempt to express and portray the presence and the will of God; in such a way, that meaning in life and comfort is contextually disclosed and discovered. He argues that practical theology is, therefore, both hermeneutical and communicative and states that pastoral care "assumes that the love of God is enfleshed in the love of neighbour and the love of the self" (Browning 1991).

Louw (1982:30-36), De Gruchy (2001:3-4) and Van der Ven (2002:21) all argue that, in the context of human suffering, God enters the human experience of suffering, which is how our faith interprets Gods intervention in human conditions. Osmer (2008) further argues that practical theology includes practises of Christian caring for others, as Christ cared for the poor (Mark 10:21). Miller-McLemore (2012:270-277) describes the development of pastoral care in the twenty first century by identifying three milestones, namely: the move away from the model of care for the individual by (ordained) individuals to a model of care by the community for the community; the development of pastoral care as a public theology; and the practice of strategic participation instead of personal insight.

In the context of this current study, some scholars assert that by addressing the challenges of HIV/AIDS, pastoral care has to address the ethical dimension of stigmatization (Louw 2007:414). *Stigmatization, alienation and discrimination are considered the real "killer" for many who are living with the HIV virus.* Stigma could be defined as any attribute that marks the bearer as culturally inferior or unacceptable. Discrimination is often the consequence of stigma. Generally, the negative impacts caused by HIV/AIDS on the lives of people who live in poorer communities, the suffering and stigma related to the disease has influenced the perceptions of HIV/AIDS in many communities. The Church in its initial response was seen to be very hesitant in its response due to fear, ignorance, and moralistic interpretation of Holy Scripture, which led to stigmatisation and exclusion of people living with HIV/AIDS.

The association of HIV/AIDS with an already stigmatised group serves to divide the world in "them" and us. This is especially prevalent in the way in which the disease is transmitted (sexually, mother-to-child, intravenously – including through contaminated blood and medical

equipment that is improperly sterilised or sharing of used needles).[9] Stigma has to do firstly with labelling, and then declaring the "other"; in this instance, the other are the HIV/AIDS infected ones. The alienating effect of labelling contributed to the fact that people are reluctant to test for the HIV-virus because of fear for exclusion and stigmatisation by partners, family members, fellow workers, and communities (Pillay 2003:115).

According to Heath (2005), disclosure is a process, not an 'event'. HIV/AIDS-positive people choose to disclose, and have the need for it, to people whom they can trust. Disclosure should not be required of people but it is problematic if people feel unable to disclose. They tend to keep their status a secret because they do not want to be stigmatised. Often in healthcare situations, a lack of confidentiality poses a problem when people have a need to disclose in an attempt to reduce stigma. Healthcare workers are often gripped by the fear of infection, often because of inadequate protective supplies or ignorance of infection methods. Sometimes, for structural reasons, special services are provided for HIV-positive people. Involuntary public disclosure often causes people not to access healthcare services or to avoid support groups (Deacon 2006:56). When pastoral care is understood to be an illustration of God's love in a given context, the only way to break through the problem of stigma is to practice the ethics of love (Louw 1998). According to Louw (2007:414), pastoral ethics in the context of HIV and AIDS encompasses four basic principles, namely:

- The reality of understanding the real and devastating impact of HIV/AIDS;
- Empathy and understanding the emotional-, psychological-, and spiritual impact caused by HIV/AIDS;
- Understanding the loneliness, fear, rejection, anxiety, and guilt on the part of the person living with HIV/AIDS; and
- Providing support and assistance for those, who are living with HIV/AIDS?

These principles impart meaning, implying that the pastoral care approach should be one which suspends judgement and adopts a positive attitude towards the recipient of care and support (Louw 1998:341-345).

9 AIDS.gov, "How Do You Get HIV or AIDS?" 31December 2015, https://www.aids.gov/hiv-aids-basics/hiv-aids-101/how-you-get-hiv-aids/. Accessed 13 June 2017.

1.3.1 Contributions from other Disciplines

As this current research project is about a critical theological investigation of the Isiseko Sokomoleza AIDS Programme, the theoretical framework for this research project includes the wide scope ranges from the challenges of HIV/AIDS at congregational level (Pick 2002); to Counselling (Sifris 1988); Pastoral Counselling Theology (Sarot 1995); Practical Theology (Browning 1991); Theology and Practical Theology (Burkhart 1983; Fowler 1987); New Methods of Pastoral Care (Capps 1990); the Church and AIDS (Genrich 2004); Ministering to and Counselling a person with AIDS (Louw 1990); Practical Psychology for Pastors (Miller and Jackson 1995); Pastoral Counselling and Suffering (Louw 1982); Ministry in Contemporary Society (Nouwen 1997); and HIV/AIDS Care and Counselling (Van Dyk 2005; Louw 1998).

While clear distinctions between theology and psychology exist at an abstract and theological level, the two disciplines converge at the applied level of mutual interest or concern (Smith 2008). Scholars (Van Dyk 2005) have long identified the development in the relationship between psychology and pastoral counselling. Van Dyk (2005) states that pastoral counselling, in the context of HIV/AIDS, could be greatly affected by medical and psychological symptoms, such as opportunistic infections and the side effects of ARV's. The discomfort and pain could be severe, which, in turn, will adversely influence the progress of counselling. In addition, disorders such as dementia, could be extremely difficult and could prevent the client from participating in counselling (Van Dyk 2005). Psychological symptoms such as hopelessness, anger, suspicion, depression, and isolation may strongly influence the client's attitude in a negative way. Other factors, such as memory loss, irritability, confusion, disorientation, and delusional thinking could lead to erratic or discordant behaviour (Van Dyk 2005). Therefore, it is imperative that the counsellor considers all these factors when engaging in pastoral care, support, and counselling. This discourse needs further research, especially in the light of the escalation in new infections and the pastoral burden it could create for the Church.

Discourse on pastoral theology is further enriched by the insightful contributions of the experiences of women, serving as pastors, academics, counsellors, and clinical pastoral educators (Moessner 1996). The response of Churches and faith-based institutions in the first quarter of the century of the pandemic has been examined and has been found wanting (Maluleke 2003; Chitando 2007). Apart from the slow and often confused response of some faith-based institutions, there has been silence and indifference, especially amongst academic theological institutions. A few exceptions can be found, but these only serve to prove the

general trend.[10] A key component of addressing the HIV/AIDS pandemic was to address the fear of death that has resulted in the numbness and the reluctance to acknowledge and celebrate the gift of life. More urgently, a "theology of life and death" has to include and urgent review of the historical understanding of sin, judgement, punishment, and death. In chapter three of this research project, examples of programmes on "Death and Dying" will show how the Anglican Church of Southern Africa have begun to address this particular theme as an integrated strategy of pastoral care towards people living with HIV/AIDS. With specific reference to prevention, care, and support, various mainline Churches have contributed greatly towards the theological responses in South Africa. The Catholic Church produced several publications which emanated from the conference in Pietermaritzburg (2003), *Responsibility in a Time of AIDS*[11].

Similarly, ACSA hosted a conference towards effective Anglican Mission, which also produced several responses in the field of Social Development and HIV/AIDS (2007)[12]. Despite the fact that the Church continued in its vigour in addressing the AIDS pandemic, HIV/AIDS continues to constitute a global emergency and remains one of the most formidable challenges to human life and dignity. For many, it undermines social and economic development throughout the world and affects all levels of society. Africa, in particular sub-Saharan Africa, continues to be the worst affected area[13] (Pillay 2003:108-121).

It is now almost three decades since the Church's initial responses to the challenges of the AIDS pandemic. Over this period, many scholars have reflected on the Church's responses, including the silence and judgement during the early days. See, for example, Nicolson (1995); Saayman (1991); Saayman and Kriel (1991); Snidle (1997); Parry (2002); Paterson (2002);

[10] See the role of theology by the Catholic Church in their response to the AIDS pandemic.

[11] This book brings together papers presented at the conference together with some significant documents of the Catholic Magisterium in Southern Africa and beyond, written during the course of the last thirty years. The first section was reproduced with permission from Grace and Truth Volume 30: No. 2 (2013). The second section was reproduced with permission from Grace and Truth Volume 30: No. 3 (2013:11- 12).

[12] Conference Theme: An International Conference on Prophetic Witness Social Development and HIV/AIDS, May 2007. The conference was held in Boksburg, Johannesburg, towards Effective Anglican Mission. The other responses included, The Millennium Development Goals, HIV/AIDS, The Role of the Church, and Mission Priorities for ACSA, matters pertaining to the Environment and sharing best practise models across the Anglican Communion.

[13] This programme was coupled with the concept of sustainable development that branched off from the Earth Summit in Rio de Janeiro in June 1992. A clear paradigm shift emerged at this conference on how to deal with natural disasters and the need to create proactive measures that would lessen the impact of a disaster, if it cannot be avoided at all. (Holloway 1993: 3; Disaster management Training Programme 1992:12) (cf. Pillay: 2003:110).

Pillay (2003); Kanyoro (2003); Birdsall (2005); Cochrane, Olivier and Schmid (2005); Mclemore (2012); Osmer (2008) and Brister (1964). Mclemore, Osmer and Brister specifically contributed to the theology and understanding of pastoral care, which is especially relevant to this research project, seeing as it seeks to contribute to the vast pool of contributions for a sustainable pastoral care response. Bristor, in particular, emphasises the relationship between counselling within the pastoral context and counselling in the field of psychology. Of particular interest to this project is the historical development of pastoral counselling, which will be discussed in chapter four of this research project. For example, Pillay (2003:110) identifies these broad socio-ethical challenges associated with the pandemic as entry points that served as effective responses to the HIV/AIDS pandemic.

Much has also been written to shape Church responses to the pandemic, for example, from the perspectives of Biblical Studies (Nadar 2006; Phiri 1997; Dube 2003); Ethics (Ackermann 2007); Ecclesiology (Smit 1970); Practical theology (Mclemore 2012); Pastoral Care (Brister 1992; Osmer 2008); and Counselling (Sifris 1988). However, the pandemic presented the Church with an even greater challenge, which Pillay (2003) puts as theological and ethical "entry points." In my opinion, these entry points should still be part of the Churches discourse at present. For the Church to provide a friendly, acceptable environment, it needs to create opportunities where people can experience "fullness of life". In other words, people are encouraged to make responsible life-sustaining decisions, develop their skills, feel a sense of belonging (identity), a sense of accountability is being fostered and where the spirit of community is being embraced.

Others have further pointed out that the HIV/AIDS pandemic presented the Church with the challenge to create opportunities where people are inspired to have life in all its fullness, where people are encouraged to develop skills to make life-sustaining decisions that are congruent with their sense of Christian identity, and where collective responsibility is fostered (Pillay 2003:112).

McClure (2012), focussed on the historical development of pastoral care its relationship to psychology (counselling) which will be unpacked in chapter four.[14]

[14] See contributions by (Pick 2002); Counselling (Sifris 1988); Pastoral Counselling Theology (Sarot 1995); Practical Theology (Browning 1991); Theology and Practical Theology (Burkhart 1983; Fowler 1987); New Methods of Pastoral Care (Caps 1990); the Church and AIDS (Genrich 2004); Ministering and Counselling a Person with AIDS (Louw 1990); Practical Psychology for Pastors (Miller 1995); Pastoral Counselling and

As this research project is about a critical theological investigation of the Isiseko Sokomoleza HIV/AIDS Programme, the theoretical framework for this research project will be the broad scope of practical theology. There is no doubt that the ongoing research in the field of research on HIV/AIDS continues to inform the discourse in Southern Africa and globally.

According to (Haddad 2011:2), the Collaborative for HIV and AIDS, Religion and Theology (CHART) was established in 2007 at the School of Religion and Theology (SORAT) for academics and practitioners from different religious and theological disciplines to engage in research and supervision of postgraduate research, in the interface between religion, theology, and HIV. This was an on-going exercise, conducted in consultation and collaboration with the community based at the Ujamaa Centre for Community Development and Research and the Sinomlando Centre for Oral History and Memory work in Africa, located in Kwa-Zulu Natal. Subsequently, theological reflection took on a new momentum, which benefitted both practitioners and academia in the on-going quest for research, rooted in the lived experiences of people living with HIV (Haddad 2011). There is recognition among scholars that religious institutions present both a positive and a negative impact in their response to the pandemic, especially in the areas such as stigma, suffering, sin, and judgement.[15]

Another major development in this field was the establishment of the Cartography of HIV and AIDS, Religion and Theology that was initiated to compile a bibliographic database to consolidate what had been accomplished through various religious disciplines (Haddad 2011:3). It also provided a database for all future research in the HIV and Religious field.

Consequently, the literature consulted, shaped the formation of the research problem of this current study. Scholars acknowledge the interplay between religion, health, and social sciences,

Suffering (Louw 1982); Ministry in Contemporary Society (Nouwen 1997); and HIV/AIDS Care and Counselling (Van Dyk 2005; Louw 1990).

[15] Peter Piot, Director of UNAIDS addressed an audience, mainly from the medical and social science fields, and reminded them that there is a need to broaden the scope of role players in addressing localised epidemics (HIV/AIDS). Piot identified five reasons why religious organisations and faith communities have a role to play in addressing the challenges of AIDS namely: that people look at religious leaders 'to explain what is happening when there is a crisis, and to provide some direction in dealing with the particular crisis. Second, religious institutions have played an educative role throughout their history; they meet their constancy at least once a week. Third, according to Piot, HIV/AIDS challenges terminologies such as, retribution, sin, sexuality and taboos. Fourth, Piot states that forty per cent of all AIDS care is done by religious groups. Last, many people, living with HIV, have strong religious beliefs and look to God and their faith community for support and comfort. Ref (Peter Piot, 'Foreword' in Islam and AIDS: Between Scorn, Pity and Justice, edited by Fareed Esack and Sarah Chiddy (Oxford: One world, 2009: xi-xii; cf Haddad, B. 2011:21).

which is a critical intersection, in order to provide a holistic response in the field of HIV/AIDS (Olivier 2009; Paterson 2001; both cited in Haddad 2011:25-44). This critical intersection strongly motivated the reason for reflecting on the implementation of Primary Healthcare as a best practice model (tool), instead of reflecting only on the implementation strategies of religious programmes that could contribute to a greater impact in the Churches' response.

Phillipe Denis (2011) focuses on the history of the religious response to the epidemic, with a special focus on Sub-Saharan Africa. He argues that religious discourses add meaning to the epidemic, and reveals that the discourses are not homogenous. Importantly, he highlights the ability of the religious sector to deal with the key aspects of human sexuality, which is a key aspect of prevention messaging that requires further research. Much seems to depend on socialisation, religious experience, indoctrination, and exclusion – all of which vary in each religious grouping. In the implementation of the Isiseko Sokomoleza Programme, 'no one size fits all'. A typical example is a comparison between the Diocese of Lebombo (Northern Mozambique) and the Diocese of False Bay, with particular reference to infrastructure, doctrinal interpretation of the biblical text, cultural practices, resources, and geographical distance (ACSA 2004a). Gerald West (2008, cited in Haddad 2011:138) reflects particularly on the Bible and the Qur'an. In his engagement with literature, he demonstrates that across various religions, the development of an HIV/AIDS hermeneutic is essential. Most sacred texts embody the notion of inclusivity and compassion and may simultaneously differ from case to case. In response to West's understanding of HIV/AIDS, Monica Jyotsna Melanchthon (2011, cited in Haddad 2011:162) asserts that it often depends on the way in which the sacred text is understood. She argues the need for religious pluralism, as her view is that the Bible no longer holds a privileged position in a multi-scriptural society. The need for multi-religious pluralism was one of the guiding principles for the implementation of the strategies for the Religious sector's response to the National Strategic Plan (South African National AIDS Council (SANAC) 2012. The engagement with various sacred texts has not affected this current research project however, but it could influence future theological discourses.

We need a multi-faceted approach to the disease, and wellness that incorporates personal transformation (behaviour change) and socio-economic justice, will offer some hope to humankind in the face of this crisis, as well as future ones. This view was expressed by the UN official in his address to the Faith Sector during a recent session of the international HIV/AIDS Conference (United Nations Programmes on HIV/AIDS [UNAIDS] 2016b). Religious

organisations have a tradition, often rooted in Scriptures, of dealing with disease holistically[16] (Haddad 2011:29). This is confirmed in literature, suggesting that 'religious responses range across the continuum of prevention, care and support, treatment and rights, and often "holistic in nature", focussing on the emotional and spiritual aspects of care as well as the physical.'

According to Haddad, Olivier and De Gruchy (2011, also cited in Haddad 2011:29), "it is often connected with emotional and spiritual aspects of care as well as physical and holistic dos not only imply an understanding of health that covers all elements but also of a wide range of services provided by religious organisations." They further assert: "There is a great variation in the speed and intensity with which religious organisations responded to the HIV epidemic in different countries". The Roman Catholic Church provides 25% of all HIV/AIDS care, including home-based care and support for orphans (Wood 2002). The strain on religious healthcare systems and organisations because of the lack of funding resulted in the waning response to HIV/AIDS by the religious sector, which is in contradiction to the observation by Jill Olivier, who averred that religious programmes proliferated in poor settings (Haddad, Olivier and De Gruchy 2008:22-30). As early as 2011, the need for more research in this particular area was identified, to ascertain whether it was the result of targeted funding, or a needs-based community response, and what its effect was on the HIV pandemic. *Scriptura*, *Theologia Evangelica* and *Missionalia* dedicated volumes of responses to the theme of HIV/AIDS. HIV/AIDS challenges Christian theology, in particular, Dube (2003b) therefore challenges theologians to engage with the epidemic. Similarly, Conradie (2014) argues that the HIV/AIDS pandemic challenges scholars to give an account of every facet of the Christian faith. Scholarly work on the challenges of HIV/AIDS was also done by Archbishop Ndungane, who played a leading role in the response of the Anglican Church in Southern Africa (Ndungane 2005).

1.4 Statement of the Research Problem

While many other HIV/AIDS programmes were introduced by ACSA, the focus of this study is to examine the impact of the Isiseko Sokomoleza programme. Despite it having been implemented by various Dioceses in ACSA, it has, in my observation, achieved limited success in eradicating the stigma of HIV/AIDS. Evidence to this observation is a statement made by

[16] The word 'holistic' here, applies not only to an understanding of health that embraces all its elements, but also to a wide range of services provided by religious organisations. Ref. (Olivier, Cochrane & Schmidt, and ARHAP Literature Review: 39-40. Haddad 2011:45).

the liaison Bishop, Rev. Dr. Johannes Seoko: "The reliance on foreign funding was the weakest link in this organizational and implementation structure" (Siyakha Report 2006), as well as the observations gathered from the literature (Deacon 2006; ACSA 2006a). Currently, there are hardly any programmes in the Diocese of False Bay aimed at reducing and mitigating the impact of HIV/AIDS-related stigma. My hunch is that whilst several factors gave rise to the limited impact of the Isiseko Sokomoleza programme, it lacked a pastoral focus, hence the research question which is pertinent to this study:

> What are the most significant reasons for the limited impact of the Isiseko Sokomoleza HIV/AIDS programme that was introduced by the Diocese of False Bay?

The above question is important since an assessment of the reasons for such limited impact would assist a critique of the pastoral praxis within the Diocese of False Bay, but also ACSA, the SACC and wider ecumenical networks. It will add particularly to the knowledge base on how the Diocese of False Bay can strengthen its response to the challenges of the HIV/AIDS pandemic based on theological premise as opposed to the availability of financial resources.

1.5 Provisional hypothesis

Before commencing the study, my expectations about the possible reasons for the limited impact may be articulated in the following way:

Firstly, the constant changes to the Provincial Programme (AAHT) impacted negatively on the efficacy of the roll out of the HIV/AIDS programme in the Diocese of False Bay. Secondly, only one HIV/AIDS-coordinator was appointed, creating a limited capacity to roll out the programme, which could have played a critical role in the monitoring and evaluation, let alone providing technical support and guidance to the care and support groups, and an inability of the Diocese of False Bay to put the necessary administrative structures and systems in place to make room for another HIV/AIDS-programme.

Thirdly, the Fikelela office was funded through the Provincial Aids Office (AAHT). This was to ensure that the programme was implemented through information sharing and training, with reference to the poster, "This Church is Aids Friendly", which was displayed in most Churches.

Fourthly, the lack of capacity and oversight of the HIV/AIDS programme at the Diocesan level had parishes in the Diocese that were impacted by this.

Fifthly, the HIV/AIDS-programme was implemented through donor funding, which indicates that there was no planning, budgeting, and ownership by the congregations to drive the

programme. With the withdrawal of donor funding, the statement by the Liaison Bishop, the Right Reverend Dr Johannes Seoko, namely that "the reliance on foreign funding was the weakest link in its organizational and implementation structure" (Siyakha Report 2006), could not have been more accurate.

Sixthly, the post of the coordinator was made redundant (Siyakha 2009) and this resulted in the inclusion of the HIV/AIDS-programme in the Diocesan social development portfolio, and oversubscribing HIV/AIDS as only a social challenge of the Church raised serious concerns about the sustainability of the programme (Profile of the Diocese of False Bay 2012). Furthermore, I also expected that a possible reason for the limited impact of the HIV/AIDS-programme could be a resistance to implement the programme in some congregations, because of the Church's initial response of silence, as well as stigma connotations to HIV/AIDS and criticism towards the implementation of the programme.

1.6 Theoretical Framework

The observation about the limited impact implies a critique of the Church's pastoral praxis. In order to do apply such a critique there are a few approaches could be considered, including a biblical perspective, a systematic perspective, an ecclesial perspective, or a practical theological perspective, specifically pastoral care and counselling. According to Osmer (2008:34), practical theology presents us with four distinct yet integrated components for theological interpretation. Firstly, the empirical task refers to the gathering of the information from various dynamics in this study (literature, key informants, and questionnaires) to ascertain what is happening in the broader context. Secondly, the interpretive task refers to drawing on theories and sciences in clarifying the dynamics and contexts in order to understand, for instance, in the case of this particular study, "the reasons for the limited impact". Thirdly, the normative task refers to the interpretation of theological concepts and learning from other best-practiced models (theological critique) – with reference to pastoral care and counselling. Fourthly, the pragmatic task refers to specific strategies that will influence desirable outcomes and lead action steps, which will assist with recommendations that will inform the strategies. In this study, the aforementioned task will be applied to the Diocese of False Bay, ACSA, SACC, and ecumenically as referred to in chapter eight.

In light of the waning response to the HIV/AIDS pandemic, this research project investigated the reasons for the limited impact of the Isiseko Sokomoleza programme. In order to study this limited impact, I opted to make use of the Primary Healthcare model, which was accepted as

the Declaration of ALMA Ata on Healthcare (World Health Organisation [WHO], 1978). This Primary Healthcare-model (PHC) is essentially care-based and follows practical, scientifically sound, and socially acceptable methods (Magawa 2012). This tool employs a comprehensive approach of responding to health needs, as well as finding ways to resolve the underlying economic, political, and social determinacy of poor health (Mthembu 2010). The overall strategy is supported by the following components: political commitment, integration, equity accessibility, affordability, availability, effectiveness, and efficiency. These aspects could be adopted as a tool for the assessment of programmes within a Church context (Denhill, King and Swanepoel 1998). The PHC theory of implementation, therefore, may assist in identifying the precise reasons for the limited impact of the Isiseko Sokomoleza HIV/AIDS Programme, especially in the areas of governance, capacity, mobilization and resources (Magawa 2012).

However, it should be noted that this model is in no way an answer to the pastoral problems. Meanwhile, since HIV/AIDS is a multi-sectorial problem, I am of the opinion that this evidence-based model could help assess an effective pastoral response, which will allow for greater impact. It is for this reason that the findings of this current study will need to be further assessed through a theological lens (pastoral care and counselling). This will be explored in more detail in chapter seven of this study. My observation is that while several factors gave rise to the limited impact of the Isiseko Sokomoleza Programme, it lacked a specific pastoral praxis. This study will therefore evaluate the reasons for the limited impact of the Isiseko Programme introduced by the Anglican Aids Office, in the Diocese of False Bay.

The main purpose of the Isiseko Sokomoleza Programme was to reduce HIV/AIDS and mitigate the impact of stigma. Based on the premise that the Church ought to respond in ways that are congruent with its pastoral identity, the implementation of specific programmes is one way of expressing its pastoral heart. McClure (2012:221-230) compares the pastoral nature of the Church to that of a shepherd caring for sheep. Considering this pastoral context, it further implies that the Church encourages concern for the "other" in the form of affection, solicitude, accompaniment, and protection. Ultimately, the aim of this research study is to contribute to the knowledge base with regard to ministries related to pastoral care and counselling.

The objectives of this research project was not to investigate the general response from the Diocese of False Bay, but rather to offer (from a theological pastoral perspective) a theological critique of the Isiseko Sokomoleza Programme. This study is important and relevant, not only

to the Church's ministries as it seeks to respond to a specific societal challenge, but also to contribute towards increasing the knowledge-base of the impact of intervention programmes, in general, and the Isiseko Sokomoleza Programme, in particular, as implemented by the Anglican Church of Southern Africa (ACSA) False Bay. The objective of this research study was to investigate some of the most significant reasons for the limited impact of the Isiseko Sokomoleza Programme, the main objective of which was to reduce stigma and mitigate the impact of HIV/AIDS.

1.6 Research procedure

In response to the research problem as stated above, the investigation will be structured as follows:

Chapter 1: The overall plan of the research project is introduced in this chapter. The observation on which this study is based is that the implementation of the Isiseko Sokomoleza Programme, in the Diocese in ACSA, had a limited impact on stigma reduction. The pertinent research question is: "What are the most significant reasons for such limited impact of the Isiseko Sokomoleza Programme introduced by the Diocese of False Bay?" The context, problem, hypothesis, methodology, and procedure for the rest of the thesis are also outlined in this chapter.

Chapter 2: This chapter offers an overview of the ecumenical international-; regional-; and national- (WCC, SACC, and ACSA) responses to the HIV/AIDS pandemic. The literature covers a very broad spectrum of how HIV/AIDS had become the catalyst of social and theological issues such as stigma and discrimination, gender, poverty, theology – pastoral care and the identity, mission and witness of the Church.

Chapter 3: This chapter provides a descriptive overview of ACSA's response to HIV/AIDS that will include a historical overview of the Isiseko Sokomoleza Programme in the Diocese of False Bay. This descriptive overview is gleaned from programme material, Synodical resolutions, reports and workshops.

Chapter 4: The Primary Healthcare Model will be discussed as an instrument to explore the limited impact of the Isiseko Sokomoleza Programme with reference to pastoral care and counselling.

Chapter 5: This chapter provides methodological clarification regarding the empirical part of this study. This study will require empirical research in order to investigate the reasons for the perceived limits impact of the Isiseko Sokomoleza Programme within various parishes and projects in the False Bay Diocese. The methods to be employed for the empirical component

will be explained in more detail in chapter five. The study will involve the completion of questionnaires by the members of the care and support groups who volunteered to be part of the study. This was necessary in order to answer the research question "What are the most significant reasons for the limited impact of the Isiseko Sokomoleza HIV/AIDS Programme that was introduced by the Anglican Aids Office, in the Diocese of False Bay?" This research question in essence is an empirical question, hence the reason for the empirical component of this research study. I will attend to the research setting, population and sampling, data collection, data analysis (quantitative and qualitative), and ethical considerations. I opted for an explanatory sequential procedure and a mixed methods approach (Creswell 2014), which comprised data collection from respondents and participants, across two phases.

Phase 1, the quantitative research phase, consisted of a survey with respondents from the care and support groups, using a structured questionnaire. Phase 2, the qualitative research phase, consisted of in-depth semi-structured interviews with participants from the programme implementation team, for a different perspective of the problem, as well as key informants, for a third perspective. The quantitative data was analysed, using descriptive and inferential statistics, while the qualitative data were captured, coded and, thereafter, analysed, using thematic analysis. The findings emanating from the data will be analysed through the tool of the Primary Healthcare model, and interpreted through Pastoral Care and Counselling.

Chapter 6: This chapter provides a presentation of the quantitative findings and a discussion on the findings.

Chapter 7: This chapter will highlight the qualitative findings and will offer theological reflection on such qualitative findings.

Chapter 8: The final chapter concludes with a summary of the study, and then proceed to offer recommendations as to how this research project could inform the HIV/AIDS agenda (pastoral praxis) of the Diocese of False Bay, South Africa and the Ecumenical Church at large.

CHAPTER TWO
ECUMENICAL RESPONSES TO HIV/AIDS

2.1 Introduction

This chapter will afford an overview of the ecumenical responses of the Churches to the HIV / AIDS pandemic through its influence and guidance by the World Council of Churches (WCC). It will also highlight the relationship between the WCC, the United Nations and the World Health Organisation in developing partnerships in developing responses to the challenges of HIV/AIDS from both health and religious bodies. Furthermore, this chapter will detail the ecumenical responses from Churches through various conferences, which influenced the Churches responds to HIV/AIDS in different ways. The outcomes of these conferences enabled Churches and faith based organisations regionally, leading to the influencing of the responses by the South African Council of Churches in addressing HIV/AIDS challenges locally. From inception of the ecumenical response to HIV/AIDS challenges, Stigma was identified as the emerging challenge. This chapter concludes with a brief discussion on stigma and deducted conclusions.

2.2 The United Nations and the World Health Organisation on HIV/AIDS

HIV/AIDS is a global challenge and calls for a response from all and sundry. At a global level, ecumenical movements such as the World Council of Churches (WCC) have responded to the challenges of HIV/AIDS and provided guidelines to Churches to assist them in their responses. The global response of Churches in many ways influenced the regional and local responses through liturgical and managerial processes. This is evident in the WCC by convening the participation of member Churches (Anglican, Eastern and Oriental Orthodox, Protestant, independent, and united Churches). Together with ecumenical partners and agencies, the WCC provided a broad scope of experience in addressing the challenges of pandemics such as HIV/AIDS. The latter is corroborated by the fact that as early as 1946, the WCC's subsidiaries, namely, the Commission of the Churches on International Affairs (CCIA) and the Medical Commission of WCC, were requested by the United Nations to address various pandemics (Kurian 2016). Since the 19th century, medical work has been identified as the touchstone of missionary focus, together with education and preaching (Kurian 2016). An example of the latter is the fact that in 1960, thousands of Christian Hospitals were addressing healthcare needs

in developing countries. According to Kurian (2016), a mind shift change from healing towards curative medicine took place and resulted in 90% of health resources being channelled towards curative medicine. The Tubingen I and II (1964-1968) Consultations were organised by WCC, where the Lutheran World Federation (LWF) and the German Institute for Medical Mission (DIFAM) worked together towards a new approach in healthcare (Kurian 2016:2). These conferences gave rise to a new focus on integrated healthcare. The approach to healthcare recognised the fact that medical care was only one component of health and that a diversity of disciplines such as social work, nutrition, agriculture, and community development contributed to effective holistic healthcare. This multidisciplinary approach to healthcare influenced the Churches' understanding of healthcare, which gave rise to the establishment of Christian Medical Council (CMC) in 1968 (WCC 1979). In consultation with the World Health Organisation (WHO), community orientated healthcare became a reality (McGilvray 1981).

Given the early history of healthcare and the establishment of a community based care system, it needs to be said that the Church's response was instrumental in the rethinking of the new healthcare approach/system. This was a radical shift from the former principles of healthcare for WHO, with massive implications for healthcare systems throughout many countries (WCC/CMC). The role of the Church became critical in ensuring that critical input from the local communities were included in the formulation of policy and systems in the delivery of healthcare. This new philosophy of primary healthcare soon became a reality (WHO Report of International Conference on Primary Healthcare 1978). The community model of care had three components in its philosophy, which emphasised an integrated framework of preventative, curative, and primitive health services for the community and the individual. As early as 1970, Christian communities began to train grassroots workers in basic healthcare and to promote the use of clean water and better hygiene conditions. During this time, the small mission hospitals formed a link between the local communities and the centralised state hospital. The Churches' contribution to the evolution of primary healthcare is a lasting contribution to public health (Litsios 2004). This development in primary healthcare is an important asset in the Churches response to the HIV/AIDS- pandemic in 1983. It was during the same time that (WHO) approached the WCC to raise awareness amongst Churches. The United States Centres for disease control and Prevention (CDC) released the following sexual categories of people at risk for HIV/AIDS: HIV patients; sexually active homosexual or bisexual men with multiple partners; Haitian entrants to the United States; present or past abusers of IV drugs; patients with haemophilia; and sexual partners of individuals at risk for

HIV (1983:101-103). The pain, suffering, and exclusion (stigma) caused by the latter "risk group statement" of people living with HIV and dying of AIDS – whether the gay communities and Haitians living in United States or the many affected form Zaire (now the Democratic Republic of the Congo) or Belgium – came to the attention of the WCC in the early1980's (Almedal 2011:360-77). As stated earlier, HIV/AIDS became classified as homosexual, paternalistic, and an African problem, which deeply challenged the Church in its pastoral concern. Churches were particularly challenged on their perceptions around HIV/AIDS, stance on human sexuality, and paternalistic structures. AIDS was officially declared by the United States as a "homosexual problem", a "Haitian problem", and an "African problem" (Kurian 2016:4). The WCC responded to the AIDS pandemic in Geneva in 1984, which led to various consultations, resulting in the historic conference in June 1986 titled "AIDS and the Church as a Healing Community". The next three years identified AIDS as a global crisis with devastating impact. The Church had to face the realities of "death, sexuality, and otherness" (Davies 1990:90, cited in Kurian 2016). At a further conference on the Aids pandemic in Reykjavik, Iceland on 15-16 September 1986, the conference executive committee of WCC recommended Church guidelines to Churches. These guidelines greatly directed the future responses of the Church as a healing community in the area of pastoral care. The guidelines can be summarised as follows (Kurian 2016:6-8).

- The Church was called upon to be the family that ought to reach out, embrace, and sustain those infected by HIV/AIDS and related diseases.
- The Churches were requested to show care without creating barriers for exclusion such as hostility and rejection (stigma); and support education and prevention.
- Churches were called upon to promote the fact that HIV/AIDS is preventable and at the same time, advocate behaviour change that will prevent modes of transmissions.
- Churches were tasked with a prevention social ministry to share correct medical and educational material about HIV/AIDS; to engage in research; advocate for the rights of medical and pastoral care, regardless of the socio-economic status, race, sex, sexual orientation, or sexual relationships.

The responses of the Churches, in return, informed the advocacy agenda at global level and was greatly influenced by the ecumenical movement such as the WCC. The initial responses were gradual, but it led to the implementation of programmes in various mainline Churches and ecumenical bodies. In many ways, the global response influenced the regional responses

in South Africa and in particular, the Anglican Church of Southern Africa (ACSA), and more specifically, the Diocese of False Bay.

It is estimated that by March 2015, over 15 million people were accessing antiretroviral therapy. It is further estimated that 51 percent of people with HIV know their status. In 2014, it was estimated that 2 million people became newly infected with HIV and 1.2 million people died of HIV (United Nations General Assembly 2016). In response to the latter statistics, the WCC responded by producing resources such as "*What is AIDS?" A Manual for Health workers (1987),* and *about HIV and AIDS: A Manual for Pastors and Teachers (1989)* with later revisions published in (1994, 2002 and 2006). Dr. Birgitta Rubenson wrote both these resources. *A Guide to Pastoral Counselling (1990),* edited by Rev. Jorge Maldonado with the support of the WCC working group on HIV/AIDS, was also published.

In Africa, (Tanzania, Uganda, and the Democratic Republic of Congo (previously DRC then Zaire)), Protestant medical agencies started Participatory Action Research (PAR) which enabled communities to do their own research (Kurian 2016:10). During the early stages of the HIV/AIDS pandemic and when it was labelled as a homosexual decease, WCC flagged the vulnerability of women. At the Beijing Conference (1995), the WCC drew together experiences on women's health from Brazil, Argentina, Costa Rica, Chile, India, Thailand, Papua New Guinea, Uganda, Zaire, Tanzania, and the USA. It needs to be noted that from the early 1990's the challenges of stigma became a real concern in Pastoral Platforms. The attitudes towards women and the cultural practises further challenged the Churches to advocate for policy changes that will make HIV infected women less vulnerable. Most of these stories appear in the work of Gillian Patterson's "Love in a Time of AIDS" (1996). This topic of women and HIV/AIDS was also addressed comprehensively in one of the issues of "Contact" titled "Women and AIDS: Building Healing Communities" (1995). The three main themes arising out of these stories were stigma and discrimination; Gender and AIDS; and Cultural practises as key theological themes within HIV/AIDS discourse.

In 1994, the HIV/AIDS Policy formulated by the Global Ecumenical context reached Southern Africa, as the WCC central committee mandated the formation of the consultative group in South Africa (Kurian 2016:10). The group, headed by Christof Benn, consisted of medical professionals, clergy, religious, laypersons and individuals either living with or working with HIV/AIDS. The mandate of this commission was to look into the pastoral, ethical, human rights, prevention, care, and support issues of people living with HIV/AIDS and other matters

related to human rights and justice. As the meeting progressed, the emergence of a common vision was eminent. This was brought about by joint worship sessions, listening together, and embracing different cultural contexts (Kurian 2016:10). This corroborative process demonstrated a good example of the nature of multi-dimensional response in dealing with the challenges of HIV/AIDS through various theological disciplines. This initiative of combining the disciplines of systematic theologies, pastoral care, and sexual and moral ethics was aimed at strengthening Churches worldwide in developing their own strategies to respond to the AIDS epidemic (Benn 1995). It could be said that an effective pastoral praxis can be further be strengthened by the other theological disciplines of systematic theology, ethics and justice. This landmark gathering resulted in the publication of the WCC Report 1996, and in 1997 the WCC Study Document "Facing AIDS". "The Challenge, the Churches' Response, stated the response of the Church from the position of its identity and mission" (WCC 1997). In essence, the call on the Church to respond to the challenges of HIV/AIDS resonates with its identity, witness and mission.

In referring to the "Church's identity" or "life of the Church", Churches were called to provide a climate of love, acceptance, and support for those who are vulnerable- or affected by HIV/AIDS. Therefore, Churches were called to reflect together on the theological rationale for their responses, as well as to interpret and offer guidance on ethical choices and to assist and support their own members, in particular healthcare professionals who were faced with ethical choices the areas of prevention and care. The plight of children affected by HIV/AIDS posed challenges to Churches to improve their provision of care towards those who were infected, and seeks to build an enabling environment. Churches were also called to promote and protect the human rights of people affected, to provide accurate information on HIV/AIDS, create environments for dialogue, and ultimately call on governments to provide financial resources and medical facilities (Kurian 2016:11-12). Churches were called upon to recognise the link between HIV/AIDS and poverty in order to advocate measures for a just and sustainable development. Special attention was afforded to migrant labourers, refugee movements, and commercial sex activities, as well as the involvement of women and young people in human sexuality as a gift, personal responsibility, family, and Christian faith. The Churches were also called to address substance abuse and to develop locally relevant responses in terms of care, de-addiction-rehabilitation and prevention (Kurian 2016: 11- 13). Given the above challenges to the Churches response, women in the Church responded by providing home-based care services and attended to the sick and dying (Rödlach 2009). This could be seen as the beginning

of care-based-responses the Church provided at local, regional and global level through the ecumenical structures.

In 1998, at the eighth WCC General Assembly in Harare, Zimbabwe there was a clear call from Christians and Churches in Africa to the global fellowship of Churches to journey with them in overcoming their fight against AIDS. The responses from various Churches culminated in the "Global Consultation on the Ecumenical Response to the challenge to the challenge of HIV/AIDS" in Nairobi, Kenya, 25 November 2001. This global ecumenical response, "Action Plan 2001", paved the way for the implementation of the Ecumenical HIV/AIDS initiative in Africa (EHAIA) by the WCC in 2002. This plan identified HIV/AIDS as a major threat to human dignity, human development, social cohesion, political stability, and the pending devastating economic impact it would have on the sustainability of families. Ecumenical partners such as Bröt für die Welt, ICCO, Norwegian Church AIDS, Christian AID, Hilfswerk der Evangelischen Kirchen Schweiz, and the Evangelical Lutheran Church in America together with many others played a crucial role in ensuring that financial resources to Churches (Kurian 2016: 14-16).These organisations assisted EHAIA in their two-pronged approach by providing skills, promoting competences, and working with theological institutions in addressing stigma and discrimination.

In 2006 the Central committee of the WCC reviewed its work and Church leaders were encouraged to exercise their role as advocates for just policies and hold governments accountable to their promises (WWW Report on Public Issues 2006). From 2000-2009 the WCC, together with Ecumenical advocacy Alliance (EAA), continued to mobilise Churches through "Live the Promise" to address stigma and discrimination, promoting prevention, mobilising resources, and advocating for universal access to treatment for Churches and governments to become more accountable (Kurian 2016:18). This initiative led to several campaigns from 2009- 2013, which are still existent to the day. In 2011, the EAA facilitated several interfaith activities (pre-conferences on faith responses to HIV/AIDS) in collaboration to UN agencies. At the Busan Conference in South Korea 2013, EHAIA was mandated to expand beyond Africa and into Jamaica, the Philippines and the Ukraine. (Kurian 2016 16-17).Churches in these areas called on the expertise and experience of the EHAIA. During this period (2008- 2014) EAA was instrumental mobilising religious leaders and people living with HIV/AIDS and this call to mobilisation became a central focus of the strategies within the Alliance. According to the GAP Report of 2016, the United Nations General Assembly in 2015

declared to end AIDS by 2030 and fast track responses to achieve the following milestones: reduce HIV infections to less than 500 000 by 20120; reduce HIV/AIDS-related deaths to less than 500 000 by 2020; eliminate HIV- related stigma and discrimination (UNAIDS Prevention Gap Report 2016:5). The above milestones also impacted on Church related programmes on HIV/AIDS as stated in the National Strategic Plan for HIV/AIDS in South Africa 2016-2020.(Kurian 2016: 120). Another important development is the announcement by UNAIDS on the Millennium Development Goals (MDG's) which had tracked the targets ahead of schedule.(Kurian 2016: 120). The first decade of the 20th century saw the rise of Churches, denominations, national networks, Church-related networks and development partners, and interreligious networks. These networks committed to work closely together breaking the silence on HIV/AIDS, stigma and discriminations, and committing to care and accompaniment.

2.3 Mobilisation of Global Responses towards HIV/AIDS

A litany or pronouncements and statements followed by various Churches across the global platforms. In 2001, the Church of Norway's Bishops Conference, the Southern Africa Conference of Bishops Conference, and the Anglican Communion across Africa took a prophetic stand on HIV/AIDS. The Anglican group called their plan "Our Vision, Our Hope: The First Step in 2002 the Pan-African Lutheran Church Leadership, The Lutheran World Federation (LWF), the Anglican Primates Meeting on HIV/AIDS (Canterbury), the World Council of Anglican Provinces (CAPA), and the World YMCA committed to breaking the silence on HIV. Since 2003, a myriad of responses to the HIV/AIDS crisis continued to mobilise the pastoral responses across denominations. The Lutheran World Federation's Latin region developed a plan of action for "Compassion, Conversion, Care," and in the same year removed all barriers that exclude people living with HIV(Kurian 2016:22) In the same year, the Anglican Primates sent pastoral letters to the entire Anglican Communion on HIV/AIDS, declaring that the "Body of Christ has AIDS". The letter also stated: "AIDS is not a punishment from God, for God does not visit disease and death upon His people". Furthermore, it stated, "it is rather an effect of fallen creation of our broken humanity" (Anglican Communion News Service 2003).

In 2003 the Network for Protestant Churches, known as the Council for World Mission, also committed itself to becoming more caring, welcoming, and healing communities that would no longer stigmatise, exclude, and discriminate against others who are living with HIV/AIDS (Kurian 2016: 20-23).

In the same instance, the Young Women's Christian Association (YWCA) addressed challenges around reproductive health and sexuality and the Norwegian Church Aid acknowledged the need towards overcoming stigma, promote prevention, care and support, and advocate for transformation.(Kurian 2016 : 21) The Episcopal conference of Africa and Madagascar (Catholic Church) identified with its members and openly stated that its members living with HIV/AIDS are part of the body of Christ (1 Cor.12:12) and strengthened its commitment to its AIDS response by sharing its resources, educational and healthcare institutions, and social services. (Kurian 2016: 20). The East African Division of the Seventh-Day Adventist Church made a strong commitment in ensuring that the rights, dignity, care and support of people living with HIV/AIDS are taken care of. They also committed themselves to upscale their fundraising efforts for the prevention, care, and support efforts in the local Churches and communities. (Kurian 2016: 22-23).

The Catholic Bishops of Myanmar and Catholic Bishops of India sent pastoral letters on HIV/AIDS to their constituencies and called on them to respond as the body of Christ in the manner they ought to respond. At the same time, the Asian Church leadership under Lutheran World Federation and the United Evangelical Mission continued its response through the "Covenant of Life" in Indonesia. In countries such as Germany, Sweden, Norway, the Netherlands, the United Kingdom, and the United States of America, the Churches continued to play their part in combatting HIV/AIDS nationally and internationally. In 2004 the Patriarch of the Romanian Orthodox Church, His Beatitude Teoctist, called on his members to be tolerant and show love to all those who are suffering from HIV/AIDS. In the same year, the United Methodist Church (UMC) started "The United Methodist Global AIDS Fund". Apart from their formation of global partnerships, they also focussed on the interrelatedness between alcohol, drugs, and HIV/AIDS. The establishment of the Special Program on Substance Abuse and Related Violence (SPSARV) later strengthened this response. In 2004 the United Evangelical Mission (UEM) in Manila, approached HIV from a theological perspective, reclaiming the role of the Church as a healing community in its efforts to address human sexuality and human dignity (Kurian 2016: 22).

The response to the HIV/AIDS pandemic also motivated the founding of the Network of Religious Leaders living with and personally affected by HIV and AIDS (ANARELA+)(Kurian 2016: 21). This movement spread through the other regions and in 2006 it evolved into INERELA + (International Network of Religious Leaders – lay and ordained,

women and men – Living with, or personally affected by, HIV). The leadership in both these groups were instrumental in breaking the silence on HIV within the Churches and other faith communities (Kurian 2016:21). The above overview of how the Churches responded to HIV/AIDS clearly demonstrates the fact that the converging voices in affecting global change had been the unique strength of the ecumenical journey on HIV/AIDS. At a summit of High level Religious Leaders in Amsterdam in March 2010, Dr Olav Fykse Tveit, general secretary of the World Council of Churches, addressed the leaders as "fellow travellers on the journey of faith" and stated that "the core attitude of accountability is appropriate when we talk about the past, but we need to consider what shall bring us forward together, to give quality to the formation of cultures and our relationships. If anything, what we are here to discuss and how are we to improve our human relationships – in so many dimensions" (Tveit 2010).

2.4 Ecclesial discourse on HIV/AIDS in South Africa

The global and regional responses directly and indirectly impacted on the South African response and in particular, the role of the South African Council of Churches (SACC).

The mission statement of the SACC is "as National Council of Churches and Institutions, the SACC, acting on behalf of its member Churches, is called by the triune God to work for moral reconstruction in South Africa, focussing on issues of justice, reconciliation, the eradication of poverty and contributing towards empowerment of all who are spiritually, and economically marginalised" (SACC, Mapping Study 2005). The SACC has 27 member Churches and unlike other Church organisations, involves the African Indigenous Churches, Council of African Churches, as well as the Charismatic Churches. The key areas for involvement by the SACC are as follows: Poverty eradication, health, and HIV/AIDS; justice; democracy; land; youth; emergency relief; ministry of uprooted people; peace building; anti-racism, and reconciliation. During the years 1999 to 2004 there was a widespread denial over HIV/AIDS in South Africa. The inability of the Church to respond at first was also common to global, ecumenical, regional, and local level within ACSA. The SACC's response was largely influenced by the actions of civil society, which challenged the South African government in a time of confusion around scientist theories, facts evidence, and the theory of poverty on HIV/AIDS (SACC, Mapping Study 2005:35). Churches failed to become centres of refuge and solace and instead, they became place of exclusion for those out there, suffering the consequences of their sins (SACC, Mapping Study 2005:35).

In all nine provinces, the alarming increase of HIV/AIDS amongst children aged 0-14 years placed a huge emphasis on programmes such as mother to child transmission. Clearly linked to HIV/AIDS was tuberculosis, which fuelled the HIV infection and caused the death of its victim (Mapping Study 200). South Africa presented with an increase in Sexually Transmitted Diseases (STI's) and these challenges were further exasperated by poverty and inequality, culture and gender (power relations), an escalation of violence in society, migrant labour, rise in unemployment, post-independence challenges, and food security due to reduced income. Furthermore, the rise in health cost, and the challenges brought about by low literacy levels and social challenges within the mining sector in South Africa had a major impact on prevention and treatment campaigns. During this period, the HIV/AIDS infection peaked in the groups between 15-24 years. The aforementioned challenges provided a backdrop for the SACC response to the HIV/AIDS pandemic (Mapping Study 2005).

The SACC in partnership with Nelson Mandela foundation, 'Love Life', an extensive media campaign aimed at raising awareness amongst youth, developed resource materials on sex and sexuality for the Churches. The aim of this project was to mobilise Churches to reflect theologically on these issues and enable Churches to communicate effectively to their constituencies. This particular project focussed on clergy, youth leaders, and parents (SACC, Mapping Study 2005:35). In 2003, SACC partnered with Youth for Christ and commissioned material on "fulfilling your sexual dream", which aimed at addressing sexuality amongst teenagers. Furthermore, the SACC established partnerships with various groups and Churches (Anglican Church of Southern Africa, Methodist Church, the Roman Catholic Church and some of the Reformed Churches in addressing the HIV/AIDS with the slogan 'Combatting AIDS'. From the outset the, SACC was of the view that addressing stigma and providing antiretroviral without addressing the core related challenges such as poverty, homelessness, illiteracy and gender inequalities would reflect the inability of the Church to respond to HIV/AIDS effectively. Accordingly, these challenges remain as huge gaps in the ongoing HIV/AIDS debate. Some of the most critical challenges the SACC faced were the initial silence from Churches, the lack of leadership, lack of information sharing and a theology for HIV/AIDS (Mapping Study 2005).

The responses from Churches picked up in momentum as the pandemic dominated the South African Health scene. It needs to be stated amongst the many Churches, the Catholic Church in South Africa played a leading role in conferences and producing literature expressing its

deep reflections on the pastoral front. Pope XVI stated that the Catholic Church is "second to none" in effective action to prevent the further transmission of HIV, mitigate the impact of the present epidemic, and provide a person to person-centred and holistic approach by HIV/AIDS, best understands the response of the Catholic Church in the statement (Czerny 2008, as cited in Munro 2014: 155). It is therefore appropriate that when we reflect on the thirty-year long history of the fight against the HIV/AIDS pandemic that the Catholic Churches' response to this crisis should be included.

Distinguishing characteristics of this Ecclesial response can be found in the Church's witness to truth. Her effective pastoral action includes her competent educational, medical and social services within a holistic approach, promoting integral human development; and the countless acts of solidarity offered and received. Given the above information, the Church should be admired for its pioneering work. On the other hand, the tensions with other social actors and their criticism attempt to undermine or marginalize the Church's efforts. It is important that the Church maintains and even strengthens her commitment "until AIDS is no more" (Czerny 2008, cited in Bate and Munro 2014:115).

Various writings emanated as the outcome of the many conferences, workshops and statements by the leaders Church of the Catholic Church (Munro 2001). This literature focussed on: The Testing of Seminarian Candidates for religious life and created some tension during the time when there was no treatment available (Munro 2004, 2005, 2007); Viljoen (2001) and Parry (2005) concentrated their writings on the response of the Church to AIDS in Southern Africa, the ethical challenges the Church had to face in the HIV/AIDS programme (2007) and work done by the Church with children, orphans and those made vulnerable by AIDS (Dowling (2004; Munro 2006a; 2012b). The effect of changed funding priorities in the global economic crisis also affected the work of programmes of the South African Catholic Bishops Conference AIDS OFFICE (Munro 2012).

The increase of gender violence against women and girls in the context of HIV/AIDS was a further focus (Munro 2013b). Several conferences, for example, the theological conference hosted at St Augustine College and by the Catholic Theological Society reflected on the theological response to AIDS in South Africa and two publications emanated out of this conference titled "Responsibility in a time of AIDS" (Bate 2003; Munro 2003).

During 2006, various other religious groups responded to the AIDS pandemic. The National Religious Forum and the National Religious Association for Social Development (NRASD) based in Stellenbosch played a leading role in mobilising faith communities to become actively involved in their responses (National Directors Meeting 2007).The HIV/AIDS directors of the Methodist, Anglican, Roman Catholic, Lutheran, Moravian, and African Independent Churches, Buddhist and Muslim groups constituted the first coordinated national response to HIV/AIDS in South Africa, Church. This network of different faith formations became known as the Religious Sector HIV/AIDS Task Team (RESSATT) under the leadership of NRASD. This organisation became the core group in representing the Faith Sector at the South African National AIDS Council. It is an important link between SANAC and their own denominations in sharing information, addressing stigma and building capacity amongst themselves in creating an effective pastoral response to the challenges of stigma at congregational level. Together with the other sectors of civil society, this body also provided caring to religious leaders and participated in the drafting of the Nation Strategic Plan for HIV/AIDS in Southern Africa in 2007 (SANAC National Strategic Plan 2007).

In 2009, the NRASD became the first religious sector principle recipient for the Global Fund to fight the challenges of HIV/AIDS. (NRASD Minutes March 2007). Since then, a number of Churches have implemented HIV/AIDS programmes that was resourced by Global Funding and other donor agencies. Another important contribution to the challenges of HIV/AIDS was initiated by the World Council on Religion for Peace. They mobilised interreligious networks through the South African Chapter, to respond and address contemporary challenges such as gender equality, the environment and matters regarding HIV/AIDS (Bate and Munro 2012:221). These interreligious networks (faith based and secular) created platforms for mutual cooperation and inclusive projects and programmes, which were extended beyond denominational traditions. Furthermore, these platforms opened the doors for collaborations on other HIV/AIDS related social driver challenges (poverty, patriarchy, and building the capacity of the local congregation).

In my view, the interreligious partnerships form a critical part of the construction and reconstruction of the pastoral responses formulated. This will be discussed in chapter eight. Responses to the AIDS pandemic were not only confined to congregations at local level, but also to religious communities, who were in many ways the touchstones of hands on pastoral care and counselling.

2.5 Stigma in discourse on HIV/AIDS

One of the direct results of HIV/AIDS related stigma is the denial that the problem exists. One could argue that as long as the problem is denied, stigmatisation will continue. The need to address stigma is became an emerging topic throughout the ecumenical discourses and continues to be a topic of importance. Several scholars, Churches, and faith-based organisations have continued to dominate the AIDS related stigma debate. One of the direct results of HIV/AIDS related stigma is the denial that the problem exists. One could argue that as long as the problem is denied, stigmatisation will continue. The need to address stigma is became an emerging topic throughout the ecumenical discourses and continues to be a topic of importance. Several scholars, Churches, and faith-based organisations have continued to dominate the AIDS related stigma debate.

Theological themes such as stigma and exclusion; disease and healing; human sexuality; gender issues; Church life; and hope and justice continue to dominate the theological discourse on HIV/AIDS (Deacon and Simbayi 2006:125). According to Dube (2003), stigmatization is directly linked with discrimination. Stigmatization not only impacts negatively on prevention efforts, it also creates fear which prevents people form revealing their status. Given the broad spectrum of theological reflection, it must be noted that stigma and exclusion are the principal themes driving the response from the Anglican Church of Southern Africa (ACSA 2002b). In 2006, Harriet Deacon and Leickness Simbayi were commissioned by the Anglican Church to assess the nature and extent of stigma in its structures (Deacon and Simbayi 2006). Stigma remains, and will continue to remain, a critical theological issue throughout the AIDS response (Haddad 2011:175). As early as 2003, UNAIDS concentrated a great deal of its resources on the mitigation of stigma (Haddad 2011:175).

Gillian Paterson, as member of the Ecumenical Advocacy Alliance, together with Michael Burke, have championed the cause of ensuring that the issues around stigma remain on the agenda of most theological discourses (Haddad 2011:175). The issues around stigma have been on the forefront of the theological response to HIV/AIDS and have attracted the interests from scholars, such as Allen (1995), as well as Brown and Hendricks (2004). Issues of "exclusion and inclusion" and "avoidance and love" have also been on the forefront of the Christian response, from as early as 1995 (Paterson and Burke (1995), cited in Haddad 2011:175). Bower (2007) continues to engage with these issues in the context of human dignity and in the face of prejudice. However, the prominence of stigma as an issue, continues to be on the agendas of

International Conferences, including the recent conference in Durban in 2016 (UNAIDS 2016b). The Church could do well to revisit and renew its call for on-going critical reflection of this issue, as it constitutes a critical component in the Churches pastoral response (Byamugisha, Raja and Chitando 2012). The Stigma Index (2012) pilot study of the South African National AIDS Council showed that for people living with AIDS (PLHIV), stigma continues to act as a barrier to access to prevention, treatment, and care services. Recommendations from this particular study motivated for a holistic comprehensive approach to address the above challenges. It also recommended that the Stigma Index be introduced nationally.

A further study conducted by Deacon and Simbayi (2006:127) on stigma in ACSA, suggested that the challenges of stigma needed to be addressed at the highest level of the Church's structures. The theological discourse needed to continue in order for the leadership of the Church to find safe spaces for members to declare their HIV status. HIV positive clergy needed assurance of employment security once their status has been disclosed. The need for a workplace policy was also identified in the study of Deacon et al. (2006). In addition, the debate around stigma needed to be integrated into the structures of the entire Church from Church grassroots level and up. This would be more effective and have greater effect than creating messages on stigma, though well meaning, yet far removed from the people who find it difficult to shake off the weight of self-stigma and quiet discrimination (Deacon et al. 2006:30-38).
Since the Windhoek Report[17], the United Nations Programmes on HIV/AIDS (UNAIDS) (2003), made it clear that courageous conversations around the theology of stigma needed to find centre space in the activities of the Church again. The lack of addressing stigma is considered one of the major reasons for the limited impact after the implementation of the Isiseko Sokomoleza Project in the Diocese of False Bay.

Given the vast scope of relevant literature, this research study is anchored within the framework of pastoral care. Richardson (2006:38-50) states that the distinctive actions of the Church, through worship and Eucharist, culminate in it being the Eucharistic Community in the world and its mission is to care. Of particular interest to this current research project is the historical development of pastoral counselling. For example, Pillay (2003:110) identifies these broad

[17] The purpose of the document is to provide a framework for theological thinking, and an opportunity, for church leaders, to pursue a deeper Christian reflection on the AIDS crisis (Windhoek Report 2003:20).

socio-ethical challenges associated with the pandemic, which serves as the entry point for effective pastoral responses to the HIV/AIDS pandemic. Further examples of the Church's response to the pandemic includes Biblical Studies (Nadar 2006; Phiri 1997; Dube 2003); Ethics (Ackermann 2007); Church doctrine (Gunston 1991); Practical theology (Miller-McLemore 2012); and Pastoral Care (Osmer 2008). The pandemic, however, presented the Church with an even greater challenge, which Pillay (2003) describes as theological and ethical "entry points".

I am of the opinion, and supported by the above discussion, that these entry points should remain part of the Church's discourse locally and ecumenically. If the Church is to provide a friendly, acceptable environment, it needs to create opportunities for people to experience the 'fullness of life' and encourage them to make responsible, life-sustaining decisions, develop their skills, and feel a sense of belonging (identity). The Church is a place where collective accountability is fostered and where the spirit of community is embraced (Pillay 2003:112). The influence of ecumenical leadership and commitment towards HIV/AIDS resulted in the mobilisation of public opinion and in turn brought about the lobbying of political leaders to make greater allocations of resources for fighting AIDS (Kurian 2016:22). Donors and funders such as the President's Emergency Fund (PEPFAR) and Global Fund were part of the major donor funding agencies. The connectedness, inclusivity, and joint responsiveness to affect global change, could be ascribed to the unique strength of the ecumenical movement. The ecumenical has provided effective inter-Church collaboration and partnerships for courageous dialogue and joint action to bring about change in the Church's response to AIDS. It could be said that the ecumenical Church amplified its prophetic voice and by setting high standards publicly, called into action various Christian denominations.

2.6 Conclusion on the state of the debate

The broad scope of literature clearly highlights the complexities around AIDS-related stigma and other related challenges such as blame, shame, fear, gender, poverty, and sexual orientations. The literature emphasise the multidimensional nature of the pandemic, which in many ways continues to dominate the discourse on HIV/AIDS. The literature details the progression of the ecumenical church from silence, non-commitment, and no pastoral responses, to a ministry by understanding communities through cooperation in the area of HIV/AIDS. As referenced earlier, we are still far from an HIV/AIDS-free South Africa. Stigma and related issues continue to be the focus alongside the increase in the prevalence of

tuberculosis (HIV/AIDS Strategic Plan for South Africa, 2016-2021). The challenges posed by stigma reduction, historically and currently, continues to threaten the responses from the ecumenical Church. The scholarly work and literature also clearly show that stigma and disclosure continues to dominate the pastoral and theological agenda. This study, as it seeks to respond to a specific societal challenge, is important and relevant, not only to the Church's ecumenical ministries, but also to contribute towards increasing the knowledge base on stigma reduction at an ecumenical level. The response to HIV/AIDS related stigma, and in particular how ACSA (Diocese of False Bay), responded through the Isiseko Sokomoleza HI/AIDS programme will be discussed in the following chapter.

CHAPTER THREE
THE ISISEKO SOKOMELEZA PROGRAMME IN THE DIOCESE OF FALSE BAY

3.1. Introduction

This chapter will give a descriptive overview of the Anglican Communion, the Anglican Church of Southern Africa (ACSA), and in particular, how the Diocese of False Bay through its structures and programmes responded to the reduction of HIV stigma. The Isiseko Sokomoleza Programme will be introduced through the following pillars such as: Stigma reduction, orphaned and vulnerable children, care and support programmes and Youth interventions which will be covered in this chapter. An overview of the various programmes will be given and some observations regarding these programmes.

3.2. Anglican Communion

The various Anglican Provinces (member Churches) around over 165 countries around the world, including the ACSA, are members of the broader international association or federation independent Churches called the Anglican Communion. Heading this Association or Federation is the Archbishop of Canterbury, also known as The Primate of All England. The Primate does not have authority over any of the member Churches, also referred to as provinces outside England, but acts as 'a focus of unity' (Anglican Church of Southern Africa Constitution and Canons, 2011: 5-6).

The Governance structure of the Anglican Communion is determined according to the Provincial Canons and the Constitution of the Anglican Church, which states that the 'instruments of unity' hold the Anglican Communion together. This term refers to the Archbishop of Canterbury, the Anglican Consultative Council and the Lambeth Quadrilateral, which comprises the sacraments of Holy Communion and Baptism, the Scriptures, the Creeds, and the Episcopacy (Deacon and Simbayi 2006:5). The Anglican Communion lacks a single source of doctrinal authority, as the Catholic Church has in the Pope, because ACSA has no body charged with maintaining sacred doctrine (Ndungane 2003:17).

The following Statement was issued by the Primates of the Anglican Communion in Canterbury on 16 April 2002: "We raise our voices to call for an end to silence about this disease – the silence of stigma, the silence of denial, the silence of fear. We confess that the Church herself has been complicit in this silence. When we have raised our voices in the past, it has too often been a voice of condemnation. We now wish to make it clear that HIV/AIDS is not a punishment from God. Our Christian faith compels us to accept that all persons, including those, who are living with HIV/AIDS, are made in the image of God and are children of God" (ACSA 2006b).

3.3. Anglican Church of Southern Africa (ACSA)

At the time of the study the Anglican Church of Southern Africa (ACSA) currently consists of twenty-eight dioceses (each headed by its own Bishop, across six countries viz. Angola; Lesotho; Mozambique; Namibia; Swaziland; and South Africa), hosting twenty-one of the total number of dioceses. Furthermore, ACSA also have as a British dependency, St. Helena and Ascension Island and Tristan da Cunha under its care and oversight. (Cole 2016:2-5)

ACSA operates on a hierarchal structure headed by the Primate of Southern Africa, currently the Most Reverent Thabo Makgoba. The Headquarters of ACSA is situated at number 20 Bishopscourt Drive, Bishops Court Cape Town, which also serves as the residence to the Archbishop's family. The Archbishop of Cape Town is also the Metropolitan and is seated at the St. Georges Cathedral (Anglican Church of Southern Africa Articles of Constitution, Canon 2, 2011).

The above countries are also referred to as "Provinces", are governed internally by a Provincial Synod that convenes every three years and is comprised of the Archbishop as president, all diocesan Bishops and elected clerical- and lay- representation from each and every diocese within the boundaries of a particular province. The Provincial Standing Committee meets during the two interim years to address matters arising.[18] Dioceses cover varying areas, some covering entire countries, (e.g. the Dioceses of Namibia and Angola) and others covering part of a metropolitan area (e.g. the Diocese of Christ the King and Johannesburg.) In this entire diocese, there are over a thousand parishes of varying sizes, each with one or more priests and lay ministers. Some parishes are grouped into archdeaconries. Some parishes are based in areas

[18] Information from Anglican AIDS office.

with complex and high technological advances, while others are situated in areas lacking running water, electricity, telephones, computers, or passable roads.[19]

3.4. ACSA's Response to AIDS

ACSA response to HIV/AIDS needs to be located against the backdrop of an escalating global HIV/AIDS pandemic, with its epicentre in sub-Saharan Africa. During the lifespan of the Isiseko Sokomoleza Programme, the full impact of the pandemic became more visible and challenging. However, simultaneously, there were also new signs of hope and responses from the public, private, and faith sector, and eventually, the emergence of access to anti-retroviral treatment. ACSA's response was also characterised by contextual issues, such as the relationship between HIV/AIDS and poverty, gender, children, stigma, and discrimination (ACSA 2003). At that stage, it was already clear that the current and projected socio-economic impacts of the epidemic greatly influenced the responses to the pandemic. The social impact has been well researched by theologians like Pillay (2003:16), who asserted that HIV/AIDS was not caused by poverty, but due to poverty being one of the key drivers of the AIDS pandemic, the poor and destitute are more prone to contracting HIV. Often the lack of financial resources, lack of nutrition, and inaccessibility to anti-retroviral therapy and proper healthcare could aggravate the plight of infected members. In this 'post-AIDS era', poverty continues to be a key component in the implementation of credible, sustainable, and pastoral programmes to produce greater impact.

"The roots of the Isiseko Sokomoleza Programme dates back to the year 2000, when Archbishop Ndungane met with other faith leaders after the XIII International Conference in Durban".[20] This initiative took on momentum in 2001, when the Archbishop of Canterbury tasked Ndungane with the development of a Communion-wide understanding regarding the scope of the AIDS pandemic in Africa (Cole 2006). The primary reason for this meeting was to request financial support from the USA Agency for International Development (USAID) to develop the capacity of the ACSA to respond, more effectively, to the HIV/AIDS pandemic in the Province of Southern Africa.

[19] Information from www.anglicanaids.org- the website of the Anglican AIDS Office.

[20] Key informant Marlene Whitehead, Financial manager of the Anglican Aids Office, Braehead Rd, Kenilworth, Cape Town, 1st September 2016.

The Conference in Boksburg, August 2001, marked the official public commitment of the Anglican Church to address the challenges of HIV/AIDS. Representatives attended this watershed conference from 12 Anglican Provinces and more than 33 African nations. A number of Archbishops from Africa, as well as donors, volunteers from the ACSA, and observers from non-governmental organisations also attended this historic event, where a framework was endorsed, which served as a guideline for an HIV/AIDS-strategic planning processes across Southern Africa consisting of six focal areas of concern, and three main at-risk/vulnerable, groups, namely women, orphans, and people living with HIV/AIDS (Cole 2006:29). The outcome of the conference led to the publication of a manual, "Planning Our Response to AIDS", as well as the drafting of the first Provincial Plan (ACSA 2002a). In addition, ACSA received a once-off support grant from the Episcopal Relief and Development (ECUSA); St John's Episcopal Church, Lafayette Square in Washington D.C.; and UNAIDS, the USA Agency for International Development.

At the Synod of October 2001, the Bishops in Southern Africa agreed on six strategic objectives for the implementation plan of the Province, as well as the establishment of the Provincial Aids Office and community ministries (Cole 2006). The six components of the strategic plan – prevention, pastoral care, care and support, death and dying, and leadership – became the baseline framework for the Isiseko Sokomoleza Programme (Cole 2006).

The ACSA response was further invigorated with the appointment of Rev. Ted Karpf as the Provincial commissioner for HIV/AIDS.[21] In 2002, Archbishop Ndungane formally applied to Christian Aid, as well as the Department for International Development in the United Kingdom (DFID) for resources to support a three-year programme (Cole 2006). The six components of the strategic plan, agreed upon by the Boksburg Anglican Conference and the Synod of Bishops in Southern Africa, informed the proposal that was jointly drafted by Christian Aid and Canon Karpf (Director of the ACSA HIV/AIDS programme), and submitted to DFID in February 2003 (ACSA 2003). The proposal requested financial assistance for the implementation of the Isiseko Sokomoleza HIV/AIDS Programme (Cole 2006).

During October 2002, the Provincial Standing Committee (PSC) and the Synod of Bishops in Southern Africa considered adopting the Strategic Plan. According to the planning report, the meeting reached consensus on the six priority areas (ACSA 2002). The implementation of the

[21] Anglican Strategic Visionary process at Boksburg SA (Our Vision, our Hope).

proposed plan required a formal structure for the coordination. The Provincial Standing Committee endorsed the formal establishment of a Provincial Office of HIV/AIDS Community Ministries and Mission (OHCMM), located within the Office of the Anglican Archbishop of Cape Town (Cole 2006). Through various synodical resolutions, conferences and workshops, the HIV/AIDS office within ACSA began raising awareness and mobilizing congregations, however, serious coordination and management at provincial, diocesan, and parish level was required.

Within a month of the establishment of the OHCMM, an extensive strategic planning process was embarked upon, in which each diocese took part in workshops to examine their specific contexts, using the six focus areas/concerns to shape their own, unique response to the challenges posed by HIV/AIDS. The OHCMM team to ensure that the ACSA response reflected emerging global patterns added two additional focal areas (orphaned/vulnerable children, and work place policy). It was clear from the documentation of the planning process that its main architects wanted to develop a Provincial plan that could address Provincial-wide concerns, leaving each diocese the freedom to determine its own agenda (ACSA 2003-2006). Simultaneously, strategic partnerships and networking with other role players in faith-based organizations, government, academic, as well as non-governmental organizations were formed in the field of HIV/AIDS. The consultations with government led to a greater participation from the faith based sector in the development of the National Plan.

Nationally and internationally Church leaders continued advocating for the rights of people living with HIV/AIDS (PLHA's) on many platforms of civil society (ACSA 2003).[22] Significant inroads were also made with respect to the formulation of the ACSA policy on HIV/AIDS. For example, a meeting of the ACSA Provincial Standing Committee (PSC), in September 2003 in Johannesburg, passed a number of resolutions generated by the OHCMM (Cole 2006:36). During the course of this influential gathering, the many references to the

[22]A resolution on sex education for children and youth was passed, as well as one on workplace policy (Pastoral Standards on HIV/AIDS). A resolution relating to accessing social grants was also passed to the effect that every parish should become a resource for the community on matters relating to social grants. This was a significant intervention, as many adults, elderly people, and children, particularly in poor urban and rural communities, do not have the necessary documentation to access grants, such as pensions and child support. Relevant materials were collected from Government Departments, as well as from NGO's like Soul City and Black Sash.

HIV/AIDS epidemic in Southern Africa and its impact on both Church and society showed the growing evidence of the centrality of this issue in the life of the ACSA.

This led to the development of a workplace policy document, entitled 'Pastoral Standards on HIV/AIDS'. These pastoral standards served as guidelines for ministry at parochial level and the continuation of a provincial-wide training of Master Trainers in Wellness Management, leading to capacity building programmes for women's organizations, which were critical for the sustainability of the new initiatives (ACSA 2003). These alliances could implement the programme, through their well-organized structures, throughout the respective dioceses. Another important initiative was the development of a strong theological framework for the Implementation of all HIV/AIDS programmes in ACSA for the HIV/AIDS ministry;[23] however, there was not enough capacity at the Provincial Office for proper implementation.

In 2003, resources were obtained from DFID UK, leading to the launch of a formal response by ACSA, the Isiseko Sokomoleza Programme *(Building the Foundation)*. The official launch took place in April at the Cathedral Church in the Diocese of Johannesburg. A process of orientation to familiarise the various dioceses with the strategic plan and financial reporting followed the launch. A considerable amount of time was also spent on the establishment of infrastructure and systems, both in the Office of Community Ministries, later renamed the Anglican AIDS and Healthcare Trust (AAHT) (ACSA 2003). This was done through a newly established Anglican Aids Office, which later became the Anglican Aids and Healthcare Trust [AAHT] (Cole 2006). ACSA's response to HIV/AIDS was situated within the context of Southern Africa, the epicentre of the HIV/AIDS pandemic (Deacon and Leickness 2006). The pandemic is exacerbated by the multiple factors of poverty, stigma, gender inequality, and violence against women and children (ACSA 2003). Therefore, a futuristic sustainable pastoral care response requires an integrated approach of children, men and women, as well as leaders at all levels within the parish structures (Cole 2006).

At a United Nations (UN) meeting in 2014, the actress Emma Watson introduced the 'He for Her' project. Through her words, she opened the door to a new way of thinking about gender inequality, which affects both men and women in society. In her speech, she quoted statesman

[23] See the Narrative financial report to DFID in 2004. These meetings took on the form of workshops, attended by recognized theologians in the broader church, who began the important task of developing theological resources on HIV/AIDS, as well as identifying and collating already existing resources.

Edmund Burke, who said: "All that is needed for evil to triumph, is for good men and women to do nothing." She continued: "We must try to mobilize as many men and boys as possible to be advocates for change. We do not just want to talk about it. Both men and women should feel free to be sensitive. Both men and women should feel free to be strong. It is time that we see gender as a spectrum, instead of two sets of opposing ideals" (Watson 2014). This is especially the case, if one considers the United Nations General Assembly (UNGASS) statements of June 2006, which refer to stigma, prevention, gender, orphans and vulnerable children, treatment, and more sensitivity toward those who act as carers for the infected and affected (Cole 2006:25). Since the early 1990's, the United Nations, largely through its Development Programme (UNDP), has been one of the world's most outspoken advocates for the multi-sector response to HIV/AIDS (Cole 2006:10). Recognising the socio-economic challenges the epidemic posed for developing countries, it has actively promoted linkages between HIV/AIDS and development policy and practice. By the year 2000, at the time of the thirteenth (13^{th}) International AIDS Conference in Durban, the UNDP had already made HIV/AIDS one of its highest priorities, integrating it into the broader efforts to support poverty reduction policies, or strategies (Cole 2006:10).

The Provincial Strategic Plan for the Isiseko Sokomoleza HIV/AIDS Programme had six strategic goals, namely:

- HIV-specific pastoral care education for clergy and lay leadership;
- The coordination of HIV/AIDS programming and development in each diocese;
- The development of AIDS-specific leadership in each diocese and congregation;
- The expansion/development of community/parish-based responses to support and care for orphans and vulnerable children;
- The study and on-going discussion on issues and policies/guidelines on care and support for orphaned and vulnerable children in the Church;
- The development of appropriate and effective workplace programmes to ensure the rights of people (clergy or laity) living with AIDS and the development of age-appropriate, culturally sensitive materials for sexual education (ACSA 2002).

The process leading up to the creation of the vision statement and translation into a strategy of sustainable activities, was a first for any faith-based response in South Africa. A need was identified for proper structures in terms of systems and staffing.

"From the outset, it was critical for ACSA to obtain the cooperation and support of all the dioceses in the Province of Southern Africa. ACSA was assisted by Christian Aid to access a generous grant from the Department for International Development (DFID) in the United Kingdom to support a programme aimed at building the capacity of ACSA, in order to respond to the growing pandemic in Southern Africa (ACSA 2003:20).

The 2004 Review (ACSA 2004c) also led to the establishment of governance structures for the Anglican HIV/AIDS office. The initial membership of the Management Committee (MANCOM) consisted of the Provincial treasurer, the Director and the chairperson, Bishop David Beetge, who was appointed by the Archbishop and Synod of Bishops as the Provincial Liaison Bishop for HIV/AIDS. He was tasked with providing Episcopal oversight over ACSA's HIV and AIDS programmes. Another important change was renaming the former OHCMM, to the ACSA HIV and AIDS Office".[24] The first task of the new structure was to implement the new plan (ACSA 2004c). In order to ensure the effective implementation of the streamlined strategic plan, the following strategic objective spearheaded the way forward in all the dioceses: Strengthen the capacity of ACSA to advocate for and provide an effective and expanded community-based response to HIV and AIDS, in partnership with other multi-sectorial role players. The goal of this strategic objective was to build the capacity of ACSA at provincial, diocesan and parish levels.[25] The Wellness Management Project (WMP) was a specific intervention with respect to care designed between Rev. Ted Karpf and Rev. Jean Underwood, as a kick-start project, even before the office was up and running and systems in place.

Building this layer of leadership to champion and implement various aspects of the programme, such as prevention, care, and counselling, has been a critical part of a broader Isiseko capacity-building strategy. The WMP consisted of training Master Trainers, 356 of whom were trained (81% of the original target of 400), but, with the exit of the Policy Project, there was inadequate support for follow up at parish level. The WMP experience demonstrated the importance of mentoring support for new initiatives introduced into dioceses through the Provincial HIV and AIDS Office. Isiseko was unable to track the success or, impact arising out of these

[24] Key informant, Marlene Whitehead, former financial officer in ACSA: 15th June 2013- Kenilworth, Cape Town.

[25] See minutes (April 25th 2004), reflecting on the need for capacity building at the Provincial Office, forming partnerships with other organizations to advocate for the reduction of stigma, discrimination, access to treatment, and increased resources for HIV and AIDS prevention and care.

interventions beyond the initial phase of the Wellness Management Project (WMP), which ended in 2003. Despite the fact that the WMP achieved uneven success, it was a significant intervention, which seemed to have built a level of capacity within Diocesan structures (MU and AWF).

The withdrawal of Rev. Ted Karpf (Director of the HIV/AIDS programme)[26] and the inadequate handover to the new staff placed additional challenges to the implementation of the programme. There was broad consensus among the Provincial Office staff that the loss of strategic and programme management negatively affected the capacity of the office. From the very beginning, the Provincial Office staff realized that the programme was essentially about 'building the foundation', and that the need for more staff was critical.[27] The Policy Project was a USAID funded, Cape Town-based agency, contracted by the Rev. Ted Karpf for the two-year lead-up to the creation of the Church of the Province of Southern Africa (CPSA) Strategic Plan. The Policy Project was responsible for training, facilitation and coordination. However, they were unable to fulfil this role because of changes in their management structure (Cole 2006:33)

Christian Aid and ACSA jointly organized the August 2004 review. The purposes of this review was to assess the experiences of the first implementation year in preparation for future strategic planning, as well as address structural and systemic challenges at office level regarding the implementation of the programme, and to seek solutions in order to address these challenges accordingly (ACSA 2004a).

"The August 2004 Programme Review was a key milestone in the evolution of the Isiseko Sokomoleza Programme, resulting in significant modifications to the original programme design. The reality was that the vision of the leadership in the Provincial Office was far removed from the vision of the local dioceses, and therefore, a need for the diocesan and provincial strategies to become more aligned with the overall strategies of the programme.

[26] Rev. Ted Karpf played an integral role in the design and oversight of the plan. He withdrew because it became evident that there was insufficient broad based consultation with dioceses in general, failure to acknowledge diocesan plans and activities that already existed, and failure to garner the support and buy-in from the leadership (Bishops and diocesan administrators), which greatly affected the on-going development of the plan.

[27] These additional appointments enabled the Provincial Office to provide more frequent and personal support to dioceses and task teams. These additional appointments also meant that by August 2003, there was a stronger team in place to move beyond the implementation phase. During the inception phase, an urgent need was identified by ACSA staff to review the original grant proposal, which resulted in a revised work plan and updated budget (November 2003).

Additionally, it required a strategy to mobilize all the Bishops to support the implementation of the programme. Simultaneously, the need to assess parallel programmes also became evident".[28] The contextual diversity across dioceses posed a huge challenge to the implementation of the programme.[29]

In order to implement the Isiseko Sokomoleza HIV/AIDS Programme, the capacity of the Provincial HIV/AIDS Office had to be developed. The responsibilities of the office were to manage, administer, and coordinate the Isiseko Sokomoleza programme and encourage greater involvement of people living with HIV/AIDS. The outcomes of the first review need to be understood as part of an integrative and learning experience for planners, implementers, and managers of the programme and its associated activities. Few (if any) organizations in South Africa, let alone a complex structure like ACSA, were fully prepared at the time Isiseko Sokomoleza began to meet the range of challenges posed by the HIV and AIDS pandemic. Phase one of the implementation strategy lacked an appropriate institutional, human, and programmatic response to a dynamic and largely unknown disease that touched human issues, such as living and dying.

During the period of 2004 to 2006, additional staff and a number of consultants were hired to support emerging functions. These functions were: undertaking a baseline survey of diocesan and parish projects and activities; strengthening the Provincial Office's communications capacity; developing resource materials; evaluating programme initiatives; and improving diocesan mobilization strategies, as well as capacity to design and implement projects at diocesan and parish levels.[30] *Forming strategic partnerships is strengthening the implementation of the Isiseko Sokomoleza Programme:* The development of strategic partnerships with organizations, such as the Christian AIDS Bureau of South Africa (CABSA), who designed the Churches Channels of Hope (CCOH) mobilization model, and the Barnabas Trust, in the Eastern Cape, were all part of building knowledge and programme management support that was needed by the dioceses, to engage in, and manage, the programme (ACSA

[28] Key informant, Lundi Joko, who was employed as a lead trainer in the Isiseko Sokomoleza Programme at ACSA, 17th September 2016: Khayelitsha, Cape Town.

[29] In year one, the Provincial AIDS Office made a monthly grant available to cover the start-up costs for the Diocesan HIV and AIDS coordinators and related costs. The dioceses had difficulty in managing the original grants that they received from the central office. It was decided, therefore, to do away with the original conditions and make the R12 500 monthly grant available to the dioceses with fewer restrictions (ACSA 2004).

[30] See Minutes of MANCOM meeting April 2004.

2004c). “At the same time, partnerships with organizations like the Christian AIDS Bureau of South Africa (CABSA) resulted in innovative new models of intervention. Dioceses were keen to educate and mobilize their clergy and laity, which led to the development of new HIV/AIDS initiatives at diocesan level.

The first comprehensive attempt at a baseline study to capture the wide range of activities was undertaken, across the dioceses, between 2004 and early 2005, gathering information from 775 parishes (out of 980) of ACSA”.[31] “According to the review (ACSA 2004c), maintaining consistent capacity at the level of senior management at the HIV/AIDS Office had been a challenge. This resulted in the inability to provide the kind of consistent and high quality strategic management support needed to direct and organize a highly complex and multi-layered HIV/AIDS programme in ACSA. During 2005, ACSA entered into a partnership with Fresh Ministries, an ecumenical organisation based in Jacksonville, Florida, USA, and the Episcopal Diocese of Washington, USA, to implement an ABY (Abstinence, Be Faithful for Youth) programme, entitled Siyafundisa. This programme was funded by a substantial five-year grant from the Government of the United States, channelled through USAID, as part of the President’s Emergency Plan for AIDS Relief (PEPFAR)”.[32] ACSA provided a level of consistent and targeted support for procuring and coordinating a number of centrally managed interventions, such as Churches Channels of Hope, Capacity Building workshops, and the development of resource tools[33] (ACSA 2009a).

Another key objective set for the ACSA HIV and AIDS Office was to encourage the greater involvement of people living with HIV and AIDS in activities of the programme. “In June 2005, Christians living with HIV and AIDS were invited to a special retreat as part of the care and support programme for members. The retreat was held at a Christian retreat Centre in Mpumalanga. The Rev. Dr Bill Doubleday of New York and the Rev. Japé Heath, African Coordinator, led it for the African Network of Religious Leaders Living with or Personally Affected by HIV and AIDS (Anerela). The programme for the retreat offered a combination of

[31] Key informant, Wendy Lewin (ex-staff member of ACSA), Kenilworth, Cape Town, June 2005.

[32] During the last quarter of 2005, the ACSA HIV and AIDS Office appointed a programme manager, an OVC programme manager and a financial officer and carried the financial cost.

[33] Additional capacity was brought in to do a baseline study on parishes, to develop a website to improve communication and sharing of information between ACSA and the dioceses, and to develop a programme management toolkit.

worship and healing services, short meditations on the themes of 'compassion', 'justice', 'reconciliation' and 'hope', opportunities for the participants to share their stories with one another, inputs on 'stigma and discrimination' and 'positive living' and, time for socializing, relaxation, and sleep. One of the lessons from this 'pilot' retreat for Christians living with HIV and AIDS was that it needed to be slightly longer. Two hundred and fifty (250) applications were received for 52 reserved places. The event was attended by 32 women and 20 men, drawn from several different denominations, with over seventy-five per cent (75%) being Anglicans, representing 18 dioceses, including the Anglican Students Federation. The participants, of whom only one was a priest, came from four countries, namely Lesotho, Mozambique, Swaziland, and South Africa. The participants represented the following denominations: Catholic, Presbyterian, Evangelical Christian Fellowship, Seventh Day Adventist, Congregational, Free Evangelical, and African Traditional Churches (ACSA 2005). At the diocesan level, there were an impressive and growing number of activities supporting people living with AIDS (PLWA's). All dioceses visited as part of this review had support groups, most of which were also involved in income generating activities. Monthly grants were allocated to dioceses to support their HIV/AIDS programs."[34]

In 2006 greater emphasis was placed globally on the troll of Civil Society. (UNIADS REPORT 2006). At the coordinators conference of ACSA that same year, the need for multi-sectorial cooperation was identified. During the lifespan of Isiseko, an impressive number of linkages and partnerships had been brokered at both provincial and diocesan levels. At a central level, these range from the Policy Project at the planning phase of the programme, to current ones like, CABSA, with whom the ACSA HIV and AIDS Office had worked in partnership with regarding the CCOH, and establishment of the Christian AIDS Bureau Resource and Information service (CARIS) at Fontainebleau Community Church, in Gauteng.

The following partnerships were formed to strengthen the response of ACSA: +Anerela; Barnabas Trust; CABSA; EDUCO Africa; Heartbeat; Lifeline; the HSRC; the National Association of Child Care Workers (NACCW); Soul City; the University of Pretoria Centre for the Study on AIDS; and numerous Church-related bodies and institutions. The Cape Town Diocese, for example, worked closely with Positive Muslims, while the Grahamstown Diocese worked with the Hindu Community. The list of partnerships built at diocesan level was equally

[34] Key informant Marlene Whitehead May 17th 2013, Kenilworth Cape Town.

impressive, especially with respect to government linkages at both provincial and local government levels (ACSA 2005).

As the programme was implemented, there was a growing need amongst many organizations to address issues of advocacy. Most, like ACSA, had been caught up in meeting the more practical demands of the pandemic, with less time spent on responding to broader policy and advocacy issues. One of the dioceses that had been actively involved in caring for children affected or infected by the pandemic was the False Bay Diocese. Through its Fikelela AIDS Project it has established two children's centres, as well as an outreach clinic for HIV positive children "to support them until they begin receiving anti-retroviral treatment".[35] Another model of care was the Over Strand care Centre that catered for inpatients, home-based patients, and even out patients.[36]

Care and Support: A review of diocesan activities and expenditure for Isiseko indicated a growing level of interest and activity in this important aspect of ACSA's response to the pandemic. As stated earlier, in the HIV and AIDS ministry, ACSA started their response with high profile interventions at international and national levels, especially with respect to voluntary testing for clergy and access to treatment. Despite the prominent role of the leadership through sermons, media statements, and/or international addresses, the review found no evidence of a clearly defined advocacy strategy with respect to the media or government (ACSA 2006a). In this instance, the Anglican Church is being referred to as an institution taking on a visible role to advocate for certain types of issues, such as access to social grants.
Encouraging "responsible" behaviour: As the HIV virus is largely, although not entirely, transmitted through human sexuality, HIV and AIDS has challenged the Church to move out of its comfort zone when it comes to talking about sexuality; something that has led to numerous and often controversial debates on the role and function of the Church. The linkages between the issue of human sexuality in the Church and stigma continue to dominate even the current discourses on HIV/AIDS (Moses-Burton, cited in Patterson and Long 2016:23).

[35] The Fikelela Children's Home in Khayelitsha and Heaven's Nest in Strandfontein.

[36] The Care Centre served the whole Overberg, a very extensive area from south-east Peninsula to Cape Aughulas. Other hospice services were started in the area to meet the needs of the community.

Given that HIV is transmitted largely through sexual contact, the disease introduces the realities of human sexual behaviour into the public domain. The inter-relation of HIV infection, with assumptions of promiscuity and immorality, poses a threat to the moral authority and respectability of churches. Religious institutions may therefore be seen as provoking denunciations, rejections, and dismissals of those deemed to have committed such "moral transgressions" (Chitando 2016:65). Committing these perceived moral transgressions were seen as a failure on the part of that particular faith tradition, and expulsion was therefore considered an appropriate sanction. Prevention-related strategies promoted during the lifespan of Isiseko have largely been based on ABC (Abstain, Behave and Condoms), promoted though various workshops at diocesan and provincial level.

Through the Siyafundisa Programme, which developed out of the Isiseko Sokomoleza Programme, more attention was given to the promotion of abstinence, something which, in turn, has generated a lively and as yet unresolved debate within the structures of the Anglican Church and the ACSA HIV and AIDS Office (SYAKHA Report 2009) Despite differences in strategy and approach between the two programmes, there was consensus that young people needed to be targeted more systematically and strategically. Many dioceses had begun to pay special attention to the issue of youth and sexuality in an attempt to prevent as many young people as possible from contracting the virus from an informed position regarding the risks of having unprotected and safer sex. There was already a strong emphasis on youth and adolescence. Over time, Isiseko has supported a number of important interventions and innovations to build and apply knowledge, especially regarding sex education. It has also provided support for a number of initiatives undertaken by Fikelela (Cape Town Dioceses), including the Africa Survivor Programme, a pilot "Agents of Change" peer education pilot, and a seminal study on youth and sexuality in the Anglican Church. Another initiative, designed by the ACSA HIV and AIDS staff in 2005, is "Time to Talk", an innovative approach to peer education, involving parents at parish level (Christian Aid Report 2005). This was eventually "put on hold" because it was deemed more difficult to implement as originally designed and costlier than anticipated. The research which was done amongst the youth (Agents of Change), raised awareness amongst many clergy and congregants who became keen on getting more involved in youth, sexuality, and prevention work.[37]

[37] This research study undertaken by the Fikelela AIDS Project in 2005 looked at Youth and Sexuality amongst Anglican youth between the ages of 12-19 in the Diocese of Cape Town.

The (Agents of Change) pilot programme was unique in that it aimed to establish whether Church-going youth adhere to the principle of 'no sex before marriage,' or whether they succumb to 'other competing voices and pressures'. Other research questions were whether or not these youth were practicing risky sexual behaviour, namely with multiple partners, without protection, and whether levels of sexual violence was a factor? The survey was undertaken to ascertain the seriousness of challenges faced and, on the strength of the results, devised ways for the Anglican Church to become more effective in dealing with issues of young people and sexuality. Rev. Rachel Mash and Roselyn Kareithi (2005) conducted a research study between October 2004 and January 2005. The research involved a detailed questionnaire and focus group discussions. Their research findings indicated that Church-going young people were not excluded from general risks faced by others. The research also revealed a gap between the traditional teachings of the Church of 'no sex before marriage' and the realities of the way in which young people behave. In addition, the Church had to take a stand against sexual messages seen in the media, as silence implies consent. The Church had to communicate its stance to society at large, in a distinct manner.

"Increased intensity, improved quality and extended geographical coverage of parish- and diocesan HIV/AIDS-related services, particularly to the poor: During the latter months of 2005, good progress was made with the preparations for an ACSA-based equivalent to the Fontainebleau Resource Centre, to be located in Braehead House, Cape Town, planned for opening in March 2006. In the process of cataloguing the books, leaflets, videos, and other materials accumulated over the past two-and-a-half years for the Braehead Resource Centre, the ACSA HIV and AIDS Office had been adding items to the central web-based CARIS Database, as well as assisting with the refinement of the categories being used by CARIS".[38]

Many other programmes were also introduced (ACSA 2009a), but the focus of this research is on the Isiseko Sokomoleza Programme.

The Anglican Aids and Healthcare Trust (AAHT) management structure: The Archbishop of Cape Town was the Patron of the Anglican HIV/AIDS Programmes. The Liaison Bishop represents ACSA at provincial level. He chaired the Management Committee and provided Episcopal oversight, as well as policy and governance oversight. In 2005, a board of Trustees

[38] Key informant Wendy Lewin: May 2012, Kenilworth CT.

was appointed to constitute a new governance structure for the AAHT. The administrative staff members of the AIDS Office are responsible for all operational matters and ensure that all contractual agreements are met by the donor agency (ACSA 2006b:25).

The role of the Fikelela AIDS Office: The Fikelela AIDS Office was responsible for the implementation of HIV/AIDS programmes and was based in the Diocese of Cape Town at Zonnebloem Training centre. The word Fikelela means to "reach out" (ACSA 2009a). Fikelela's vision and mission was to mobilise the Anglican Community to make a sustained positive contribution to the reduction of new HIV infections, while driving HIV and AIDS education and care, in partnership with others. One of the outreach programmes introduced by Fikelela was 'This Church is HIV/AIDS friendly' (Appendix 1). The Isiseko Programme was initially introduced in the False Bay Diocese through the structures of Fikelela in 2003.

3.5. Diocese of False Bay

The following overview of the framework outlines the structure of the Diocese False Bay.

The Diocese of False Bay was inaugurated on the first Sunday in Advent 2005 (Diocesan Profile 2012:5). In 2007, the first session of the Diocesan Synod created the following vision: "God is our mission". The Constitution of Synod is the main decision-making body of the Diocese and shall be summoned and presided upon by the Bishop, who is elected in accordance with the provisions of Canon 4 every three years. The Bishop is assisted on clergy deployment and pastoral care by an Advisory chapter. The Diocesan Trusts Board is appointed by Synod to exercise the powers designated by the Constitution and the Diocesan Finance Board (DFB) provides oversight of finances. The Social Development Department (DFSDD) is a Non-Profit Organisation (NPO) with the objectives to support, strengthen, and facilitate initiatives in respect of development, transformation, empowerment, and upliftment within the parishes and communities of the Diocese. The Department of Training for Ministries co-ordinates and enables the formation and training of clergy and lay people for mission and ministry (Diocese of False Bay, profile 2012).

A call was made to Churches to recommit to raising awareness, breaking the stigma and silence, promoting abstinence and faithfulness, as well as protection in order to raise a generation free from HIV/AIDS (Diocese of False Bay 2012). At the first Diocesan Standing

Committee in 2007, the first Diocesan HIV/AIDS Coordinator was appointed.[39] The funds for the sustainability of this position were in the form of a grant allocated to the Diocese of False Bay by the Anglican Aids Office (AAHT).[40] The activities of this Standing Committee provided the agenda for the next Diocesan Synod in September 2009. At the same meeting, the establishment of the Gender desk for the Diocese was implemented. A committee for the establishment of the Social Development ministry in the Diocese was also established. The third Standing Committee in the Diocese of False Bay was constituted in November 2010.[41] Due to the financial recession in the country (South Africa) at that time, several parishes were hit hard by the lack of financial resources. This resulted in the termination of the position of the HIV/AIDS Coordinator in the Diocese of False Bay.[42] The HIV/AIDS ministry was incorporated into the Orphaned and Vulnerable Children (OVC) programme, which emerged as a new programme, followed by the next Diocesan Standing Committee in November 2011.[43]

This programme focused on the Orphaned or Vulnerable Children (OVC). Structures for the protection of children's rights were implemented at all levels via this programme. The vision of this programme was to ensure that orphaned and vulnerable children receive appropriate care and support to grow to their full potential. It provided counselling, education, care, and support to communities and trained individuals to respond their needs. The staff of the Vana Vetu programme also mobilised communities to respond and commit to addressing the challenges of HIV/AIDS, particularly as they affect children (ACSA 2009b). By the time the third Standing Committee materialised in November 2011, AAHT and Fikelela supported most of the activities around HIV/AIDS. A governance structure was brought into being through a resolution taken at the synod (Diocese of False BAY, Acts Chapter 11B). This resolution enabled the Diocese to establish a non-profit organisation (NPO) in January 2011. A Social Development officer responsible for the coordination of all Social Development activities, including HIV/AIDS, was appointed in April of the same year (Diocese of False Bay 2012:12-14). It needs to be noted that no resources were allocated for the sustainability of the HIV/AIDS ministry in the Diocese of False Bay, let alone the strengthening of the Diocesan HIV/AIDS

[39] Key informant Pam Parenzee, 13 April 2013 Diocesan Office Somerset - West.

[40] At the second Standing Committee Meeting of the Diocese of FALSE bay in 2008, it was reported that the HIV/AIDS ministry in the Diocese was making good progress.

[41] See the Profile of the Diocese of False Bay (2012:6-8)

[42] Minutes of Social Development Department 2012.

[43] Key informant Rozette Jeptha, Director VANA VETU 10th March 2016, Marvin Park- Macassar, Cape Town.

ministry, in general.[44] In response to the HIV/AIDS challenges, several centres of care and support were initiated in the Diocese:

Heavens Nest near Ottery: This facility was an emergency home of care and was instituted in 2004 as an initiative of the parish of St Francis of Assisi, Strandfontein. This facility had the capacity to house 14 children at that time. It was registered as a foster-care facility by the government. All the sub-headings fall under the Diocesan profile (SYAKHA Report, 2006)

Fikelela Children's Home in Khayelitsha: As was indicated previously, the Fikelela office were instrumental in the implementation of the programmes in the Diocese of False Bay, which was resourced by the AAHT office (SIYAKHA 2006). This centre was established in 2001 by St Paul's, a place of hope in Ocean View. This foster-care home is owned by the Diocese of False Bay, and is managed by a foster-care couple. It is based in Ocean View and the local church, St Clare's, provides support to the care parents. The home is able to accommodate six children at a time, who are placed from the surrounding areas (SYAKHA Report 2006).

Overberg Care Centre: Initially, this faculty operated as a hospice, serving as a place of rest and a home for patients to spend their last days in dignity, another project initiated by the local congregation, St Andrews. This project enjoyed the financial assistance of Hope Africa (Social Development Organisation within AAHT). At the time of its establishment, the facility housed 23 nursing, 5 administrative, and 5 housekeeping staff. The centre served over 120 outpatients on a daily basis (ACSA 2009a:42-50). *Overstrand Care and support Centre:* Another project that dates back to 2001 is the Overstrand Care Centre. The Anglican Church in Hawston has a long history of providing healthcare in the community. Since 2001, members of the Hawston Health and Welfare Committee (HHWC) recognised the need for a Hospice in the area. The coordinator of the HIV/AIDS task team (the priest in the parish), together with a local task team initiated the process.

There were several community meetings to involve the community. The first home-based carers were borrowed from the local Dutch Reformed Church Service Centre. This was the first partnership formed around this important project in the community. The Dutch Reformed Church assisted with the payment of the stipend. The two banks, First National Bank, and later, Absa bank, assisted with the first Home Based Care Training Programme. The Red Cross Society in Hawston was responsible for the training. The Centre became a residential hospice for people who were sick and unable stay at home, as they were too ill and sometimes at the

[44] See the AAHT Annual Report (2009:10-15). The Vana Vetu programme was funded by PEPFAR.

point of death. The home-based carers would visit the homes, and concurrently, assist the in-patients with medical procedures as needed. With the introduction of ARV's, staff members were trained in counselling skills. More than a hundred and thirty patients were taken care of by ten care workers. The care workers provided holistic care to all the patients (DFID Report 2005).

Siyakha Programme: Funded by (DIFFID), this programme undertook to strengthen the understanding between Church and community, with the particular focus on the reduction of stigma through care and impact mitigation, as well as the prevention of the further spread of HIV/AIDS. Siyakha has built on the skills and capacity developed in the Isiseko Sokomoleza Programme, which was the forerunner aimed at building capacity and a foundation for the Church to launch its concerted response to HIV/AIDS. Siyakha, therefore, strengthened the projects initiated by dioceses, of which False Bay Diocese was one (ACSA 2009c:10).

Siyafundisa Programme: This programme was funded by the President Emergency Fund for AIDS (PEPFAR). The focus of this programme was to address unhealthy and risky behaviour affecting the safety and well-being of young people. It aimed to help young people to make informed decisions, as well as empower adults to become positive agents and role models of healthy behaviour. Young people in the Dioceses of False Bay championed this programme, and as much as these programmes strengthened the existing Isiseko Sokomoleza Programme in the Diocese of False Bay, they met with great challenges due to the lack of proper strategic planning and the availability of funds from the donors and funders (SYAKHA Report 2006).

Vana Vetu Programme: This programme left the biggest footprint in the Diocese of False Bay due to its holistic and integrated approach to children, governance structure and well-trained staff. The President Emergency Fund funded this programme for AIDS (PEPFAR) throughout its lifespan (ACSA 2009b). The Vana Vetu Programme built on a successful Orphans and Vulnerable Children (OVC) model, piloted between 2004 and 2005, under the ACSA Isiseko Sokomoleza (Building a Foundation) Programme. This was implemented in partnership with Heartbeat Centre for Community Development, the Barnabas Trust, and the Mothers Union (MU) in the Eastern Cape Province's four dioceses, namely Grahamstown, Port Elizabeth, Umzimvubu and Mthatha. All activities were implemented directly by the MU, an important women's group of the Anglican Church, who worked beyond the Anglican Church, including community volunteers from other faith-based organisation. AAHT conducted a needs

assessment in 2005 in targeted dioceses, to determine the support they required to strengthen services to OVC and CCW's (ACSA 2009b).

AAHT concluded that OVC services implemented by parishes were unstructured and uncoordinated, and that training for CCWs was needed to strengthen support to OVC. In 2006, AAHT management decided that the programme for the Orphans and Vulnerable Children should become a stand-alone programme, after funding was received from the Johns Hopkins Health and Education South Africa (JHHESA). This ensured the establishment of structures in the four dioceses where the programme was piloted (ACSA 2009b). With the dawn of the PEPFAR funding in October 2007, AAHT managed to build further capacity of more community volunteers, and expanded to seven new dioceses. However, due to losing volunteers (who objected to the administrative responsibilities of the programme), unsupportive clergy, and unresolved conflict between team members, four sites closed down.

The Vana Vetu Programme operated in six dioceses, ten urban/rural districts and sites of parishes in four provinces: Eastern Cape, KwaZulu-Natal, Western Cape, and Limpopo. In 2007, the programme changed its name from Anglican Care for OVC to Vana Vetu, meaning "our children", to epitomise the reality of 'our' children, who are suffering and in need of 'our' care and support. In order to strengthen the governance and implementation structure of this programme, strategic changes were implemented. Additional staff, including DOVCs, to coordinate programme activities at each diocese, and TL's to coordinate the team of child-care workers (CCW's) at each parish, were employed. Later in year 2009, cluster coordinators were also appointed to coordinate activities at the various dioceses in the Eastern Cape and Limpopo (ACSA 2009b). Additionally, staff members were given clear job descriptions, and the number of CCW's was standardised to four or five per parish. The staff members employed, work toward achieving output targets set at each parish, and were charged to monitor its impact (Vana Vetu Report 2006).

This formalisation of the Vana Vetu structure also entailed formalising the objectives and activities included in this programme, as well as the monitoring of services rendered to OVC. The programme expanded after 2007 and operated in six dioceses and four provinces.[45] A growing number of children were made orphans and were vulnerable because of the increase

[45] See Vana Vetu Report 2009.

of HIV in South Africa at that time. To date, the number of infected people in South Africa is 5.7 million of the 48.3 million (11.8%). It has been estimated that about 1.4 million - 1.9 million children (0-17 years) are orphaned in South Africa. Statistics have also revealed that there is a significant variation in HIV prevalence ranging from 39.1 % in KwaZulu-Natal to 15.8 % in Western Cape. Inter-district HIV prevalence variation in the country is between 46%- and 3.8%. The relevance of these statistics was to provide a social context for the Vana Vetu programme for orphaned and vulnerable children. AAHT was continuously faced with families that had lost parents, as well as households where children were left without care, protection, and parental guidance. Children dropped out of school, lacked school-uniforms, while others did not perform or progress at school. Due to the loss of parents, children suffered depression and failed to cope with the loss, which affected their progress at school. The Church was strategically positioned in communities to provide assistance towards mitigating the plight resulting from this pandemic. Through the Church networks, AAHT designed a programme that would respond to some of the dire needs of these orphans and vulnerable children and move toward improving their quality of life.[46]

The management and leadership provided by Vana Vetu (VV) staff at AAHT, as well as by DOVCs and team leaders at VV, were perceived to be the significant enablers of the VV programme. The introduction of a "Cluster Coordinator" into the programme was recognised as a positive step towards increasing support to DOVCs. Leadership from the Provincial office was characterised as encouraging a culture of transparency and teamwork. Communication between site level staff and AAHT office was strengthened by having proper equipment (including cell phones and laptops). This initiative was particularly important, given the challenges of communicating from remote areas (ACSA 2009b). Network coverage in more remote areas remained a challenge for communication. A positive culture was created around monitoring and evaluation across the organisation; a number of interviews acknowledged support received in this area. A data management system was further revised and improved upon, and processes were explained to field workers and management staff (Vana Vetu Report 2006).

The Diocese had several outreach programmes such as soup kitchens, home visits, and 12 HIV/AIDS care and support groups. These groups were located in the following congregations:

[46] USAID, Southern Africa Regional Program HIV/AIDS Care cf. Vana Vetu Report 2009.

Belhar, Lavender Hill, Portlands, Lotus River, Hawston, Strandfontein, Phillipi, Sweet Home Farm, Harare, Site C, Mandela Park, and Zwelenthemba. These groups met regularly when they started (Dioceses of False Bay 2012). In partnership with the Warehouse (an organisation providing food parcels to the needy in Ottery, Cape Town) and Fikelela, the Diocese was able to provide food parcels collected from parishes in the Diocese to the needy within the community. Other major challenges in the communities were unemployment, substance abuse, teenage pregnancies, crime, and unemployment amongst young people (ACSA 2009b).

OVC Care and Support: The overall goal of Vana Vetu was to contribute to improving the lives of OVCs and that of their families, in order that they become independent young adults, who are able to manage their emotional, physical, and economic needs, be financially independent in their adult lives, and be part of a healthy and safe community. It did so by integrating OVC services, namely, educational support, psychological support, and child protection, into specially strengthened structures at 22 selected parish-sites, in six dioceses, through a process of mentoring, training, management, support, monitoring, and evaluation. Vana Vetu was well aligned to the National AIDS Plan (NAP), 'to mobilize and strengthen community base responses to care and protect OVC' (ACSA 2009b:7).

Geographical Coverage: Since the implementation of the Vana Vetu Programme, it has been established at 22 parish-sites, located throughout the country, being present and active in four Provinces. The programme employed 144 community volunteers in 10 districts identified as priority districts. These districts were geographically diverse, but all had areas of deep poverty and high unemployment. The beneficiaries hailed from marginalised families and lived in impoverished homes, in informal and formal settlements (for example, in KwaZulu-Natal children lived in mud-grass thatched houses and in the Western Cape, Sir Lowry's Pass children lived in shacks). The overall goal of the programme was to contribute to improving the lives of OVC and that of their families, so that they can became independent young adults, who are able to cope with their emotional, physical, and economic needs, and be part of a functional, healthy, and safe community.[47] AAHT established linkages and partnerships to ensure that a comprehensive package of services is provided in communities where the OVC reside. The fact that volunteers from the same communities were empowered to take on the role of secondary caregivers, further guaranteed that those communities would continue to take responsibility for their own Churches. Activities, aimed at achieving the results, are as follows:

[47] Key informant Charmaine Liddle Diocesan office 18 May 2015.

Education support addressed the problem that children who are left without parents or suitable guardians dropped out of school, lack school uniforms, and did not progress or perform well at school. The educational support programme ensured that children who were eligible for school, stayed in school, performed well, and completed basic schooling. This includes homework supervision in the after school activities (Vana Vetu Report 2009b).

Child Protection predominantly focused on ensuring that the children identified as vulnerable in the communities by the volunteers and their caregivers, received the necessary social grants. They also received information about how to protect themselves from harm and danger in the community.

Psychological healthcare and support was provided by AAHT through psychological care, with the assistance of tertiary student social workers, auxiliary social workers, and psychologists. The social workers from the Department of Social Development and other welfare organisation in the community were also consulted. Some identified psychological issues include child resilience, life post bereavement of parents/guardians, and challenges of vulnerability. It was intended that this would address the identified problem, namely, children who suffer depression and fail to cope with the loss also perform badly at school (Vana Vetu Report 2009b).

HIV and AIDS prevention education and Life Skills programme ensured that the children were equipped with the knowledge to prevent HIV infections. The objective was to assist children to choose abstinence or to delay their sexual debut and the knowledge and skills to enhance their social competence. The HIV and AIDS prevention and life skills programme followed the Rutaneng peer education curriculum. This is also provided after school activities. Children who successfully completed and graduated from their 10-hour sessions, were part of the youth initiatives in the Diocese (ACSA 2009b).

The Monitoring and Evaluation by engaging specialists to build the capacity of M&E field staff through training and technical support in the different dioceses, and for overseeing, managing and maintaining the implementation of a comprehensive M&E system for the Vana Vetu programme. *The M&R consultant* was contracted to provide mentoring, reporting, and supervision and serve as an advisor to the programme staff on issues related to Monitoring, Evaluation, and Reporting. The contract was from January to September 2012 and covered assistance with reporting, data verification, updating the MER plan, and mentoring/supervision of the M&E Specialist (Vana Vetu Report 2009b).

The Development officer was responsible for training, facilitation, coaching, mentoring, monitoring, data entry at AAHT level, filing, assisting with data collection, and the training of

primary data collectors; building capacity, knowledge of HIV and AIDS, and development issues as required (Vana Vetu Report 2009).

The Programme officer was responsible for providing assistance to the Diocesan OVC Coordinators (DOVC) through mentoring projects and assisting with the implementation of the programme at the diocesan parish-sites. This officer also assisted DOVCs with planning and strengthening capacity building (Vana Vetu Report 2009b).

The Programme administrator was responsible for administration for the programme.

The Cluster Co-coordinators were responsible for providing assistance to DOVCs through mentoring projects and assisting with the implementation of the programme in the Diocesan parish-sites (Vana Vetu Report 2009b).

The Diocesan Orphaned and Vulnerable Children's Coordinators (DOVC) conducted diocese level data collation and reporting to AAHT, and supervised the team leaders and CCWS on data collection (Vana Vetu Report 2009b).

The Social Auxiliary Workers were two graduates from the SAW training, who worked at two sites in the Diocese of False Bay, respectively. They promoted the general well-being and development of the beneficiaries. They made referrals to organizations that provided specialized and essential services (Vana Vetu Report 2009b)

Peer Educators were trained under the Siyafundisa Programme and have since the close-down been integrated into the Vana Vetu programme to continue with the facilitation of HIV Prevention Programmes, with priority on abstinence and delay of sexual initiation (12-17 years). These peer educators had one primary focus, specifically, young people. The programmes were specifically designed to maximize the participation of the youth in this programme (SIAKHA Programme 2009b).

Team leaders (TLs) and Child Care Workers (CCWs) were responsible for collecting data at community level, doing first level data entry, generating records and supportive documentation (hard copy notepads), and submitting monthly statistics and reports to the DOVCs. Team leaders supervised the CCWs and ensured that the OVC and his/her family receive services as needed. They were also responsible for networking and establishing Child Care Community Forums.[48]

[48] Key informant Rosette Jephta, former Director of the OVC programme for AAHT, 15th July 2015, Marvin Park, Macassar. If the key informant is the source of all the information in the paragraphs above this footnote, the footnote should be inserted at the beginning of the information and should indicate that she is the reference for

Multi-Sectorial co-operation in strenthening the Churches' response: Throughout the implementation of the Vana Vetu programme, the importance of multi-sectorial participation was one of the key growth factors in the implementation thereof.

In 2008, as part of Child Protection week, the parish of St. Paul's held a joint awareness programme at the local school. The role players involved were the South African Police Services (SAPS) (who covered the danger of drugs and peer pressure), PATCH (who focused on child abuse) and the Ambulance Services (who focused on road safety). This was very educational and beneficial, as most of the children who attended the school had to cross a busy road in order to get home (ACSA 2009b).

Challenges in the implementation cycle: There had been some errors in numbers and accordingly, data verification was critical. With the challenged capacity at diocese and parish level, AAHT employed a dedicated MER person to improve programme capacity in this regard. AAHT and Stellenbosch University compiled a booklet that served as an information guide for all OVC team members, which contained information on the PEPFAR indicators, core programme areas, and data gathering forms relevant to the programme. After the appointment of the MER specialist, training in data collection was done in conjunction with internal verification of data. AAHT has endeavoured to improve the quality of data, as reported in its Annual Report (ACSA 2009c). Rigorous cleaning up and verification of data was done during AAHT has translated and simplified data collection tools. Turnover in CCWs, due to poor incentives and low stipends, affected the ability of the programme to retain its staff. AAHT, however, addressed this problem (Vana Vetu Programme 2009b).

3.5 Isiseko Sokomoleza and its focus on HIV stigma

As previously indicated, the Isiseko Sokomoleza Programme was a programme conducted in partnership with Christian Aid, and supported by the Department for International Development in the United Kingdom (DFID). It was different to earlier initiatives, as it was the first provincially managed and coordinated programme with the aim of contributing to the reduction of stigma, discrimination, and transmission of HI through care, support, and impact mitigation (Cole 2006). The objective was to build a Church-based response that could be replicated by faith-based organisations (ACSA 2003). In order to achieve these aims, the

all that follows in the section. This pattern is a useful one to use throughout the chapter where a single informant has been the source for much program information.

programme focused on a number of specific intervention strategies. This included Leadership; Pastoral care; Prevention; Care and counselling; Death and dying; Policy formulation on HIV/AIDS in the workplace; and the development of a strategic response to the growing number of orphans and vulnerable children (ACSA 2003). Broadly outlined, the programme's components were: HIV-specific pastoral care; The education for clergy and lay leadership; The coordination for HIV/AIDS programming and development in each diocese; The development of AIDS-specific leadership in each diocese and congregation; The expansion/development of community- or parish-based responses to support and care for orphans and vulnerable children; The study and on-going discussion on issues and policies/guidelines on care and support for orphaned and vulnerable children in the Church; The development of appropriate and effective workplace programmes that ensure the rights of people (clergy and laity) living with AIDS; The development of age-appropriate, culturally sensitive materials for sexual education in the Church; and The study, as well as on-going discussions of issues, policies and guidelines surrounding death and dying (ACSA 2003).

The Programme identified six strategic outputs, namely: To strengthen capacity and advocate for effective community-based responses to HIV/AIDS; To increase and improve the quality of AIDS related programmes; To reduce HIV/AIDS vulnerability through increased knowledge, while encouraging responsible behaviour; To manage the programme in an effective and efficient manner; To develop a workplace policy; and To respond strategically to the challenges facing orphaned and vulnerable children. (ACSA 2006b).

During the lifespan of Isiseko Sokomoleza, 2003-2006, the full impact of the HIV/AIDS pandemic became more visible and devastating; especially with respect to women and children and for this reason the inception, evolution, and outcomes of Isiseko Sokomoleza need to be understood as an interactive, learning, and adaptive exercise for its planners and managers. The implementation of Isiseko was as much a capacity building process for the implementing ACSA and AIDS Office as it was for the parish structures collaborating in the process. A challenge, under-estimated by the original designers of the Isiseko Sokomoleza programme, was convincing the staff of the various dioceses, as well as their respective Bishops to become involved, as the commitment of every diocese in ACSA was vital for the programme to serve its intended purpose (DFID Report 2205). Reference By 2004, great strides were made in the dioceses regarding assuming ownership for the programme. In the three years of the Isiseko

programme, the ACSA and Aids Office was able to offer support and innovative new models of intervention to the dioceses and parishes and other implementing partners". Examples of these initiatives were Churches, Channels of Hope; The Practice of Living and Dying; Retreats for Christians living with HIV; The Christian AIDS BUREAU Resource and Information Service; Communication and Information Support and the Anti-Stigma Campaign (Greyling Churches Channels of Hope 2007).

In the Diocese of False Bay, as indicated earlier, the Isiseko Programme was initially introduced through the structures of Fikelela in 2003. One of the outreach programmes introduced by Fikelela was 'This Church is HIV/AIDS friendly' (Appendix 1). The broad strategic objectives of the Isiseko Sokomoleza Programme were developed and adopted at a diocesan and parish level[49] and introduced via the AIDS desk through an HIV/AIDS coordinator responsible for the programme, as well as the administrative workload. From the onset of the diocesan HIV/AIDS- response, it experienced a lack of capacity, oversight, and monitoring, which posed a huge challenge to the implementation of the programme. At diocesan level, the need to build the baseline for support services necessary to respond to the HIV/AIDS pandemic, was identified. The financial report to DFID also indicated a significant project under-spend in the programme (ACSA 2004b). There was a need to dissect and interpret the information on diocesan and parish activities in order to provide context-specific capacity building programmes. The under-spending, therefore, also reflected insufficient human resource capacity in the ACSA office (ACSA 2004b).

In August 2005, during the Coordinators' Week, the Provincial Office reported that significant strides had been made in building the capacity of staff.[50] At this meeting, it became apparent that social mobilization was a major gap and there was a great need to educate the Church about the pandemic. In order to acknowledge and reduce stigma, once mobilized, established structures like HIV and AIDS Task Teams worked with existing structures at parish levels (MU and AWF) to champion the issue. A key initiative for developing capacity at diocesan and parish level and mobilizing the Church has been the training of diocesan staff, clergy, and volunteers in the Churches Channels of Hope Programme (CCOH), aimed at mobilizing

[49] Key informant Beverly Hendricks- manager of Fikelela, 13th May 2014, Cape Town.

[50] Both training workshops were facilitated by Barnabas Trust, a faith-based organization that provides mentoring to community-based organizations working in the field of HIV and AIDS in and around Port Elizabeth as well as elsewhere in South Africa. AAHT, Mother's Union, OVC Programme.

congregations and their leaders to respond appropriately and effectively as Christians to the enormous practical and spiritual challenges of the HIV and AIDS pandemic (Greyling Churches Channels Of Hope 2007). A joint venture between ACSA HIV and AIDS Office and the Christian AIDS Bureau for Southern Africa (CABSA), was one of the most important contributions that Isiseko has made to the HIV/AIDS response. Seven provincially organised CCOH workshops have been held since May 2004, with more than 140 people trained in the methodology, 71 of whom had reached level two and 3 statuses.[51]

Very few programmes on stigma and discrimination were introduced or mainstreamed into the organisational life of the Diocese. However, in December 2005 the Diocese of False Bay joined ACSA in a massive anti-stigma campaign with the slogan: "In Christ, there is no difference between positive and negative" (ACSA 2006b).Theology developed around stigma and the Christian response to HIV/AIDS was used to design pamphlets, tee-shirts, posters, and liturgies with anti-stigma messages. A commission to the Human Sciences Research Council (HSRC) to do research on HIV/AIDS-related stigma in the Anglican Church followed this campaign (ACSA 2006b). Furthermore, the Diocese participated in AIDS candle light memorial services where anti-stigma messages were promoted. The anti-stigma campaign has been instrumental in the increasing discourse around stigma and the Church's response (ACSA Siyakha Proposal, August 2009a).

> From the inception of Isiseko, there had been recognition of the importance of creating an understanding and sensitivity of the impact on the HIV and AIDS pandemic on clergy. A number of clergy schools were held during the lifespan of the Isiseko Programme. Grants were also made available to support the work of the Theological College of Transfiguration in Grahamstown; yet, clergy were still reluctant to introduce the HIV/AIDS programme (ACSA 20006b). The reasons could have been fear and the lack of confidence to engage with issues such as HIV/AIDS. "It is true that our own clergy are poorly equipped and trained to take on this role. The Church is paying for the fact that so little time and resources have gone into building a strong clerical and spiritual base for the Church, at a time when the Church is being called upon to fulfil this role. The level of training and teaching in the Anglican Church is poor, and the level of spirituality for most clergy is dubious, to say the least. The kinds of roles

[51] The Churches Channels of Hope (CCOH) is a CABSA initiative to develop the skills of facilitators across Southern Africa.

> demanded by HIV and AIDS – bereavement counselling – are beyond the capacity of most. Few have disclosed and, therefore, are living a lie, not dealing with it because they cannot face the stigma. In our context where human sexuality is not acknowledged, it becomes a blockage to doing something about the pandemic. The Church is reaping the bitter harvest of centuries of preaching sexual ethics, which denies that we are sexual human beings. In our CCOH workshops, there are never less than 65% of clergy, who admit to having more than one partner. So, even they are sexually active".[52]

Financial and capacity challenges at provincial level (AAHT) also started to have a negative impact on the diocesan programmes. In addition, the lack of proper policies, procedures, strategic leadership, and resources hampered the mobilisation of the various congregations, to adopt the programmes (ACSA 2006b). A further major challenge to the Isiseko Sokomoleza Programme occurred in late 2005, when most of the staff members were required to assume multiple tasks, which demanded more time between the Isiseko Sokomoleza and the new Siyafundisa Programme. Although additional staff members were eventually brought in to support the Siyafundisa Programme, the new programme raised new human resource challenges for the Isiseko Sokomoleza programme (Cole 2006:51). The Diocese of False Bay had no resource mobilisation strategy to obtain additional resources to sustain the programme, resulting in a fast waning of the Isiseko Sokomoleza Programme.[53]

The ACSA response to the HIV/AIDS pandemic came full circle when the Isiseko Sokomoleza Programme, responsible for the initial funding in 26 dioceses, ended. Isiseko Sokomoleza left many dioceses with resources; better coordination of its response, capacity building, care and support, and networking with other stakeholders and local organisations in the area of HIV/AIDS (ACSA 2009a).

In the Diocese of False Bay, some of these projects such as hospices, food gardens, child-care centres, home based care projects, school uniform projects, and many others, have developed into facilities that made a difference. Through funding from DFID and others, such as PEPFAR, AHHT was able to sustain most of the projects. AAHT also assisted these projects by empowering their leaders with skills, such as resource mobilisation, monitoring and evaluation

[52] Key informant interview August 2006, Kenilworth, Professor Denise Ackerman.
[53] Key informant Charmaine Liddle 15th June 2016 Somerset – West (Former AAHT employee)

and financial management. However, by 2009 the Annual Report of AAHT indicated, despite the mobilization of the various Church organizations, such as the Mothers Union, Church Men Society, Youth, and Bernard Mizeke (group for men), no alternative plans were implemented to sustain the pastoral responses in the Dioceses of False Bay (ACSA 2009c:3-5). During this period, most overseas governments had scaled down their funding for HIV/AIDS work. As a result, most of the fieldworkers in AHHT became redundant, which resulted into despondency, an exodus of capacity and, in some instances, a loss of leadership. As mentioned previously, at this time, the Diocese of False Bay also terminated the services of its HIV/AIDS coordinator, with no replacement to follow. The Provincial Standing Committee of ACSA responded to the short-term need, by providing only R250 000 for such a critical ministry, where the pandemic was far from being over (ACSA 2009c:4); it was considered a good gesture towards self-reliance.

3.6. Concluding observations

According to the ACSA Report 2009, it can be concluded that the Isiseko Programme initiative was a major strategic intervention for the Anglican Church of Southern Africa, placing it alongside the Catholic Church as FBO pioneers with respect to HIV and AIDS related work. These initiatives were replicated in the False Bay Diocese and provided a range of activities to reduce stigma, provide care, and mitigate against the further spread of the pandemic. While its programme structure had some clear fault lines, its framework, nonetheless, created specific focal points that gave guidance to Bishops, Diocesan Coordinators, and Diocesan HIV/AIDS Task Teams to focus on targeted activities and projects, aimed at addressing and potentially mitigating the impact of the pandemic (ACSA 2009b).

However, in terms of effective oversight, monitoring, evaluating, and reporting from the AIDS office, the implementation of the programme in various parishes became a major challenge (ACSA 2009b). A significant weakness was the fact that not enough mentoring and support was built into the design of the programme.[54] The constant changes to the Provincial Programme (AAHT) also had a negative impact on the effectiveness of the programme in the Diocese of False Bay. Furthermore, the statement by the Liaison Bishop, the Right Reverend Dr Johannes Seoko, “the reliance on foreign funding was the weakest link in its organizational

[54] See DIFID Report (2005). There was no structured mentoring and support process designed or in place to strengthen the program.

and implementation structure" (Siyakha Report 2006), could not have been more accurate, because when donor funding was withdrawn most programmes, especially the Isiseko Sekomoleza programme, was detrimentally impacted. The loss in funding resulted in job losses across ACSA on various levels, including the Diocese of False Bay. Although the funding in the Diocese of False Bay was well accounted for, the sustainability, impact, and governance, as well as implementation structures that were established over the past ten years, posed a risk and challenge for the future response from ACSA.[55] The Diocese of False Bay had no single umbrella structure responding to the AIDS pandemic. The programmes were all linear-dependent on the availability of donor funding. It is clear from the reports, that the implementation of the Programmes in the Diocese of False Bay lacked a coherent plan, with clear objectives and implementation strategies. Furthermore, the diocesan systems, policies, and procedures were often not compliant with the resolutions from synods. In addition, the lack of proper policies, procedures, strategic leadership, and resources hampered the mobilisation of the various congregations to adopt the programmes. Regarding the financial resources, the programme was implemented against a very limited budget.

The Diocese itself did not embark on a resource mobilisation strategy in order to obtain additional resources to sustain the programme. In some instances, systemic challenges in the Diocese of False Bay were in need of transformation, in order to provide a pastoral response that was more effective, efficient, and sustainable. However, while work related to the overall HIV and AIDS ministry had expanded, particularly in relation to new programmes, such as Siyafundisa and an emerging OVC Programme, the Diocese of False Bay had not expanded its administrative and financial staff, with the exception of one additional staff person, dedicated to work on the financial accounting and monitoring side of Siyafundisa. Regarding the quality of the programme, it expanded with an additional programme (Siyakha and Vulnerable Children), affecting the implementation of the Isiseko Sokomoleza Programme due to the lack of capacity. A further observation is also that the Isiseko Programme in the Diocese was waning because it was it was provincially driven, and secondly, it was waning because in the first place it was implemented because of the availability of funding.

The lack of understanding of the mandate and scope, resources, capacity, and local ownership could be considered as challenges that influenced the slow start of the programmes in the

[55] See Annual Report of AAHT (2009). Bishop J, Seoko stated that he was still optimistic "that money will be found to pursue the good work at AAHT".

diocese. Additionally, this programme failed to acknowledge diocesan activities and projects already in place, at the time. The mobilisation of clergy and diocesan bishops was one of the key results, a significant part of the start-up phase of Isiseko was spent on "public relations" and "diplomacy" work to create a higher level of legitimacy and support for Isiseko within the structures and hierarchy of the Church. The under-spending at a provincial level, also reflects insufficient human resource capacity in the ACSA office (ACSA 2004b).

The phase-one implementation strategy lacked an appropriate institutional, human, and programmatic response to a dynamic and largely unknown disease, which touched human issues, such as living and dying. For this reason, the inception, evolution, and outcomes of Isiseko need to be understood as an interactive and learning exercise for its planners, implementers, and managers. Another challenge observed throughout the lifespan of the programme was the high turnover of staff at the level of senior management. This resulted in the inability to provide the kind of consistent and high quality strategic management support necessary to strategically direct and organize a highly complex and multi-layer programme. Although additional staff members were eventually brought in to support Siyafundisa, the new programme raised human resource challenges for Isiseko, given the broad spectrum of the successes, gaps, and challenges of the Isiseko Sokomoleza Programme. During the preparation for the next phase of programmes, especially the Siyakha programme, ACSA had its own review process of the Isiseko Sokomoleza Programme. These observations will be tested in chapter six in the empirical section of the research.

In this chapter, I have given an overview of the structure of ACSA and its implementing structures. More specifically, this study introduced the programmes in the Diocese of False Bay. Given the many programmes that were introduced in the Dioceses of False Bay, some of the fault lines in the programmes were the systemic and structural challenges it had to face. Despite the programmes covering many different age groups, it lacked one common thread in reducing the impact of stigma. The observation was that the programmes had no single objective and were implemented in silos.

It needs to be stated that the Diocese of False Bay did respond to the challenges of HIV/AIDS through the implementation of the Isiseko Sokomoleza HIV/AIDS programme. However, it would appear through the above observations that there could have been several reasons that contributed to the impact of the Isiseko Sokomoleza Programme. The following chapter

provides a descriptive overview of the Primary Healthcare model as an evaluative tool for these reasons. Yet it can influence the pastoral care framework winch will also be discussed.

CHAPTER FOUR

THEORETICAL FRAMEWORK

4.1 Introduction

In this chapter, the Primary Healthcare (PHC) model is discussed as an appropriate framework to interpret the reasons for, as well as the theological framework for the assessment of the contributing factors for the impact of the Isiseko Sokomoleza HIV/AIDS Programme in the Diocese of False Bay. Given the Church's involvement in the area of healing in the earlier chapter that the Church informed the health agenda, in this chapter it will be argued that the elements in the implementation of PHC can inform the Church's responses in order to ensure maximum impact. The literature on HIV/AIDS since the beginning of the pandemic clearly identifies the relationship between health and religion as not necessarily complete opposites, but indicates how health informed the pastoral agenda in order to create an effective pastoral response. Inasmuch as the elements in the implementation of the PHC Model could assist in the assessment the findings of the study, it is not competent to make a theological assessment. Therefore, another assessment, namely pastoral care, will also be used in order to arrive at a theological assessment of the findings of the study. The theories in pastoral care that will be applied in the assessment for this study is based on the contributions of Daniel Louw on pastoral care and counselling (Louw 2011).

4.2 Background and overview of the Primary Healthcare Model in Brazil

In 1948, the World Health Organisation (WHO) recognised that 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity' (Holley 2013:13). For many, this had been the chosen vocation since the founding stories of Christ's healing in the Gospels. In the meantime, the compassionate care that the Christian institutions offered was overtaken by the effective innovations of medical science. Although Churches have retained their presence in health services through many agencies, their primary role (ministry) to health changed substantially in recent years. Economic pressures and the demand for evidence-based effectiveness makes the role of the Church more vulnerable to decline (Holley 2013:13).

Most developing countries during the period of the 1970's saw grave inequalities in the provision of health services and a burden of disease with severe increase in the cost of

healthcare. As a result, in the period during the mid-seventies, international health organisations began to explore a different approach to improve health. In 1978 'Health for all' was introduced and endorsed at an international conference on Primary Healthcare (PHC) in Alma Ata, services, and the worsening burden of disease with soaring healthcare costs. This Conference statement read as follows: "This conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector" (Alma Ata Declaration 1978). The objective of the PHC was to address community-driven healthcare programmes, which focussed on prevention and management in order to rekindle hope about the possibility of improving universal health. Global healthcare organisations accepted the initiative and worked together through a comprehensive approach called primary healthcare (PHC) (Magnussen and Jolly 2004:167-176).

The Brazil Primary Healthcare Model is essentially care-based and follows practical, scientifically-sound, and socially accepted methods, which was made universally accessible to individuals and families in the communities of Brazil (Magawa 2012). This PHC health framework encompasses a comprehensive approach of responding to health needs, as well as finding ways to resolve the underlying economic, political, and social determinacy of poor health (Ntembu 2010). The PHC health framework in Brazil encompasses a comprehensive approach of responding to health needs, as well as finding ways to resolve the underlying economic, political, and social determinacy of poor health (Logie 2010). This overall strategy is supported by the following components: Political commitments, integration, equity, accessibility, affordability, availability, effectiveness, and efficiency (Denhill, King and Swanepoel 1998).

Another important element of the PHC model in Brazil was implemented through their full participation, and was offered at an affordable cost for the community and the country. The objectives were to develop a spirit of self-reliance and self-determination through every step of social and economic development. The PHC Model had a wide reach, which included individuals, families, and communities with one national health system. The objective was also to bring healthcare as close as possible to where people live and work, and constituted the first element of continuing healthcare services (Magawa 2012). Furthermore, the goal of this healthcare system was to provide universal access to appropriate, effective, efficient, and

quality health services with the objective to improve the health of the people across various communities in their local context. This initiative led to a more coordinated global response to work together toward providing people with basic health needs through a comprehensive approach (Magawa 2012). Brazil, in particular, required political commitment to decentralise universal access to all in need. Together with the local government providing integrated free healthcare to all, the financing thereof was the responsibility of the government of the day. In the next section, the principles that could be considered as key building blocks towards the successful implementation of the PHC Model will be discussed.

4.3 Basic principles of the Primary Healthcare

The PHC health framework in Brazil encompasses a comprehensive approach of responding to health needs, as well as finding ways to resolve the underlying economic, political, and social determinacy of poor health (Ntembu 2010). As indicated earlier, overall strategy is supported by the following principles: Political commitments, integration, equity, accessibility, affordability, availability, effectiveness, and efficiency. These aspects could be adopted as a framework for the programmes within a Church context (Denhill, King and Swanepoel 1998). These principles have largely contributed towards the successful implementation of this PHC Model, which contributed to the decentralisation of PHC in most regions, especially in the deep rural areas. However, these seven principles were key in the provision of good governance and the importance of community participation could therefore not be downplayed in the successful implementation of the PHC model. With reference to this study, these seven principles will be applied in the interpretation of the findings in chapter six. These principles will be applied in chapter six to assess some of the reasons for the waning response to HIV AIDS as key factors to assess the implementation of the Isiseko Sokomoleza HIV/AIDS Programme in the Diocese of False Bay.

Political commitment: The presence of political will is a key factor to the success of any health plan. The reason for the successful implementation of this PHC model was result of good governance, policies for equitable, efficient, and cost effective healthcare interventions, together with the support and interest from committed leaders at all tiers of governance. The support and strategic leadership from all systems of government and the mainstreaming of the projects are critical (Denhill, King and Swanepoel 1998). In this instance, Brazil's healthcare system is based on decentralised universal access and was also financed by the government. Committed leadership is critical in the implementation of programmes, for example in the field

of HIV/AIDS, all the National Strategic Plans for HIV/AIDS in South Africa (National Strategic Plans for HIV/AIDS in 2007-2021) highlight the strategic importance of leadership. In the context of the implementation of HIV/AIDS programmes in faith communities, the principle of effective governance is regarded as critical providing in providing assistance and guidance for other leaders in order to increase the effectiveness of programme implementation (Parry 2008:64).

Equity: Everyone must have equal access to basic healthcare and social services without segregation and discrimination of sub-groups in the provision of care. From a structural and systemic point, all levels of federal state and municipal structures were geared towards making primary healthcare available to all. According to Denhill, King and Swanepoel (1998) more than 190 million people, about 70%, has now access to health services. It could be argued that with the provision of government financial and technical support, the reach of the PHC programme could be rolled out to a vast section of the population. The principle of equity can also be threatened by different factors, for example, structural and social factors of inequality or the lack of access to healthcare services, gender imbalances, negative cultural practices, mobility of migration, displacement into informal settlements, conflict, and poverty (Pillay 2003). These factors were also major threats to the implementation of the Isiseko Sokomoleza Programme.

Accessibility: This relates to how easy it is for the users to get to the services they need, when they need them, where they need them, and what is considered as a reasonable cost. Services must be accessible geographically, financially, and functionally. Due to the influence of government leadership, the decentralisation of health services became a reality inasmuch as the restructuring of healthcare services infiltrated the deep rural areas and the local communities could visit the local healthcare services. These community health centres in Brazil also made resources available and accessible related to the provision of information about the programmes, communication strategies on behaviour change for reduction and prevention, testing centres, counselling centres, prevention of mother to child centres, anti-retroviral therapy, nutritional support, and referral systems (Declaration of ALMA ATA 1978). Affordability: In Brazil the Primary Healthcare was designed to be aligned with what the community and country can manage to pay for. The inability of the community to pay should not be a limiting factor to receiving healthcare. The new model of care enabled the poor to

access healthcare at a reasonable cost without the segregation of subgroups in the provision of care. The incapability to pay should not be limiting factor to receiving healthcare (Black 1990).

Availability: There should be adequate and appropriate services to meet particular health needs and the resources earmarked for the services should be applied as per budget regulations. The Brazil model of care through restructuring and decentralisation of key services enabled to address the local needs. Communities no longer had to travel outside their immediate area of living and work to access the health services which were provided at localised centres (Denhill, King and Swanepoel 1998).

Effectiveness: Services provided must meet the objective for which they were intended and should be justifiable in terms of cost. Earlier it was stated that the government of Brazil provided the financial and human resources to decentralised healthcare. The following principles was critical in the rolling out of the programme. Parry (2008), who implemented HIV/AIDS programmes for the World Council of Churches in Southern Africa, identifies the following principles for effective implementation of programmes: Be on time; this implies developing programmes to the stage of the epidemic in our communities. Be pro-active and read the signs of the time. Formulate programmes appropriate to the audience; for example, prevention programmes initiated with and for the young and gender sensitive involving life-skills training, self-worth and assertiveness, and dealing with peer pressure before they face the challenge. As was referred to earlier in chapter three in the home based care programme, create relationships with children before they become orphans. Minimise the risk, disruption and uncertainty when the programme is threatened by external factors. Forward-planning in all activities with affected communities and be prepared for negative impact on the programmes.

It is also important to the agreed deadlines, especially with reporting, accounting, and payment of creditors. Do it at a high standard; standards relate to the way something is done and not so much the tools with which it is being done. In order to provide services of excellence, all implementers need to be properly trained. They also need to become knowledgeable of what the service should represent and aim for high standards. With the resources available implementers should offer the best services irrespective of the restraints and limited. Do it with no wastage; maximise the effective use of all available resources. Hold governments and other implementers to account for the resources allocated to fulfil the responsibilities they are set out to do. Commitment and passion; in the context of HIV/AIDS, Parry (2008) advocates for a

response that is driven by compassion and the recipients of the services should also be given the opportunity to contribute towards the successful implementation of the programme.

The following factors contributed greatly towards the successful implementation of the Primary Healthcare Programme in Brazil. These principles will be applied in chapter six for understanding some of the reasons for the impact of the Isiseko Sokomoleza HIV/AIDS Programme. These principles mainly address the governance, resources, management, and the monitoring and evaluation principles in most programmes in order to ensure technical competencies for successful implementation. However, it lacked a theological approach to the assessment of the findings. It is for this reason that a theological framework based on pastoral care and counselling will be applied in order to respond theologically to the reasons that impacted on the Isiseko Sokomoleza HIV/AIDS Programme.

Efficiency: Results accomplished in the efficient implementation of the Primary Healthcare could be ascribed to the change in the following areas:
Community Participation. The successful implementation of the Brazil PHC Model could be ascribed to the three categories of community participation, for example, it was human right based; people have the rights and responsibilities to exercise their power over the decisions; mechanisms should be provided in the community in order to implement programmes that are community driven; and a proper action plan for community participation is necessary, which contributed towards the attainment of optimal health of the community. Another significant feature of the Brazil PHC Programme was also that the Family Health programme was a central pillar of the primary healthcare strategy in Brazil (Mtembu 2010).

This new approach to healthcare shifted from a curative care in hospitals towards a focus on primary and preventative care and where the shift moved to the local communities as the first point of contact. PHC changed to become the gatekeeper of the healthcare system and the first point of entry into a regional hierarchical system. The focus of care the shifted from the individual to the family (Macinko, Almeida, Dos Santos Oliveira and De SA 2004). The Brazil model was found to be potentially very relevant for developing countries like Cuba. It is relatively cheap and technologically easy to expand access to basic healthcare to poorer families. On a structural level, it reduced the overload, pressure, and lack of capacity at traditional institutions as clinics and hospitals (Moreno-Serra 2009). The number of families per catchment area ranged from one thousand families, or between three thousand and four

thousand five hundred individuals (Giugliani and Nascimento 2007). The family physician would provide the highest level of healthcare and is responsible for referring patients to secondary and tertiary care. The nurse provides the primary care activities and also provides supervision. During this era many other countries, such as China, had already embarked on the different approaches (community based) health programmes. In addressing inequality to improve universal health, this bottom up approach, which is focused on prevention and management of health problems in their social setting Brazil, in particular, required political commitment to decentralise universal access to all in need. Together with the local government providing integrated free healthcare to all, the financing thereof was the responsibility of the government of the day (Magava 2012). Government commitment has proved critical in the decentralisation of healthcare services in the poorer areas. New healthcare units were set up in needy areas that had no facilities. The impact of this process resulted in more trained staff in the community and implementation of key health policies, which resulted in the reduction of in infant mortality rate (Magawa 2012:1).

Broad-based support from the community contributed greatly to the successful implementation of the healthcare plan. This community participation could be divided into three basic categories: Participation must be active – people have the right and responsibilities to exercise power over the decisions that affect their lives; mechanisms should be provided within the community in order to implement programmes that are community driven; and a proper action plan for community participation, in an organised manner, contributed towards the attainment of optimal health of the community. It was not so much a theoretical exercise, but the active community-led response – the value of community involvement in participatory responses to healthcare planning and implementation, which led to improved health outcomes.[56] In no way could it be said that the PHC model was completely successful, but it could be stated that the model was instrumental in the majority of people having access to basic healthcare. Most successful comprehensive PHC programmes are the result of good government policies and legislature for equitable implementation if efficient and cost-effective healthcare interventions, and have emphasised the need for community and individual participation. In comparison with Brazil, countries such as Cuba, Thailand, and Omen had better health outcomes (Binge 2010). Primary evidence indicated that the increase in coverage improved healthcare outcomes in

[56] See Magawa (2012). Cuba and Mozambique expanded their primary healthcare programmes with phenomenal health outcomes. These successes were largely driven by active community involvement, political will to meet the basic health needs of citizens, and increased economic and social equity.

Brazil significantly. For example, from 1990 to 2002 there was a phenomenal growth of healthcare teams for example in 1994 with 328 teams in 55 municipalities. In 1998, 5,100 out of 5,564 municipalities across the country had 27,140 teams covering about 90 million people of the population (Girardi and Carvalho 2008). This resulted in a further reduction of infant mortality rates, increased female labour supply, and improved school enrolment. Government commitment has proved critical in the decentralisation of healthcare services in the poorer areas. New healthcare units were set up in needy areas that had no facilities.

Most successful comprehensive PHC programmes are the result of good government policies and legislature for equitable implementation of efficient and cost-effective healthcare interventions, and have emphasised the need for community and individual participation. In Tanzania in particular, following the endorsement of comprehensive PHC in 1978, the Tanzanian government embarked on a health strategy that led to the doubling of health facilities and an increase in the number of trained community staff. The government prioritised expansion of health facilities and an increase in the number of trained community health staff (Dennill, King and Swanepoel 1998). On the contrary, the implementation of PHC in Mozambique was slow due to political instability it hampered its progress. At the same time, Cuba has sustained steady progress, which could be attributed to its commitment to the process. For example, the life expectancy in Cuba is 77 years and infant mortality is 7.7 per 1000 live births, which puts Cuba among 25 countries worldwide with the lowest infant mortality rates (Dennill 1998). The uniqueness about the PHC system in Cuba is that PHC is the law (policy) and the foundation upon which the health system is built.

This is yet another example for the Church to mainstream stigma and discrimination in all its documents as a basis for building relationships that is free from stigma and discrimination, especially gender inequality. In Cuba it entailed not only integration into other health services, but became the main vehicle through which all other health systems are run. As is the cases in Brazil, the communities are involved in the identification (diagnoses) of their own healthcare problems and with the assistance of the government develop action plans to address health diagnostic priorities (Magnussen, Ehiri and Jolly 2004). It has been shown that countries with a well-functioning PHC system (such as Cuba, Thailand, Brazil, and Oman) enjoy better health outcomes at low costs. This principle of equity led to the abolishment of user fees at the primary healthcare level in countries such as South Africa, Uganda, and Zambia. This resulted in an increase of access to basic health services, particularly to women. In addition, women also

received basic health education, which empowered them to improve their efforts to clean water and sanitation, evidenced by the falling numbers of cases of water diseases reported breastfeeding, household involvement in treatment of diarrhoea, and monitoring child growth and nutrition (Black 1990).

4.4 Secondary Assessment of the PHC model

One such assessment of the PHC model was undertaken by the Kings College London, division of Health and Social Care Seminars in 2013 (Nassar 2013). In the findings of the research on the Brazil PHC Model two major challenges were identified; quality of care and the implementation of actions that work towards comprehensiveness. The study also recommended guidelines to overcome these challenges through the development of practical technologies, improvement of democratic management, and quality assessment of services and programmes. Of particular interest was the promotion and the autonomy of wellbeing and contribution to their citizenship and the reduction of vulnerability to sexually transmitted diseases and avoiding pregnancies, drug use, and violence. Despite the importance of the unified system of healthcare health public policy; structures; healthcare programmes such as adolescent healthcare, sexual reproductive health programmes, and primary healthcare, it still lacked comprehensiveness in implementation(World Health Organisation 2010). Other assessments that were undertaken was the "Evaluation of the Brazilian Primary Healthcare from the Perspective of the Users" (Sanders 2003).

The objective was to examine the experience of the users of the primary care centres from a user's perspective scoring to the quality of the structure, in relation to the aspects of accessibility, continuity and accessibility. Since 1990 the Brazilian unified system of Healthcare were aimed at coordinating the care provide at the local touch points. Despite the investments made by the government of Brazil, studies show that there are still challenges for strengthening the PHC in Brazil.[57] These include the challenges in the integration of services between PHC and other services to ensure continuity of care. These and other challenges amplified the question of the quality of access to PHC services in Brazil, which challenges the attributes assigned to it for comprehensive, timely, and suitable care. The findings of the Brazil assessment concluded with the following observations: In the area of accessibility, it was found

[57] https://www.nclm.nih.gov/pmc/articles/PPMC5338884 accessed 10 August 2018

that some areas were more accessible than others (Sanders 2003). There were also challenges regarding continued care, particularly in the area specialist care. Patients reported easier accessibility when the local care units were better structured. Other services to users requiring access to services for hypertension scored favourably in the above assessment. Despite these and other challenges, the healthcare services continue to advance on leading a proposal for a stronger, inclusive, integrated, and comprehensive care around the country. The programme has mobilised most of its communities from 24055 local primary centres and sought the opinion of 109919 service users in PHC. The overall observation of the assessment was that despite the various variables related to accessibility and continuity, from a user perspective, the teams of PHC services in Brazil are doing their jobs (Nassar 2013) Inasmuch as the PHC model can be used to assess the implementation component of the findings in chapter six, on the other hand, it cannot be considered to assess the findings theologically. In order to provide a theologically informed the framework of pastoral care and counselling will be applied as the theological lens to assess the findings of this study. The following framework will give a theoretical overview of pastoral care and counselling as was earlier alluded to.

4.5 Pastoral care and Counselling

The concept of pastoral care has been discussed earlier in one of the earlier chapters and in the following section I will briefly relate to pastoral care in the framework of pastoral counselling. The unique feature of pastoral care, in distinction from all other disciplines within the field of healthcare, is that pastoral care implies more than empathy. "It embodies the identification of the suffering Christ within our human predicament. In reality (human context) it meets people where they are and to reach out through different models of care and counselling. Within the tradition of 'cura anima rum', healing and sustaining has been identified as concepts in the field of care and counselling. Healing is regarded as the restoration of a loss and the search for integration and identity, to coping mechanisms, or the reframing of existing concepts and ideas (Louw 1997:54).

Earlier literature revealed that HIV/AIDS related stigma is a multifaceted challenge and that a holistic and comprehensive approach (physical, psychological, relational, contextual, and spiritual healing) is needed in addressing related stigma. On the other hand, the pastoral role should also sustain the capacity to accept what cannot be changed and the realisation that a support system is needed in order to take the necessary steps in the right direction (Hamilton 1997: 10). It is within this context that pastoral care and counselling in the professional field in

theological education, as well as in the practical theological mode of comfort, enable us to find comfort and clarity on the functions of pastoral care and counselling. Practical theology tries to link appropriate understandings of God with the pastoral and hermeneutical endeavour of understanding Gods acts of salvation in the human context. "Therefore, pastoral care and spiritual healing is related in practical theology through the following praxis principles praxis of understanding; interpretation; communication; acting; hoping; imagining and seeing" (Louw 1997:51).

Pastoral care is a form of ministry within practical theology that attempts to describe and identify appropriate categories of understanding the comfort and compassion of God within the realm of human suffering and pain. Pastoral care is about the enfleshment and embodiment of the engagement with God with life issues in such a way that will result in comfort, change, liberation, and transformation as an expression of the vivid and actual presence of God. Pastoral care fosters hope and instils anticipatory experiences of eschatology in such a way that our being functions are comforted. In this regard, comfort means the empowerment in one's being, functions, and to discover significance and meaning, which results in courage, relativity, and imagination. Pastoral care inspires people for the ensoulment of life by stirring creativity and imagination in such a way that the human soul can be illumined. Pastoral care enables the viewer to experience God's presence through the spiritual dimension through narratives, symbols, and storytelling (Louw 1998:22).

It represents the counselling procedures and counselling skills that try to communicate and verbalise the meaning dimension and the comfort of the Gospel, which consoles people. Pastoral care and counselling is the process whereby the dynamic relationship of the Gospel and pastoral care help in the healing of life. In relation to addressing stigma, pastoral care and counselling provide the medium through which healing and wholeness can be manifested. According to Hamilton (1997:9-10), pastoral care asks the ultimate question of self-worth, acceptance, forgiveness, hope, and change.

In the light of the above, the challenges of stigma go well beyond the realms of technical, structural, and medical responses. It raises deep spiritual, pastoral, and theological questions central to our faith and what kind of God we need. The following questions could be classified as follows: What is the meaning of life in the midst of being affected; how my faith in God empowers me to make choices in life; why am I suffering and where will this disease, HIV/AIDS lead me? In this regard, this is an existential approach. I will attend to Louw's (2008) existential approach to healing as a model of pastoral care and counselling. In this

approach, Louw (2008) refers to the existential threats, anxiety, guilt feelings, shame, despair, doubt, helplessness, vulnerability, frustration, and disillusionment HIV affected members (People living with AIDS) are experiencing in the face of stigma and exclusion. Louw proposes an existential approach to healing in his books, *Pastoral care and counselling: A guide to caregivers* and *Cura Vitae: Illness and healing of life.* Louw (2008:63) looks at the existential threats as viruses in life which threatens the quality of life "ensoulment of life and the embodiment of the soul". From a theological perspective, he argues that spiritual healing is the process which deals with the existential threats of anxiety, despair, doubt, helplessness, and disillusionment (Louw 2008:66). Pastoral care and counselling helps to interpret the need for the human quest to find meaning through the medium of grace and love (Louw 1990).

In other words, it is the attempt to understand humanity (human beings) as they communicate or relate to God. It is the quest to find meaning and purpose in human activities (Louw 1998:140). In the context of HIV/AIDS, where people are confronted with the reality of stigma, pastoral care and counselling serve as a conduit towards helping people to find that meaning and purpose. Therefore, in order to construct a theory for pastoral care praxis the objective should be to help people cope with suffering because it impacts on their humanity and spirituality, which are inseparable. It could be stated that suffering influences the human disposition, for example, attitude, norms, and values, in other words, their philosophy of life in their quest for meaning and purpose. In this way, the anthropological aspect in pastoral care and counselling could be offered as a pastoral framework for assessing the findings of the empirical component of this project. The following four principles demonstrates how the four principles towards healing could be applied individually and collectively in order to arrive at the stage where the images of God begin to translate into meaning and purpose in the lives of people.

The following four stages are critical in understanding holistic healing in the pastoral context (Louw 1998:352). These includes the (a) *affective,* (b) *cognitive,* (c) *conative,* and (d) *normative* stages. These anthropological components are related to the four basic human functions of life, namely the experience (*affective),* the reflection (*cognitive),* the responsible doing (*conative),* and the beliefs or impact of meaning *(normative)* (cf. Louw 1998:352). In this instance, a pastoral intervention would mean looking beyond the framework of cause and effect. Johnson affirms: "The aim of counselling with the HIV positive individual is therefore to focus on life beyond the infection and not to dwell unnecessarily on the constraints of the disease" (as cited in Van Dyk 2008:220). What follows is a discussion on how each of the

above anthropological components can function within the framework of pastoral care and counselling and how it can facilitate the healing of the PLWHA and their families. However, it should be noted that even though each component will be discussed separately, the model assumes that each component interrelates with the others, organically, to build an interactive process. These are areas of concern to pastoral care givers intending to use as a model for healing. In the context of pastoral care and in the instance where care and support groups provide care and support, these four basic principles as demonstrated above should be considered as critical steps in constructing a theory for pastoral praxis. In pastoral praxis the four theories could be understood as follows: experience (affective); reflection (cognitive); responsible doing (conative); and beliefs or impact of meaning (normative) (Louw 1998:352). In this way, the pastoral intervention should look beyond the framework of cause and effect and not focus on the limitations of the disease as (cited in Van Dyk 2008:220) In this instance, pastoral care and counselling looks beyond the infection and not to dwell on the constraints of the disease. These stages may be briefly outlined as follows:

Affective stage: In the process of counselling this is the quest for homecoming, building relationships, and the building of trust. This stage presents as the quest for welcome, acceptance, and embrace. At this stage the counselling should start. This stage is aimed at building a relationship of trust. The aim of counselling at this stage should be to ensure that the sense of belonging and welcome is strongly emphasised Cognitive stage: This stage in the process of counselling refers to the moment of reflection, meditation, and the outlining of the identification of the problems. This stage also focuses on the deconstructing of oppressive narratives. Oppressive narratives in the mind of the client cause the client to experience discomfort. In order to bring about deconstruction, the counsellor use God images to replace the oppressive images that is life giving and enhancing. This process of utilising God images enables the client to react constructively and more positively. The outcome is normally that people are helped to adapt to life, which means that in projection toward God the anger, frustration, and disappointments may perceive God in various ways (Stützner 20115:140).

Conative stage: According to Louw (1988:353), this third anthropological stage reflects on behaviour, action, planning, decision making, and emotions related to the problem. This stage also consists of the diagnostic and advising elements admonishing responses from the client.
Normative stage: In this moment of care there is a quest for spiritual care and the need to link with the ultimate. It also focuses on the values, as well as fostering a true discernment of the

will and the presence of God. This stage involves meaningful anticipation and purposeful transcendence as a way of encouragement (Stützner 2015: 151-153).

This is also considered to be the moment of empowerment and edification stage where counselling is concluded. In counselling related to HIV/AIDS related stigma this is a critical stage. In this stage, the question of evil, suffering, judgement in relation to God's love, justice, and forgiveness becomes a reality in the pastoral conversation (Louw 2000:25). People who are affected enters is to the why-mode, "why am I affected, why me, why God"? "The whole understanding human dignity and the faithfulness of God allows pastoral caregivers the scope to probe the ways that suffering impact on the quest for meaning and purpose by the client. This highlights the need for the client to understand the interconnectedness between their identity and spirituality, their love for God, and His compassionate involvement in their lives. At this stage, the challenge to the counsellor is to foster growth and hope by looking beyond the pastoral interventions" (Stützner 2015:152).

In the following section, a description will be given of the framework for counselling that will be highlighted an integrated activity of the pastoral process.

4.6 Pastoral counselling

Over the decades, the practice of pastoral counselling was dominated by techniques of empathetic listening. Healing in this context was predominantly related to the realm of feelings (the affective dimension). In an article by Louw (1988), "Philosophical counselling: Towards a 'new approach 'to pastoral counselling", a new avenue of meaning and connectedness to world views remained unknown to theories of pastoral care and counselling. In this article the theory of philosophical counselling is introduced. Philosophical counselling enters (probes) into the realm of different schemata of interpretation. This model makes a spiritual existential analysis of different schemata of interpretation in order to detect the impact of the Christian spiritual schemata on the interpretation of existential (Stützner 2015: 30).

Louw (1988) argues that philosophy could be considered as the most primary and fundamental science in theological theory formation. "In this regard, going back to our philosophical roots can assist practical theology and particularly pastoral theology in order to discover uncharted field for the formation in counselling. In order to change people this practice of counselling could be applied in the human quest for meaning." The question that needs to be asked in pastoral theologians should be asking is: What is the undergirding theory behind the practice and which idea is shaping my mind in the counselling praxis? As mentioned earlier,

historically, the focus in pastoral care was leaning towards the empathetic counselling, with the emphasis on emotional probing and memory analysis. This shift towards philosophical counselling is therefore a shift towards wisdom and it is connected to meaning, future life views, and convictions (Louw 1988). It assists in helping to place the narrow insights into a coherent, workable outlook on life (Marinhoff 1999:30-31). In other words, one learns about yourself in the bigger picture of life. Marinhoff (1999:31) is of the view that the root of most problems are philosophical and no form of medication can give lasting relief.

"Philosophical counselling is therefore aware of the fact that for healing to take place, the outside world and the framework for meaning, as well as the interpretation of events, need to be changed. Healing then implies more than empathetic listening and talking. Healing also implies paradigmatic changes and the development of a functional philosophical disposition towards your situation" (Louw 1988). In a philosophical approach, the following type of questioning guides the conversation; what meaning, purpose or value is implied? What is motivating you to decide for a specific direction or definite goal? How do you envision a possible outcome and what are realistic options? What are the factors preventing you to act in a particular way to achieve your goal/what do you hope for? According to Louw (1988), these questions cannot be separated from the philosophical context, which is determined by different schemata interpretations and patterns of thinking (paradigms). In philosophical counselling, aesthetics is more fundamental than ethics and morality. It is about the beauty of life. "Through this mode one views life and tries to understand the challenges of life, while at the same time looking for deeper meaning, gratitude, and significance. Aesthetic is the pattern of thanksgiving such as grace and not in terms of fate". Philosophical counselling digs deeper into the art of human life on a daily living and wisdom decision making (Raabe 2001:4).

It is for this reason that I have selected this pastoral care framework for the assessment of the findings in chapter seven of this research. My motivation is based on the understanding that addressing stigma calls for a 'world view' interpretation or wise therapy (Lebon 2001:9). In this regard, philosophical counselling helps people to look beyond their immediate situation and help to identify the gap between the actual way of life and a potential way of life that could nurture and encourage an individual to make responsible decisions. The value of philosophical counselling in pastoral care is that it enable the person to differentiate between meaning and the pursuit of happiness. In order to deal with appropriate God images, it becomes crucial to make a pastoral diagnosis. In the pastoral diagnosis, for example, the existential realities of

guilt and shame can be connected to the spiritual realities. The method implies is hermeneutics, which is only a portrayal of possible connectedness between life issues and spiritual paradigms. In this model, doubt and despair or dread; helpless vulnerability and frustration; anger or aggression urge to be validated and acknowledged; the urge to be successful and perfect the urge for absolute control over future events; the urge for independence and power and the urge to process (greed) (Stützner 2015). In the same way, in the existential mode, the following existential needs can be identified as intimacy: the need to be accepted unconditionally for whom one is without the fear for rejection freedom deliverance; hope and the anticipation of something new or different; the need for sustainable support systems and life fulfilment, satisfaction or happiness.

In the pastoral diagnosis, the question is whether the spiritual framework for life can be connected meaningfully to the existential framework, which can be a threat to meaning and purpose. Within the Christian pastoral context, for example, one can identify the resurrection hope, the support system of koinonia (fellowship) and diaconal (service) and the sacraments as modes of explain Gods faithfulness and fulfilled promises resulting in joy and gratitude. Additionally, the Word (kerygma) is part of the modes of sharing Gods faithfulness and love, which could lead to joy and gratitude. Pastoral care and philosophical counselling meet at the pastoral encounter (Stützner 2015:17). "The pastoral moment of encounter in the individual and God and the pastor act as mediator. This mediatory role of the pastoral encounter brings about meaning and the destiny in the faith perspective of the eschatology". In this regard, Louw (1988) argues that eschatology defines the theological stance of pastoral care in terms of the resurrection, which is eventually linked with hope. The theology of the cross as an act of God, and action of Christ which gives triumph over evil in this context pastoral care is then offered as a sign of hope for the world (Louw 1998:59). In this instance, practical theology and philosophical counselling interacts in an interdisciplinary relationship.

Both pastoral care and philosophical counselling probe into the meaning and dimensions of concepts. The analytical method for studying pastoral care is the hermeneutical interpretation of actions, which gives meaning in everyday life. It is the process whereby the dynamic relationship of the Gospel and pastoral care help in the healing of life. Peter Raabe (2001:133), a philosopher and counsellor, argues that the interconnectedness between pastoral hermeneutic of care and philosophical counselling can be constructed into four stages. The pastoral care profession in terms of practical goals is to interpret the concepts and schema of the client's threats and crisis. Thus the four stages could be described as follows: free-floating; immediate

problem resolution; teaching as an intentional act; and transcendence. A pastoral hermeneutics of care is worked out by Stützner in the following four stages of counselling:
In the free floating stage, the pastor focuses on the communicative abilities of the clients. The pastors tries to understand the client's choice of words and convictions precisely. The client will anticipate empathy and patience and are seeking help in enlarging the complex structure of the circumstances. The pastor also narrows down the conversation to a specific area of discussion. Both the client and the pastor ought to agree on the particular issue agreed upon as it is recognised as the immediate lead up to stage two (Stützner 2015:111-120).

The second stage is recognised as the immediate problem resolution in pastoral care. In asking definite questions from the client, this task will require of the pastor to research the systemic nature of the concepts of the client. This stage requires the pastor to ask specific and appropriate questions regarding the specific conception problem. This dialogical encounter between the pastor and the client will put the spotlight on specific issues; the actual and specific words of the client must be considered. There are techniques in understanding the client's words. In this context, these techniques are related to model cases, contrary cases, related cases, invented cases, social context, underlying anxiety, practical results, and results in language. The purpose in asking more questions by the pastor and the application of the above techniques, is to bring more sense to the dialogue. The pastor is then able to assist in the client's interpretation of the hermeneutical approach of care (Stützner 2015:15).

The third stage is the process of teaching the client to understand the analysis of life views. The client learns how the objective interpretation of emotional factors impact upon life meaning. This assessment of self-understanding and self-confidence are critical awareness of needs, expectations, and role functions. At this stage, the client is more ready to understand their self and the need for interconnectedness with others. It provides the opportunity to nurture the identity of the client in the Scriptural understanding of the uniqueness of humanity created in the image of God. Furthermore, the individual identity is fostered within the community of metaphor and forms. The learning of metaphor, symbols, and God-images then moves unto the fourth stage (Stützner 2015:111).

The fourth stage is an interactive engagement between the counsellor and the client. Although the counsellor guides the conversation, the client is actively involved in meaningful self-diagnosis. The client is far more aware of life values and the process towards processing of the

cognitive decisions is grasped by a responsibility to the Word of God. The impact of threats on the client's life makes the client aware of the need for the Gospel upon decisions. The client is now wiser and ready to discern the need to shift paradigms as a result of the pathology. The client is more confident about God's grace and how it directs their life toward the meaning and purpose of life. The shift in paradigm leads to clarity of resolving problems in terms of the truth of behaviour (Stützner 2015:12; Louw 2012:36). The study of philosophical counselling in theory formation for a pastoral hermeneutic of care is largely methodological. For pastoral care to assist in bringing healing, it must explore the systemic epistemological issues related to the concept of human behaviour. In understanding the existential threats, the pastor can better understand the client's ideologies. As pastoral theology continue to focus on God images of the Gospel, the pastor needs to become aware of healthy and unhealthy God images within the hermeneutical approach. These conversations around the related crisis in relation Gods love and forgiveness can bring about change (Louw 2012:37).

Given the potential of the theology of pastoral care it could be argued that pastoral care and counselling has the potential to change people and to deepen their faith and understanding, towards healing and wholeness. In the context of addressing stigma, theology cannot be limited to the theologically trained. Pastoral theology is alive and with the conviction that God's love and redeeming power can enter into the everyday spaces of suffering, helplessness, poverty, injustice, sinfulness, stigma, and exclusion through the medium of pastoral care, hope can be restored. It could be argued that pastoral theology in context of pastoral praxis has the potential to initiate change. In this way, God's involvement in human life is not without hope and fulfilment. From a Christian perspective, the power of the resurrection is central image of hope and cannot be separated from salvation of God which brings justice to life (Louw 1998:59).
The principles of the PHC Model, together with the framework of pastoral theology, and pastoral care and counselling will be used as the theological framework to assess the reasons for the limited impact of the Isiseko Sokomoleza HIV/AIDS Programme in the Diocese of False Bay.

4.7 Conclusion

This chapter has attempted to provide a descriptive overview of the PHC Model; the background and key elements of the programme such as the outline, assessment, and impact that could serve as an assessment for the reasons of the limited impact of the Isiseko Sokomoleza HIV/AIDS Programme was discussed. It also highlighted some of the challenges

(lack of resources), which impacted negatively on the implementation of Healthcare Model. Despite the governance, management, and resources as key principles of the PHC Model as a framework to assess findings in chapter six, it lacked theological competencies to address the theological assessment of the Isiseko Sokomoleza Programme. The theological framework of pastoral care and counselling was broadly outlined, which will further assess both the qualitative and the quantitative findings from the care and support groups in the Diocese of False Bay. The following chapter will give an overview of the methodological procedures that were applied in the empirical section of the work.

CHAPTER FIVE

METHODOLOGICAL CLARIFICATION REGARDING EMPIRICAL RESEARCH

5.1. Introduction

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In this chapter, the methodology employed in this study is presented. It highlights, specifically, a brief background to the research site, and explores the research design, research methods (qualitative and quantitative, mixed), sampling techniques, data collection tools, methods of data collection and analysis, as well as the statement of ethics that guided the conduct of this research.

5.2. Sampling

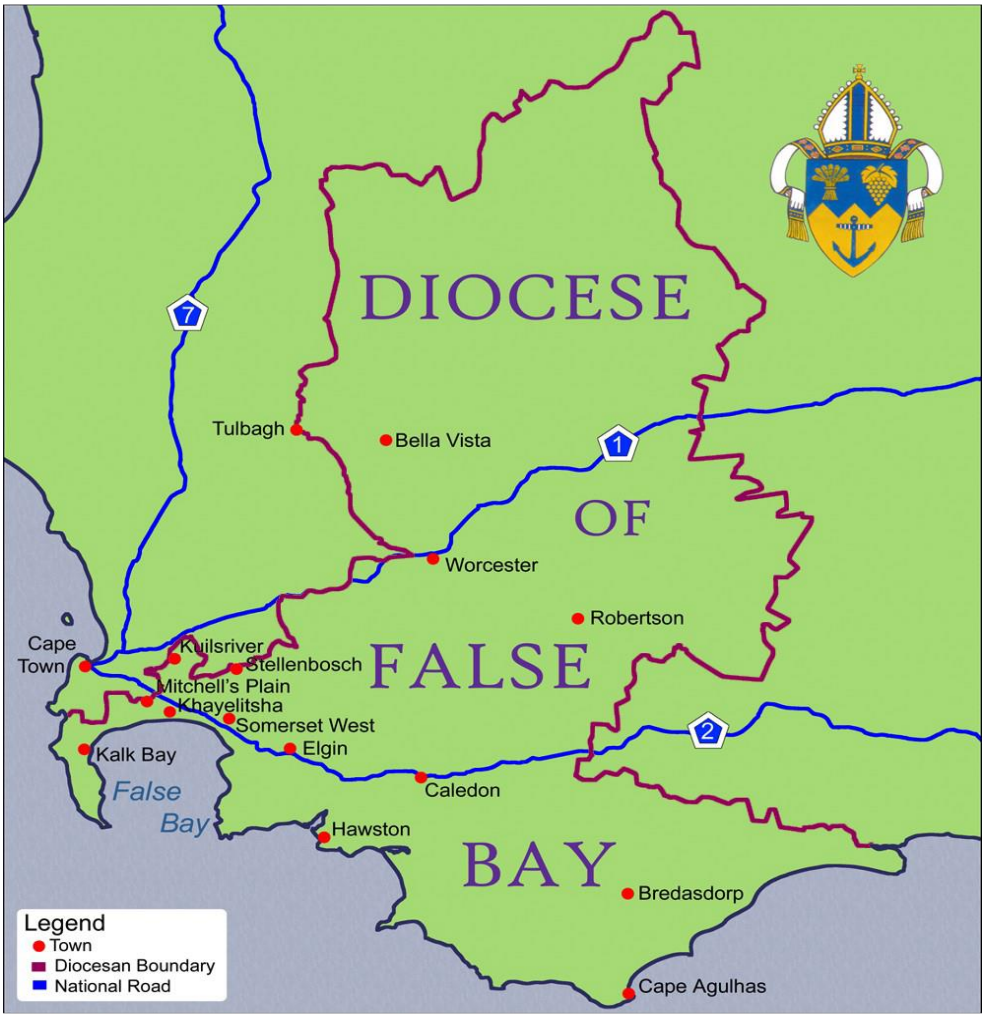
The research site for this current study was the Diocese of False Bay. This particular research site was chosen because the care and support groups that participated in this research project were members of congregations within the Diocese of False Bay. For the quantitative phase, the population was members of 16 specific congregations within the Diocese of False Bay, where care and support groups were still operating. Gaining access to the site was equally important (Marshall and Rossman 2006). The permission of the Bishop of the Diocese of False Bay was obtained by means of a formal letter (Appendix 4). The Bishop responded by writing to every parish in Diocese of False Bay, informing them of his consent (Appendix 5).

For the qualitative phase, members of the programme implementation team were targeted for a different perspective. The sample of respondents for the quantitative phase and participants for the qualitative phase of this study were selected using the purposive sampling method, as well as my judgement. In addition, key informants were also purposively selected as supplementary participants in the qualitative phase.

The Diocese of False Bay (DFB) was established in 2005 when the Diocese of Cape Town divided into three dioceses. The DFB stretches from the Atlantic Coast of the Southern Peninsula in the west, to the Overberg region of the Western Cape in the East, and from Cape Agulhas (the southernmost tip of Africa) in the south, to the edge of the Koue Bokkeveld in

the south. The DFB incorporates communities ranging from the densely populated suburbs of Khayelitsha and Mitchells Plain on the Cape Flats, to the seaside towns of the False Bay on the Southern Cape Coast. The Diocese consists of forty-nine (49) congregations and six (6) archdeaconries. The six (6) archdeaconries are the Helderberg area, the Blue Downs area, the Mitchells Plain area and the Kalkbay area, as well as the Caledon area and the Breede Valley area. The various parishes offer services in Xhosa, Afrikaans, and English, depending on where they are located. The governance structure in the diocese of False Bay was responsible for the oversight role in the Isiseko programme (Diocese of False Bay 2012).

Figure 5.2.1: The Diocese of False Bay (Appendix 2)



5.2.1. Procedure

Generally, in the arena of social sciences, there are three approaches of research; the quantitative approach, qualitative approach and the mixed methods approach (Creswell 2014; Denzin and Lincoln 2011; Richard & Munsters, 2010).

- **Quantitative research,** in general, refers to quantification in the collection and analysis of data. As a research strategy, it is deductivist and objectivist. Many cases, or respondents, are involved, while statistical analysis is the method of choice, with the researcher maintaining a detached attitude (Bryman and Bell 2007). This approach focuses chiefly on the collection of objective information about the occurrence of certain phenomena, using variables, hypotheses, and measurements, while testing theories (Creswell 2009).
- **Qualitative research,** on the other hand, begins with assumptions, a paradigm, the possible use of a theoretical lens, and the study of research problems, while probing into the meanings that individuals, or groups, ascribe to a social, or human problem. Qualitative researchers use an emerging qualitative approach of enquiry with open-ended collection of data that occurs in a natural setting, sensitive to the people and places under study, and data analysis that is inductive, establishing patterns or themes. The final written report includes the voices or narratives of the participants, the researcher's reflexivity, as well as a detailed description and interpretation of the problem. It also extends to the literature, or indicates a call for action. In general, qualitative research employs words in the collection and analysis of data. As a research strategy, it can be inductive, constructive, and interpretive (Creswell 2014; Bryman and Bell 2007).
- **Mixed methods research,** in the social sciences, according to Bryman and Bell (2007), enables a thorough investigation of the phenomenon under study and, therefore, remains highly relevant in generating knowledge for pastoral responses. The advantage of the mixed method approach for the researcher is that it opens the door to multiple research methods, different world views, different assumptions, as well as a different focus on data collection and analysis (Creswell 2014; Plano Clarke 2007, cited in Creswell 2009)

For the purposes of this current study, I employed a combination of both the quantitative and the qualitative methodological approaches to conduct the empirical research (Plano Clarke 2007, cited in Creswell 2009). The reason for choosing this strategy is that both approaches have their relative strengths and weaknesses, and, therefore, in the impact assessment of the Isiseko Sokomoleza HIV/AIDS Programme, the weakness of the one would be complimented by the strength of the other (Creswell 2014; Babbie and Mouton 2008).

5.2.2 Research Design

Creswell defines the concept 'research design' as follows: "Research designs are plans and the procedures for research that span the decision from broad assumptions to detailed methods of data collection and analysis" (2009:3). A research design forms the foundation of a research study and determines its quality. It is a strategic framework detailing *what* the research methods inherent in the chosen research approach are, and *how* they must be implemented to answer the research question, stemming from the identified research problem (Terreblanche, Durrheim and Painter 2006).

The *explanatory and contextual research designs* for both the quantitative and qualitative methods of data collection and analysis were employed. According to Creswell (2009), an explanatory strategy is regarded as popular for mixed method approaches. It is characterised by the collection of qualitative data in the (second phase) that builds on the results of the first phase quantitative data. This strategy presents two forms of data, which are separate but connected. According to Morse (1991, cited in Creswell 2009:211), this strategy is particularly useful when unexpected results flow from the quantitative study. In this instance, the qualitative data collection that follows can be used to examine or evaluate the theoretical results in more detail. In essence, this strategy is straightforward and easy to implement because the steps fall into clear separate stages. In addition, a strong feature of this strategy is that it makes it easy to describe and report information; however, in contrast, it could prolong the data collection process.

Contextual research focuses on specific events in naturalistic settings. Naturalistic settings refer to real-life situations that cannot be controlled, as they occur naturally (Burns 2003). Conley (2005:229) concurs that contextual research gathers information about everyday situations, or contexts, suggesting that the following steps exist in contextual research:

- Design the study – this entails deciding on the research approach in order to decide which participants to include, as well as how to collect data from them.
- Gather field data – this step entails contacting and collecting the data from participants.
- Code and analyze – once the data has been collected, the researcher approaches the data with rigor. During this step, the analyses ensure 'coverage of the context, check/validate assumptions, and help to generalize anecdotal evidence into substantiated recommendations' (Conley 2005:229).

The findings of this study substantiated some of the main reasons for the limited impact of the Isiseko Sokomoleza Programme. The recommendations in the final chapter are solely based on the findings of this study. Firstly, the quantitative phase was conducted, and thereafter, the qualitative phase of this study (Creswell 2014; Creswell and Plano Clarke 2007). Creswell (2014) refers to this as an explanatory sequential design.

A population can be described as "the totality of persons, events, organisation units, case records, or other sampling units with which the research problem is concerned" (Welman, Kruger and Mitchell 2005). The population for the purpose of this study's quantitative and qualitative phases was the members of 16 congregations in the False Bay Diocese, who were still active in the care and support groups for the quantitative phase and members of the programme implementation team for the qualitative phase.

In order to derive the desired sample, purposive sampling was employed for both the quantitative and qualitative phases of this current study. According to De Vos, Strydom, Fouché and Delport (2005), as well as Creswell (2009), this method is based on specific purpose, rather than random selection. Several other authors (Creswell 2009; Miles & Huberman 1994, cited in Creswell 2009; Patton 2002) have also presented typologies of the purposive sampling technique. Purposive sampling leads to greater depth of information from a smaller number of carefully selected cases, whereas probability sampling, leads to greater breadth of information from a larger number of units selected from a representative population (Patton 2002). Purposive sampling is typically informal, based on the expert judgement of the researcher (Mason 2002:140).

The criteria used for purposive sampling in this current study were as follows:

- The study subjects should belong to the local community care and support groups – These care and support groups were located in the local congregations, and, therefore, in the local community. Some of these support groups were also involved in other local community structures;
- They should represent different geographical and age groups – In this study, the different congregations were located in different parts of the diocese of False Bay, for example, the area of Khayelitsha is geographically, politically, and socially different to the area of Eersteriver, or the Strand. The final sample for the quantitative phase of this

study, for example, comprised 21 respondents, from 16 congregations in the False Bay Diocese, ranging in age from 25-68 years, both male and female;

- They should recognise the leadership of ACSA in the community – The members of the care and support groups who participated in this study were volunteers from the local community, most of whom, if not all, attended the Anglican Church and, therefore, recognised the leadership of ACSA in the community;
- They should be as homogeneous as possible, in terms of educational level and socio economic and cultural status – The care and support groups were connected to the local ACSA congregation that hosted them in the Church hall or Church. Most of them were of low economic groupings in the community, who spoke the same language and resided within the boundaries of the parish, where they operated.

For this current study, the above selection criteria were applied when selecting the sample from the study population. I purposively targeted members of the care and support groups of 16 congregations in the False Bay Diocese, where care and support groups were still operating (Creswell 2009; Bryman and Bell, 2007). According to Bryman and Bell, "decisions about sample size represent a compromise between the constraints of time and cost, and the need for precision" (2007:197). Therefore, the choice of sample was based on the constraints of time, as well as the very limited resources available to the researcher for this study. The sample size was determined by the researcher and study supervisor. Three sampling procedures ensued in this current study.

Ethical clearance to conduct this study was first obtained from the University of the Western Cape (Appendix 3), while permission for access to the congregations/parishes was also obtained from the Bishop of the Diocese of False Bay (Appendix 5). The Bishop informed the clergy in the 16, targeted parishes (Appendix 5) that the research, involving the HIV/AIDS Task Teams (care and support groups), would be conducted.

Together with the Social Development Task Team for the Diocese of False Bay (research team), [58] I contacted the leaders of the care and support groups by letters and emails with

[58] The Research team were two staff members of the Department of Social Development in the Diocese of False Bay. They had experience and training in research processes due to the nature of their work in the Diocese. In addition, the researcher conducted a one-day workshop, going through the research proposal, discussing ethical considerations, and logistics. The staff members voluntarily expressed their commitment to participate in this research project. The respondents were consulted and agreed on the participation of the research team. The role

information about the proposed research study. The leaders of the groups, consequently, disseminated the information to the members and encouraged them to attend a meeting at a mutually agreed-upon venue. The research team followed up the original letters and emails with telephone calls to confirm the arrangements. The potential subjects for the study were transported via taxis (paid for by ACSA) to the agreed-upon venue. Information sheets were distributed to all who attended, and the research process was explained in English, Afrikaans, and Xhosa (Appendix 6). After every person present acknowledged that the process was understood, those who were willing to participate were requested to sign a consent form (Appendix 7). Twenty-one subjects agreed to be involved in this quantitative phase.

The congregations where care and support groups still exist are as follows:

- St. George the Martyr (Kuilsriver);
- St Mark Rotterdam (Kuilsriver);
- Good Shepherd (Grassy Park);
- St Luke's (Eerste River);
- St Paul (Faure);
- St John (Strand);
- St Andrew (Hermanus);
- St Mark (Lavender Hill);
- St Augustine (Lotus River);
- St Francis of Assisi (Strandfontein);
- St Michaels (Khayelitsha);
- St Peters (Khayelitsha);
- St Francis (Khayelitsha);
- Christ the King (Rocklands);
- Christ the Mediator (Portlands);
- St Clare of Assisi (Ocean View).

Considering the timeframe available for the study, as well as the fact that only a few care and support groups were still functioning, simple sampling made it less complicated for the researcher, since all the communities were accessible and could easily be located.

of the research team was to assist in the issuing of the questionnaires and, in particular, assisted with the explanation of some questions in the language of some of the participants

The same ethical considerations were followed as with the sampling procedures for the quantitative phase. The sampling was done by the researcher, in consultation with the Social Development Task Team of the Diocese of False Bay (research team). This group of subjects was part of the programme implementation team.

The prospective participants were contacted via letters and emails and followed up with telephone calls by the Social Development team. A meeting was arranged at St John's Church, Strand, which was a separate venue to those used for the quantitative groups. At this meeting, which was prior to the actual day of the interviews, the subjects were informed of the purpose and objectives of the research study. Twelve (12) subjects consented to participate in the qualitative phase of the study.

The same ethical considerations were followed, as with the sampling of the members of the care and support groups, as well as the members of the programme implementation team. The sampling was done by the researcher in consultation with the study supervisor and the research team. Ten (10) prospective subjects were purposively approached via e-mail. The aims and objectives of the study, as well as the research process were explained to them in the emails. An information sheet (Appendix 6), explaining the process in English, was also included in the e-mail. After four (4) participants indicated, via e-mail, that they understood the process and were willing to participate, they were requested to sign the consent form (Appendix 7), which was also done via e-mail. With relevance to this study, four **(**4) participants were selected out of the 10 contacted. The key informants were skilled in programme management of the Isiseko Sokomoleza and Vana Vetu Programmes. They demonstrated leadership skills at four different levels, namely, a project director, project manager, project coordinator, and a field worker in HIV/AIDS.

The data collection tool employed for the *Quantitative Phase* of this study was a survey, aided by a structured questionnaire. A structured questionnaire, according to Langdridge and Hagger-Johnson (2009), is a valuable method of collecting data from a number of respondents for the purpose of statistical analysis. The data elicited centred around the areas reflecting the role and response of the care and support groups, their impact and value in the area of pastoral, support and counselling, training, resources, sustainability, partnerships, stigma, and discrimination. Therefore, in the context of this study, a survey was employed, with the aid of a structured

questionnaire (Appendix 8) containing both open- and close-ended questions, to elicit and collect relevant information from the members of the care and support groups, who were selected as respondents for the quantitative phase of this study. The questionnaire was developed by me, in consultation with the study supervisor. According to Babbie, a questionnaire is "a document containing questions and/or other types of items designed to solicit information appropriate for analysis" (2007:246). The basic goal of a questionnaire is to gather information regarding a specific phenomenon from individuals who are knowledgeable on the subject. There are various types of questionnaires; however, for the purpose of this study, a group-administered questionnaire (De Vos et al. 2011) was utilised. In group-administered questionnaires, each respondent completes the questionnaire on his/her own, while the researcher is available to answer any questions, or clarify any misunderstandings. A few such data collection sessions were conducted by me, as the respondents hailed from different areas in the False Bay Diocese. The reasoning behind the multiple sessions was ease of access for the respondents.

Before the main data collection session, the questionnaire (Appendix 8) was shared with three groups of Social Development staff, who assisted in the process of testing the questionnaire, as they had been involved in previous studies. These three groups were randomly selected by the Department of Social Development, to conduct a pilot study, to detect errors for correction, as well as test the relevance and the simplicity of the questions. My aim was to simplify the language of the questionnaire, so that the respondents would be able to understand, and answer the questions, without any difficulty.

The data collection tool employed for the *Qualitative Phase* of this study was in-depth, semi-structured, individual interviews, with the aid of an interview guide. Qualitative researchers use an emerging qualitative approach of enquiry with open-ended collection of data that occurs in a natural setting, sensitive to the people and places under study, and the data analysis that is inductive, establishing patterns or themes. Qualitative interviews are "...flexible, iterative and continuous rather than being prepared in advanced or locked in stone" (Rubin and Rubin 2005, cited in Babbie and Mouton 2008:289). Qualitative data-collection methods, such as interviews, are useful because they allow the participants to express themselves in their own words (Flick 2002). This provides them with an opportunity to have their voices heard and to offer personal views on interpretations, experiences, and opinions. Qualitative research methods seek to ascertain the underlying fundamental nature of the participants' experiences,

and ultimately to inform the conclusions of any research (Creswell 2009). Therefore, for the researcher, the purpose of these interviews were to gain much deeper insight into some of the reasons why the care and support groups could not sustain themselves, to attain a detailed understanding of the institutional challenges that confronted the care and support groups, as well as the on-going impact of stigma, even in those groups.

For the qualitative phase of this study, in-depth, semi-structured, individual interviews were conducted with the participants selected from the programme implementation team. Johnson (2001:104) proposes that in-depth interviews can lead to an intimacy that is normally encountered among friends. A semi-structured interview guide allowed for flexibility in the discussions. Fontana and Frey (2005) suggest that unstructured (or semi-structured) questioning, in contrast to structured questioning, is particularly relevant to in-depth interviewing, especially "…when one is particularly interested in complexity or process, or when an issue is controversial or personal" (De Vos et al. 2011:352).

The individual interviews with the participants were recorded on a voice recorder, after permission was initially obtained, prior to commencement of the data collection process. The recorded data allowed verbatim reporting on the participants' accounts of their experiences. A pilot study was conducted with one participant, who did not form part of the main study, in order to obtain guidance regarding the above-mentioned process. In addition, I conducted e-mail interviews with key informants (a project director, project manager, project coordinator, and a field worker in HIV/AIDS). The reason for this was that these participants were uncomfortable with face-to-face interviews.

The Data collection took place from July to August 2015. Permission was obtained to utilise the Church halls on specific dates for quantitative, as well as qualitative data collection.
The Care and Support groups in the parishes involved in this research study received letters informing them about the data collection sessions. The following information was communicated to the respondents, namely, a reiteration of the purpose of the study, dates, venues and times for data collection sessions, as well as the availability of refreshments. The respondents attended the data collection sessions as scheduled. For logistical reasons, namely transport and location/availability of venues (Church halls), different sessions were held to accommodate the various task teams (care and support groups), by organising the sessions in venues closest to the various respondents.

Data collection for the quantitative phase involved surveys, during which questionnaires (Appendix 8) were disseminated to the twenty-one (21) selected respondents for completion. Twenty-one (21) respondents completed the questionnaire, with support from the research team. I wrote a letter to the Church leadership of St. John's Church, Strand, to request the use of the facilities for both the sampling and interviewing meetings. The researcher explained the reason for the use, stated how many people would be involved and confirmed the days, times and rooms to be assigned for the events. An interview schedule was drawn up based on the following question: 'Why did the Care and Support groups in DFB come to an end?" Subsequently, an interview was conducted with a participant, who was not involved the main study, as a pilot study, to test the process and data collection tool.

At the meetings for the interviews, the participants were comprehensively briefed once again, and reminded that they could withdraw from the process at any time, without prejudice. The participants were requested to sign the consent forms, after which the interviews proceeded. Each interview was conducted by the researcher, while a member of the research team took field notes, and lasted about 30 minutes. A few meetings were necessary to accommodate all the participants. Ultimately, twelve (12) interviews were conducted with the participants. The information gathered were audio recorded, with permission from the participants, and transcribed by a professional person with the appropriate skills in transcribing data. This person was not privy to the personal details of the participants, as each interviewee was allocated a code. Only the researcher and the research team member knew the identity of the participants.

5.2.3 Key Informants of the Qualitative Phase

These participants were keen to participate in the study, but did not feel comfortable being interviewed one-to-one or face-to-face. As all contact with these participants had been via e-mail, the researcher enquired whether they would be comfortable with e-mail interviews. According to Hunt and McHale, "Although e-mail has been widely used for more than a decade, its value as an interview technique has not been thoroughly reviewed and assessed" (2008:1415, cited in De Vos et al. 2011). They continue that "…e-mail interview method is in a state of infancy, but it has huge future potential". However, according to the referenced date, the statement was made nine years ago. The participants agreed to the e-mail interviews and the researcher proceeded to formulate some ground rules regarding the process. The researcher indicated the length of the interview, the number of questions (drawn from the same interview

schedule used with the one-to-one interviews) that would be asked, as well as a request that the participants answer in as much detail as possible. The researcher proceeded to send each participant one question (the same question) at a time and waited for their responses, before sending the next. The process reached closure when all the questions were sent and the participants advised that they had nothing further to comment. Four key informants participated in the e-mail interview. Transcription was not required for these interviews as they were already in written format.

The quantitative data were analysed statistically. Descriptive statistics are the most commonly used method of analysis for quantitative research (Nicholas 2006). Descriptive statistics simply describes what the data shows and is used to present quantitative data in a manageable form. It consists of methods for organizing or summarizing data, which includes the construction of graphs, charts, and tables. It also helps to simplify large amounts of data in a sensible way. Even though it has its limitations, Descriptive statistics still provide a useful summary that enables comparisons across other units (Nicholas 2006).

For the qualitative data, this research adopted an interpretive approach to analysing the data. The purpose of interpretive analysis is to provide a thorough description of the characteristics, processes, transactions, and context that the participants constitute of, which are the 'thick descriptions' (Terre Blanche, Durrheim and Painter 2006). In addition, this approach acknowledges that research is an interactive process, which is shaped by the researcher, as well as the participant's own personal history, biography, gender, social class, and ethnicity (Denzin and Lincoln 2005). Therefore, I was constantly aware of personal experiences, as a priest in a Church setting, as well as how it affected the analysis of the data.

This study aimed to explore the reasons for the limited impact of the Isiseko Sokomoleza Programme's implementation and, therefore, targeted the individuals who were directly involved with HIV/AIDS sufferers, members of the care and support groups. All the parishes in the Diocese of False Bay, therefore, were not considered, but only those that still had care and support groups (16 parishes in total), as most had closed down at other parishes due to lack of funding and interest. A larger sample would have provided a more comprehensive study of the problem, however, the research was restricted due to limited time and available resources.

The quantitative data were analysed statistically with the aid of computerised data analysis software. According to Bryman (2008; 2012; 2016), descriptive statistics are statistical

computations describing either the characteristics of a sample, or the relationship among variables in a sample. Descriptive statistics summarise a set of sample observations. The descriptive statistics in this current research were reported in the form of tables, charts, and graphs (Bryman 2008; 2012; 2016). Inferential statistics are used to make inferences, or judgments, about a larger population, based on the data collected from a small sample drawn from the population (Bryman 2008; 2012; 2016).

A qualitative content analysis, according to Zhang and Wildemuth, involves the identification of unique themes that "…illustrate the range of the meanings of the phenomenon…" (2009:2). They continue by highlighting that the intention of qualitative content analysis is to reduce raw data to themes and/or categories based on valid inference and interpretation. The qualitative data, therefore, were transcribed and a thematic analysis was done. The following guidelines, as recorded in Creswell (2014:140-142), were followed for the analysing of the data:

- I began by reading through all transcripts in order to get a sense of the whole. I then jotted down first impressions/ideas/concepts in the margin of the text. In this process, I also reflected on field notes and observations.
- Thereafter, I returned to the transcripts and organized the data by means of coding, sorting the images into themes and sub-themes of a chronicle. To understand the participants' construction of reality, the analysis moved beyond content analysis (*what was said*), to also note the structure and format of the 'story' (*how it was said*) – the way in which their experiences and perceptions were conveyed, their interpretations and reflections of the sequence of events used to portrait their 'story'.
- Central generic themes (storylines) that emerged were identified and reported. Ultimately, five themes were identified.

5.4 Ethical Considerations

The essential purpose of research ethics is to protect the dignity and welfare of the research participants (Terreblanche et al. 2006).

This study was conducted in accordance with the research standards of the University of the Western Cape. At the outset, permission to conduct the research, as well as ethical clearance, had to be obtained from the UWC Senate Ethics Committee. As such, the study only

commenced after the research proposal was duly approved by the University of the Western Cape Senate, the Arts Faculty Board and the Department of Theology and Religion (Appendix 3). Permission was sought from (Appendix 4), and granted by (Appendix 5) the Bishop of the Diocese of False Bay.

Thereafter, the Bishop of False Bay granted permission for me to engage with the clergy and parishes in the Diocese of False Bay. The Bishop sent a formal letter to all the clergy and Churchwardens towards the end May 2014. A brief introduction of the research project was shared, by me, with the Bishop and leadership of the parishes.

The respondents and participants were drawn from the congregations/parishes, as reported previously, and informed that their involvement in this study were completely voluntary and anonymous and therefore gave them the option to participate or withdraw from the process at any given time without prejudice. They were requested to complete and sign consent forms, and were assured that their personal details and responses would be confidential and anonymous. No obligation was placed on anyone to participate in this research.

Wheeler (2003) argues that consent forms should be used to reframe the subject paradigm, in order to be more inclusive and participatory. Before conducting the research, the participants had to give their permission for the voice recorder to be used to record the interviews.

At the end of the interviews, the participants were asked whether they were in need of debriefing, or a referral to a therapist. This was done to manage the possible risks related to participation in the study. Before the sampling and data collection processes commenced, the prospective respondents/participants were provided with information sheets (Appendix 6) about this research project, and requested to complete a consent form (Appendix 7), after they expressed a willingness to participate. In the quantitative phase, the respondents were requested to complete a questionnaire (Appendix 8). Some respondents were uncomfortable with the content of the questionnaire and did not provide answers to all the questions. The questionnaire was anonymous, and the data were processed by the researcher. It was agreed that the full data assets would be kept by the researcher and that the Dioceses of False Bay would receive a summary of the findings, which would be kept in the Diocesan office. The report would not reveal the identity of the respondents/participants.

Additionally, the researcher took cognisance of the socio-cultural values of the study area and behaved in a manner that did not offend the socio-cultural sensibilities of the

respondents/participants. To ensure confidentially, the information collected was stored in a lockable cupboard at the researcher's workplace. Only the researcher and the study supervisor had access to the data, which were used for the intended purposes only (Creswell 2009; Bryman 2008; 2012; 2016).

In the qualitative phase, the research entailed interviewing individuals as participants; therefore, appropriate ethical conduct was imperative. Creswell (2009) stresses the importance of research ethics, and highlights the pitfalls that the researcher should avoid when making ethically responsible decisions. While focusing on the importance of ethical considerations in research, Creswell (2009) advises that these aspects be specifically addressed:

- informed and voluntary consent;
- confidentiality of information shared;
- anonymity of research participants; and
- no harm to participants.

Informed and voluntary consent: According to Terre Blance et al. (2006) the components of informed consent are:

- Provision of appropriate information
- Participants' competence and understanding
- Voluntariness in participating and freedom to decline or withdraw after the study had started

Formalization of consent: In the process of recruiting participants, the researcher provided all potential participants with information regarding the study face-to-face, in writing, telephonically or via e-mail, focusing on the purpose, as well as their role in participating (Appendix 6). Participants were informed of the reasons why they were approached, based on the criteria of inclusion. They were also informed that they were not going to be coerced into participating and could withdraw from the study at any time, without prejudice. Finally, in order to formalize the consent, participants were requested to sign the consent form provided (Appendix 7).

Anonymity/Confidentiality: The confidentiality with which information was handled was explained in the participant information document. Confidentiality was guaranteed in the following ways: Codes were used for the individual participants and organisation to protect anonymity. The raw data were only available to me and my supervisor (Creswell 2009).

Avoidance of harm: Since this study focussed on the experiences of the service user, it is possible that participants might share emotional information that left them feeling vulnerable (Creswell 2014), therefore, throughout the research process the necessary support were availed. I was familiar with some of the participants, as they were colleagues. I was also fully aware of potential bias during the interviews. In consultation with the study supervisor, I was guided on how to limit personal biases regarding colleagues, so as not to influence the analysis process. My objectivity was also guided by the Code of Ethics, which recommends that social workers inform the participants of their right to withdraw their participation, at any stage of the research, without prejudice. After the interviews, I also had to be conscious of any interaction with the participants on a professional and personal level, so as not influence the research process. At times, the periods between interviews were prolonged, due to the participants cancelling appointments, and momentum was lost. I had to revisit the interview guide constantly, in order to become familiar again with the flow of the interview.

5.5. Conclusion

In the above section the various methods of data collection and the processes of data analysis were presented, as well as the research design, sampling techniques and, finally, the statement of ethical considerations. The methodological processes provided the framework for the empirical investigation of the research problem. The findings of the investigation which will be presented in the following chapter of this research study.

CHAPTER SIX
QUANTITATIVE FINDINGS AND DISCUSSIONS

6.1 Introduction

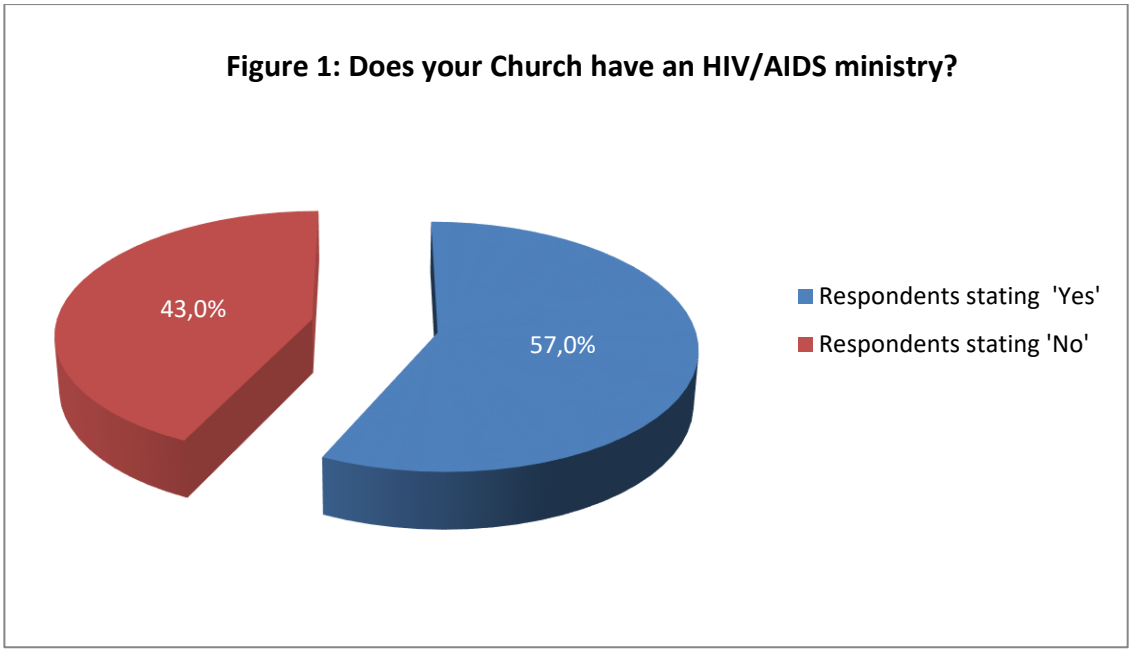
In this section, the quantitative results of the findings are presented and a discussion of the empirical findings that emanated from this study provided. It is noted that the empirical investigation was done during the period of 26th August to 20th March 2016 and since the time of the investigation and documentation of the findings, the context in the Diocese of False Bay could have changed for the better or the challenges facing AIDS could have become more intense. Through this discussion, it is anticipated that an answer could be provided to the research question, "What are the most significant reasons for the limited impact of the Isiseko Sokomoleza Programme introduced by the Anglican Aids Office, in the Diocese of False Bay?", as posed in the first chapter of this study.

6.2 Quantitative Findings

This section contains the statistical findings related to 'the most significant reasons for the limited impact of the Isiseko Programme'. The following questions, from the quantitative phase questionnaire, were posed to the respondents, who responded as follows:

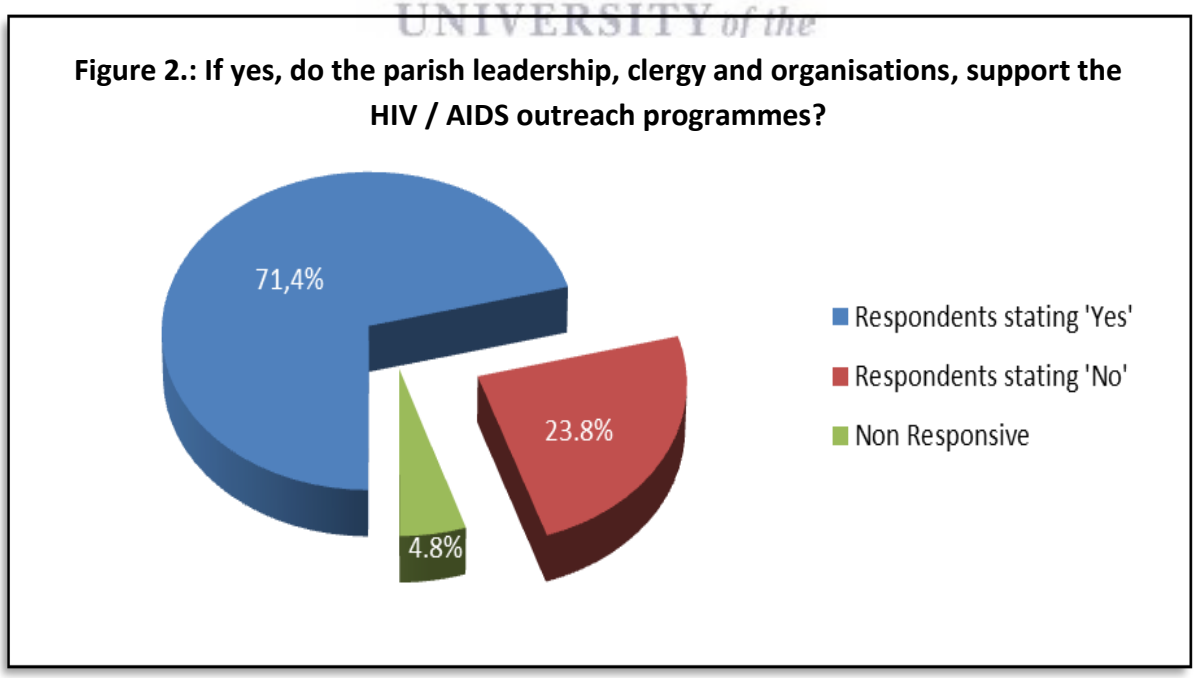
6.2.1. Governance Structures

Does your Church have an HIV/AIDS ministry?



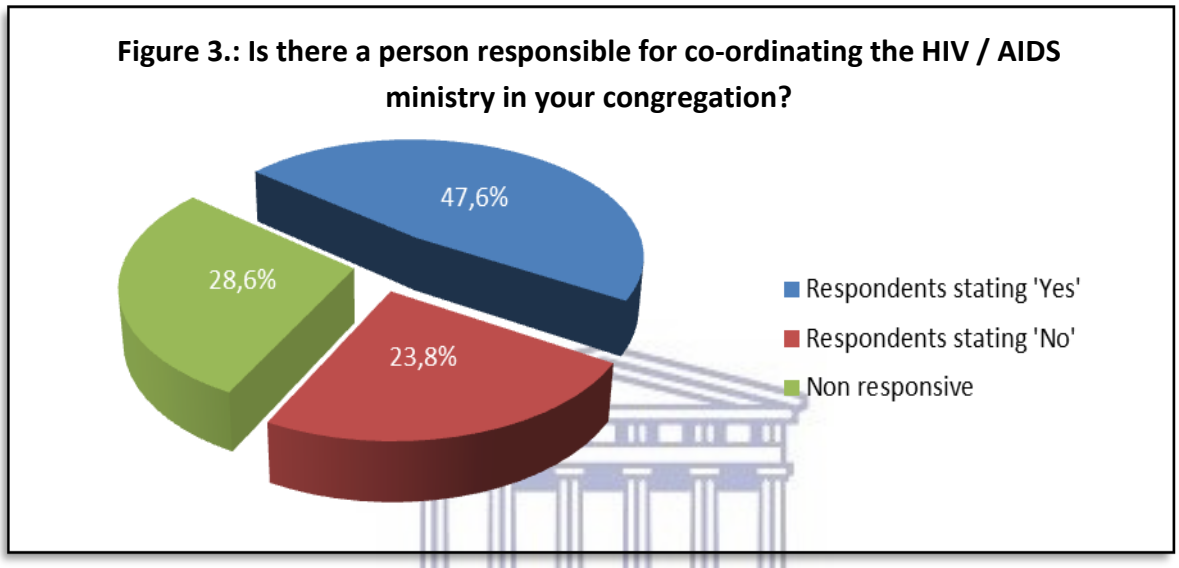
Of the 21 respondents, 12 (57%) indicated that their Church does have an HIV/AIDS ministry. A significant number, nine (43%), indicated that their Church does not have an HIV/AIDS ministry.

6.2.2. If yes, do the parish leadership, clergy and organisations, support the HIV/AIDS outreach programmes?



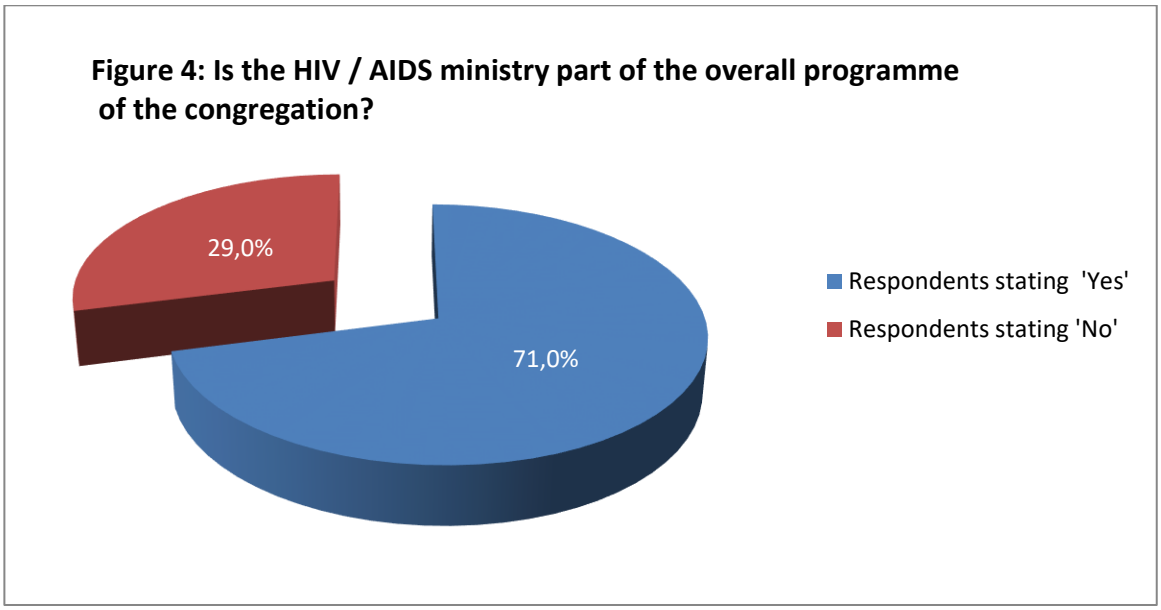
Of the 21 respondents, 20 (95.2%) responded to this question, while one (4.8%) was non-responsive. A high percentage of the respondents, 15 (71.4%), stated that their parish leadership, clergy, and organisations supported the HIV/AIDS ministry, while five (23.8%) indicated that the HIV/AIDS ministry was not supported by the parish leadership, clergy, and organisations.

6.2.3. Is there a person responsible for co-ordinating the HIV/AIDS ministry in your congregation?



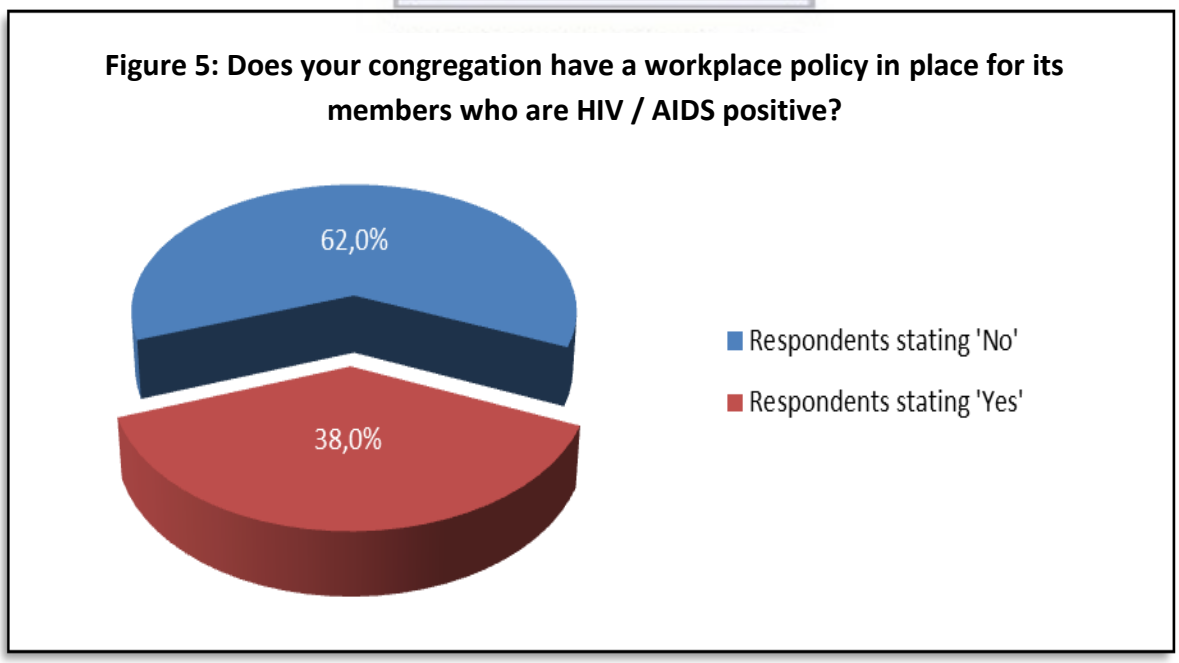
Of the smallish sample of 21 respondents, 15 (71.4%) responded to this question, with 10 (47.6%) indicating that most congregations have a responsible coordinator for the HIV/AIDS ministry, while five (23.8%) indicated that their parishes did not have HIV/AIDS ministry coordinators. The six (28.6%) non-responses could be a possible indication of the respondents not knowing and/or not being aware of a responsible HIV/AIDS ministry coordinator in the congregation.

6.2.4. Is the HIV/AIDS ministry part of the overall programme of the congregation?



A large percentage of the respondents, 15 (71%), stated that the HIV/AIDS ministry was part of the overall programme of the congregation, while six (29%) indicated that it was not part of the congregation's overall programme.

6.2.5. Does your congregation have a workplace policy in place for its members who are HIV/AIDS positive?

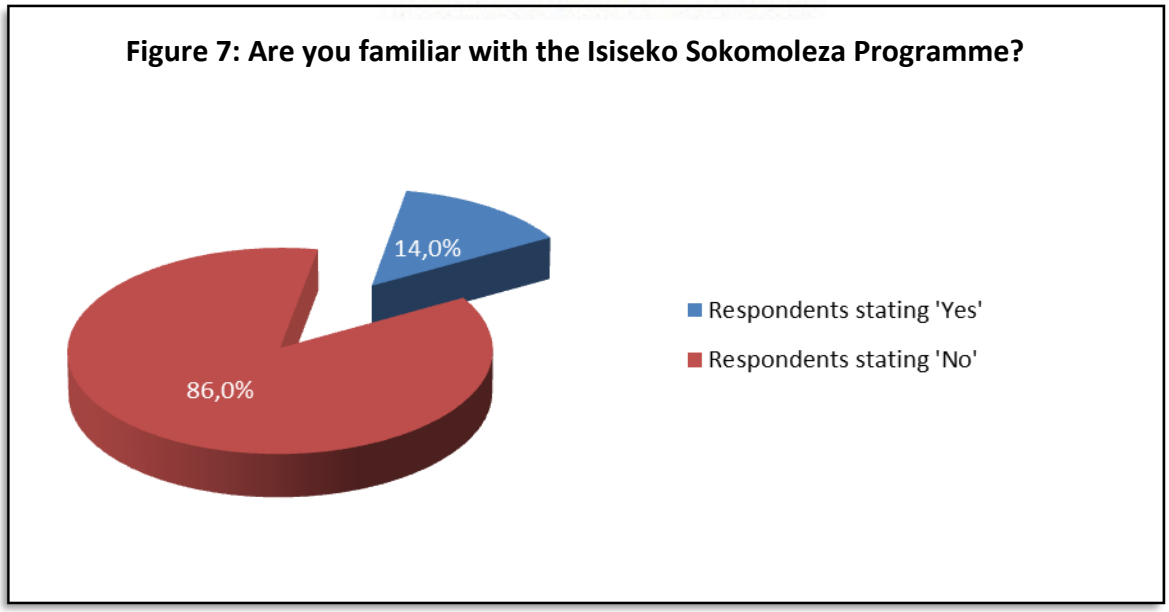


A large percentage of the respondents, 13 (62%), indicated that their congregation did not have a workplace policy in place for its HIV/AIDS positive members, whereas only eight (38%) indicated that their congregations had workplace policies in place.

6.2.6. Is there a special task team in the congregation to provide oversight, leadership, and direction to the programme, if any?

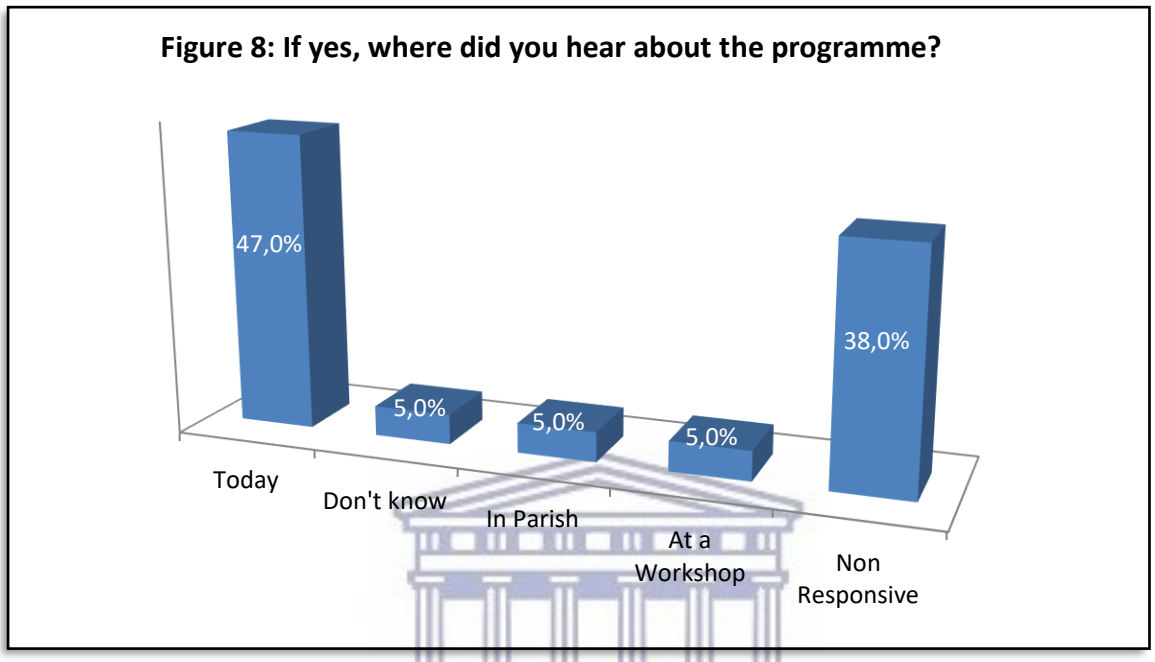
Twenty respondents answered this question, while one (5%) did not participate. Four respondents (19%) indicated that there was a special task team in their congregation that provided oversight, leadership, and direction to the HIV/AIDS programme. A significantly high percentage of the respondents, 16 (76%), indicated that their congregations did not have a special task team.

6.2.7. Are you familiar with the Isiseko Sokomoleza programme? Yes/No



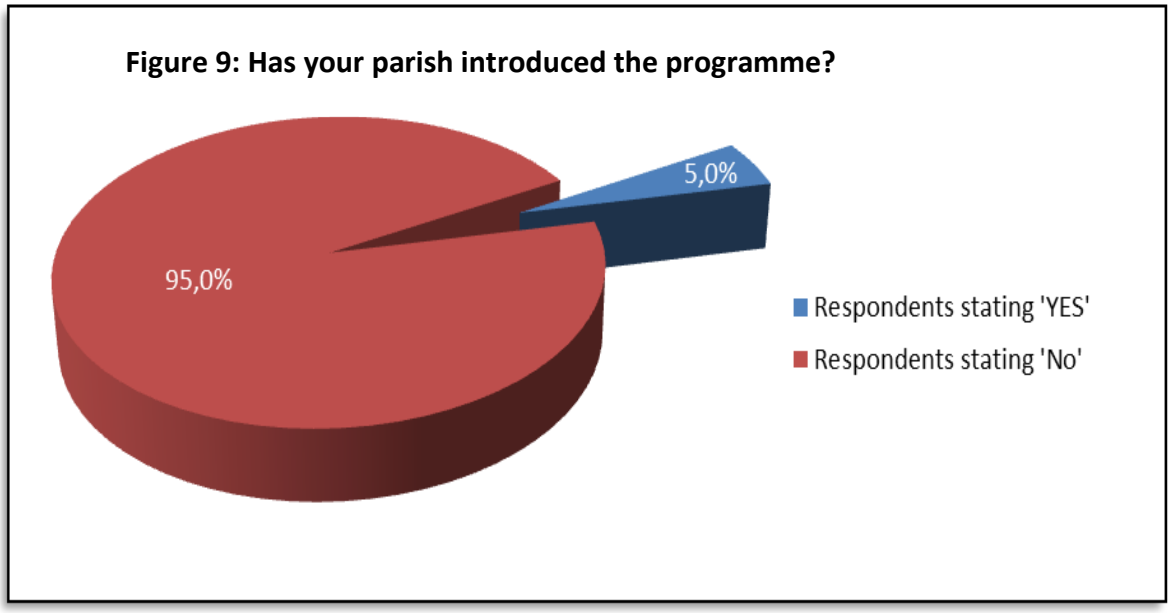
A very low percentage of respondents, three (14%), were familiar with the Isiseko Sokomoleza Programme, with a significantly high percentage (86%) of respondents, 18, who were not familiar with the Programme.

6.2.8. If yes, where did you hear about the programme?



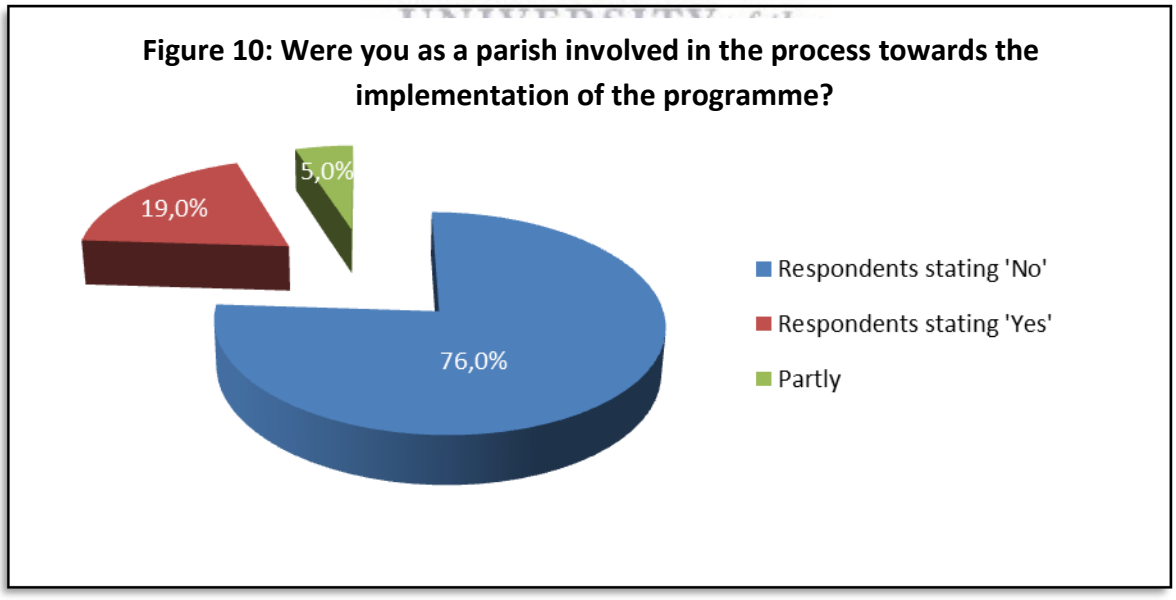
Thirteen respondents (62%) answered the above question, while eight respondents (38%) were non-responsive. Ten respondents (47%) heard about the Isiseko Sokomoleza Programme for the first time while they were completing the researcher's questionnaire. One respondent (5%) heard about the programme in the local parish, another one did not, or could, not remember where s/he had heard about the programme, while yet another one had heard about it during a workshop.

6.2.9. Has your parish introduced the programme? Yes/No



Almost all of the respondents indicated that their parishes had not introduced the Isiseko Sokomoleza Programme. Of the 21, 20 (95%) indicated that their parishes had not introduced the Isiseko Sokomoleza Programme.

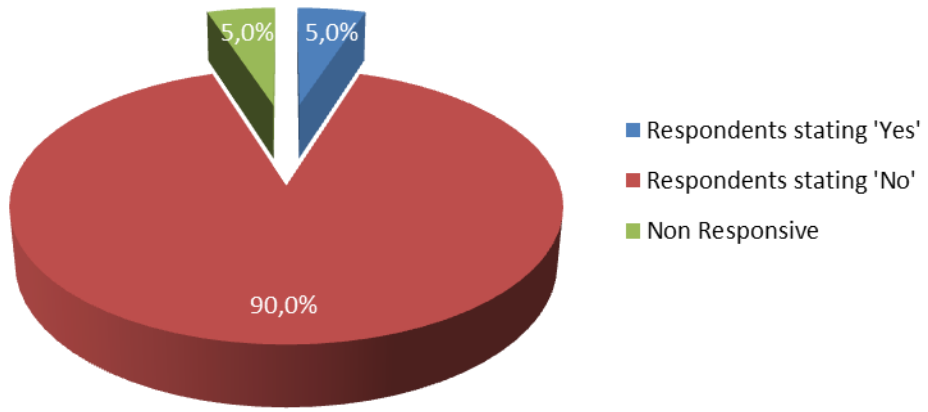
6.2.10. Were you as a parish involved in the process towards the implementation of the programme? Yes/No



Sixteen respondents (76%) felt that their congregation were not involved in the process towards the implementation of the programme, while four (19%) indicated that their congregations were involved in the implementation of the programme and one participant (5%) felt that his/her congregation was partly involved.

6.2.11. Have you received funding for the Isiseko Sokomoleza project? Yes/No

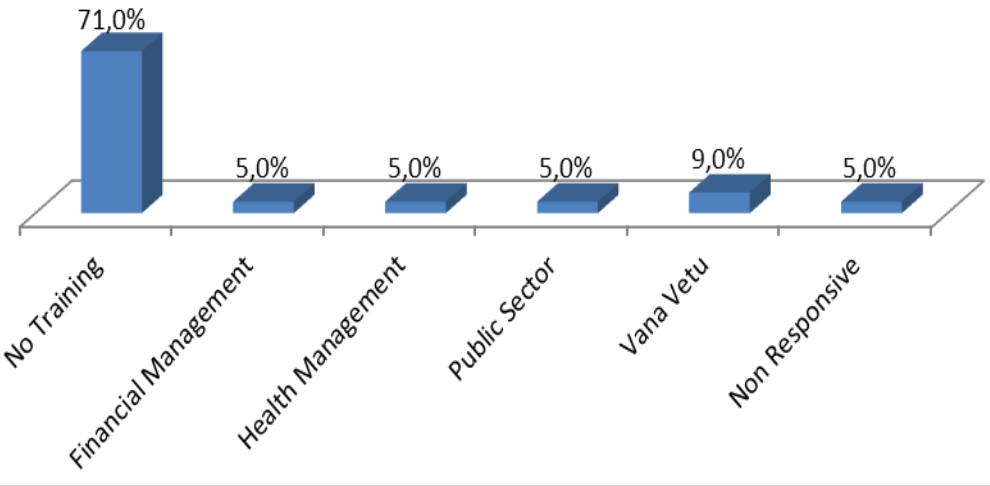
Figure 11: Have you received funding for the Isiseko Sokomoleza project?



Twenty respondents (95%) answered this question, while one (5%) did not participate. Nineteen respondents (90%) indicated that they did not receive funding for the Isiseko Sokomoleza project, while one (5%) respondent indicated that they received funding.

6.2.12. Did you receive training in programme management, financial management, or writing reports? Please elaborate.

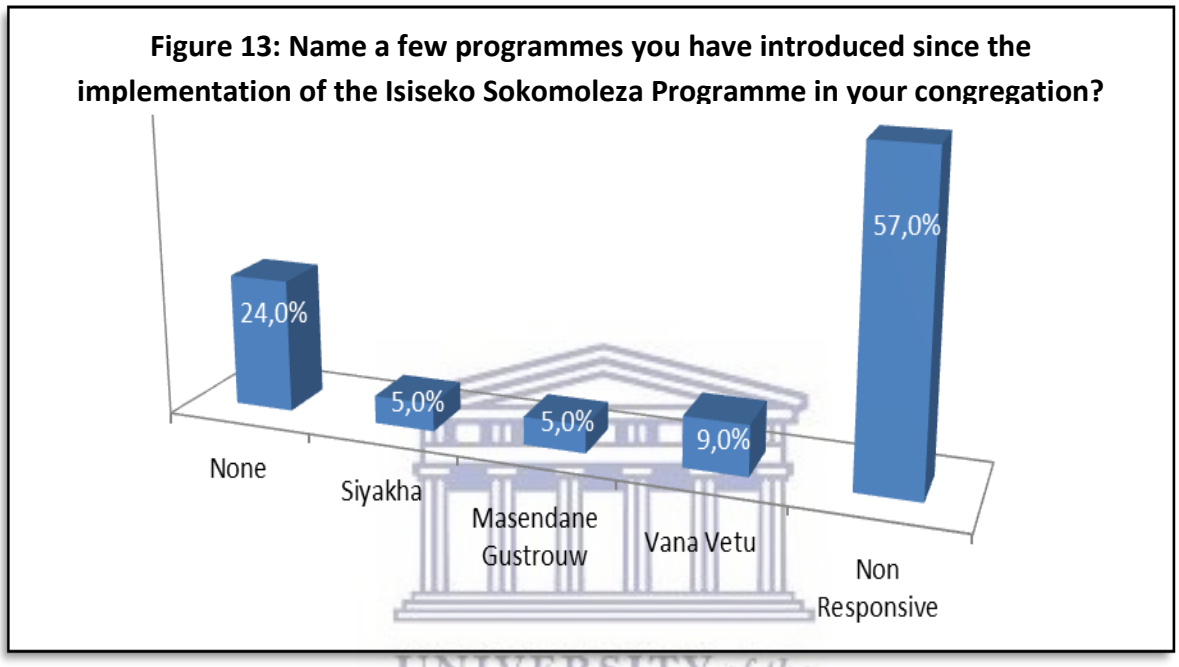
Figure 12: Did you receive training in programme management, financial management, or writing reports? Please elaborate.



Twenty respondents (95%) answered the question, while one (5%) did not answer.

Fifteen respondents (71%) did not receive any training, while one (5%) reported having received financial management training, one (5%) received health management training, one (5%) received public sector training, and two (9%) received Vana Vetu training.
None of the respondents received training in programme management or report writing.

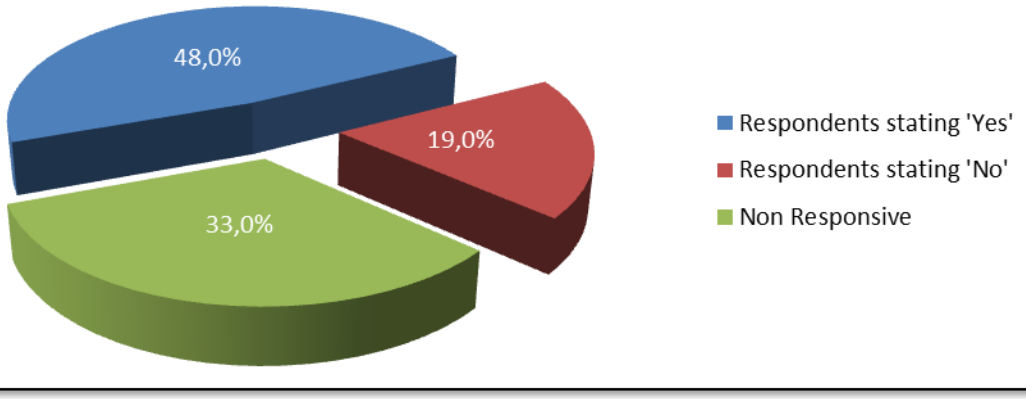
6.2.13. Name a few programmes you have introduced since the implementation of the Isiseko Sokomoleza Programme in your congregation.



Only nine respondents (43%) reacted to this question, while 12 (57%) did not. Five respondents had not introduced any programmes since the implementation of Isiseko Sokomoleza, while one (5%) of the respondents introduced Siyakha, one (5%) introduced Masendane Gustrouw, and two (9%) introduced Vana Vetu.

6.2.14. What, in your opinion, were the changes or impact brought about by the programme?

Figure 14: What, in your opinion, were the changes or impact brought about by the programme?



Of the 21 respondents, 14 (67%) answered this question, while seven (33%) did not respond. Ten of the 14 respondents were positive about the HIV/AIDS programme, representing 48% of the respondents, while four (19%) were negative about the HIV/AIDS programme implementation. The responses from the 14 respondents who answered the question are presented in Table 1 below, which is divided into the positive and negative responses.

Table 1: Respondents' responses to question seven

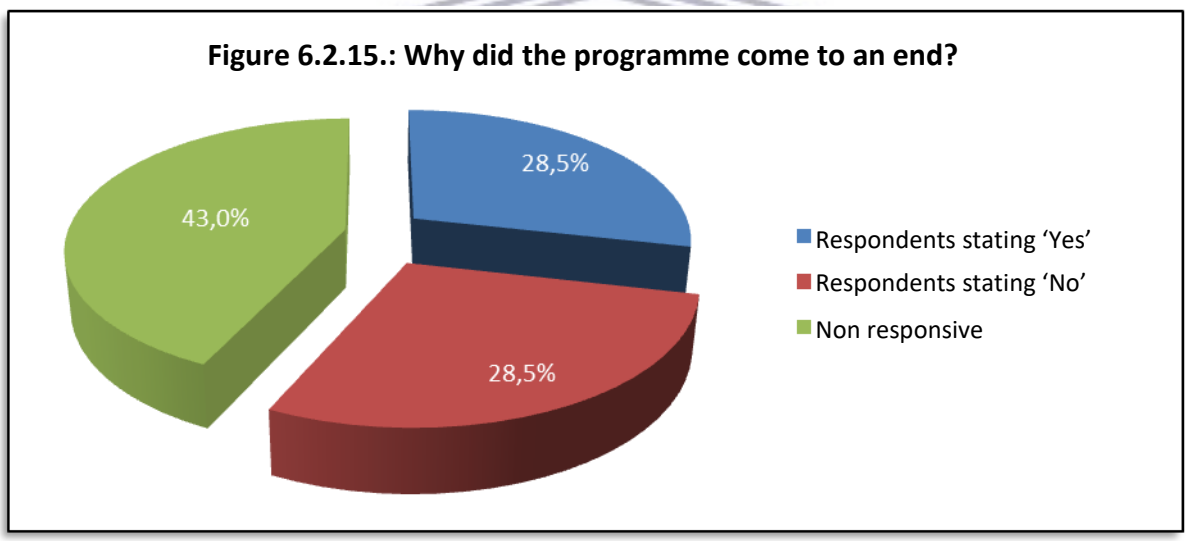
POSITIVE RESPONSES	NEGATIVE RESPONSES
The awareness and education made people's perception about HIV/AIDS change.	No awareness and little impact.
Those who were visited were happy and the food parcels are being appreciated.	No impact education.
Food parcels are being handed out and there is always an ear to listen.	No impact and sometimes little food parcels.
People are positive because of the health talks and food parcels.	Only the lighting of candles and the handing out of ribbons.
Children's participation was good and they are eager to be part of the programme.	
Food parcels are good and the youth talks help them to know to protect themselves against sickness.	
The programme created awareness, participation and opportunities.	
By giving food parcels.	
By giving food parcels.	
It uplifted people through food parcels and they learn to cook their own food.	

The positive responses to the HIV/AIDS programme could be ascribed to congregations where there was a workplace policy in place, where the HIV/AIDS programme was part of the overall congregation programme, where the clergy and Church leadership supported the programme, and where the structures of the congregation supported the HIV/AIDS outreach programme. The negative responses could be linked to congregations where there was a lack of congregational structure support and where the HIV/AIDS ministry programme was not part of the congregational programme.

The researcher also identified (from the analysis) that the provision of food parcels was instrumental in the rolling out of the HIV/AIDS programme. Seven (33.3%) respondents identified the importance of food parcels in their responses. The data analysis also revealed a remarkable link between poverty and HIV/AIDS.

6.2.15. Why did the programme come to an end?

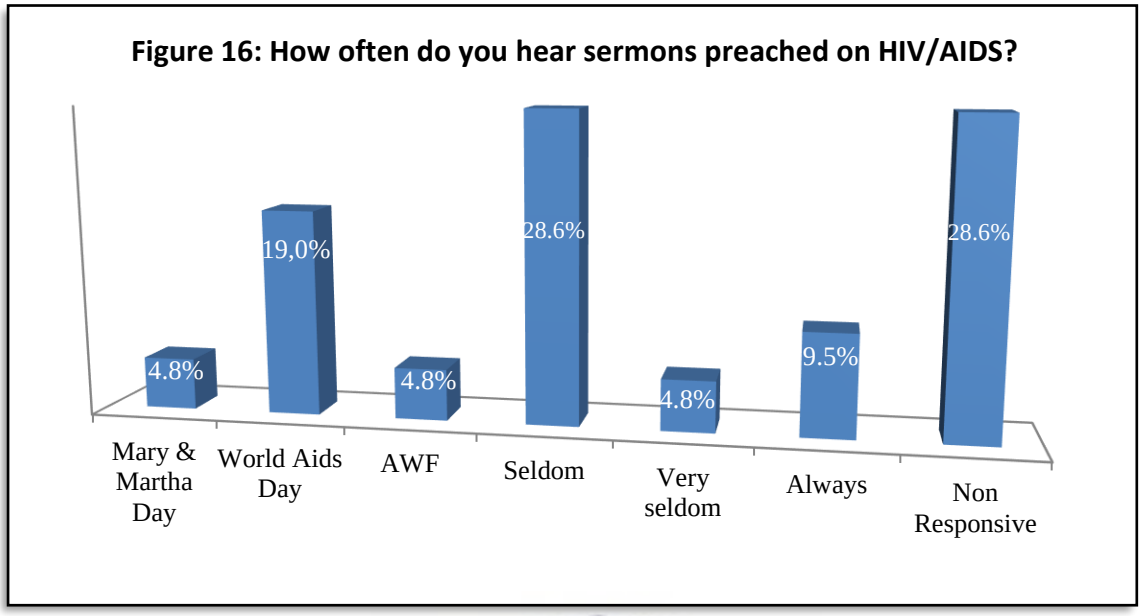
Figure 6.2.15.: Why did the programme come to an end?



Only twelve respondents (57%) answered this question, while nine (43%) did not. Six respondents (28.5%) indicated that the HIV/AIDS programme was still running, while the remaining six (28.5%) indicated that the programme did not exist anymore. The lack of coordinators was revealed as the main reason that the programme was not running at congregations anymore.

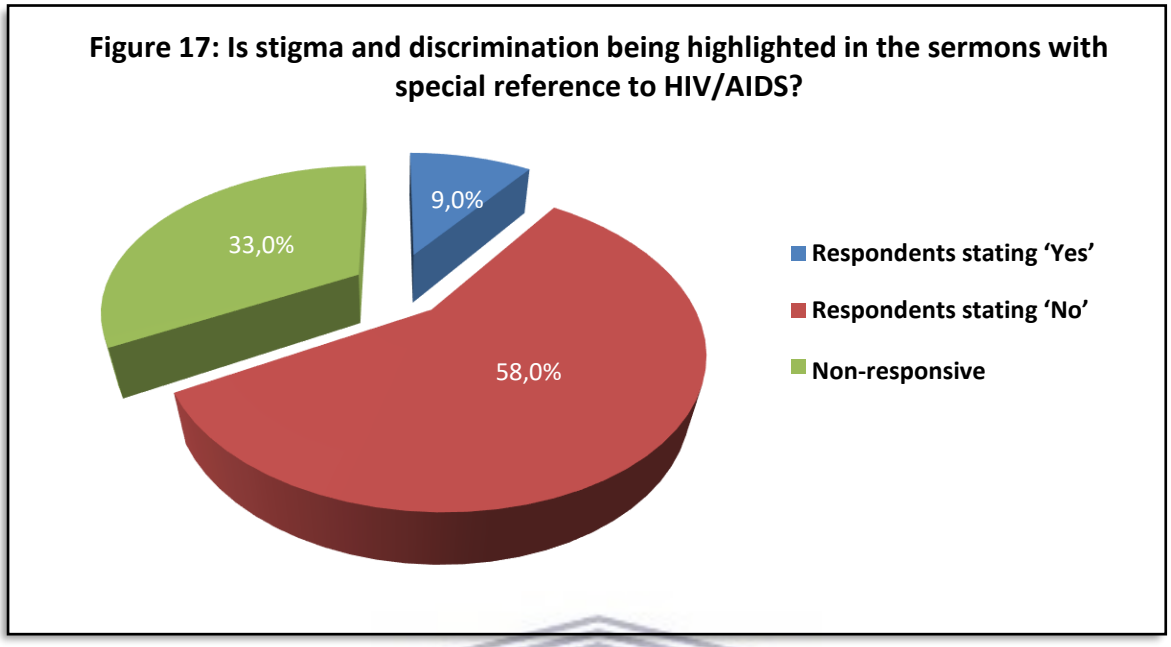
6.3. Communication and Information about HIV/AIDS

6.3.1. How often do you hear sermons preached on HIV/AIDS?



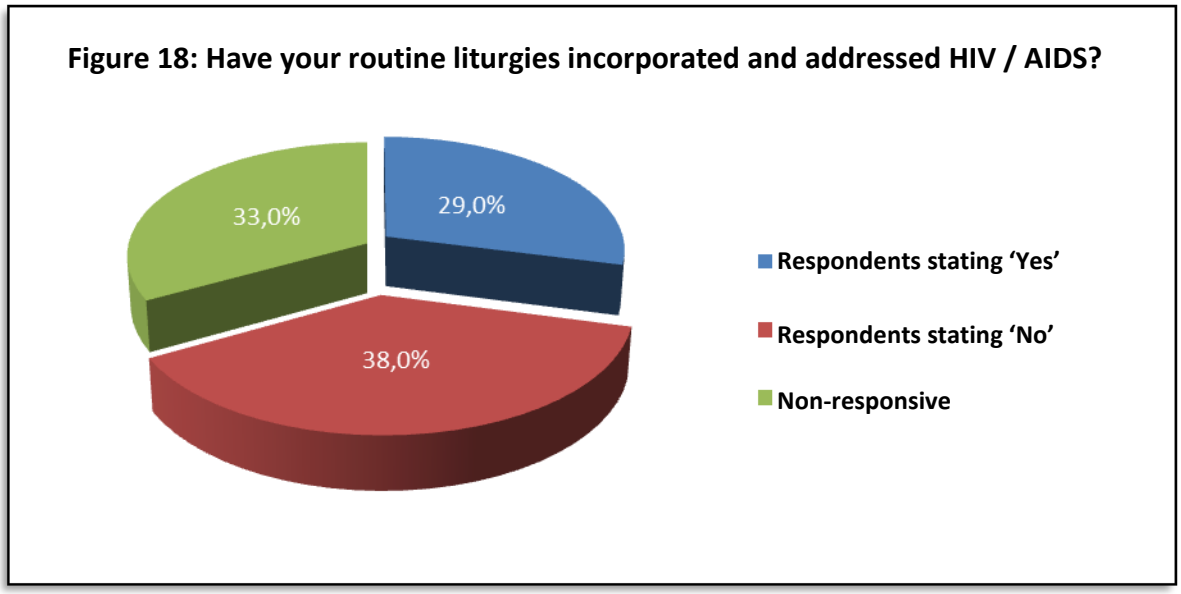
Fifteen respondents (71.4%) answered this question, while six respondents (28.6%) did not respond. One respondent (4.8%) indicated that sermons on HIV/AIDS were preached only on Mary and Martha Day. Four respondents (19%) indicated that sermons on HIV/AIDS were preached only on World Aids Day. Another one respondent (4.8%) indicated that HIV/AIDS is discussed in AWF meetings. A larger percentage, six (28.6%) of the respondents disclosed that sermons on HIV/AIDS are seldom preached. A further one respondent (4.5%) felt that sermons on HIV/AIDS were very seldom preached. Only two (9,5%) respondents indicated that sermons on HIV/AIDS were always preached.

6.3.2. Is stigma and discrimination being highlighted in the sermons with special reference to HIV/AIDS?



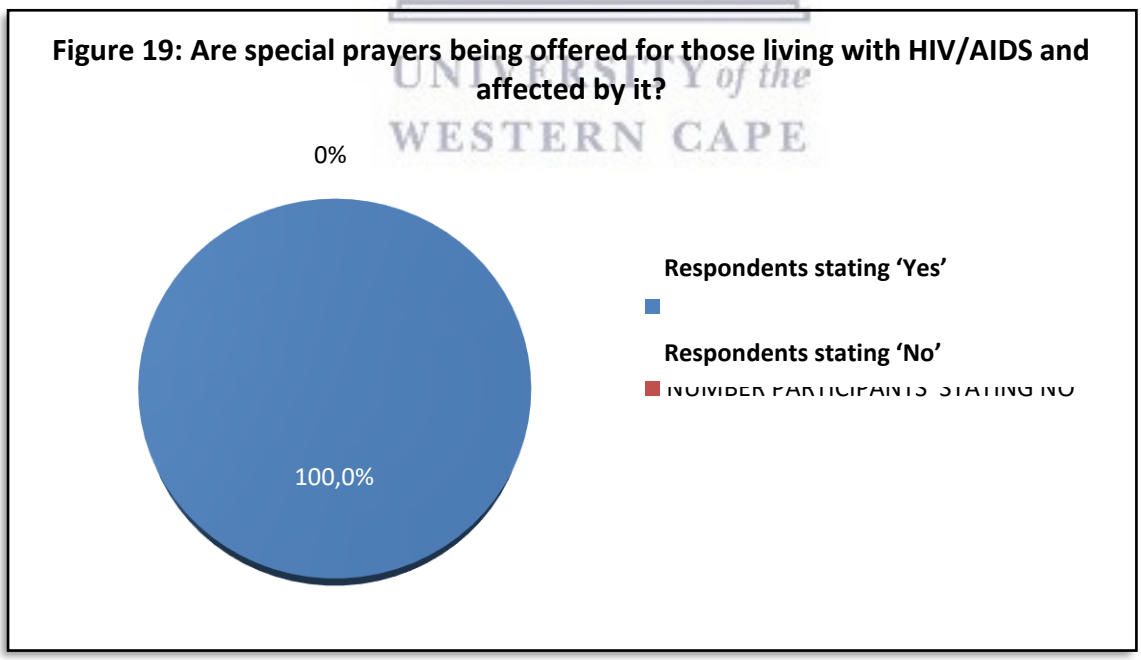
Fourteen respondents (67%) answered the question, while seven (33%) did not respond. Two respondents (9%) felt that the stigma around HIV/AIDS was being highlighted in the sermons, while 12 (58%) of the respondents indicated that the stigma around HIV/AIDS was not highlighted in sermons.

6.3.3. Have your routine liturgies incorporated and addressed HIV/AIDS?



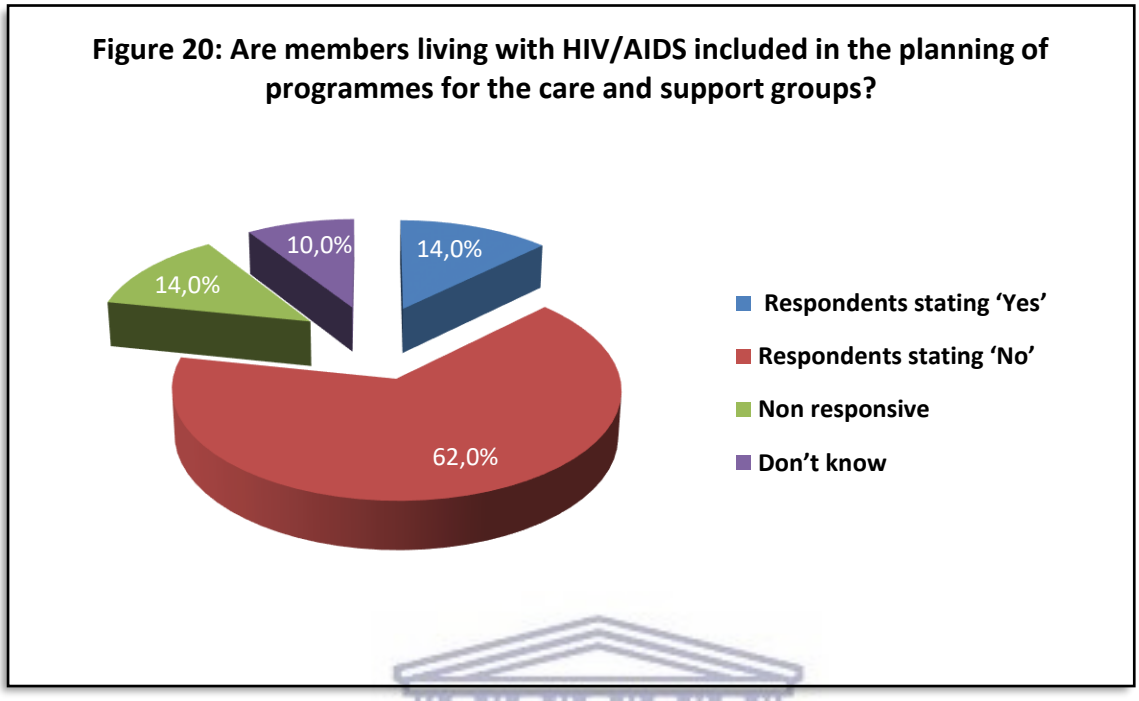
Only 14 (67%) of the respondents answered the question, while seven (33%) did not participate. Eight respondents (38%) indicated that their routine liturgies did not incorporate and did not address HIV/AIDS, while six (29%) of the participants indicated that their routine liturgies incorporated and addressed HIV/AIDS.

6.3.4. Are special prayers being offered for those living with HIV/AIDS and affected by it?



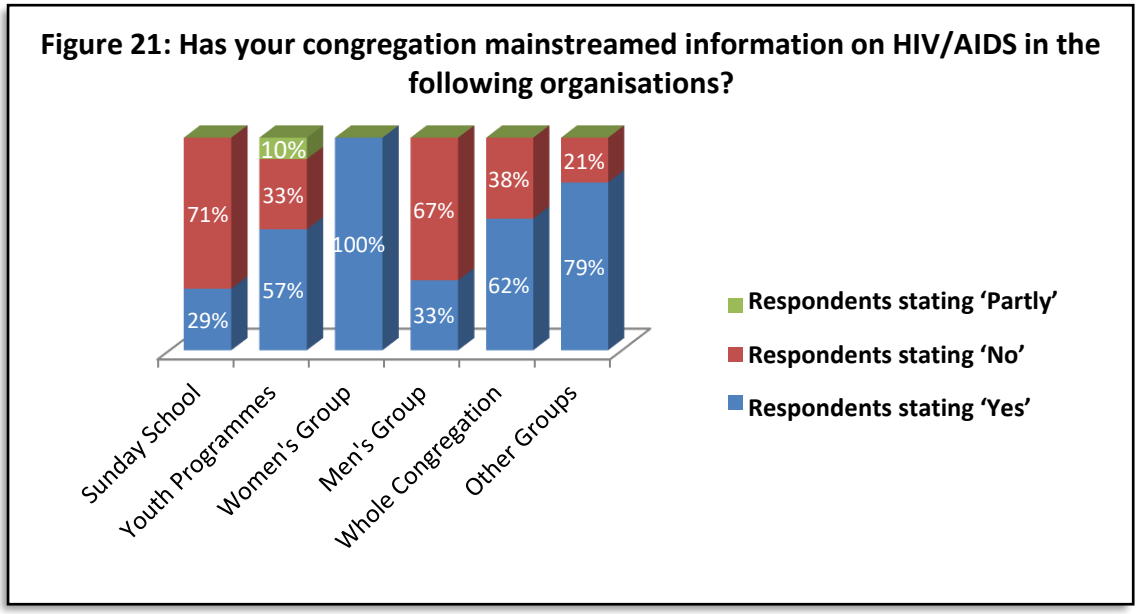
All participants indicated that special prayers are being offered for those living with HIV/AIDS and affected by it.

6.3.5. Are members living with HIV/AIDS included in the planning of programmes for the care and support groups?



Only 18 (76%) of the respondents answered the question, while two (10%) did not know the answer. Three respondents (14%) indicated that members living with HIV/AIDS were included in the planning of programmes for care and support groups. Most of the respondents, 13 (62%), indicated that members living with HIV/AIDS were not included in the planning of programmes.

6.3.6. Has your congregation mainstreamed information on HIV/AIDS in the following organisations?



- **Sunday school: YES / NO.**

  Six respondents (29%) indicated that their Sunday schools have mainstreamed information on HIV/AIDS. Most of the respondents, 15 (71%), indicated that their Sunday schools have not mainstreamed information on HIV/AIDS.

- **Youth Programmes**: **YES / NO.**

  Of the respondents, 12 (57%) indicated that their Youth Programmes have mainstreamed information on HIV/AIDS. Seven respondents (33%) indicated no mainstreamed information on HIV/AIDS, while two disclosed that their Youth Programmes have partly mainstreamed information on HIV/AIDS.

- **Women's Group: YES / NO.**

  All of the participants, 21 (100%), indicated that their Women's Group have mainstreamed information on HIV/AIDS.

- **Men's Group: YES / NO.**

  Only 7 (33%) of the respondents indicated that their Men's Groups have mainstreamed information on HIV/AIDS, while 14 (67%) indicated that they have not mainstreamed information on HIV/AIDS.

- **The Whole Congregation: YES / NO.**

  Thirteen of the respondents (62%) indicated that their whole congregation have mainstreamed information on HIV/AIDS. Eight respondents (38%) indicated that their whole congregation have not mainstreamed information on HIV/AIDS.

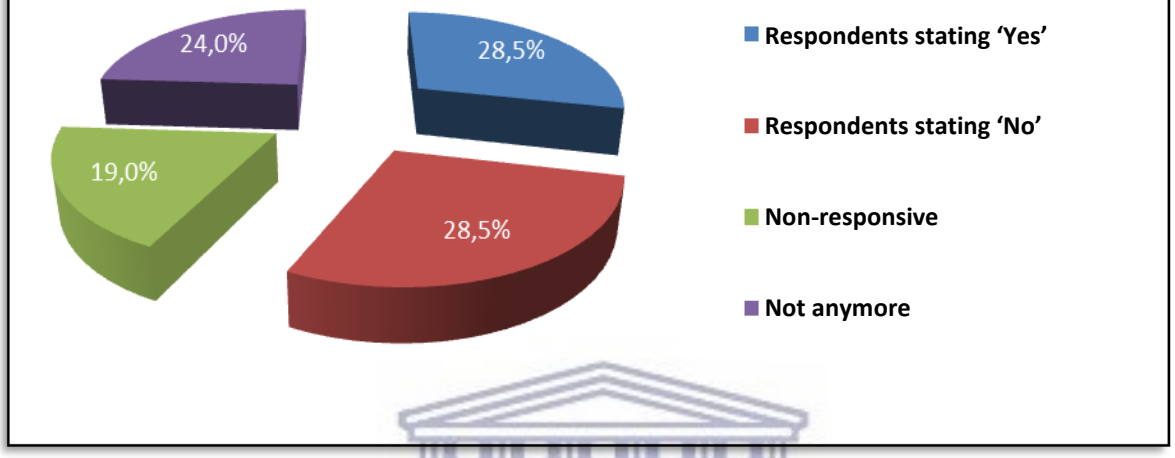
- **Other Groups: YES / NO.**

  A large percentage of respondents, 17 (79%), indicated that other groups have mainstreamed information on HIV/AIDS, while 4 (21%) indicated that other groups have not mainstreamed information on HIV/AIDS.

6.4. Meaningful participation of HIV+ persons

6.4.1. Does your Church have safe spaces for people who want to share their experiences?

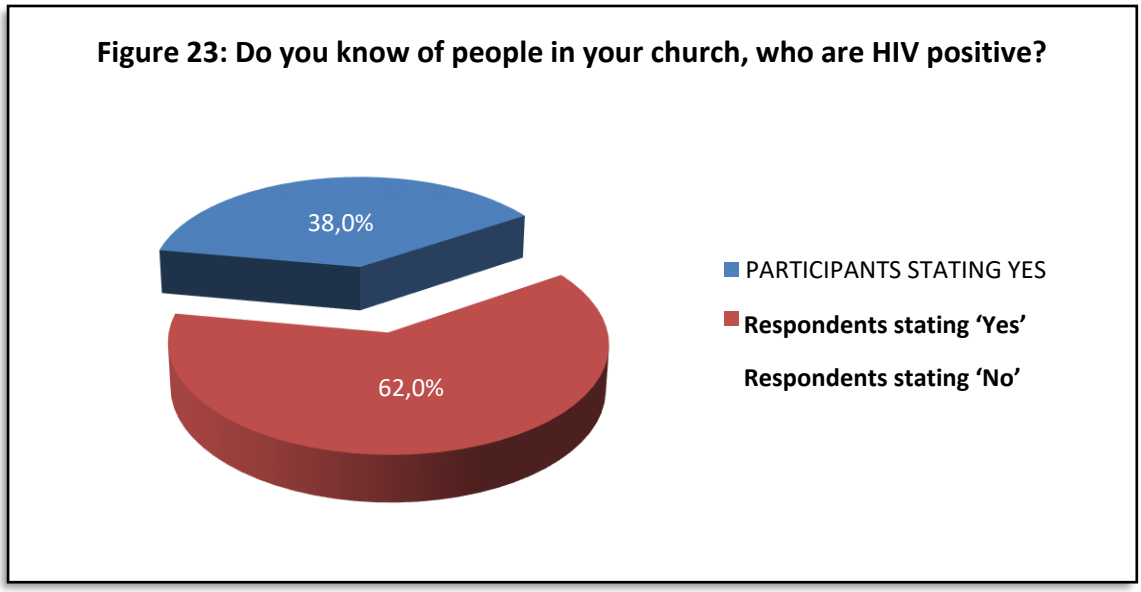
Figure 22: Does your church have safe spaces for people who want to share their experiences?



Seventeen respondents (81%) answered the question. Six respondents (28.5%) indicated that their Church had safe spaces for people who wanted to share their experiences. Most respondents, 11 (52%), indicated that their Churches did not have safe spaces for people who wanted to share their experiences. Of these 11 (52%) indicated that their Churches previously had safe spaces, which no longer existed.

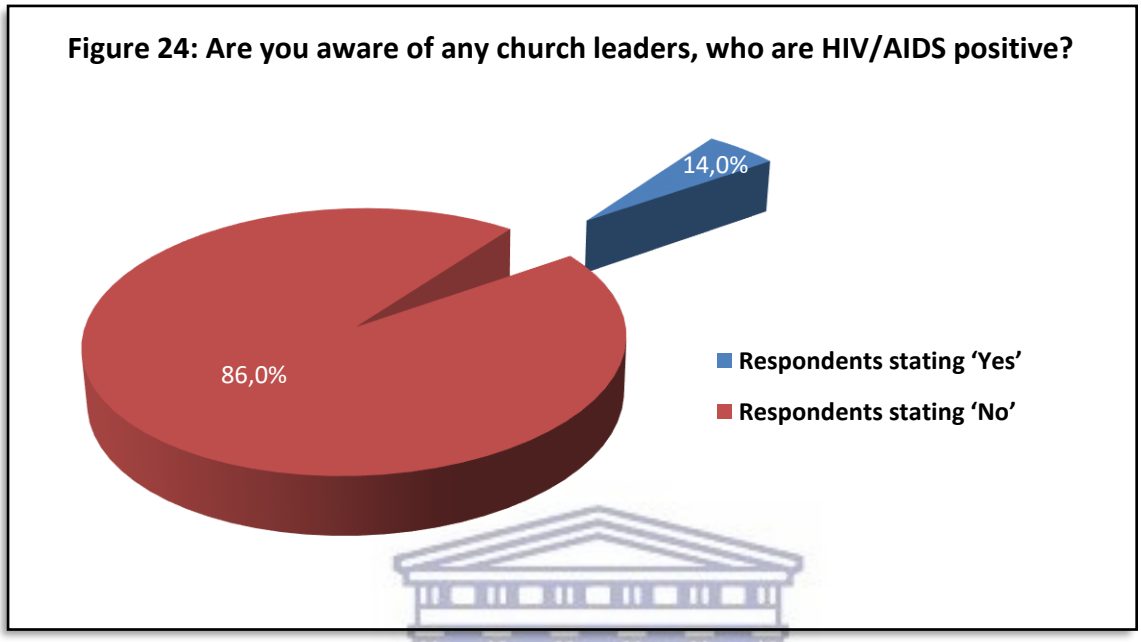
6.4.2. Do you know of people in your Church, who are HIV positive?

Figure 23: Do you know of people in your church, who are HIV positive?



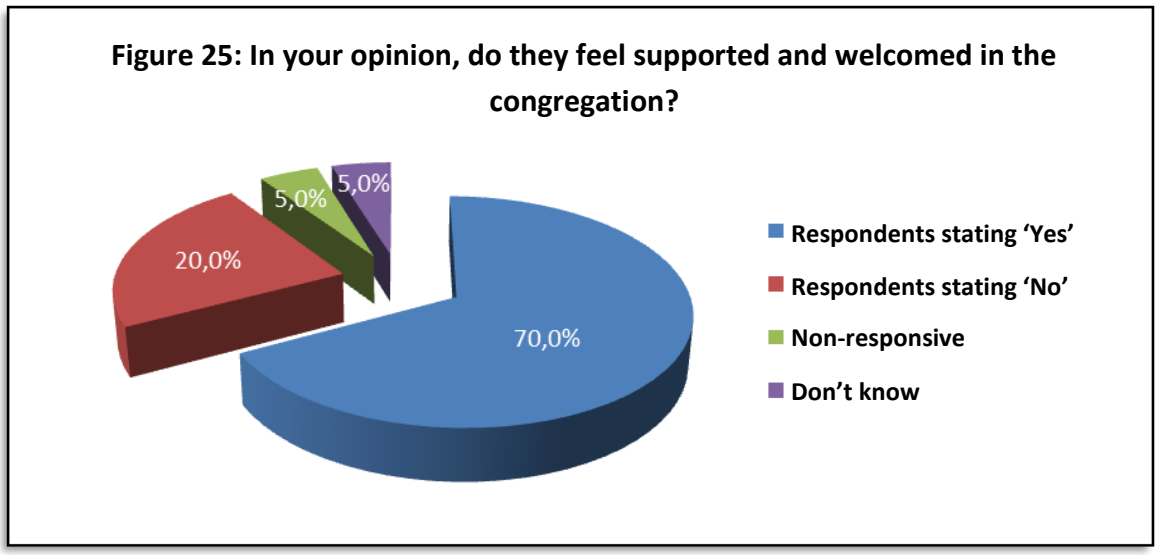
Most of the respondents, 13 (62%), did not know of people in their Church who were HIV-positive. Eight respondents (38%) knew of people in the Church who were HIV-positive

6.4.3. Are you aware of any Church leaders who are HIV/AIDS positive?



Most of the respondents, 18 (86%), were unaware of any Church leaders who were HIV/AIDS-positive. Three respondents (14%) were aware of Church leaders, who were HIV/AIDS-positive.

6.4.4. In your opinion, do they feel supported and welcomed in the congregation?

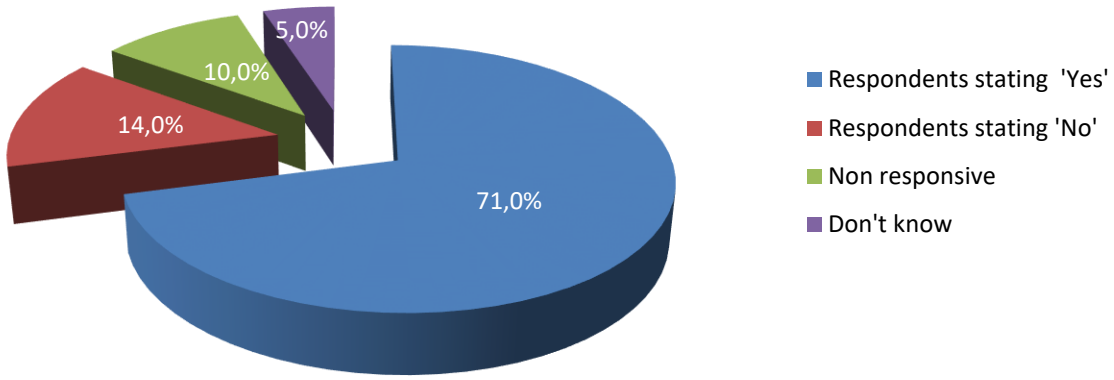


Twenty respondents (95%) participated in this question, while one (5%) respondent did not respond. Fourteen respondents (70%) were of the opinion that HIV-positive people were

supported and welcomed in the congregation. Five respondents (20%) were of the opinion that HIV-positive people were not supported or welcomed in the congregation, while 5% of the participants were not sure whether they were supported or welcomed in the congregation.

6.4.5. Are members being encouraged to undertake the HIV/AIDS test?

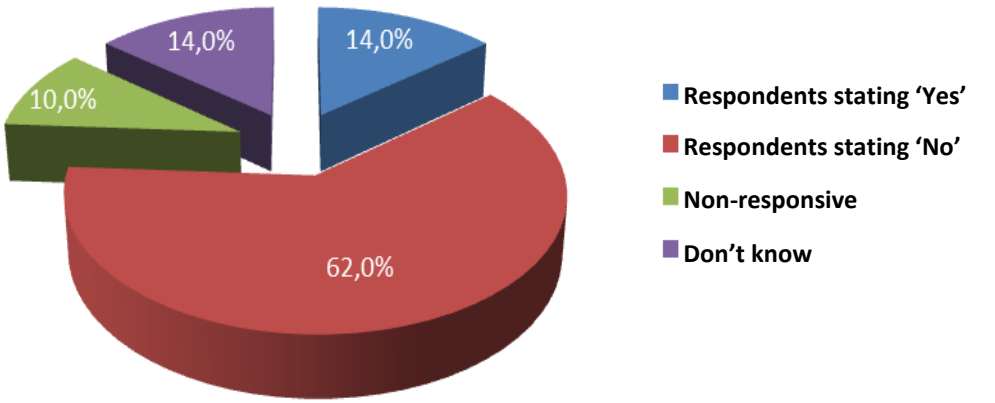
Figure 26: Are members being encouraged to undertake the HIV/AIDS



Nineteen respondents (95%) answered this question, while two (10%) did not participate. Fifteen respondents (71%) indicated that members were being encouraged to undertake the HIV/AIDS tests. Three respondents (14%) were of the view that members were not being encouraged to undertake the tests, while one (5%) respondent was not sure whether members were being encouraged or not.

6.4.6. Does your parish provide on-going counselling and support to those who have declared their status?

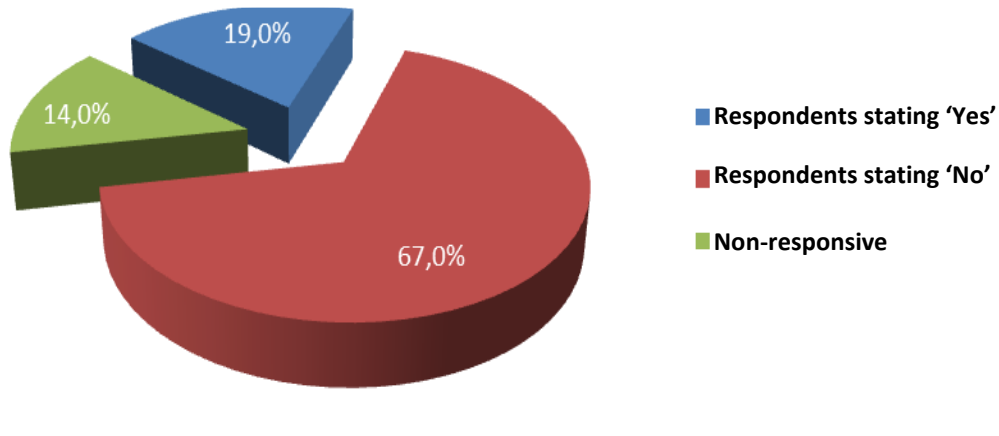
Figure 27: Does your parish provide on-going counselling and support to those who have declared their status?



Nineteen respondents (90%) replied to the question, while two respondents (10%) abstained. Thirteen respondents (62%) indicated that their congregation did not provide on-going counselling and support to those who had declared their status. On the other hand, three of the respondents (14%) indicated that counselling and support were being provided. Another three (14%) of the respondents were not sure whether counselling or support was being provided on an on-going basis.

6.4.7. Are you having discussions on HIV/AIDS in your congregation?

Figure 28: Are you having discussions on HIV / AIDS in your congregation?



Eighteen respondents (86%) answered this question, while three respondents (14%) were non-responsive. Most of the respondents, 14 (67%), indicated that no discussions on HIV/AIDS were taking place in their congregation, while four (19%) indicated that discussions were taking place in their congregations.

6.5. Programmes

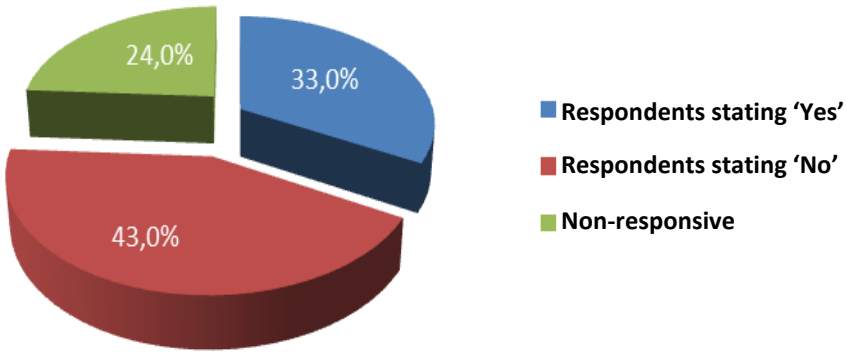
6.5.1. What should the Church do?

Seventeen respondents (81%) answered the question as follows:

- Clergy should be more visible and interact with the congregation and become more involved;
- The Church should not only be talked about on special days;
- The Church is a safe haven and a place of worship;
- The Church should support people with HIV/AIDS and counselling support;
- People are the Church;
- The Church must care where possible;
- There is too little involvement from the side of the Church;
- The Church is place where you get the word of God;
- Die kerk is die instansie waar liefde die hoofdoel is;
- In kerk moet jy welkom voel en die kerk moet uitreik en omgee;
- The Church should be a caring community;
- Love the lord, love your neighbour as yourself; and
- The Church should start more programmes.

6.5.2. Do you see a link between your programmes for HIV/AIDS and the Church?

Figure 29: Do you see a link between your programmes for HIV / AIDS and the church?

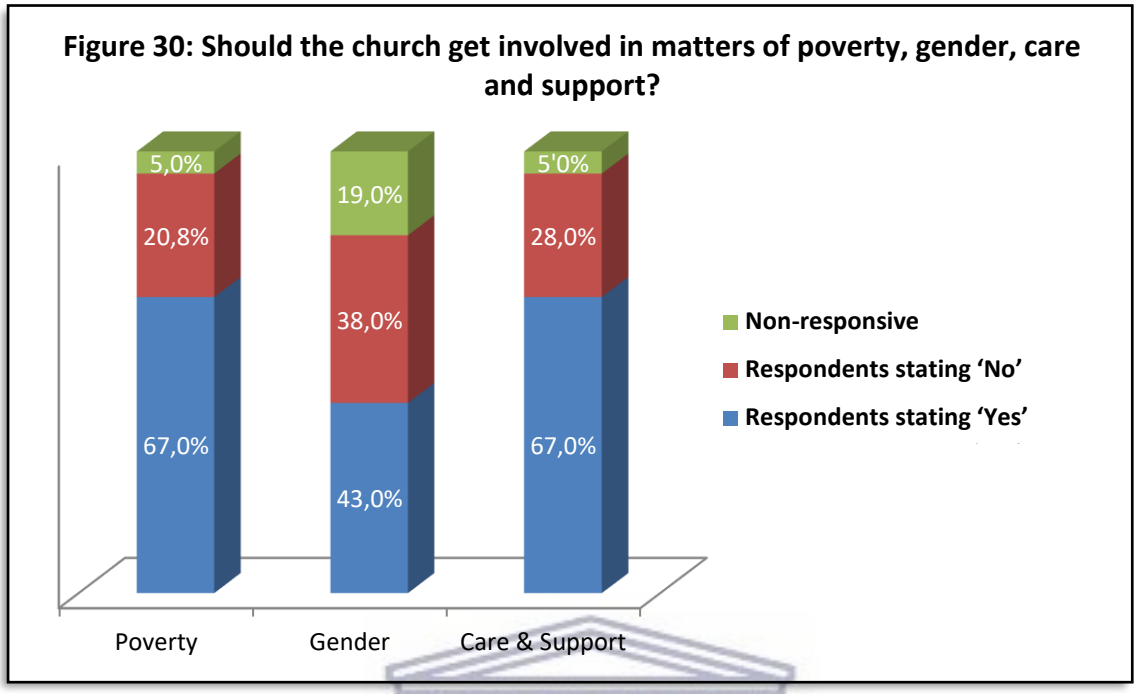


Sixteen respondents (76%) answered this question, while five respondents (24%) were non-responsive. Seven respondents (33%) noticed a link between their programmes for HIV/AIDS and the Church, while nine respondents (43%) did not see a link between their programmes for HIV/AIDS and the Church. The following are brief explanations provided to their responses:

- "People will be well informed" – The participants who responded indicated that the link between the programme and the Church would keep people informed.
- "People will feel welcome" – Members will feel a sense of welcome in the Church.
- "There can only be a link if there is a constant programme" – The link.
- "I give support" – Could be that the Church ought to care and the groups provide the care.
- "Should one be established?" – Care groups should be established in the Church, which could mean that there was none in existence.
- "The focus is care" – The focus between the Church and the care group should always be one of care.
- "Work hand in hand with wardens" – The care groups and the leadership of the Church should work together.

6.5.3. Should the Church get involved in matters of poverty, gender, care and support?

Yes /No



- **Poverty:**

  Twenty respondents (95%) answered the question, while one respondent (5%) abstained. Fourteen respondents (67%) indicated that the Church had a poverty programme, while six (28%) of the respondents indicated that the Church did not have a poverty programme.

- **Gender:**

  Seventeen respondents (81%) answered the question, while four respondents (19%) abstained. Nine respondents (43%) indicated that the Church had a gender programme, while eight (38%) of the respondents indicated that the Church did not have a gender programme.

- **Care and Support:**

  Twenty respondents (95%) answered the question, while one respondent (5%) abstained. Fourteen respondents (67%) indicated that the Church had a care and support programme, while six (28%) indicated that the Church did not have a care and support programme.

6.5.4. Should the Church reach out to the vulnerable groups in the congregation or do we behave as if they do not exist?

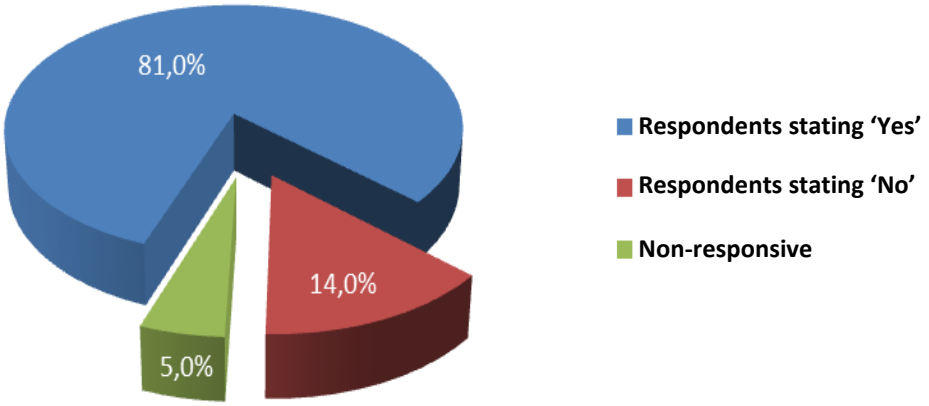
All of the respondents (100%) replied: 'Yes the Church has to reach out to vulnerable groups. The Church in its pastoral care role ought to reach out to the needy, the sick and the marginalised. This is its primary role'.

6.5.5. Do you talk about cultural differences and practices within your communities that are harmful, or protect its members?

Although the topic of cultural differences and practices were flagged in this study, it did not receive the necessary attention. However, Chitando (2016) asserts that religious and cultural practices are often regarded as static by some communities; static and unchanging. Chitando (2016) continues to note that the impact of HIV/AIDS on communities calls for a fundamental change in beliefs and practices in order to adapt to the crisis. In order to do this, researchers need to discern how the HIV epidemic has forced a number of gatekeepers to rethink indigenous beliefs and practices. Cultural differences and harmful practices could be impact on HIV/AIDS programmes negatively or positively.

6.5.6. Does your Church write reports on HIV/AIDS programmes?

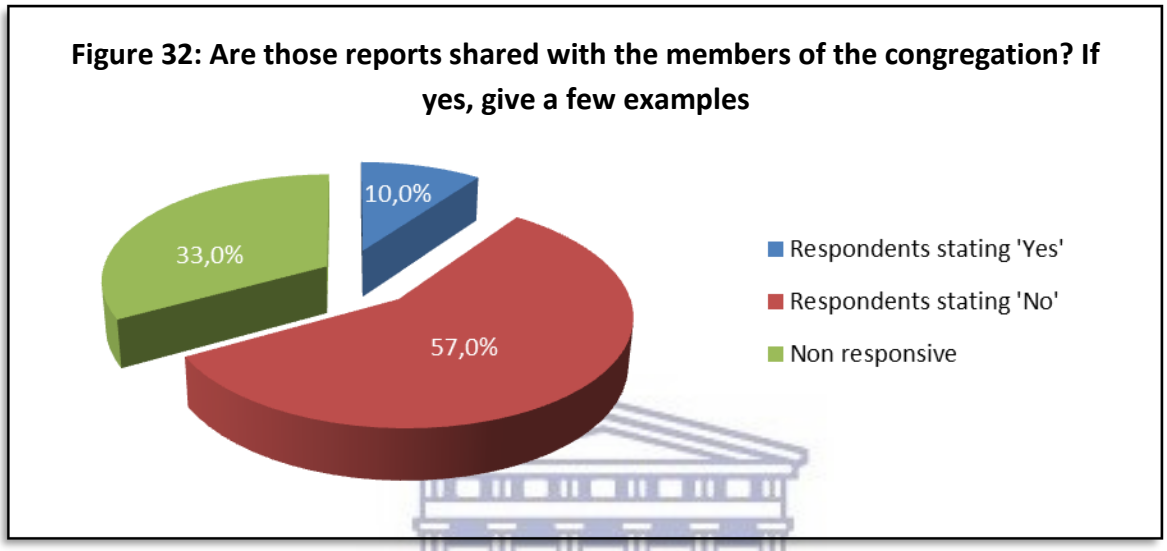
Figure 31: Does your church write reports on HIV / Aids programmes?



Twenty respondents (95%) answered the question, while one respondent (5%) abstained. Most of the respondents, 17 (81%), indicated that their Churches wrote reports on HIV/AIDS programmes, while three (14%) indicated that no reports were written on HIV/AIDS programmes at their Churches.

6.5.7. Are those reports shared with the members of the congregation?

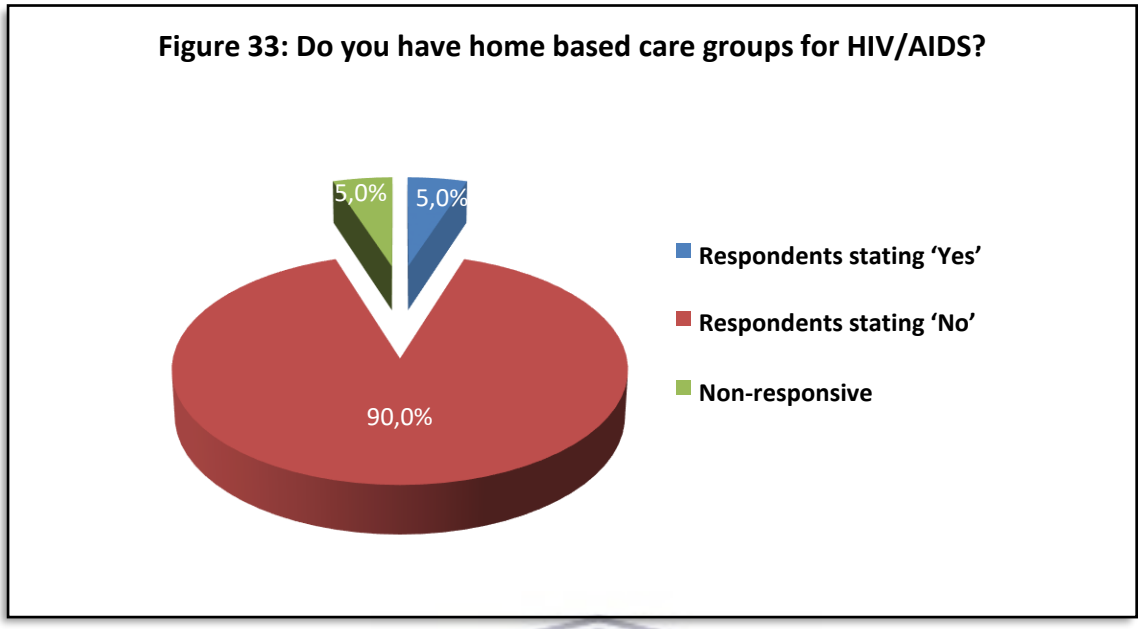
Figure 32: Are those reports shared with the members of the congregation? If yes, give a few examples



Fourteen respondents (67%) answered the question, while seven respondents (33%) were unresponsive. Most of the respondents, 12 (57%), disclosed that the reports on HIV/AIDS were not shared with the congregation, while two (10%) indicated that the HIV/AIDS reports were shared during Vestry- (Congregational meetings) or Annual General Meetings.

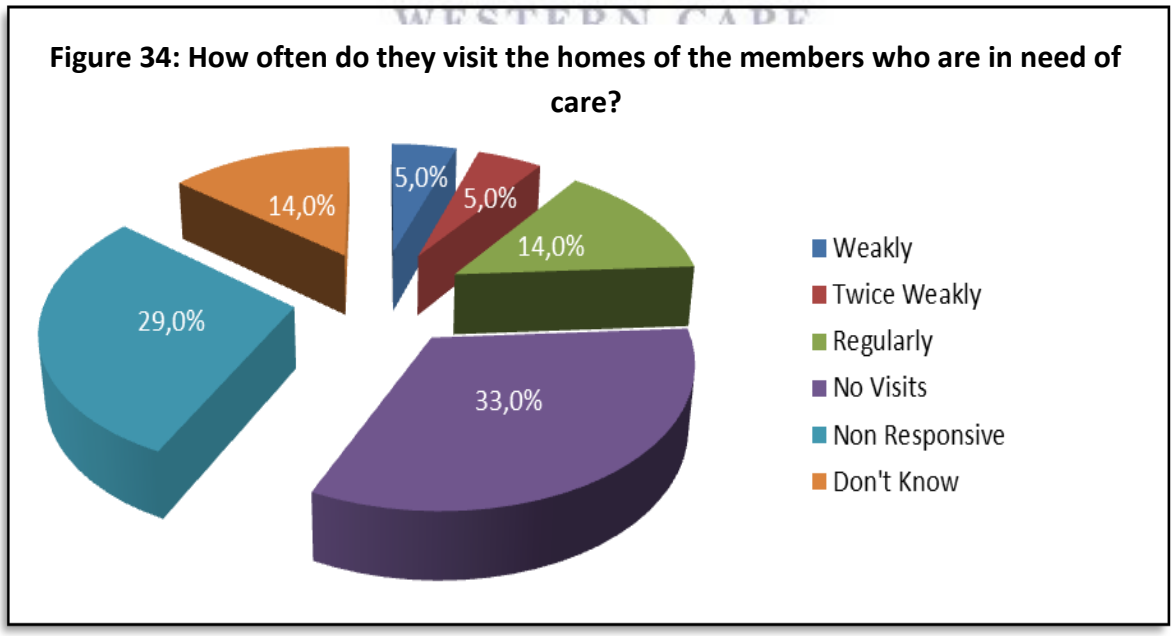
6.6 Care and Support

6.6.1. Do you have home based care groups?



Twenty respondents (95%) answered the question, while one respondent (5%) abstained. Nineteen respondents (90%) indicated that their congregations did not have home based care groups for HIV/AIDS, while one (5%) of the respondents indicated that a home based care group for HIV/AIDS existed.

6.6.2. How often do they visit the homes of the members in need of care?



Fifteen respondents (71%) answered the question, while six respondents did not. Seven respondents (33%) indicated that no visits were taking place, while five (24%) of the

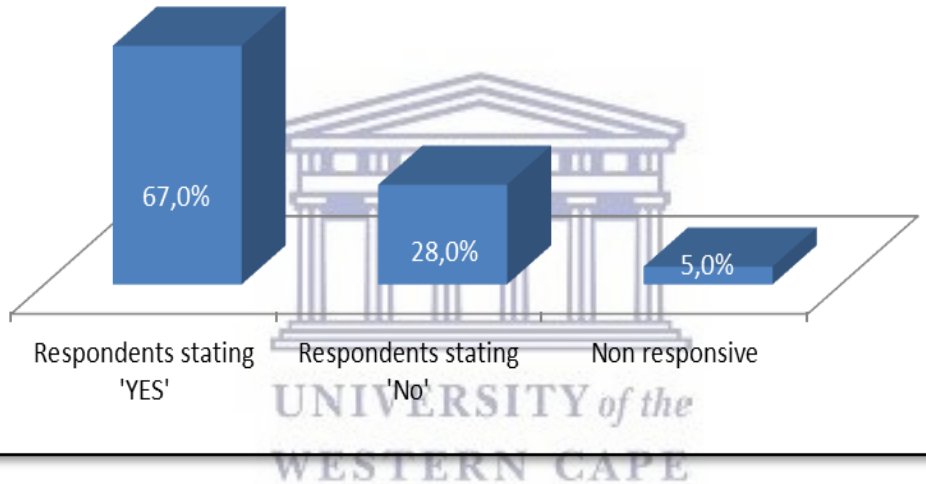
respondents indicated that visits to the homes of members, in need of care often took place as follows:

- One (5%) indicated weekly;
- One (5%) indicated twice weekly;
- Three (14%) indicated regularly.
- Three (14%) of the respondents did not know the frequency of visits.

6.7. Counselling and Testing

6.7.1. Are there opportunities for testing in your support group or Church?

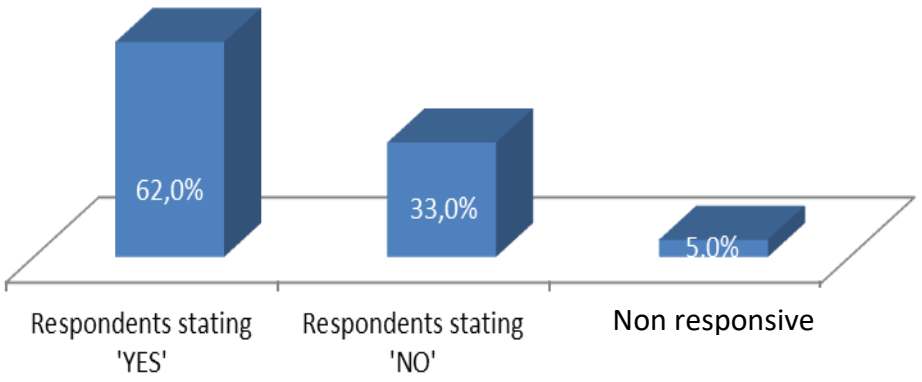
Figure 35: Are there opportunities for testing in your support group or church?



Twenty respondents (95%) answered the question, while one (5%) abstained. Fourteen respondents (67%) indicated that there were opportunities for testing in their support group, or Church, while six (28%) indicated that there were no opportunities for testing.

6.7.2. Do the leaders or members know where the testing is being done?

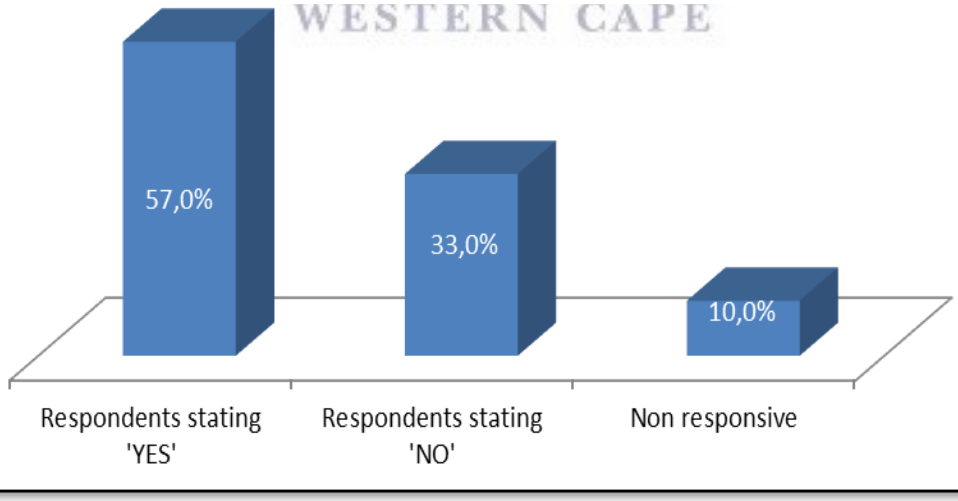
Figure 36: Do the leaders or members know where testing is being done?



Twenty respondents answered the question, while one abstained. Seven respondents felt that the leaders or members do not know where testing is being done and 13 (62%) of the participants indicated that the leaders and members do know.

6.7.3. Is the congregation connected to the testing site and do they refer people there?

Figure 37: Is the congregation connected to the testing site and do they refer people there? YES / NO

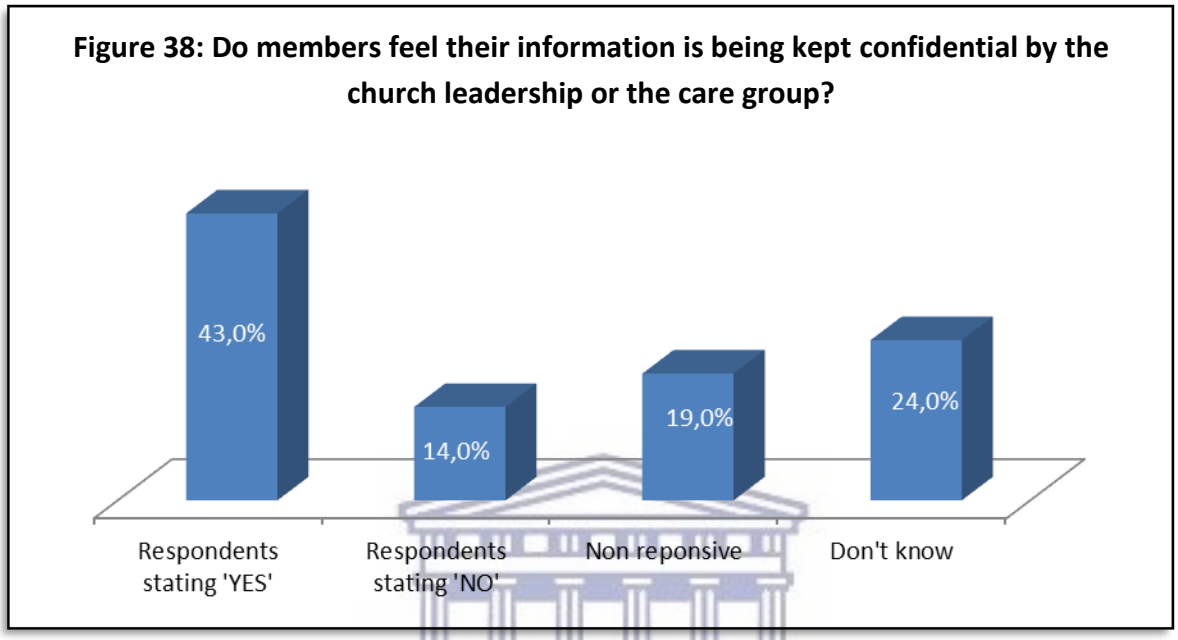


Nineteen respondents answered the question, while two respondents (10%) abstained. Seven respondents (33%) indicated that their congregations were not connected to the testing site and

did not refer people to the sites. Twelve (57%) respondents indicated that their congregations were connected to the testing sites and did refer people.

6.7.4. Do members feel their information is being kept confidential by the Church leadership or the care group?

Figure 38: Do members feel their information is being kept confidential by the church leadership or the care group?



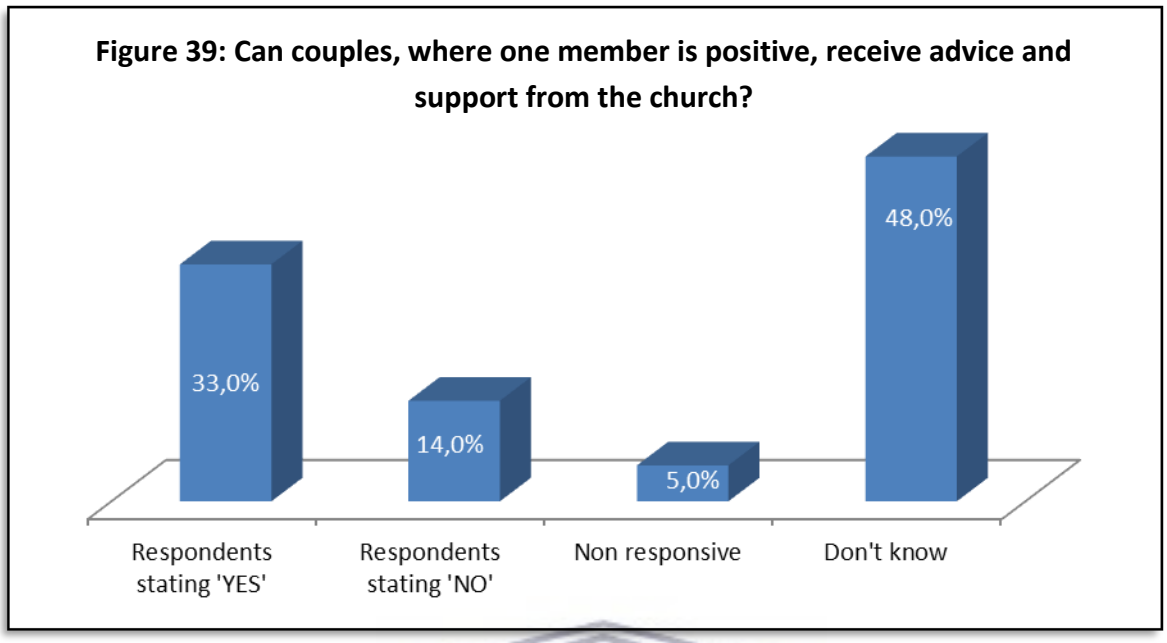
Seventeen respondents (81%) answered the question, while four respondents (19%) were non-responsive. Five respondents (24%) did not know whether information was being kept confidential by the Church leadership or the care group. Three respondents (14%) indicated that members felt that the information was not kept confidential by the Church leadership, or by the care group, and their responses were being elaborated as follows:

- People are very sensitive to their status;
- Members are still despondent to come forward; and
- They are scared to expose themselves.

Nine respondents (43%) indicated that members felt that their information was being kept confidential by the Church leadership, or by the care group, and the following are the reasons given for their responses:

- They trust people in a group;
- Confidential files are kept by the appointed member; and
- Members appointed are trained.

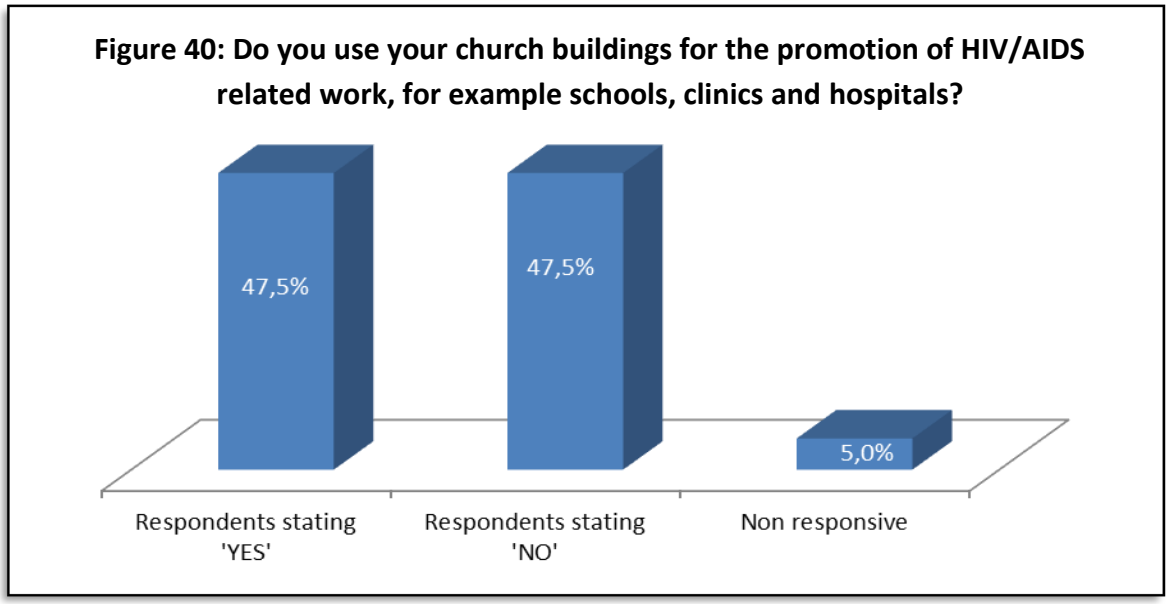
6.7.5. Can couples, where one member is positive, receive advice and support from the Church?



Twenty respondents (95%) answered the question, of which 10 (50%) indicated that they did not know. Three respondents (14%) felt that couples, where one member is positive, could not receive advice and support from the Church, while seven (33%) indicated that they could.

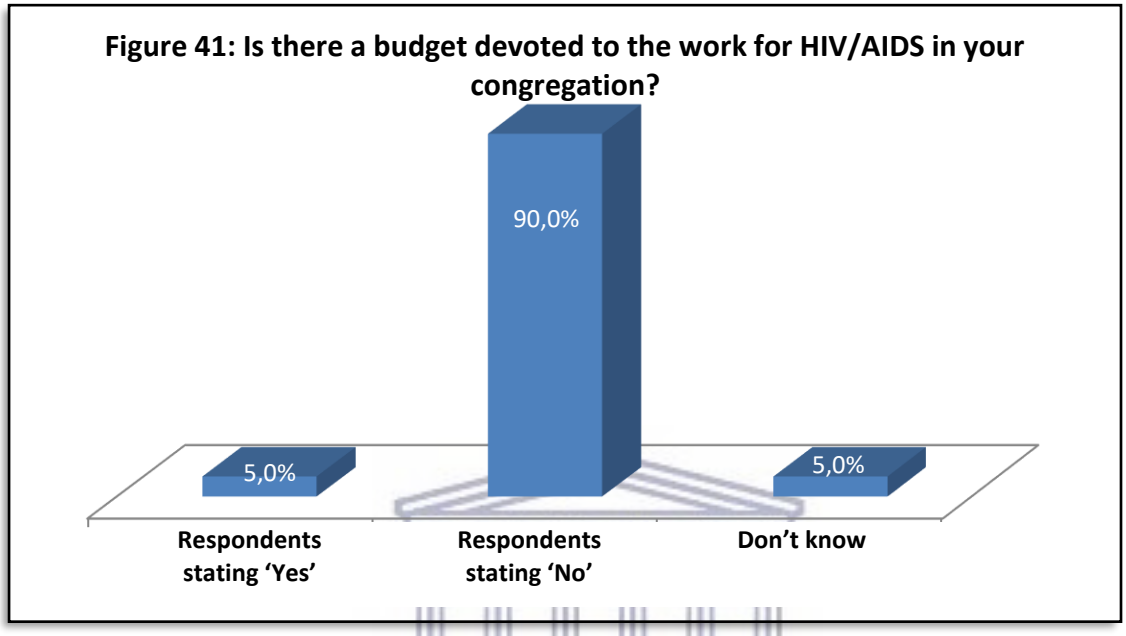
6.8 Finances, Resources and Sustainability

6.8.1. Do you use your Church buildings for the promotion of HIV/AIDS related work, for example schools, clinics and hospitals?



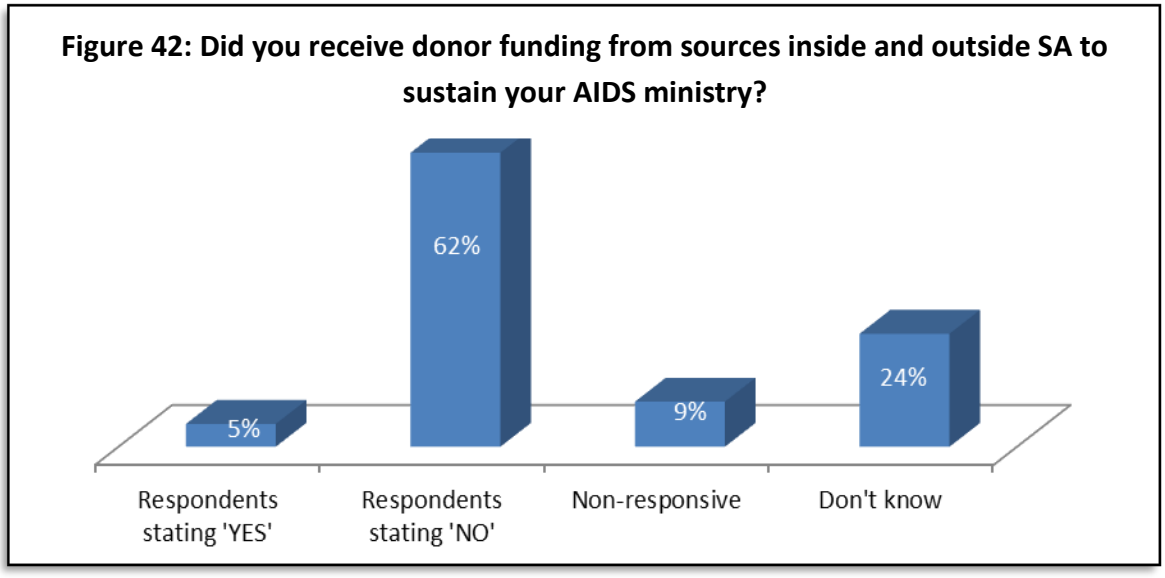
Twenty respondents (95%) answered this question, while one respondent (5%) abstained. Ten respondents (47.5%) indicated that their Church buildings were being used for the promotion of HIV/AIDS related work versus another 10 (47.5%), who indicated that it was not.

6.8.2. Is there a budget devoted to the work for HIV/AIDS in your congregation?



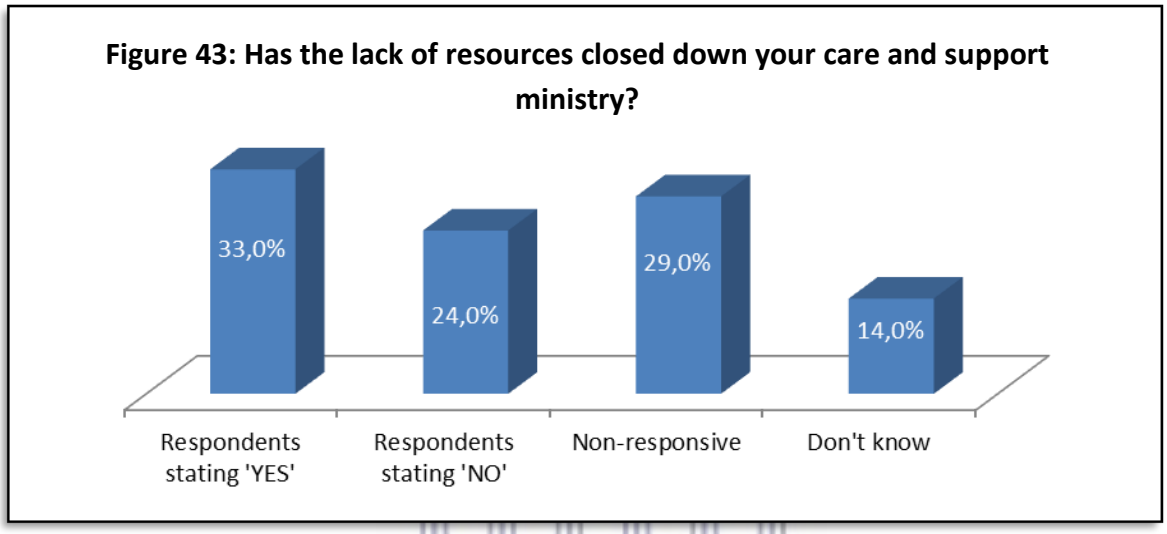
Only one (5%) of the respondents indicated that there was a budget devoted to work for HIV/AIDS in their congregation and another one (5%) did not know. Most of the respondents, 19 (90%), indicated that their congregations did not have a budget for HIV/AIDS work.

6.8.3. Did you receive donor funding from sources inside and outside SA to sustain your AIDS ministry?



Nineteen (19) respondents (91%) answered this question, five (5) of whom (24%), did not know whether any donor funding was received. One (1) respondent (5%) indicated that donor funding was received, but failed to mention the source. Thirteen (13) respondents (62%) indicated that their Churches did not receive any donor funding to sustain their HIV/AIDS ministry.

6.8.4. Has the lack of resources closed down your care and support ministry?

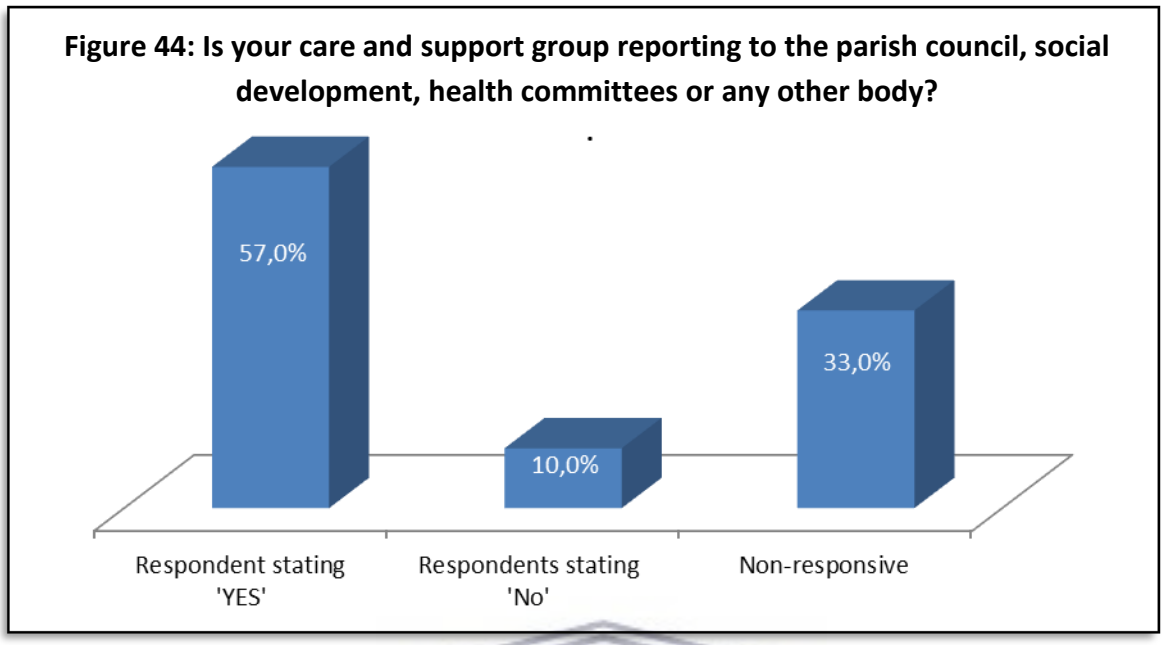


Fifteen respondents (71%) answered this question, while six respondents (29%) were non-responsive. Three respondents (14%) indicated that they did not know. Seven respondents (33%) stated that the lack of funding and resources had closed down their HIV/AIDS care and support ministry, while five (24%) respondents claimed that the lack of funding and resources did not close down their HIV/AIDS care and support ministry.

6.8.5. Have you received funding for the Isiseko Sokomoleza Project?

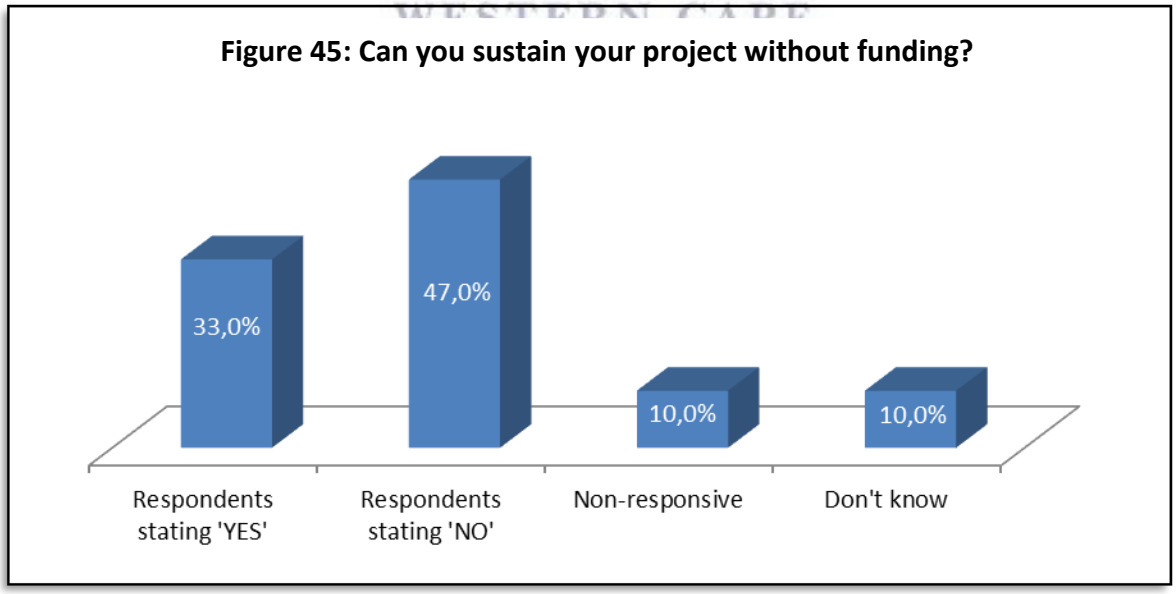
Only some of the participants were aware of the funding that their parishes received. However, the overall impression was that when the funding ceased most of the programmes came to a halt. This is my contention, as it would appear that the Church's response was motivated by the availability of funding and not out of pastoral conviction.

6.8.6. Is your care and support group reporting to the parish council, social development department, health committees or any other body?



Fourteen respondents (67%) answered the question, with twelve respondents indicating that their care and support groups report to the parish council, Social Development Department, and health committees to any other relevant body. Two respondents (10%) indicated that they do not, while seven respondents (33%) abstained.

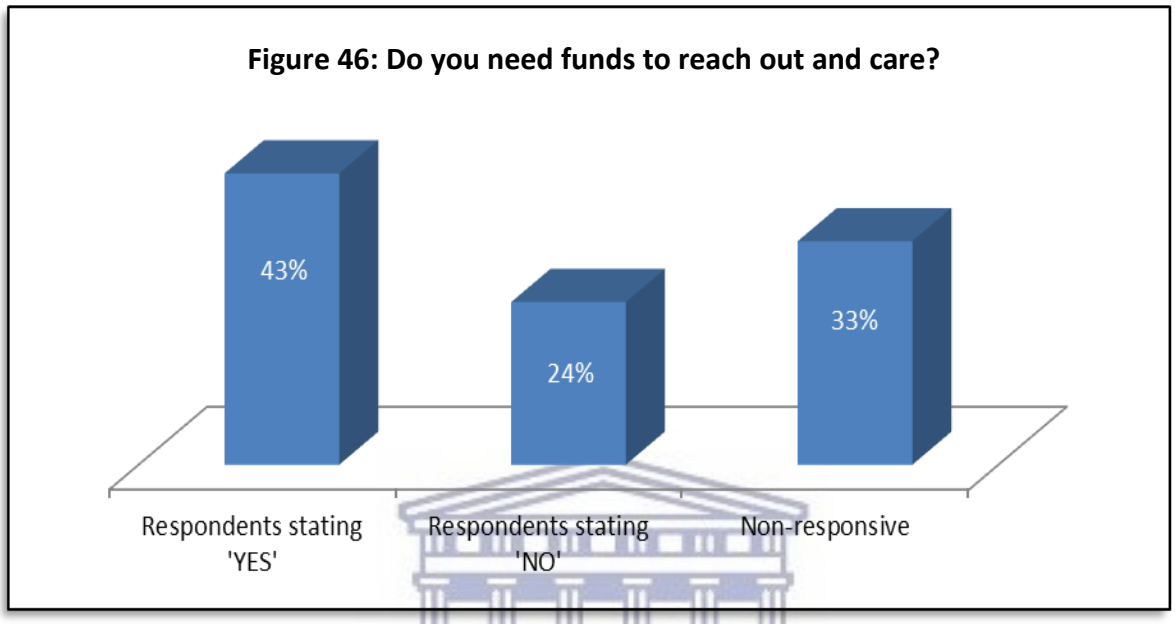
6.8.7. Can you sustain your project without funding?



Nineteen respondents (90%) answered this question, while two respondents (10%) were non-responsive. Two respondents (10%) claimed that they did not know whether they could sustain

their project without funding from outside funders. Seven respondents (33%) maintained that they could sustain their project without outside funders, whereas 10 (47%) stated that they could not sustain their project without outside funding.

6.8.8. Do you need funds to reach out and care?



Fourteen respondents (67%) answered this question, seven (33%) did not respond. Nine respondents (43%) confirmed that they needed funds to reach out and care, while five (24%) claimed that they did not need funds.

6.9. Quantitative Findings – History

6.19.1. When did you start the HIV/AIDS Care and Support group?

Thirteen respondents (62%) answered this question, of which three respondents (23%) did not know when the group was started. Eight respondents (38%) did not provide an answer to this question. According to the responses of the remaining eight, the HIV/AIDS care and support groups were started as early as 2004 (two groups), 2006 (three groups), 2008 (one group), and in 2013 (four groups).

6.9.2. How many members belong to the original group?

Twelve respondents (57%) answered this question, while nine respondents (43%) did not. Cumulatively, 230 members belonged to the original group and, currently, membership varies from a minimum of six to a maximum of forty per group.

6.9.3. Why have they left the group?

Thirteen respondents (62%) answered this question, while eight respondents (38%) did not provide an answer. Five respondents (38%) did not know why they left the group. The rest indicated the following reasons for members leaving the group:

- No support;
- Communication gap;
- Financial problems;
- Unresolved conflict;
- Lack of support;
- Lack of interest from leaders and no support;
- Illness;
- To look after their grandchildren;
- Other work; and
- Too old for the group.

6.9.4. Why are you continuing with the group? Briefly provide the reasons.

Twelve respondents (57%) answered this question, while nine (43%) did not respond.

Two respondents (9.5%) stated that they did not know why they should continue with the programme. Ten respondents (47.5%) provided the following reasons why they were continuing with the programme:

- To appreciate each other's company;
- To learn more and develop their passion and love for each other;
- To learn about wellness; what it means;
- Care and passionate about it;
- To help others;
- Care about the community;
- They have a passion to work with the sick and the elderly; and
- They have a passion and love to work for their neighbours.

6.9.5. What would you consider as achievements of the care and support group? Name at least three to four achievements.

Only 12 (57%) respondents answered the question, while nine (43%) did not. Of the twelve, two respondents (9.5%) did not know what to consider as achievements of the care and support

group. The other ten respondents (47.5%) identified the following to be considered as achievements:

- Visits, phone calls, keeping each other informed on health related issues;
- We pray for them, and they appreciate what we do;
- To teach my children, tell others, to help them through what I learn;
- Awareness, education about testing and lifestyle;
- Helping your neighbours;
- Teaching children about the Bible;
- People are more positive regarding their HIV status and become involved with other groups;
- Keep children off the streets and pray with them;
- Youth information session;
- Sense of belonging, they feel good; and
- We pray for them and they appreciate it.

6.9.6. What do you consider as challenges for your HIV/AIDS ministry in your congregation presently?

Seventeen respondents (81%) answered the question and four (19%) abstained. The following are the considered challenges for the HIV/AIDS ministry:

- Stigma;
- Talks at Church;
- Need greater participation;
- Sunday school teaching and training of youth;
- The need for more workshops;
- Lack of talks about illness; different groups need to be involved (youth, mothers and men)
- Sometimes we feel offended, but we get motivated;
- Prayers for people;
- The Church liturgy needs to provide more information about HIV/AIDS;
- Lack of members joining/lack of participation, as HIV/AIDS ministry not seen as important to continue;
- Poverty – lack of resources;
- To get members of congregation more involved.

6.9.7. What would be your recommendations for future HIV/AIDS programmes in the Church?

Seventeen respondents (81%) answered this question, while four respondents (19%) abstained. The following are their recommendations for future HIV/AIDS programmes for local congregations:

- People should go for training; there should be trained counsellors in Church;
- Trained counsellors;
- Training would be welcome;
- Train counsellors in safe spaces;
- To give them awareness and advise them to go for HIV/AIDS test;
- More presentations, workshops, fundraising, awareness;
- To get more youth involved in HIV/AIDS programmes;
- People need more information, even Church leaders;
- Become involved;
- Networking with other Churches;
- The Church needs to be more HIV/AIDS friendly;
- The need for a plan with resources;
- HIV/AIDS programme to be written in the liturgy of the Church;
- All organisations in the Church must be trained in the HIV/AIDS programme;
- Need greater awareness and working together

6.3 Results and discussions of the quantitative findings

The following section will provide an overview of the key reasons that critically influenced the impact of the Isiseko Sokomoleza Programme.

In order to understand the reasons for the waning of the Programme, the findings of the empirical study will be discussed against the backdrop of the research question: "What were the most significant reasons for the limited impact of the Isiseko Sokomoleza Programme in the Diocese False Bay?" The seven principles (leadership, equity, availability, affordability accessibility, effectiveness, and efficiency) within the Primary Healthcare Model as referenced in chapter four will be the frame for understanding the reasons for the impact. These principles, such as committed leadership, broad based consultation, resources, community involvement, planning, monitoring and evaluation, as well as structure of the Primary Healthcare Model

could be of value to the Church in reviewing its implementation strategies. These principles are necessary steps in programme implementation but are dependent upon other factors, which could compromise its successful implementation. It is clear from the list of principles that the above principles fell short of a pastoral theological focus needed to assess the Isiseko Sokomoleza HIV/AIDS Programme from a theological perspective.

Implementation and ownership of the Isiseko Sokomoleza HIV/AIDS Programme: One of the most critical findings in this study is found in Section 6.2.7, in response to the question: "Are you familiar with the Isiseko Sokomoleza Programme." A significantly high percentage of the respondents (86%) indicated that they were not familiar with the programme. In response to the question, "If yes, where did you hear about the programme?", the findings in Section 6.2.8 reveal that 38% of the respondents were non-responsive, which could have been because of the previous findings (that they were unfamiliar to the programme). The result is that a very small percentage (14%) claimed to have heard of the programme prior to this study. In Section 6.2.9, in response to the question, "Has your parish introduced the Isiseko Sokomoleza programme?" almost all the respondents declared that it was not introduced. The findings in Section 6.2.10, in response to the question, "Was your congregation involved in the process towards the implementation of the programme?" revealed that 19% of the respondents claimed involvement, while a significant percentage (76%) indicated that some congregations were not involved in the process towards the implementation of the programme.

It is unsurprising, therefore, that the findings of Section 6.2.11, in response to the question, "Did you receive funding for the Isiseko Sokomoleza programme?" revealed that a significantly high percentage (90%) of the respondents declared that they had received no funding. In Section 6.2.14, in response to the question, "What in your opinion were the changes or impact brought about by the programme?", a fairly high percentage of the respondents (33%) were non-responsive, while 48% responded positively, especially about the provision of food parcels, and 19% were negative about the HIV/AIDS programme implementation. The non-responses (33%), and the negative responses (19%), represent the majority of the respondents, which emphasises the fact that the majority, probably, could not identify with the question because the Isiseko Sokomoleza programme was unknown to most of them. The inconsistencies in the percentages regarding previous responses could be ascribed to the fact that the respondents misinterpreted the question and were instead referring to the activities of the care and support groups. Therefore, the findings highlight that there was a 'huge gap'

between the provincial HIV/AIDS (ACSA) office and the Care and Support groups in the various congregations of the False Bay Diocese. The overwhelming majority of respondents claimed that they were unfamiliar with the Isiseko Sokomoleza Programme, or were never introduced to the programme in their congregations. In addition, their congregations failed to become involved in the implementation process, and never received any funding for the introduction of the Isiseko Sokomoleza Programme.

Additionally, the majority of the respondents were unresponsive and or negative about the changes brought about by the Programme. Evidently, the orientation, introduction, implementation, and funding of the Isiseko Sokomoleza Programme did not reach the intended grassroots target group, namely the Care and Support groups on congregational level. It would seem, therefore, that effective strategic planning, proper financial management, as well as broad-based consultation and discussions regarding the Isiseko Sokomoleza Programme, in particular, did not take place in the Diocese of False Bay. The aforementioned facts contributed to the major reasons for the limited impact of the Isiseko Sokomoleza Programme, and explained the non-involvement of the members of the congregation, as well as other organisations in the parishes. Ultimately, the majority of the initial Care and Support groups seized to exist, while the remaining groups, according to Section 6.9.4, appear to have taken on different functions, such as 'distribution Centres for food parcels', fellowship- or health and wellness groups, and soup kitchens.

It was clear from the responses that there were different understandings of what the Church meant. It was also clear that most of the members in the care and support groups could not make the connection between the care and support group and the pastoral role of the Church. Twelve respondents (57%) answered this question, while nine (43%) did not respond. Only two respondents (9.5%) stated that they did not know why they should continue with the programme. Ten respondents (47.5%) provided a number of reasons why they were continuing with the programme. The percentage of members who understood the pastoral reasons for the programme is less than 10%, which confirms my view that the care and support groups were ill equipped pastorally in handling such an ambitious programme. Some of the reasons given by participants are as follows: Appreciate each other's company; learn more and develop their passion and love for each other; learn about wellness; what it means; care and passionate about it; help others; care about the community; they have a passion to work with the sick and the elderly; and they have a passion and love to work for their neighbours.

6.3.1 Sustainability of the Isiseko Sokomoleza Programme in the Diocese of False Bay

The aim of the Isiseko Sokomoleza Programme was to build a long term, sustainable structure on which the future of HIV/AIDS interventions could be based. Failure to grasp the complexity in rural and urban parishes, the systemic and structural differences, and the lack of implementation structures led to unnecessary conflict and crisis of management to the present day. Most of the co-coordinators and members left which resulted in the closure of many of the Care and Support groups. The participants in Figure 7 expressed their lack of base line knowledge about the programme. The formulation of the Isiseko Programme also failed to take the vast experiences and resources in the Diocese of False Bay, both human and financial into account. This particular programme's implementation strategies failed to build the knowledge base of the congregants across the Diocese. Of the 21 participants who answered this particular question in the questionnaire, three (14%) responded 'yes', and 18 (86%) reported 'no'. The fact that such a high percentage of participants were not aware of the Programme suggests that there were very few consultations with congregations and, in particular, the care and support groups within the congregations.

The aforementioned findings determined that the Isiseko Sokomoleza Programme was unknown to most of the respondents, and that it had never been implemented in the majority of congregations participating in this study. However, the rest of the questions and findings greatly affected this study, as it would appear that the respondents were still able to relate to most of the research questions, seemingly because the same factors that contributed to the limited impact of the Isiseko Sokomoleza Programme, directly affected the effective and efficient functioning of the Care and Support groups. The findings highlighted that the original number of members who started the Care and Support groups totalled 230 members, (6.9.2). It also identified the reasons why members have left the group (6.9.3). The reasons are as follows, lack of support by members; intergenerational communication gap; financial problems; unresolved conflict; lack of interest from the leadership; family commitments; health reasons; unemployment reasons; and some members felt they were getting to old to continue as members of the care and support groups.

In addition, Section 6.5 the response to the question, "Is the programme still running?" reveals that 28.5% of the respondents answered 'No', while 43% were non-responsive, leaving a significantly low percentage of only 28% claiming that their programmes were still in operation. This finding relates to the observation that the response towards HIV/AIDS had

waned, in this instance even on a congregational level. Additionally, a major reason for the limited impact on the implementation and sustainability of programmes could have been due to a lack of funding, financial management, strategic planning and training.

In Section 6.8.4, in response to the question, 'Does your Church receive donor funding from sources inside and outside SA to sustain your HIV/AIDS ministry?', 62% of the respondents claimed that their Churches did not receive funding to sustain their project, while 24% reported not knowing whether they had received funding, and a very small percentage (5%) disclosed that their Church received donor funding, but the respondent did not know the source of the funding. The effects of the lack of funding were confirmed in the findings of Section 6.8.7, in response to the question "Can you sustain your project without funding from outside funders?" Ten respondents (47%) claimed that they could not sustain their project without outside funding, while 10% of the respondents stated that they did not know. In Section 6.8.3, in response to the question, "Is there a budget devoted to the work for HIV/AIDS in your congregation?" an overwhelming 90% of the respondents indicated that no budgets were allocated for this ministry.

As stated in Sections 6.6.1 to 6.6.7, Care and Support groups were flourishing during 2005-2009, with 230 members in total. It was noted that, during that time, the sizes of the groups ranged from six to forty members per group, as reported on in Section 6.6.2. The reasons for some members leaving the group were also identified in Section 6.9.3. Members were of the opinion that there was no support; the communication among group members was very poor; financial problems prevailed; and conflicts and disagreements were unresolved. Others left because they had to care for their grandchildren and were too old for the group, and younger members needed to take over. Some left for health reasons and better work opportunities.

These findings confirm that most of the members in the Care and Support groups were volunteers. Given the above findings pertaining to the lack of funding, financial management and strategic planning, a majority of respondents cited the lack of financial support as a major reason for the unsustainability of the Care and Support groups, resulting in the closure of most. Another factor was that the Isiseko Sokomoleza Programme was never formally introduced or implemented in the congregations, which, ultimately, contributed towards the waning response to the HIV/AIDS ministry.

1. Leadership/political will: According to Figure 2, a high percentage of respondents felt that the bishop and clergy supported this ministry. However, it appeared that support was only generated when there was funding available. Some of the diocesan bishops and clergy felt that without financial resources the programmes would not get off the ground. At parish level, the support of the Church and the clergy varied in the sample. Most of the participants who answered that particular question were of the opinion that 30% of the clergy were not supportive of this particular ministry. However, others felt that the interest shown by their leaders at a local level inspired the group to continue. This observation demonstrates the fact that not all diocesan and provincial programmes are being executed by the local clergy. Another lesson learned through the findings is that the decisions taken at synods and other diocesan structures are sometimes far removed from the local context; a major reason for the limited impact of the Isiseko Sokomoleza Programme could be ascribed to the fact that not much provision was made for oversight, leadership planning design, and direction to the Programme. Without committed leadership, recognition of the social drivers of the epidemic, and the appropriate engagement by all affected parties, the Church's pastoral responses will still fall short. The principle of sustainable pastoral leadership is critical, also in future challenges affecting the Diocese of False Bay and upon reflection on its response to HIV/AIDS, there is a need for a mind-set change from reactive to proactive (preventative) pastoral strategies.

2. The principle of equity in the Isiseko Sokomoleza Programme: In Section 6.2.6, a significantly high percentage of respondents indicated the absence of a special HIV/AIDS task team. Furthermore, it is clearly stated in Figure 10 that members of the Care and Support groups were not always part of the planning of the programmes and as a result they felt excluded and not acknowledged for their gifts and contributions they could bring to the management of the Care and Support groups. Some of them also left the group because they never felt welcomed or a strong sense of belonging. In order to address the principle of equity, the Diocese could do well in ensuring that the availability of Care and Support services reach every congregation, especially the deep rural congregations where there are limited accesses to information and members do not have transport to go to health services in the community. The challenge of equity affords the Diocese of False Bay the opportunity to establish one stop pastorally driven health and wellness centres, which were formally driven by members of the Mothers Union (MU) and the Anglican Women Fellowship (AWF).

3. Affordability of the Isiseko Sokomoleza Programme in the Diocese of False Bay: It would seem, therefore, that effective strategic planning, proper financial management, as well as broad-based consultation and discussions regarding the Isiseko Sokomoleza Programme, in particular, did not take place in the Diocese of False Bay. According to Parry (2008:8), a prerequisite to an authentic, holistic response is recognising the current challenges facing the Church, for example, the rise in the new infection rate among young people, getting past the denial, as well as the resistance to change, and moving forward to acceptance and action. The Church needs to reactivate its pastoral response in order to re-address the current challenges of HIV/AIDS in a meaningful way. It would appear that broad based consultation and discussions regarding the Isiseko Sokomoleza Programme in particular, did not take place in the Diocese of False Bay. The findings also confirm that most of the members in the Care and Support groups were volunteers. Given the above findings pertaining to the lack of funding, financial management, and strategic planning, a majority of respondents cited the lack of financial support as a major reason for the unsustainability of the Care and Support groups, resulting in the closure of most. In as much as the Diocese of False Bay introduced the Isiseko Sokomoleza Programme it was doing so due to the availability of donor funding, which could according to the findings be considered as the main reason for lack of sustainability.

4. Accessibility to programmes: Another critical finding emanates from Section 6.2.1 of this study, in response to the question, "Does your Church have an HIV/AIDS ministry?" Only 57% of the respondents indicated that their Churches did have an HIV/AIDS ministry, but a fairly high percentage (43%) indicated that their Churches did not have a ministry, specifically related to HIV/AIDS. This could impact negatively on those congregations where some people have been tested and found positive yet there is no immediate support at parochial level to welcome them to be part of a caring environment. The unavailability of programmes means that affected members had to access the services elsewhere and often the local Church was not equipped with a proper referral system.

5. Availability of Care and Support groups in congregations: Other than the 12 care and support groups in the Diocese of False Bay, others had no access to the services rendered by the Care and Support groups in their respective congregations. As stated in Sections 6.6.1 to 6.6.7, Care and Support groups were flourishing at some stage, with 230 members in total. It was already noted that, during that time, the sizes of the groups ranged from six to forty members per group, as reported on in Section 6.6.2.

The reasons for some members leaving the group were also identified in Section 6.9.3. Another factor was that the Isiseko Sokomoleza Programme was never properly introduced or implemented across the Diocese, which ultimately contributed towards the lack of response to the Programme and can be considered as one of the major reasons for the ultimate waning response to the HIV/AIDS ministry in the Diocese of False Bay. It could be said that the lack of information and the purpose and objectives of the Isiseko Sokomoleza HIV/AIDS Programme were unknown to the congregations who had no Care and Support groups.

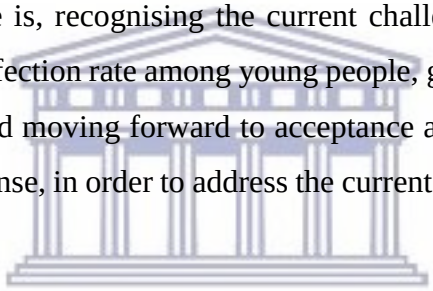
6. Effectiveness of the Programme: The same can be said about members of the congregation as stated in figure 6.2.2. This programme was indeed a parish-driven initiative, yet the of implementation theories, designs, and strategies were developed at the Diocesan (False Bay) Office at a provincial level. The general lack of understanding, programme design, and implementation could be another reason for the limited impact of the programme outcome. The Bridges of Hope Report (Cole 2006:65) highlighted the linear effect of the programmes, as did other reports from the Diocese of False Bay. This could largely be attributed to the fact that every donor agency had its own compliance regulations. This challenge could have been resolved if the response from the Diocese was based on a pastoral theological foundation and not a financial one. At present, there is a serious rift between the provincial, diocesan and parish structures to provide a workable, integrated strategy, which is financially viable for the Diocese. Despite the above reflections on implementation, improved infrastructure, human capacity, technical skills, and sufficient resources, I am of the opinion that the response of the Church (Diocese of False Bay) will still be deficient. Without committed leadership, recognition of the social drivers of the epidemic and the appropriate engagement by all affected parties, the Church's pastoral responses will still fall short.

7. Efficiency in addressing stigma: The findings of the quantitative section of this study confirmed that despite the main scope of the Isiseko Sokomoleza Programme to militate against stigma and discrimination, it experienced some challenges. The findings further highlighted that the Isiseko Sokomoleza Programme was never introduced and implemented in some congregations; a challenge is posed to the Church in Section 6.3.2 by the question: "Is stigma and discrimination being highlighted in sermons with special reference to HIV/AIDS?" Fifty-seven per cent (57%) of the participants felt that stigma was not highlighted or given any prominence in the AIDS response. Some of the members in the Care and Support groups felt offended by others in the Church who told them that this was not an important ministry in their

Church. The responses revealed that stigma was not being addressed in workshops, liturgy, or Bible studies. The participants expressed strong opinions that anti-stigma messages needed to intensify and programmes for the mitigating impact had to be revisited. The findings also revealed that some members left the groups because they felt that they were stigmatised and disrespected. The involvement of the congregation is critical in the mobilisation of its response. This is a clear indication that the original mandate to mitigate against HIV related of the programme have waned over a period of time in the Diocese of False Bay. The reason for this is that the theological interpretation on the impact of stigma was clearly the biggest gap in the implementation of the Isiseko Sokomoleza HIV/AIDS Programme. If there was any theological reflection, it failed to translate the theology of care and support in the implementation and life of the programme, even when the Donor Funding ceased to be. The same can be said about members of the congregation as stated in Figure 2. This Programme was indeed a parish-driven initiative, yet the of implementation theories, designs and strategies were developed at the Diocesan (False Bay) Office at a provincial level. The general lack of understanding, programme design, and implementation could be another reason for the limited impact of the programme outcome.

In Section 6.2.3, 28.5% of the respondents were non-responsive to the question, "Is there a person responsible for coordinating the HIV/AIDS ministry in your congregation", while another 28.5% claimed that their HIV/AIDS ministry did not have a coordinator. In Section 6.2.6, a fairly high percentage of participants (43%) indicated that congregations did not support the HIV/AIDS programmes. The lack of capacity as stated in Figure 12 was one of the major reasons why the care and support groups were unsustainable. There was very little succession planning and development of skills in the group. The lack of adequate capacity hampered the implementation of the programme from its inception. Although staffing changes were made in order to address the problem, the lack of capacity, in terms of oversight, monitoring and evaluation, budgeting, and accountability to funders was a great burden throughout the programme. Clergy were not properly trained in HIV/AIDS related matters such as stigma. Neither were members of Care and Support groups capacitated to provide effective oversight in these groups. This resulted in more responsibility falling on the parish resources, which resulted in financial strain for the Care and Support Groups (12), which in turn, negatively affected the sustainability of the programme. Previous findings established that the majority of Care and Support groups seized to exist.

It would seem that another factor that contributed to the limited impact of the Isiseko Sokomoleza programme was the lack of broad-based consultation resulting in the program not having been introduced in congregations due to the absence of oversight, a lack of responsible leadership, lack of co-ordination, and finally, a lack of financial support and succession planning, which is critical in the response to the HIV/AIDS ministry. It would further seem that these factors also eventually contributed towards the closing down of the majority care and support groups. As mentioned previously, the Bridges of Hope Report (Cole 2006:65) highlighted the linear effect of the programmes, as did other reports from the Diocese of False Bay. Despite the above reflections on implementation, improved infrastructure, human capacity, technical skills and sufficient resources, I would argue that the response of the Church (Diocese of False Bay) will still be deficient. Without committed leadership, recognition of the social drivers of the epidemic and the appropriate engagement by all affected parties, the Church's pastoral responses will still fall short. According to Parry (2008:8), a prerequisite to an authentic, holistic response is, recognising the current challenges facing the Church, for example, the rise in the new infection rate among young people, getting past the denial, as well as the resistance to change, and moving forward to acceptance and action. The Church needs to resuscitate its pastoral response, in order to address the current challenges of stigma in all its shapes and structures.



The findings of the quantitative section of this study confirmed that despite the main scope of the Isiseko Sokomoleza Programme to reduce stigma, its premise was not from a pastoral theological perspective but from a financial perspective. Furthermore, the findings revealed that stigma was never mainstreamed into the worship life of congregations; as mentioned previously, in Section 6.3.2, a challenge is posed to the Church: "Is stigma and discrimination being highlighted in sermons with special reference to HIV/AIDS?" The responses revealed that stigma was not being addressed in workshops, liturgy, or Bible studies and that anti-stigma messages needed to intensify and programmes for the mitigating impact had to be revisited. The findings revealed that some members left the groups because they felt that they were stigmatised and disrespected. The involvement of the congregation is critical in the mobilisation of its response. The lack of involvement or participation weakens the response. In Section 6.9.6, participants re-iterate stigma as a challenge together with the lack of awareness programmes; the lack of integration into the Sunday school- and confirmation syllabi; lack of training workshops; poverty; and a lack of resources to get congregations more involved. They also identified the need to raise awareness and training of young adolescence (Sunday school,

youth, confirmation, Bible study and others). It was noted in the findings that those who belonged to other denominations did not always feel welcomed or integrated in the leadership of the Care and Support groups. This also contributed to some of the reasons why people of other denominations were reluctant to continue their involvement in the Care and Support groups. Some of the Care and Support groups are still operate are captured in the findings, as stated earlier.

The Church ought to respond in a manner that is congruent with its identity of service and witness. Hence my observation, which strengthens my argument that although the Diocese of False Bay did respond through the Isiseko Sokomoleza HIV/AIDS Programme, which was driven by donor funding, it lacked a pastoral focus, particularly pastoral care and counselling in its response. Despite the fact that there were little or no financial resources available, no budget, and definitely no donor funding, they showed dedication, commitment, compassion, and neighbourly love; "…and the second is like it: love your neighbour as yourself" (Mathew 22:37-39 NIV). It further supports the view of some scholars (Olivier and Haddad 2012) that the Church has remarkable spiritual assets in its delivery of care and support services.

The above findings and conclusions need to be placed in the light of the problem statement of this research study: "The reasons for the limited impact of the Isiseko Sokomoleza Programme". While many other HIV/AIDS programmes were introduced by ACSA, the focus of this study is to examine the impact of the Isiseko Sokomoleza Programme, which despite it having been implemented by various Dioceses in ACSA, has in my observation achieved limited success in eradicating the stigma of HIV/AIDS. Evidence to this observation is a statement made by the liaison Bishop, Rev. Dr. Johannes Seoko: "The reliance on foreign funding was the weakest link in this organizational and implementation structure" (Siyakha Report 2006), as well as the observations gathered from the literature (Deacon 2006; ACSA 2006a). Currently, there are hardly any programmes in the Diocese of False Bay aimed at reducing and mitigating the impact of HIV/AIDS-related stigma. My hunch is that whilst several factors gave rise to the limited impact of the Isiseko Sokomoleza Programme, it lacked a pastoral focus, hence the research question which is pertinent to this study:

What are the most significant reasons for the limited impact of the Isiseko Sokomoleza HIV/ AIDS Programme that was introduced by the Diocese of False Bay?

The above question is important since an assessment of the reasons for such limited impact would assist a critique of the pastoral praxis within the Diocese of False Bay but also ACSA,

the SACC, and wider ecumenical networks. It will add particularly to the knowledge base on how the Diocese of False Bay can strengthen its response to the challenges of the HIV/AIDS pandemic based on theological premise as appose to the availability of financial resources.

6.4 Conclusion

The findings covered a whole range of reasons as to why there was limited impact for the Isiseko Sokomoleza Programme. The most critical reason could be identified as the following: Dependency on donor funding, leadership, inability to address stigma theologically, and the lack of a proper pastoral praxis. In the following chapter, these reasons will be unpacked as the most important reasons for the limited impact of the Isiseko Sokomoleza programme in response to the research question above.

CHAPTER SEVEN

A QUALITATIVE ANALYSIS OF THE REASONS FOR THE LIMITED IMPACT

7.1 Introduction

Flowing from the quantitative findings in the previous chapter, this chapter will discuss the main reasons for the limited impact made by the Isiseko Sokomoleza HIV/AIDS Programme in addressing stigma. Pertinent factors worth mentioning at the beginning of this chapter are financial dependency; inadequate leadership; theological inabilities in addressing stigma; and an inadequate pastoral care model for addressing stigma in an effective and efficient manner. The research question: "What are the most significant reasons for the limited impact of the Isiseko Sokomoleza programme introduced by the Anglican AIDS s office, in the Diocese of False Bay" will be addressed.

7.2 Dependency on financial resources from donor agencies

According to the Primary Healthcare (PHC) Model, which was discussed in chapter four, the availability of financial resources is one of the key components in programme implementation. The lack of financial resources caused the demise of the Care and Support groups. The following statements, derived from interviews done on 25 and 26 August 2016, indicate the role of financial resources. The interviewees are members of the Care and Support groups in the Diocese of False Bay. Each interview highlights pertinent reasons for the failure of the programme and hence, each interview is discussed in its entirety before moving on to the next interview.

Interview (1) (Mitchell's Plain)

"A lack of resources and funding closed down our Support group; Support group members who were unemployed had the responsibility of taking care of their grandchildren and as a result, were not able to attend meetings; Support group members stayed away because there was no money to buy food in order to take their medication; the Support group became a soup kitchen as the need for people to be fed became far greater than expected".

The above interview indicates that the financial challenges did not only affect the sustainability of the Programme, but that the Care and Support groups became dependent on donor funding. The lack of financial resources also hampered the availability of Care and Support group members who could not attend the activities at Care and Support groups meetings due to the lack of personal finances to pay for public transport from time to time. Financial challenges amongst infected members also led to adherence problems because members could not buy a substantial meal before they took their medication. The findings also show that some parishes did not have a budget for the Care and Support groups. The result is that they could not appoint an HIV/AIDS coordinator to oversee the programmes in their respective parishes. The dependency on donor funding also presented the Church with major challenges at a provincial and diocesan level. When funding came to an end, the Diocese could no longer afford an AIDS coordinator at that level either. This confirms the impact that limited resources had on support groups. A lack of funding and/or resources was identified as a leading cause that contributed to the demise of the support groups. It is evident from the findings that the lack of financial resources had serious negative consequences on the sustainability of the programme and the response waned due to the dependency on donor funding as a silo project which was not integrated in the mainstream of pastoral care.

Bate and Munro (2013:30) state that donor organisations had established new priorities for funding, and South Africa was no longer a priority area for funding. This decision directly affected the sustainability of programmes at congregational level, which led to the decline in programme implementation. This change in donor priorities had a major impact on this programme based on the understanding that the Isiseko Sokomoleza Programme was hundred percent funded as discussed earlier in chapter three. On the other hand, Parry (2008) argues that the scale of HIV-infection is fast outstripping traditional resources in faith based organisations, with the result that faith groups now need to compete with their counterparts in civil society for the same funds.

The dependency on donor funding also presents the Church with major challenges at a provincial and diocesan level. This confirms the impact that limited resources had on support groups. The Church was encouraged to find ways in which the public and private sector could contribute towards projects. According to Child (2010), the responses from the participants also indicate an increased dependency on donor and/or government funding.

Chikoto, Neely, and Stecker (2014) raise the same concern, namely that dependency on donor and/or government funding posed great difficulties for the continuation of the mission and witness priorities of the Church. In the era of HIV/AIDS, dependency on donor funding played in pivotal role in the implementation and monitoring and evaluation of HIV/AIDS programmes. AbouAssi (2013) argues that donor agencies have been placing funding conditions on their development agendas and have maintained control over these funds granted to recipients. Pfeffer and Salancik (2003) state that organisations seeking funding required interaction with the donors. On the other hand, Gras and Arca (2014) further clarified that such resources are controlled by environmental conditions of scarcity and uncertainty. It is therefore incumbent upon Churches such as the Diocese of False Bay to create a culture of maintaining their independence through reliance on different sources in the future. Fowler (2016) warns against the relationship between project sustainability and long-term sustainability as a major challenge in donor relationships. In essence, the local agency receives funding from a donor and the donor in return receives funding from international agencies. Hence, the decline in donor funding places immense pressure and demands on local bodies such as Churches and NGO's. This resulted in the Diocese of False Bay and many other faith-based organisations closing many well managed grassroots programmes.

Due to the lack of donor funding, many Care and Support groups closed down and resulted in the waning response of the Church to HIV/AIDS. In light of the above there is enough evidence to suggest the there is indeed a great need for Church organisations to become self-reliant in order to develop and sustain an effective and efficient pastoral response to future challenges facing the wider Church.

7.3 Inadequate leadership / political will

The successful implementation of the PHC programme as discussed in chapter four could be ascribed to the committed demonstration of the political will and strategic leadership. The impact of sustained leadership contributed positively towards the roll out of the programme and is a key component for the sustainability of the any programme.

Interview 2: Khayelitsha

The objective of this interview was to ascertain the efficacy of leadership in the implementation of the Isiseko Sokomoleza Programme.

"Poor leadership affects the programme badly". This interview identified the important role of leadership in the implementation of programmes especially HIV/AIDS.

Since the launch of the Isiseko Sokomoleza Programme, the lack of leadership in the Diocese of False Bay posed a major challenge to the operational (day to day) activities within the programme. The implementation of the PHC Model as discussed in chapter four identified leadership as the most important factor in implementing programmes that impact the community at large. In the findings in Section 4.2.6, a significantly high percentage of respondents indicated that the absence of a special task team to provide leadership in the Diocese contributed to the fragmentation of Care and Support groups. This was further aggravated by the absence of an HIV/AIDS coordinator who was recalled when the funding agencies withdrew their funds. The Diocese failed to replace the coordinator because it did not make any succession plans to sustain the work already done by some of the care and support groups. In addition, 28% of the respondents claimed that in their respective congregations they did not have a coordinator and in 4.2.6, 43% indicated that neither was there any support from the leaders in their congregation. In the findings in Sections 4.2.2 and 4.2.3, the value and positive impact of leadership were instrumental in the sustainability of HIV/AIDS programmes is some of the congregation.

The participants and educational groups such as Sunday school, Confirmation classes, and other organisations also expressed that the leadership and the Church could have done much more to address the stigma issues. The Church was not adequately equipped to deal with HIV/Aids at the time and therefore proper advice was not given at the time of the Isiseko Project. The lack of broad-based consultation and collective ownership contributed negatively in developing leadership at a grassroots level. When donor funding dropped there was also a new silence from the leadership of the Diocese to give strategic direction to the Church, which also made the leaders in the Care and Support groups despondent and eventually the agendas of Synods and Diocesan workshops showed no interest in stigma.

The dependence on donor funding and the lack of sustainable leadership contributed greatly towards the closing down of most of the Care and Support groups. Effective leadership is particularly required when the organisation suffers from donor fatigue and it is at this stage organisation's life that leadership need to provide strategic guidance and capacity. In my own experience at ACSA and the Diocese of False Bay, board members could not take the

organisation beyond donor funding, which resulted in the loss of well-trained staff. This waning of the Church's response to the challenges of HIV/AIDS and its accompanying need for the reduction of stigma and other challenges was resultant. In the Diocese of False Bay this reality played out when the Diocesan HIV/AIDS office closed in 2009 (ACSA Report). This was further aggravated by the absence of an AIDS coordinator who, as mentioned previously, was recalled when the funding agencies withdrew their funds. The Diocese failed to replace the coordinator and it did not make any succession plans to sustain the work already done by some of the Care and Support groups.

Leadership is not only telling people what to do but also living by example (UNICEF 2009). Leadership should grow from the heart and create enabling environments for members to feel at home in their congregations through spiritual support and building HIV resilience in their communities. In many instances, the clergy in the Diocese of False Bay were not overly excited in getting involved in matters relating to HIV/AIDS.

Scholars such as Olivier and Paterson have long highlighted the need to reflect theologically on the intersection between the medical narrative and the religious narrative in the on-going discourse between health and religion (Haddad 2011a:6). The discourse also highlighted the strengths and weaknesses of the religious sector in the areas of prevention, care and support, as well as the need for more research.

Sustained leadership is critical in creating a consciousness that could permeate every aspect of the congregation's daily existence; their homes; their interaction in their families; communities; and their workplaces in responding to the challenges of stigma. It has long been identified that religious leaders can generate action against stigma within their own communities (UNICEF 2003). The need for an integrated pastoral praxis for the Diocese of False Bay is therefore very important in the ongoing response to address the impact of stigma. As was indicated before, HIV/AIDS does not only inflict the individual, but collectively challenges people whether positive or negative, as it instils fear, suspicion, and tremendous insecurity. In order to construct a pastoral praxis for leadership at all levels, the Diocese needs to understand the complexities of members having to face living with the HIV/AIDS related stigma.

The Diocese of False Bay needs to develop a sustained succession leadership plan to address its challenges effective and efficiently. Pastoral leadership is not only needed when the Church faces external challenges. It is congruent with its identity to provide pastoral care and support

in every aspect of being Church. The argument can be made that when there was funding the leadership showed interest but when funding ceased, HIV/AIDS dropped off the agendas of not only the Diocese of False Bay, but also in ACSA as a whole. In this regard, the Isiseko Sokomoleza Programme was not so much pastorally driven, but rather financially. In reconstructing a sustainable pastoral praxis, the Diocese of False Bay needs to take in consideration that without committed leadership from the Bishop at congregational level, any response to social challenges will be at futile.

7.4 Theological inability to handle stigma

The Diocese of False Bay was ill prepared to handle the challenges of stigma in the Isiseko Sokomoleza HIV/AIDS programme. The Diocese of False Bay lacked a theological baseline for pastoral care in implementing the Isiseko Sokomoleza Programme.

The theme that emerged from the findings, as expressed by the participants of this present research study, was that they do not feel welcome or have a sense of belonging. The following quotes derived from participants confirmed this finding.

Interview 3: Kuils River

"I am not attending the care and support group because they treat you differently because I am HIV positive and you do not feel welcomed."

"They do not understand what I am going through."

Stigma was not effectively addressed in the Isiseko Sokomoleza Programme. This statement is confirmed by the finding in Section 6.3.2 in which 14 (67%) of respondents felt that the issue of stigma has not been addressed in a systematic pastoral manner in the Diocese of False Bay.

The above interview above raises a very important theological question. If God is a reality, stated differently, if God is love, then how can love remain silent and inactive in the face of torture, needless death and disease? The biblical example of Jesus in the Gospels presents the Church with a model of how to address stigma. Jesus is confronted with sickness and suffering of people together with their rejection by society as they were considered to be "sinners". The leper said to him: "Lord, if you want to, you can cure me." And Jesus' replied: "I want to" (Mark 1:40-41). Jesus sought to overcome the stigma and prejudice, suspicion and fear that was associated with diseases such as leprosy. Faith-based organisations to provide spiritual, emotional, and psychological care and support in facing the challenges brought about by the impact of HIV/AIDS. The morality of care and compassion obliges the Church to become

involved in the prevention of the spread of HIV and to care for the sick and those whose lives and are affected by sickness and death of family members.

In light of the above, it motivated me to use the theological discipline of practical theology, with special reference to pastoral care and counselling to strengthen the health assessment tool since this research study is seeking to find a theologically based strategy for future pastoral care responses towards HIV/AIDS and other social challenges. Scholars such as Saayman (1992) and Kriel (1999) have long lamented the prevailing philosophical model behind the HIV/AIDS campaign, which overemphasised the human body in a biomedical concern. As stated before, HIV/AIDS challenges the spiritual, pastoral, cultural, social, economic, and psychological wellbeing of all, therefore the need for reconstructing a theological frame that could contribute to perhaps greater emphasis on pastoral care.

De Waal (2005:29) stated that care and support forms an integral part of understanding Christian mission and witness. The findings of this study continues to support the call for new approaches to theology through the lens of pastoral care and counselling. Haddad (2011:105) states that HIV/AIDS is not only shaping theology, but also providing new habitats for new ways of doing theology. This statement is supported by Ackerman (2005), who refers to theology as an embodied experience. Such an embodied theological response, which derived from her hermeneutical stance that "Christians are charged with living out the values of the reign of God". This means that the Church needs to confront the sin of stigma and articulate the hope that is embedded within Scriptures and in our traditions and so doing, the communication about God's mercy, grace, and compassion will reflect more clearly in our pastoral responses (Anglican Prayer Book 2012).

Care and compassion towards those in need is a fundamental part of Christianity. It gives voices to the voiceless. In the Old Testament, the prophets denounced the leaders of the nations as shepherds who failed the flocks entrusted to their care, since they have not "strengthened the weak, healed the sick, and bound up the injured" (Ez. 34:4). In the New Testament, Jesus tells His followers to be servants of all (Mark 10:35), for even the Son of God did not come to be served but to serve and to give His life to redeem many people (Mark 10:45). God is embodied with life issues, in such a way that concrete comfort, change, liberation, and transformation takes place as an expression of the vivid and actual presence of God (Louw 2007). Additionally,

pastoral care presents the counselling procedures and verbalises the dimension of meaning and comfort from the perspective of Scripture. This theme is further developed by the fact that pastoral care inspires, heals, consoles, and comforts people, as well as reconstructs human life (Louw 2005:83). The unique feature of pastoral care is that it embodies the identification of the suffering Christ with our human condition (Makgoba 2015). Daniel Louw (2011), in his work on the theology of resurrection, argues that the focus on the creation, incarnation and passion are not enough to engage the depth of the pandemic. He calls for "theologies of resurrection", which can serve as a baseline for critique on all forms of human suffering, including the spiritual suffering of punishment, guilt, rejection, and stigmatization. He further states that pastoral ministry in the Church becomes a direct renouncement against all forms of death (stigma and human discrimination). The resurrection hope empowers people to resist all shades of labelling and prejudice. Through the salvific acts of God, all of humankind, including people living with HIV, is being encouraged to live life in all its fullness.

It is at this juncture that the theoretical framework of pastoral care and counselling integrates with the findings of this study. Through the hermeneutical interpretation the process moves to activity. The process of interpreting the individual's concepts is a scientifically theory- praxis-theory process. According to Louw (2008: 17), "it reflects on and deals with the praxis of God as related in the praxis of faith within a vivid social and cultural encounter between God and human beings." In practical terms the pastoral intervention of the church is to journey with stigmatised people by applying specific techniques. The existential threats of stigma are being conceptually processed through the grounded word of God (Stutzner 2015: 119). In praxis pastoral care and counselling focus on the language of the member. Often the language of the members are threats of anger, aggression, frustration, helplessness, and vulnerability, and dread are all forms in which members express meaning.

The following four stages as indicated earlier (Affective stage) the time for dialogue and the reason for seeking pastoral guidance. (Reflective, Cognitive stage) Conceptualisation of the problem through the words of the client through specific questioning. Followed by intensive values and beliefs. (Conative stage) The client learns how the objective interpretation of emotional experimental factors impact upon life meaning. The assessment of self-understanding and self-confidence are aspects of critical awareness. The client is more ready to deal with who they are and there interconnectedness with others. Identity is nurtured in the scriptural understanding of humankind created in God's image. (Normative stage) The client

become far more aware of the gospel values. The client is confident in God's grace acknowledge how God is directing their life towards meaning and hope. The understanding of the gospel values and how it impacts the knowledge structures of behaviour. The shift of paradigm is ultimately the clarity of resolving the problem.

Stigma affects the quality of care, access to treatment, and support networks such as family, friends, and Church. At care and support and the wider congregational level, the people who had to address stigma lacked the competencies to do so. The above interviews relate to the statement made by Deacon and Simbayi (2006:126), who stated that Churches need to create a safe and confidential space for disclosure. People do not seem sure that their confidentiality will be respected. Stigma should be highlighted and relevant policies implemented at all levels in the Church.

In addition, those elected to educate on the matter did not have sufficient resources or material on the matter to make the necessary impact. This information was gathered from the participants in the care and support groups. The facilitators lacked the necessary skills or sensitivity to handle working with HIV-infected individuals, as the statuses of members in the support groups were disclosed to the rest of the group. Consequently, the participants felt betrayed and exposed. The findings indicated very little was done in the Diocese of False Bay to maximise the opportunities in their liturgy and workshops to raise awareness of stigma. The evidence further identified that members were hardly aware of the Isiseko Sokomoleza HIV/AIDS Programme, let alone embracing the main objective programme, which was to reduce stigma.

The findings also identified a serious lack of training and capacity in understanding the emotional, spiritual, and psychosocial impact of stigma. The coordinators proved to be misinformed and therefore, could not provide proper advice regarding the disease.

The above lacking building blocks limited the capacity of coordinators to address stigma and impacted on the effectiveness of the remaining caregivers to address stigma. In response to the above, Dube (2003:156) comments that there has also been theological poverty and a real need for educational programmes at all levels in the Church. Since then the research agenda have contributed immensely to the stigma debate as was highlighted in literature. HIV/AIDS has indeed challenged the way we think, operate, and the traditional way we handle contentious issues. Once again, the findings have confirmed that HIV/AIDS has forced the Diocese of False Bay and the wider Church at ecumenical level to revisit its core values, which is to be a

welcoming, caring, pastoral community with the objective to vigorously address impact of stigma (Louw 2005).

The need for an integrated pastoral response has long been identified by Pillay (2003) and other scholars. Especially in the area of pastoral care and counselling, it is important to note that HIV/AIDS has taught us the need for a theology around AIDS. Likewise, the need for a pastoral response that is deeply rooted in theology has also long been identified by Ackerman and other feminist theologians. Ackerman (1988) "states that when the private and collective pain of sexist oppression is reflected upon critically and systematically in the light of faith, feminist theology is born". "It endeavors to challenge the Church, to recognize the distortions of the Christian message created in the Church's patriarchal socialization and to reconstruct its social patterns, language and theology to affirm the full humanity of both women and men (Ackerman 1988:33)". Feminist theology not only involves deconstructing patriarchal values in the text, but vigorously demands a reconstructing of the narrative from the perspective of women. This would mean that "We must stretch our theological imaginations, our reading of Holy Scripture" (Kanyoro 2002:35). In this way pastoral care can only bring healing to particular paradigms it seeks to understand the epistemological issues related to the conceptualization of human behavior (Stutzner 2015: 154). This approach has reinforced my pastoral understanding for deepening of theological baseline for all future responses of the Church for whatever the social demand might be.

7.5 An inadequate Pastoral Care Model

The findings confirmed that the Diocese of False Bay lacked a common pastoral praxis that was effective and efficient (PHC model) enough to maintain a strong pastoral base for stigma reduction through the Isiseko Sokomoleza HIV/AIDS programme.

Interview 4: Khayelitsha

"We blame the Church for the closing down, now that there is no money they don't care for us anymore." "Where are the Church people now to help us?"

In this instance, it lacked a pastoral vision that is congruent with its identity mission and witness as captured in its Diocesan vision statement: "Be a visible, affirming, adaptable, and relevant Christian community" (Vision Statement 2009). The vision statement embodies what the Diocese ought to be doing in its pastoral role to those in need, suffering, and marginalised such

as HIV infected members in the Care and Support groups. It could be argued that in the context of stigma reduction that the pastoral role of Churches in the Diocese of False Bay never came to its full potential due to the lack of a clear pastoral theological response to the HIV/AIDS pandemic. It could further be argued that the implementation strategies showed a disconnection between ecclesial components such as preaching, teaching, Bible studies, worship, and other pastoral practices. From the evidence presented, it is also clear that the response of the Diocese of False Bay waned due to the withdrawal of donor funding and the Programme could not be sustained due to the lack of a sustainable pastoral plan in the Diocese of False Bay. In some instances, programmes came to a halt and the life span of the programme suffered except within the 12 congregations where the Care and Support groups are still operational. In many instances, most of the Care and Support groups no longer live out their original mandate, but instead provide food parcels and run soup kitchens. The participants in the support groups felt that they were not adequately supported by rest of the parishioners and the fact that their statuses were publicised by the coordinators of the support group, exacerbated their already vulnerable state. The participants' basic human needs were not met and many avoided the support groups.

Healthy nutrition was important before medication and the need for food was overlooked by the support groups as they did not provide food. The support groups did not expand, illustrating that the Churches were ill equipped and misinformed about the needs of the participants in the support groups, in order for the programme to succeed. This lack of caring shows how the lack of understanding the reasons for the Isiseko Programme, which was to provide care and support to the members who attended the support groups.

In the following section, the four stages will be used as basis for the further analysis of the inadequacy of the pastoral care model in the Diocese of False Bay. In chapter four I made reference to four anthropological components in pastoral care and counselling. In reconstructing an appropriate pastoral theology, these factors could serve as a framework in the pastoral praxis. It enables care givers to assess and explore existential threats facing people living with HIV/AIDS and their families. During the effective stage, the caregivers could create spaces of healing through the welcoming, embracing reception, and embracing those who are affected into the local care and support groups and into the broader ministries of the Church. The findings as described in Sections 6.9.4 and 6.9.7 confirmed that members in the Care and Support groups felt the need for fellowship amongst themselves. They also welcomed the

opportunity of reaching out to others in the community and sharing a prayer, or word of encouragement. In the cognitive stage the caregivers could assess or evaluate the thought contents of the people living with HIV/AIDS and assist in deconstructing their oppressive narratives. As mentioned previously, the AIDS pandemic forces the Church to reflect critically on the notion of God, and the place of God in daily life. One of the participants raised the question during one of the dialogues: "Is there a God, why is He allowing all the suffering?" "Why is God allowing His people to undergo dehumanizing experiences?" "If God is a reality, more so, if God is love, then how can love remain silent and inactive in the face of torture, needles death and disease?" These questions present deep spiritual and theological challenges, which are central to faith. PLWHV are responding to existential threats, which is determined by their quality and maturity of faith, the content of their belief system (worldview), the normative dimensions of their life, value system, and the nature of their relationship with God, family, friends, community, and environment.

The conative stage could be described as the empowerment of caregivers, especially in the 12 congregations in mobilising the communities in taking care for PLHW and particular addressing the challenges of HIV/AIDS related stigma. This stage could also provide caregivers the opportunity to network the PLWH with the wider community and their local congregations. Barbara McClure (2012) advocates for the development of a more effective pastoral care model, and this study reveals that the concept of active participation by the community needs to be taken to the next level. The Diocese of False Bay could do well to develop the skills of its caregivers, who should be taught how to interpret particular contexts before responding to it. In doing so, the following questions are important in this new way of doing effective pastoral care. Caregivers need to ask, "What is going on?"; "What has led to the need for support now?"; "What is the historical context?"; "Are we, as caregivers, equipped to offer any support?"; "What is the particular request from the person in need of care?"; and "Are there resources to address them?" Effective caregivers on the other hand, are persons, who have reflected and come to terms with their own experiences of suffering (Nouwen 1992).

The following principles remain the basic elements of effective pastoral care; careful attention, theologically informed diagnosis, and compassionate support and intervention (Miller-McLemore 2012). This informs my argument that a responsible pastoral praxis involves theory and the lived experiences. Any effective pastoral theology needs to make room for human experience, including religious experience. Grassroots experience (human experience) can

only enhance, or significantly affect the other, more traditional forms of theological reflection. To a great extent, the traditional approach, as stated through the literature review, often excluded human experience, therefore, pastoral care and counselling needs to hold a balance of theory and praxis. The call for new approaches to theology through the lens of pastoral care and counselling is ongoing. Ackerman provides a set of theological tools for such an embodied theological response, which derived from her hermeneutical stance that "Christians are charged with living out the values of the reign of God" (Ackerman 2005. This means that the Church needs to confront the sinful nature of stigma and articulate the hope that is embedded within Scriptures and in our traditions and so doing, the communication about Gods mercy, grace, and compassion will reflect more clearly in our pastoral responses.

The biblical text itself summed up this vocation for humanity in the two greatest commandments: To love God with all our heart, soul, mind, and strength, and to love our neighbours as ourselves. The promise for abundant life involves our emotional, spiritual, mental, and physical selves, together with members of the community (Ackerman 2009:55). "Jesus Christ, through His incarnational love (presence of God), meets us in our own contexts and culture across the broad spectrum of humanity. God reassures us by shaping and molding us through life's challenges and reassuring us of a glorious future". Therefore, the task of the practical theologian is to provoke and challenge how we can be part of the unfolding of God's good to its maximum in "all things". The above statement underscores my view that the implementation of the Isiseko Sokomoleza Programme lacked an adequate theological base in most of its programmes. "My own theological position is informed by the understanding that theory and praxis should not be in contradiction, but that the one informs the other. Theory and praxis are inextricably linked". As Volf states: "Practices are essentially belief-shaped, and beliefs are essentially practice shaping" (2002:254).

According to Ackerman, theology must be done in service of Christian practices, because it is about our beliefs about God. It calls us to a way of life that expresses these beliefs. It is in this engagement that pastoral care invites us reflect again how pastoral care is shape by our beliefs in a caring, loving, and forgiving God (Ackerman 2009:273). In the normative stage, the focus is on values cultivating true discernment and an understanding of the will and the presence of God in their lives. This stage provides the process whereby people apply their resources of faith far more purposefully and explore the meaning of life through their faith experiences. These four stages could serve as a potential healing tool, which the pastoral care givers can use to

compliment other types of counselling when dealing with PLWHA in the Church. Given the four areas (effective, cognitive, conative. and normative) stages of pastoral anthropology (Louw 2008:75-77), pastoral care implies more than empathy, and functions to heal, sustain, guide, reconcile, nurture, liberate, empower, and interpret. In this way, pastoral care could, as discussed earlier, create spaces for reflection, listening, rational conversation, and for God's grace to bring about transformation. This also provides the milieu for serving, empowering, and loving others, building relationships of trust and facilitating trust from within. This recognizes God's love for creation and God's will to reconcile and heal the broken relationships with the world (Kurian 2016:60).

The success of the PHC could be ascribed to the broad based community consultation and ownership, decentralization of the oversight, and monitoring and evaluation role of PHC to every village and local ward. In this instance, the HIV/AIDS programmes in Diocese of False Bay was initially spearheaded by ACSA at a provincial level and there was very little consultation with local congregations. These programmes were determined by donor driven guidelines managed from the ACSA offices and Dioceses such False Bay were mere recipients of monthly grants (ACSA Report 2005). The PHC model could assist the Church to adopt a new approach, namely the bottom up approach, which strengthens my earlier discussion on how theory and praxis could lend itself to greater impact for the implementation of programmes other than the perceived limited impact that is currently being experienced in the evidence gained through the implementation of the Isiseko Sokomoleza Programme.

Given the understanding of pastoral care, the pastoral role of the Church ought to come from the deepest theological convictions about the nature of creation, God's unconditional love, the Church as the body of Christ, and the reality of Christian hope through the resurrection. In my opinion, HIV/AIDS challenges not only the systemic and structural barriers but more so moves the Church to confront its own understanding of being the body of Christ, Gods love for creation, human beings created in the image of God, sin and judgement, and ultimately death. The Church exists to address the needs of its people, but the effectiveness of its mission or outreach strategies are equally important. Most sacred texts call for a response to human need with love and compassion. McClure (2012:271) states that pastoral care assumes that the love of God is embodied in love of neighbour and love of self. HIV/AIDS challenges humanity to the core of its faith, and the disease goes well beyond the scope of mere technical responses of medicine (Parry 2008:45).

Louw (2011) argues that the focus on the creation, incarnation, and passion are not enough to engage the depth of the pandemic and calls for "theologies of resurrection", as mentioned earlier. The resurrection hope empowers people to resist all shades of labelling and prejudice. Through the salvific acts of God, all of humankind, including people living with HIV, is being encouraged to live life in all its fullness. This theme of life in its fullness is further developed by Michael Czerny (2006), who asserts that the Church's response to the AIDS pandemic is not just to 'respond to a problem', "but a pastoral one, which involves embracing and affirming the dignity of all". In crafting a responsible pastoral care programme the Diocese of False Bay cannot ignore role of women and girls in the pastoral cycle of care and support.

In return, this renewed model of pastoral praxis could contribute towards an awareness where governance and leadership will enhance the possibility that decision makers and those in various hierarchical structures within the Diocese of False Bay will introduce policies that are conducive of creating informed, healthy and balanced societies. Pastoral praxis could influence the spaces where analysis, teaching, dogma, practice, dogma, spirituality, celebrations, worship, and liturgies provide the possibilities for the challenges concerned to be addressed in a theological manner.

Through renewed pastoral praxis, the affective stage of separation, anxiety, pain, and hurt caused by stigma could be discussed without fear or people made to feel uncomfortable, unwelcomed, or unsafe. Instead, in all the diocesan structures, new guidelines regarding self-respect and integrity should be encouraged by everyone. The renewed pastoral praxis could strengthen the 12 Care and Support groups and create new responses in the other congregations within the Diocese of False Bay. These could involve the youth, women's groups, men's groups, and Christian education groups such as Sunday school and Confirmation groups.

Through this renewed pastoral praxis, the inclusion of families could become safe and equitable spaces where the sacredness of relationships and sustained abuse is prevented and could consider using the normative stage as a credible model of pastoral praxis. Through renewed pastoral care and counselling psychological, emotional, economical, and spiritual support needed by PLWHA could be available and by so doing, pastoral care and counselling becomes a useful tool in fighting HIV-related stigma locally and globally. Given the above, the Diocese of False Bay need to reactivate its pastoral response to HIV/AIDS in a meaningful way because the challenges of HIV/AIDS is far from being over. In the following chapter, recommendations

and suggestions will be made on the reconstruction of the pastoral praxis in the Diocese of False Bay.

7.5 Conclusion

This chapter concludes both the quantitative and qualitative findings, which indicate that the implementation of the Isiseko Sokomoleza Programme had limited impact to address the challenges of stigma. Some of the most critical reasons for the limited impact was discussed, such as inadequate leadership; theological inability to handle stigma; and inadequate pastoral care models. The findings confirmed that response to HIV/AIDS in the Diocese of False Bay have waned, however there are still twelve congregations that are involved in Care and Support groups. Despite the attempts of the Diocese of False Bay to address stigma, it still remains a major challenge in the pastoral response towards HIV/AIDS. In the light of the above findings and a theological rationale for sustained pastoral praxis future social challenges, the following chapter will make some recommendations towards a pastoral care praxis.

CHAPTER EIGHT

RECOMMENDATIONS FOR AN APPROPRIATE PASTORAL PRAXIS

8.1 Introduction

This chapter will offer recommendations and suggestions towards a sustainable pastoral praxis with regard to pastoral care and counselling in the Diocese of False Bay, ACSA, SACC and Ecumenically (WCC).

The aim of this study is to investigate the reasons for the limited impact on stigma reduction through the Isiseko Sokomoleza HIV/AIDS Programme in the Diocese of False Bay. This study confirms that the implementation of the Isiseko Sokomoleza HIV/AIDS programme had a limited impact on stigma reduction. It also confirms that the Church's pastoral response towards the challenges of HIV/AIDS has indeed waned and, in some instances, no longer exists. I have argued that the reason for this was that the Isiseko Sokomoleza HIV/AIDS programme lacked a theologically founded pastoral care response. However, although it was hypothesized that there were some positive contributions made by the programme, the study indicates that there were some significant reasons why the programme had a limited impact based on the observations as discussed earlier, such as dependency on financial resources from donor agencies; inadequate leadership; theological inability to address stigma; and a sustainable pastoral care model.

The implementation of the Isiseko Sokomoleza programme started with enthusiasm and sufficient resources. The pastoral responses waned due to the following: In its implementation phase, there was no broad based consultation at grassroots level; therefore, the majority of the participants only came to know about the programme during the course of this current study. It also indicates that the remaining care and support groups were still active, albeit fellowship groups, providing soup or food parcels to the needy. The qualitative analysis confirms the findings in the quantitative analysis, namely, that a lack of resources negatively affected the sustainability of the programmes.

It is very clear from the findings that the pastoral care and support provided by the Diocese of False Bay fell short in addressing stigma appropriately. The lack of leadership support and

congregational support negatively influenced the sustainability of the care and support groups. The situation was exacerbated by the fact that there was no person or group responsible for this ministry. The findings further revealed that the HIV/AIDS ministry in the parishes were not budgeted for, which contributed to the reality that out of the 49 congregations, only a few active care and support groups remains. The respondents expressed that when donor funding ceased, the responses of HIV/AIDS ministry also waned.

The waning response in the Diocese became real when the Diocese of False Bay hosted a Youth Synod in Robertson on Saturday, 6th July 2017. Several resolutions were passed, but none addressing the impact of HIV/AIDS. Despite all of the above reasons, most of the respondents stated that they were still involved in the ministry for the fellowship, their passion for the work, providing food parcels, and praying with those whom they had visited. In strengthening the existing practices, care should be given to the anthropological components of effective, cognitive, conative, and normative stages, in order to enable PLWHA, their families move from a position of existential threat to a position where hope, acceptance, belonging, welcome, forgiveness, and justice is experienced. Given this brief summary of the findings, the following recommendations could contribute to strengthen pastoral praxis beyond the boundaries of the Diocese of False Bay and impact on the broader pastoral landscape at a national and ecumenical level.

8.2 Diocese of False Bay

(a) Dependency on donor funding

The Diocese of False Bay need to change its mind set from donor dependency and make resources available to develop and sustain responsible pastoral praxis, which could form the baseline for all ministries in the Diocese of False Bay. The Diocese of False Bay could invest in the development of programmes which creatively address those who are HIV positive in the face of the economic decline in the South African context. A revived pastoral praxis should include theological reflection on stewardship as resource mobilisation across the Diocese and through teaching and training from a pastoral care perspective the joy of giving.

In Section 6.8.2, 90% of the respondents stated that the Churches made no, or very few, resources available for the ministry of HIV/AIDS. Projects also stopped when donor funding was no longer forthcoming. Local responses resulted in occasional candle memorial services

and World AIDS Day activities. From the lessons learnt over the past years, it was apparent that, in most cases if not all, this ministry was driven by the availability of donor funding and not the other religious assets (care, counselling, and support). The Diocese of False Bay made no provision in the budget for 2016-2017.[59] Despite the lack of donor funding, the Diocese of False Bay needs to reclaim its prophetic pastoral voice. Based on the findings, it is recommended that the planning and budgeting procedures in the Diocese of False Bay allocate funds for the implementation of theologically based pastoral messages and training programs on Stigma reduction for all organisations and parishes within the Diocese.

Furthermore, the Diocese of False Bay could also support more effective interventions for orphaned and vulnerable children with additional resources. The Diocese should also ensure that the ongoing response to reduce stigma becomes integrated in the pastoral strategic plan of all the structures and the diocese, from governance to implementation. Regarding donor funding, it is recommended that the faith based sector in general develop alternative methods for raising funds in other sectors of the economy that supports social entrepreneurships (Lehner 2013). Furthermore, for the sustainability of programmes in the Diocese of False Bay, there is a need to strive towards a balance between donor funding and independent financial resources. This would enable faith communities such as the Diocese of False Bay to overcome the donor pressure and retain their autonomy with regard to the biblical mandates (Hershey 2013). Partnerships with communities and non-profit organisations together with the private sector could greatly reduce the pressure of one particular denomination in providing resources for the reduction of stigma.

Some care and support groups continue despite the lack of funding because they are commitment to serve others. Through the renewal of its pastoral praxis, the programme could include broader goals such as stewardship, evangelism, spiritual growth, care and support, programmes to the poor and the marginalised, the involvement of women and children, and strategies on implementation and effective governance. In this renewal of its pastoral praxis, it is recommended that capacitating leaders forms an integral part of the ongoing response to address stigma, whether there are funds or not. Our pastoral responses should not be determined

[59] See the Budget presented at Diocese of False Bay's Standing Committee held in Somerset West, 13 Nov 2015

by funders, but by the Gospel imperative to welcome and embrace one another in a spirit of openness without being judgemental.

(b) Inadequate leadership

A responsible pastoral praxis calls for renewed commitment from all leadership structures in the Diocese of False Bay. Through pastoral care and counselling, the ministry and witness could have greater impact on other ministries in the Diocese of False Bay.

The implementation the Isiseko Sokomoleza Programme could be attributed to the visionary leadership of many of the Church leaders. In the findings in Sections 6.2.2 and 6.2.3, the value and positive impact of leadership were instrumental in the sustainability of the care and support groups.

Especially as the findings indicated that care and support groups perceived the groups as projects and not as a pastoral response from the Church. This statement is supported by Parry (2008), who claims that it is in reaching out that the actions of the Church are socially relevant and culturally appropriate. However, it is also noted in the findings that the absence of leadership at all levels within the Diocese contributed towards the waning pastoral response to HIV/AIDS. It is critical for the leadership in the Diocese of False Bay to renew and revive its pastoral responsibility towards those infected and the affected. In looking through the stigma lens, the Diocese of False Bay need to reflect critically on the pastoral model that was informed by patriarchy. The Diocese of False Bay need to train more women counsellors, since women have been marginalised not only at a structural level, but also the pastoral environment of addressing HIV related stigma often reflected male dominance. Additionally, the attitude of male clergy towards women clergy are often characterised by gender discrimination, which are in violation to the principles of pastoral care for example, healing, wholeness, acceptance, forgiveness, and justice.

As highlighted earlier, women and girls are mostly affected by the challenges of HIV/AIDS, therefore the need exists for women to be trained as pastoral counsellors in order to understand the counselling of women. Women are affected the most by of HIV/AIDS related stigma through cultural practices, poverty, hierarchical structures in the Church as the body of Christ. The Diocese of False Bay should embark on an empowerment programme for women who often fall easy prey to the HIV virus, oppression, stigma, and discrimination. Through pastoral care and counselling, the Church could be helped to address the imbalance in power and strive towards a leadership model that provides gender equality at all levels in its structural formations.

In its efforts to implement an effective and efficient pastoral care praxis, it is recommended that the Diocese of False Bay transform from a "top down" hierarchical model, inherited from historical centralised power in the bishop, towards a model where the congregations are also empowered in the care of PLWHA and their families. The Church ought to shift its focus from an exclusive ecclesiological model to be replaced by pastoral paradigms of accommodativeness, sharing inclusiveness, and embrace. By doing so, the women should be empowered economically to move from being victims to victors of the challenges they are faced with in addressing stigma. Women and other marginalised groups in the care and support groups could provide joint leadership in mobilising the wider community in addressing the challenges of AIDS related stigma beyond the boundaries of the Diocese of False Bay.

It is recommended that young people also play a more prominent leadership role in the decision-making processes of the care and support groups. From the findings it was evident that members of the care and support groups who were HIV positive did not participate in the management of the care and support groups, which in itself could be perceived as stigmatization. This recommendation is based on the evidence that the Primary Healthcare model (PHC), which was outlined in chapter four, where broad-based consultation contributed towards the successful implementation of the health programmes. Through the implementation of the Primary Healthcare model, communities were capacitated to take ownership, which subsequently contributed towards the successful implementation thereof.

It needs to be noted that many religious leaders have been actively engaged in raising awareness on HIV/AIDS related matters, however stigma is still prevalent in our pews as we are now faced with care and support to the Gay and Lesbian (LGBTQI) members in our congregations. (Diocese of False Bay, Standing Committee Meeting 3 November 2018, West ridge, Mitchell's Plain). The quest for leadership will continue in the pastoral spaces beyond the HIV/AIDS response.

(c) A Theological inability to handle stigma

From the findings and interviews it became known that members of the care and support groups felt excluded from the daily activities in the groups. The Diocese of False Bay and the Church at large is being challenged to take responsibility to overcome stigma and discrimination within its own structures and play a leading role in encouraging society to respect the rights and dignity of all within its ranks (Kurian 2016:27). For example, people who have tested zero-positive

should be encouraged to continue to live and sustain their lifestyles in a healthy way and live positive and productive lives. Stigmatisation and discrimination, in various contexts, have proven to be the biggest "killer" in the experiences of members, who are HIV-positive (Byamugisha 2009). In creating a pastoral theological response, which need to be mainstreamed in all structures of parochial, provincial, national and ecumenical responses, a viable theology must develop a sound doctrine of brokenness, sin, and the world so that the Church makes a realistic contribution to society (Vroom 2007:472). In order to do this, the Church needs to free itself from historical negative outlooks of a simplistic, moralistic, judgmental rule-based sexual ethic (Kurian 2016:16). Instead, it needs to provide a response that is life sustaining and holistic, where all are equal, whether HIV-negative or positive. Earlier in the study, reference was made to the research conducted among young adults with special reference to sexuality and faith practices (Mash and Kareithi 2012).

It was evident that young people did not act out of a spiritual conviction of their faith experiences with the choices they have to make. This notion of belief and action needs much more reflection. Paula Clifford (2012:132) endorses this need to engage with the pillars of belief and praxis. According to Messer (2004:21), an effective pastoral praxis is critical and the following constructs such as "a constructive pastoral engagement in the context of HIV/AIDS; pastoral exhortation and systematic ethical education on AIDS related issues, continues development of theological resources on HIV/AIDS)". According to Messer (2004:21), the following constructs such as a constructive pastoral engagement in the context of HIV/AIDS; pastoral exhortation and systematic ethical education on AIDS related issues, and the development of theological resources could sustain the responses to stigma. These emerging trends in this research project could create ongoing dialogues and conversations, which could influence the effective responses to stigma reduction in the Diocese of False Bay.

In restructuring an appropriate pastoral care praxis the Church should revisit its mandate of Jesus, who healed the sick, the injured, widows, orphans the aged, strangers, prisoners, the hungry, and also slaves. The Church is compelled to revisit its primary calling, mission and witness that is embedded within the pastoral frame of biblical inclusive caring (I Cor 8:1; 12:7; Eph 4:12; Col 3:14; 1 Pet4:10). The findings confirmed the need for a sustainable pastoral praxis in order to respond effectively to the challenges of HIV/AIDS and all future social challenges. The findings also revealed that there were hardly any initiative from the Church to call on renewed efforts through its structures to reactivate their pastoral response to stigma with

clearer understanding on the theological basis in addressing stigma. It is recommended that the Diocese of False Bay should continue to address stigma through its synods, conferences and workshops. The findings could inform the future theological approaches to address stigma in the Diocese of False Bay more effectively.

The Diocese of False Bay could become most effective in its response by creating pastoral centres where those infected and affected seeking a home, a shoulder, and embrace and the acceptance to identify with their pain, should be welcomed and supported (Kurian 2016:40; Parry 2008:45; Louw 2009).

Through its ecclesial practices, the Diocese of False Bay could promote the messages of hope, restoration, welcome, and justice as pastoral care and counselling opportunities**.** The findings of the respondents motivated for greater alignment of liturgies and other educational materials. The Churches need to create more safe spaces for members, especially women and girls, to create a therapeutic environment and safe spaces for HIV/AIDS counselling. The Churches needed to do more in the teaching on the theology of care and support. From the findings, 57% of the participants identified the lack of HIV/AIDS initiatives in the liturgy and worship life of the congregations. Another observation from the findings is that 68% of the participants indicated that their congregations have no on-going counselling and support efforts in place. The Diocese of False Bay is therefore challenged to look inwards and recognise that HIV/AIDS is part of the life of the Church in various ways. Despite the many theological discourses on stigma and discrimination, it continues to challenge our attitudes towards people who are infected, our language, judgements, and assumptions. The question to be asked is: "Are the messages we send out still contextual, relevant and effective, efficient, participatory, non-judgemental, gender friendly and are our Church spaces welcoming?"

Therefore, it is recommended that through trained clergy and laity in the area of stigma reduction, ecclesial structures and opportunities for preaching, liturgy development, prayer meetings, bible studies etc., could be turned into platforms of using scripture to anchor a holistic integrated pastoral praxis. People feel cared for, comforted, encouraged, and reconciled through the pastoral and prayerful action of the people of God. Especially the Sacrament of Holy Communion, which is central to the Anglican worship, praying and laying-on of hands and services of anointing could play a much greater role in the healing agenda of the Church if it is accompanied by proper theological teaching. These ministries could provide safe spaces for pastoral care encounters in which God's presence may be realised. They also set an atmosphere in which healthy living becomes a common aspiration. This intersection of

sacramental healing, pastoral care and the common life of Christians provide an effective base upon which individuals may increase wellbeing (Holley 2015).

(d) Inadequate pastoral care response

In providing an effective pastoral response the Church at large should address the absence of effective pastoral messaging that will take into consideration that many of the adolescents today were born HIV positive. This would require different strategies in in tackling stigma especially for young women whose lifestyle choices leads to HIV vulnerability due to various reasons, some of their own and some not. The Diocese of False Bay, ACSA and the Ecumenical Community can only become more effective in its pastoral response if there is an in depth understanding of the current context of HIV/AIDS in South Africa. Through pastoral care and counselling, the Church could dismantle her dysfunctional, hierarchical structures of exclusivity and move towards a more inclusive ministry, one in which she is seen to be in the midst of pain, suffering, and exclusion and not one in which the leadership is dependent on outside resources in order to provide care and support. A renewed vision for pastoral care and counselling will create an appropriate pastoral praxis with an inclusive ecclesiology that could facilitate welcoming, accommodating, belonging, and appreciation of the PLWHA and their families (Murage 2011:396). We cannot speak of "us" and "them" when it comes to HIV/AIDS. The pain, fear and exclusion has touched us all, and we need to look at our members living with HIV/AIDS as our greatest resource for pastoral care and counselling. We all have been created in the image of God and discrimination is a sin, and stigmatising to anyone is contrary to the will of God (Kurian 2016:27).

Historically, the Diocese of False Bay is known for its social activism embedded in a compassionate and humanitarian theology. Often confronted with the organisational history of stigmatization and exclusion itself, but also the weight of societal stigma leading to hate speech, abuse, violence, and killings at times.

From the findings in Sections 6.2 - 6.5, pastoral care was not clearly defined in the main objectives of the Isiseko Sokomoleza programme and it is recommended that all pastoral responses be embedded within the praxis of care and support. It is therefore recommended that the Diocese renew its response by appointing full time staff and committed volunteers that could initiate programmes at parish and archdeaconry level. These co-ordinators could engage in workshops, integrated prevention programmes such as home based care, catering for orphans

and vulnerable children, widows, and to reinstate food gardens as a means of addressing food security challenges in communities.

It was also clear that most of the members in the care and support groups could not make the connection between the care and support group, the programme, and the mission or pastoral role of the Church. Pastoral care and counselling should become integrated in the vision and mission strategies of the Diocese of False Bay that claims to be an integrated Eucharistic community (Vision Statement: Diocese of False Bay 2012). With proper training of both clergy and congregation, the Church would be able to establish a community of care, whereby the majority of her members could learn to engage in pastoral care and counselling to orphans, widows and their families. Furthermore, the Church could move beyond its local boundaries by starting up VCT centres, more Home Based Care ministries and Hospice ministries such as the Home Based Care unit in Hawston, which was started in the Diocese of False Bay. These ministries should deal with stigma and discrimination in a meaningful way and mobilise the community to engage in compassionate care, acceptance, unconditional love, and ongoing support (Munro 2013).

It is clear from the findings in Sections 6.4.6 - 6.7 that there was an alarming percentage (62%) of the respondents who indicated that the provision of pastoral care counselling was seriously lacking in the Isiseko Sekomoleza programme, which contributed to the exiting of many members from the care and support groups within the Diocese of False Bay. Since clergy and lay leaders are seen by grassroots as models in the communities, they should be trained as counsellors in the area of pastoral care and counselling to PLWHA and their families. HIV/AIDS continues to have enormous emotional, psychological, economic, and social impact both the individual and the family (Pillay 2003:17). As discussed in chapter four, effective pastoral care and counselling can move people from a position of helplessness, exclusion, and vulnerability to a position where they are able to feel emotionally, spiritually, psychologically and socially empowered (Murage 2011:400).

Families and children who are orphaned are accepted into households of relatives or child-headed households, pose an enormous pastoral burden to the Church. The Diocese should strive towards meaningful partnerships, especially with government institutions in developing multi-sectoral responses in order to be more effective in its efforts towards stigma reduction. Given the multidimensional nature of the pandemic (Pillay 2003), there is an urgency for the Church

to engage with ecumenical bodies and various government departments such as social security, protection, equality, and education, health services, and food security, social and cultural, economic and political departments in a joint mobilisation strategy towards fighting stigma at a much broader level. This makes the Church a meaningful actor in the multi-sectoral approach and she need not feel the weight of doing it alone.

Churches are best placed to provide safe spaces for pastoral conversations to happen. Pastoral care and counselling conversations should also be geared towards the young people and children who often suffer the greatest impact of HIV/AIDS related stigma. It is clear from the findings in Sections 6.4.6 - 6.7.7 that there was an alarming percentage (62%) of the respondents who indicated that the provision of counselling was seriously lacking in the Isiseko Sekomoleza programme, which contributed substantially to the reasons for the limited impact on stigma which was under investigation. This further underlines the vital role of ensuring that the Diocese of False Bay, ACSA and the Ecumenical Churches should advocate for creation of safe spaces in order for members to share their stories of HIV and stigma in a welcoming and safe environment. The recommendation is that the Diocese of False Bay address the need for providing safe spaces for pastoral care and counselling, not only in addressing HIV/AIDS, but also in being proactive in addressing other challenges related to stigma. In providing these safe spaces, the Church embodies the gospel mandate to welcome the stranger, bind up the wounded, the lame, the blind and care for the sick (Luke 14:12).

Furthermore, based on the findings from Sections 6.21 - 6.2.14, these safe spaces should be provided at a governance and leadership level where the lessons learnt from the findings could influence all hierarchical structures and decision making bodies in the Diocese. In order to improve the way in which the Diocese responds to HIV/AIDS related stigma, it is recommended that the Diocese of False Bay needs to reconnect its response with actions that is congruent with its identity mission and witness anchored in a theology of pastoral care and counselling. The challenges of HIV/AIDS compels us to recover, discover, and uncover the essence of being Church today (Messer 2004:21). As the pandemic unfolded over the past years, the Roman Catholic Church in Africa has gradually discovered the purpose of its mission as the community of solidarity, compassion and care for the "least of these" members of the Body of Christ living with AIDS".

In the light of the findings, this study should enable the Diocese of False Bay to continue to strengthen its response to stigma by revisiting its identity as Church, mission and witness in reconstructing its operations to become what it ought to be. “The nature and mission of the church proceeds from the triune God’s own identity and mission with the emphasis on community in which there is sharing in a dynamic of interdependence. It belongs to the very essence of the church – understood as the of Christ created by the Holy Spirit to live as a healing community, to recognize and nurture healing charisms and maintain ministries of healing as visible signs of presence of the kingdom of God” (WCC 2005). In this way, the Church national, global, and universal shares in this identity of the Church being the reconciling community of God and should inform and drive the pastoral agendas in ACSA, SACC and Ecumenically (WCC) and beyond.

8.2 The significance of the findings for ACSA.

The findings of this study could increase the knowledge base in ACSA and assist by addressing the negative effects of stigma and discrimination. This could lead to sharing and inspiring a vision for the future of an inclusive Church working towards social justice. The findings could contribute to the missionary objectives of ACSA (Provincial Synod 2010) and provide a roadmap to affect change by uniting leadership with the capacity to advocate for the rights of people living with HIV/AIDS. Liturgical renewal for transformational worship could be broadened by including a non-discriminatory and equitable language in all the elements of the worship services. This study could inform the ongoing theological conversations and further strengthen the public theology agenda at various colleges and other institutions of learnings (schools, colleges, lay-training centres). Through leadership formation, ACSA could promote participatory processes that will include the cross section of organisations and members, including members who are stigmatised against. Leadership should be strengthened in the various dioceses through capacity building workshops. These processes should include new strategies for stigma reduction. Through its policies and structural arrangements, the role of women and youth need to become integrated in the ongoing discourses on the impact of stigma on their lives. The theological reflections in ACSA could be greatly strengthened by the findings of this study, especially the pastoral role of the wider Church and what an appropriate pastoral praxis could change the mind-set of the Anglican Dioceses in the greater ACSA.

ACSA is well placed to create opportunities for greater youth participation in the development of strategic processes through its Archdeaconry and Parish structures based on the evidence that young people are most at risk for new infections (Gap report 2016). In the area of Public Advocacy, ACSA could network with other National denominations in addressing challenges of financial resources on a much wider scale. The creation of safe spaces at Churches could be increased at every Church throughout ACSA. The need for privacy, confidentiality and respect should be emphasised. They could also be given opportunities to address the congregations as safe spaces to share their experiences of stigma in the Church, as well as in the community. This could be an opportunity for pastoral care and counselling in a meaningful way (Ackerman 2013).

The findings strongly emphasized the need to address poverty and food security as part of a national strategy with relevant national government organisations and non-profit organisations.

8.3 Implications for the South African Council of Churches (SACC)

The recommendations of this study could also be shared with the already existing research initiatives within the SACC in order to strengthen their national responses. There is a need for SACC to refocus on the pastoral agenda is also critical in the current context. SACC could reclaim its role as giving guidance to affiliated Churches and others as to how pastoral praxis could sustain the ongoing responses facing the Church in South Africa today.

As indicated before, the findings identified that the social drivers contributing towards stigma, such as economic and gender inequalities, require urgent action from the national Church. This will include addressing the broader cultural and social issues such as HIV/AIDS, substance abuse, gender violence, inequality, and poverty through integrated programmes and workshops for youth, women and children. As early as 2005, the SACC embarked on a multi-sectoral response to HIV/AIDS whereby the trade unions, Church leaders, and civil society undertook to raise awareness around HIV/AIDS. The findings of this research could contribute to the exiting pool of scholarly work of scholars such as Koegelenberg (2012), Parry (2014), Dube (2001), Chitando (2016), Maluleke (2016), Haddad (2011), Pillay (2007), Cochrane (2006), Clifford (2010), Ackerman (2007), Bower (2007), Olivier (2011), Paterson (2011), and others that can take the HIV/AIDS national discourse forward.

Existing partnerships with SANAC could be revived in order to lobby and advocate for stronger partnerships to address stigma related issues. In the area of the training programmes for laity

and clergy in order to continue the theological discourses on topics of sin, blame, guilt, restoration and reconciliation.

Stigma continues to manifest itself in many regional formations, this research could continue to inform regional initiatives on the continent to strengthen its pastoral responses that to become less dependent on donor driven initiatives. National leadership capacity building sessions could be revived as new challenges of stigma continue s to be a major threat in civil society today.

8.4 Informing the International Ecumenical agenda

At an ecumenical level, this study could take forward the contributions of the WCC such as Anderson, Karen, and Rupert (1999). Rather the study offers an account of how those who are HIV positive still feel stigmatised and lack pastoral care etc.]

of calling Churches to continue to respond to the HIV/AIDS pandemic by providing basic guidelines on Church mobilisation; biblical guidelines (theological material); literature and theological education material in training of theological students. Almedal (2011) and Heath (2005) shared their personal journeys on stigma and living with AIDS on an ecumenical platform. Dube (2001) unsettled many Christian denominations on the topic of liturgy and worship. AIDS was integrated into the curriculum (2003). Gennrich (2008; 2013) reflected extensively on the toolkit on gender relations in the Churches and listening as a very important skill in counselling process of HIV infected members. Monaj (2012) drew up his framework for liberating human sexuality, while Paterson (2005) wrote extensively on the stigma index with special emphasis on the impact of AIDS on women. Cochrane (2011) reflected on the alignment between health and religion. Phiri (2003) sketched the impact of HIV/AIDS on women in the village, as well as faith communities.

Denis (2005) provided practical suggestions in how to be resilient in the world of AIDS through calling to mind the memories of loved ones who died of AIDS. Kurian (2016) compiled a range of WCC contributions on the historical development of the ecumenical response and in particular, providing pastor oral guidelines which again called on Churches to provide safe spaces from governance to programme implementation and pastoral praxis. Together with other WCC publications, this contributed extensively in many ways guiding Churches through various responses and at various intervals through the challenges of HIV/AIDS. Bodies such as the Ecumenical HIV/AIDS Alliance (EHAIA), Anglican Communion, World Alliance, Nairobi Council of Churches, Methodist bodies in Southern Africa and ACSA, have made

contributions to address stigma. However, most of these responses were donor driven and are now also facing closure or stopped functioning as the HIV/AIDS programmes in ACSA and the Diocese of False Bay (Bates and Munro 2012). The findings could influence the development of theologies for pastoral care that could serve as best practice and evidence based models, ecumenically and in interfaith platforms. What is important about this study is the fact that research carried out with those living with HIV in 2015/2016 is still showing that the issues of stigma and lack of pastoral care remain. The implications of this for ACSA, SACC, and the wider ecumenical movement is what should be stressed and teased out.] The regional ecumenical bodies could also be instrumental in tapping resources through lobbying for the upscaling of existing theologically driven pastoral responses to address stigma and discrimination. Through its global links ACSA in particular could approach international Churches to provide technical skills and support to the development of appropriate literature, manuals, and workshops in partnerships with international strategic plans in addressing the impact of stigma and work towards maximum impact. From the findings, the Diocese of False Bay could initiate local discussions with different NGO's, local government, and localizing the challenges on human sexuality, poverty, and stigma.

8.5 Limitations and value of this current study

This study fulfilled its basic aim of assessing some of the reasons for the limited impact of the Isiseko Sokomoleza Programme. Firstly, the study did not consider all the parishes in the Diocese, but only those that still had Care and Support groups. Additionally, a much larger sample would have provided a more comprehensive study of the problem; however, my scope for this research was restricted because of the limited time and resources available. Future research could focus on a more in-depth study of the current state of HIV/AIDS, which will highlight other gender related issues and its impact on HIV/AIDS. A more in-depth study on alternative methods of funding and implementation strategies for the up scaling of the implementation of HIV/AIDS programmes could also be part of the future research agenda.

Another theme that could form part of the future research agenda is human rights and the challenges of HIV/AIDS, which was not within the scope of this research. Especially the area of structural change within the response to HIV/AIDS is critical. According to the 2016 UNAIDS Prevention Gap Report, which strengthens the case for no one to be left behind. It also states that HIV-related vulnerabilities are fuelled by inequalities and prejudices entrenched within the legal, social, and economic structures of society. The following prevention gaps identified by the report could create new challenges to the responses of the Church in the future,

such as gender inequalities, including gender-based violence, which increase women and girls' vulnerability to HIV and prevent their access to treatment. The challenges in accessing sexual and reproductive health services among adolescents and young people continue to challenge the pastoral landscape. Groups or "key populations", whose human rights are being violated and women who are amongst key populations who are particularly affected. In this way, this research could influence the knowledge base of national bodies such as the National Religious Association for Social development, locally and regionally.

Despite the many theological discourses on stigma and discrimination, stigma continues to challenge our attitudes towards people who are infected, our language, judgements, and assumptions. The qualitative research could be designed as action participatory research. Very little was done to address stigma and we need to know more about HIV/AIDS stigma in the Church in order to tackle the problem more effectively. As stated before, we do not know enough about how people interpret God's action within humanity and how their relation with God or the supernatural may help or hinder their interpretation HIV/AIDS. This research could influence the ecumenical agendas of the WCC's other Churches globally and could serve as relevant information in the global advocacy and policy agendas of partners through ongoing dialogue and strategic processes. We also need to know more about various experiences of stigma and discrimination, especially experienced by children, in order for the Diocese to respond with stigma-appropriate messages and material such as "In Christ we are not Negative or positive" (SIYKHA 2009).

Human Rights, which was not covered in this thesis, needs to be considered as a major component for a sustainable pastoral praxis. In the development of a theology around AIDS today, human rights have taken up its place in the theological landscape. Scholars like Chitando (2016:64) have argued that the sacred text needs to be reread and opt for a participatory method of interpreting the sacred text e.g. young people, especially women, are often not in the room when theology is developed. The initiative of CHART, allowing theory and praxis to merge in a theological context could be most beneficial, especially to young people. Chitando (201:64) asserts that theological tools for the future need to be readjusted, replaced, and revisited by open and honest dialogues around sex and sexuality, diversity and social justice. This discourse around human rights is indeed a debate for the Church in Africa. Faith-based communities are already being challenged as to what a rights-based response would resemble.

It is my view that listening, reflecting, and responding in a consultative manner form the basis for pastoral care (Louw 2009). At this time of KAIROS in HIV/AIDS, the Church, the Diocese of False Bay in particular, needs to embrace the theme of transformation, to amplify its calling (Hoffman 2003; Cochrane 2006). This transformation needs to lead the Church into being agents of healing, hope, and fellowship to all infected and affected by HIV/AIDS (Van Wyngaard 2006, cited in Haddad 2011:183). Given the above, more qualitative research in this area needs to be conducted in order to address HIV/AIDS and the need for a comprehensive integrated pastoral care model.

At a recent conference, Heinrich Bedford-Strohm, presiding bishop of the German Protestant Churches, made the statement that theology must be a public theology; that is, a theology that addresses the whole person (EFSA Institute 2016). Other programmes have focussed on the epidemiology of HIV and on behavioural change. In the process, the cultural, traditional, socio-economic, and political challenges have undermined the health initiatives (Parry 2008:8). The HIV/AIDS pandemic has taught us that unbalanced responses will always be a challenge. Sound technical knowledge, improved infrastructure and human capacity, and sufficient resources will still be deficient if it is not supported by committed leadership, who take the social drivers of the pandemic and appropriate engagement into consideration.

In addition, an authentic response will need to consider the real impact of the problem. This will mean moving past denial and resistance to change (individually, institutionally, culturally, as well as traditionally). A paradigm shift is needed within the ACSA (Diocese of False Bay) for on-going research, which will strengthen the pastoral significance for the Diocese in the future. It needs to be said that the Church is not a fellowship for the religious, or a service agency for the unfortunate, or a counselling centre for the disturbed, or a talking shop for theologians, although all of these things are important and many others have to follow. The Church is, firstly, the community that lives by faith, hope, and love and all for God because that is how it was with Jesus (Stacey 1977:366). Through an appropriate pastoral praxis, I would conclude that theory and praxis meet, hand and heart embrace one each other, hope, love, forgiveness, and non-judgementalism interlock where the rational, intellectual, and the cognitive (doing) all in work together in ushering in the reign of God. In this way, the Diocese of False Bay continue to act in congruence with the Church's identity mission and witness.
According to Maluleke (2012:172-173), the 'veil of misery' can be turned into the 'valley of hope' where forgiveness in Churches become centres of welcome and reconciliation. In light

of the above, all attempts to understand and interpret the challenges of HIV/AIDS theologically enabled me to arrive at the theological intersection that there is no 'big' theology or 'small' theology; all theologies form one rainbow cloth depicting the different shades of interpretation of the same text.

This study has already begun to influence a pastoral theology in the workplace such as the mining sector in South Africa. There is a need for pastoral praxis that addresses the social agenda on a local, national, regional, and global level.[60] One such example is how this research study has begun to inform workspaces beyond outside the boundaries of the Diocese of False Bay. This programme is an initiative between Church Leaders and Mining companies to respond to the pastoral needs on miners. My understanding of theology of pastoral care (theory and praxis) prompted me and a small task team embark on a process of consultation for "Safe Spaces" of pastoral care in the mines. This process is referred to as Inclusive Pastoral Care and Support (IPCS) in the mines. These pastoral interventions at the mines will be an integrated pastoral response related to family violence, alcohol and drug abuse, violence against women and children, and community unrest, to mention but a few. It is also aimed at healing of hurtful memories and building trust and good relationships between individuals, employers, and employees, as well as good relationships and trust in families and communities. It further aims to strengthen the already existing pastoral ministries undertaken by various faith groups in the mines. This Inclusive Pastoral Care and Support (IPCS) also seeks to find path to the wider community through the various faith and social structures.

Haddad (2011:188) referred to the gaps in future HIV/AIDS work from a theological perspective. This research project was located in the context of practical theology (pastoral care and counselling) and in this way this research has contributed to the already exiting volume of scholarly work. Scholars such as Conradie (2005), Soongie (2005), Kanyoro (2004), Czerny (2006), and many others have already made great strides in the area of practical theology. However, as a scholar, the question remains: "If the Church has taken on the role of chasing funders, where is the soul of what she ought to be doing?" This value of this research for the Diocese of False Bay could inform the future strategic planning processes, with a theologically

[60] See Minutes of the Theological Task Team, September 2016, held in Stellenbosch.

(pastoral) care focus that will reaffirm its identity, service, and witness. This will require a mind-set change from donor driven programmes to theologically pastorally driven ministries.

8.6 Conclusion

This study confirmed that the future responses of the local and global Church could have much greater impact to address stigma and other socially related changes if it is grounded in an appropriate pastoral praxis and theologically authentic response.

Given the fact that that the Diocese of False Bay is best placed to address stigma and discrimination, ongoing efforts are required to address attitude change and impact on reduction of stigma. By doing so, the Church assumes its identity through its mission witness and service. HIV/AIDS related stigma has already challenged the way we think, operate, and the traditional way we handle contentious issues. Once again, the findings of this study affirms the fact that HIV/AIDS has brought the Church back to revisit the core values of its mandate, mission, and witness through love and compassion. The Anglican Church in False Bay could be proactive in reclaiming, reconnecting, and reconciling its prophetic ministry and be a voice for the voiceless, the vulnerable, and the marginalised. As a faith community, the Church is seen as the moral compass providing hope and courage and being the conscience of society. Furthermore, being God's instrument of reconciliation and restoration it is compelled to be that Beacon of Hope (Parry 2008) for many in this century as the millions who are in need of a Church that is loving, caring, welcoming, embracing, healing, accommodating, transforming, and forgiving. This mission can only fulfilled by giving witness to the Gospels by preaching and teaching, and by the social and liberating activities of Christian communities.

Communities that serve its members who are suffering, and, in recent decades, by taking better care of the created world. This "imperative commission" is to be fulfilled in Christ's way (John 13:16). So the mission of the Church is to witness to the salvation of all who offer prophetic witness (martyrs). In this way, the mission to the world in koinonia becomes a testimony of Christ himself (WCC 2012:394). As a pastoral issue, HIV/AIDS, like globalisation, debt relief, or environmental degradation, is an issue of justice and ethics. Therefore, alongside these parallel ministries, the Diocese of False Bay should not forget that it has a prophetic ministry to remind the leaders in the society of the importance of truth and justice.

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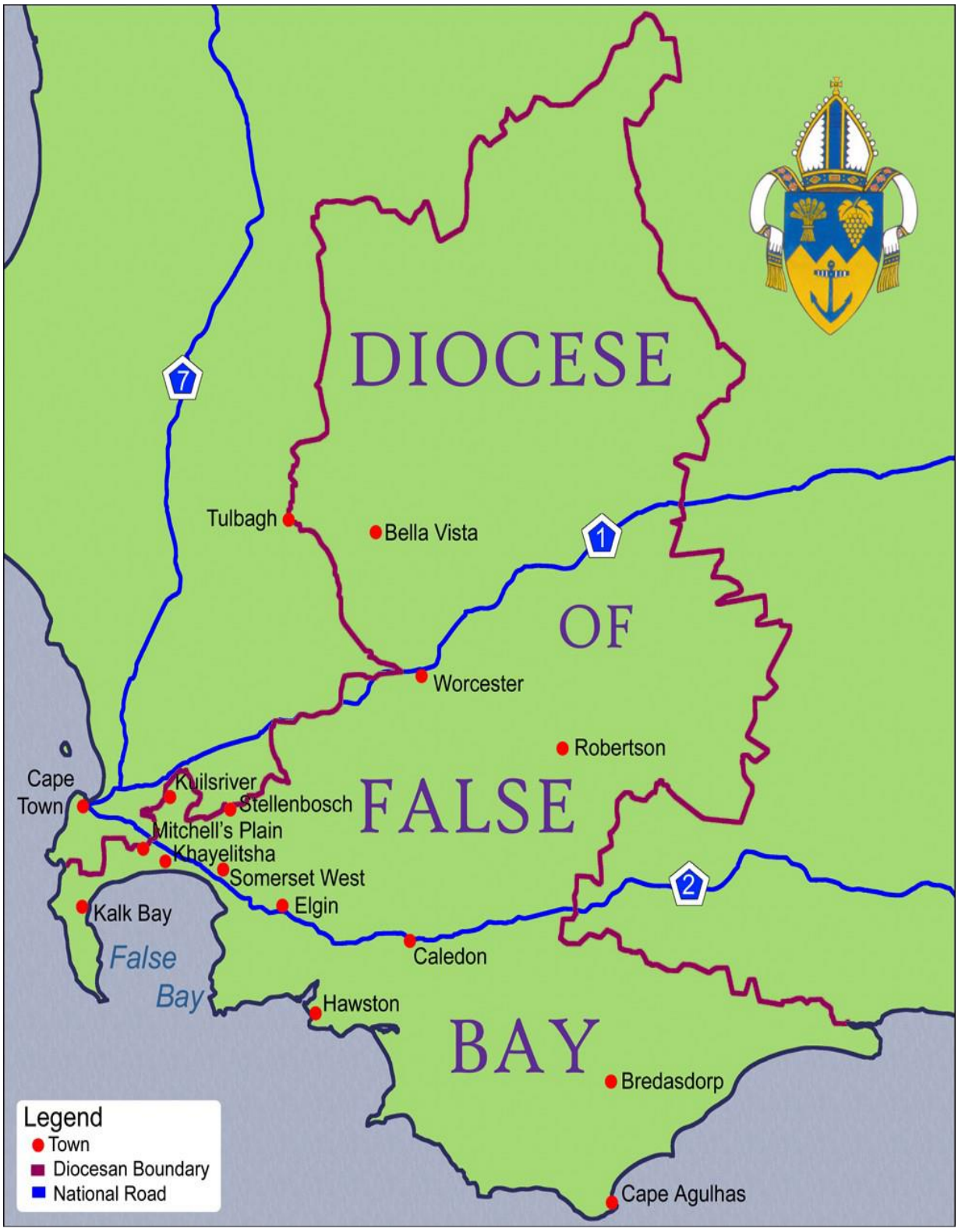
APPENDICES

Appendix 1: AIDS Poster

Appendix 2: Diocese of False Bay



Appendix 3: Letter of Approval from the University of the Western Cape Senate, the Arts Faculty Board and the Department of Theology and Religion

UNIVERSITY of the WESTERN CAPE

OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

24 July 2015

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by: Reverend D Lambrechts (Religion and Theology)

Research Project:	The implementation of the Isiseko Sokomoleza HIV/AIDS programme in the Diocese of False Bay: Critical Theological investigation.
Registration no:	15/4/10

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

Private Bag X17, Bellville 7535, South Africa
T: +27 21 959 2988/2948 . F: +27 21 959 3170
E: pjosias@uwc.ac.za
www.uwc.ac.za

A place of quality,
a place to grow, from hope
to action through knowledge

Appendix 4: Formal letter of request for permission to conduct the study from the Bishop of the Diocese of False Bay

Diocese of False Bay 5th March 2015

Bishop Margaret Vertue

Ref: Permission to do Research Study in the Diocese of False Bay.

Dear Bishop

As per our discussion earlier this year I hereby seek permission to do my Research Project with the Care and Support groups (task teams) in the Diocese of False Bay.

The Study is titled: **The implementation of the ISISEKO SOKOMOLEZA HIV/AIDS Programme in the Diocese of False Bay: A Critical Theological Investigation.**

It would be highly appreciated if the parishes within the Diocese of False Bay could be formerly introduced to the project.

Your support and guidance is greatly appreciated.

Thanking you

Rev Desmond Lambrechts

Appendix 5: The Bishop's letter of consent for the study to be conducted, sent to the parishes in the Diocese of False Bay

The Bishop of False Bay
The Rt Revd Margaret B Vertue
Diocese of False Bay Bisdom Van Valsbaai Idayosisi False Bay

P O Box 2804
Somerset West
7129 RSA

Tel: + 27 021 852 5243
Fax: + 27 021 852 9430
Email: bishopm@falsebaydiocese.org.za

16 May 2014

To: All Clergy and Parish Councils

Dear friends

Greetings to you all.

It gives me great pleasure to inform you that Canon Desmond Lambrechts is reading for his Doctoral Studies in Practical Theology (Pastoral Theology) at the University of the Western Cape. A component of the project will entail some empirical research with care and support groups in our Diocese. This process will be in the form of open dialogues (conversations) sessions with the care and support groups (HIV/AIDS) within our Diocese. The research project is titled. "An assessment of care and support groups within the Diocese of False Bay, against the backdrop "THIS CHURCH IS AIDS FRIENDLY". I will closely work with the department of Social Development in identifying the parishes. Appointments will be set up with the respective groups who wish to be part of this process. I kindly invite them to be part of the process which is optional. The objective of the research project is to engage with the current groups and past groups about their history, development and sustainability for their future existence, with the emphasis on sustainability. Meetings will be set up with the respective groups.

This research will be of great value to the Diocese in providing a status report on our overall response to HIV/AIDS in the Diocese. It will also provide the Diocese with an updated response on the growth, challenges and recommendations from these care and support groups. The research will also benefit the wider Church on the approaches to pastoral care models in a landscape that is affected by changing norms and standards, social, cultural gender and poverty issues which has greatly influenced our pastoral agendas.

I am fully in support of this initiative and I do believe it will indeed strengthen the scope of work we are already doing in the Department of Social Development. The outcome of the research will also provide us with evidence that will inform fresh opportunities for alternative pastoral care models.

Please keep Fr Desmond and this process in your prayers.

Prayers and blessings

+ Margaret False Bay

BISHOP MARGARET B VERTUE

Appendix 6: Information sheets in English, Afrikaans and Xhosa

Private Bag X17, Bellville, 7535
South Africa
Secretary: Sonia Stroud
Tel: +27 (0) 21 959 2137
Fax: +27 (0) 21 959 3659

UNIVERSITY of the WESTERN CAPE

FACULTY OF ARTS

INFORMATION SHEET

The aim of this project is to investigate the reasons for the limited impact of the implementation of the Isiseko Sokomoleza Programme in the Diocese of False Bay.

In order to do this I will have to ascertain what the current impact of Isiseko Sokomoleza programme is. This will be done through open dialogues with participants – clergy and laity. To this end I have sought the necessary permission from the Bishop who has informed the Parishes about the envisaged research to be done.

As participants in the open dialogues it is important to note that:

- 'Open dialogues' means that the participants involved would agree on the topics to be discussed.
- At the start of any given open dialogue a brief overview of the topic to be discussed will be given including the purpose of such.
- The purpose of the open dialogues is to gather information and sessions will be structured using three the principles of Primary Health Care (Alma Ata Declaration 2012) , viz . effectiveness, efficiency and affordability.
- Advance notice will be given f the date, time, venue and duration of the proposed dialogues.
- It is not clear at this stage how many session would be necessary to gather all the data needed.
- Participation in the open dialogues is voluntary and participants may withdraw from the process at any time.
- Information gathered will be treated confidentially and the anonymity of participants will be respected.
- Information gathered will be used solely for the purpose of this research project
- Should you need further information about this project, please contact Dr Miranda Pillay, Department of Religion and Theology, University of the Western Cape, mpillay@uwc.ac.za: Telephone 021 959 2201/06

Thank you

Desmond Lambrechts

.....
PhD Candidate
11 February 2015

Appendix 7: Consent form

Consent Form University of the Western Cape

"Title" Research Project

Researcher:

Please initial box

1. I confirm that I have read and understand the information sheet explaining the above research project and I have had the opportunity to ask questions about the project. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline. (If I wish to withdraw I may contact the lead research at anytime) ☐
3. I understand my responses and personal data will be kept strictly confidential. I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the reports or publications that result for the research. ☐
4. As a participant of the discussion, I will not discuss or divulge information shared by others in the group or the researcher outside of this group. ☐
5. I agree for the data collected from me to be used in future research. ☐
6. I agree for to take part in the above research project. ☐

Name of Participant (*or legal representative*)	Date	Signature
Name of person taking consent (*If different from lead researcher)*	Date	Signature
Lead Researcher (*To be signed and dated in presence of the participant*)	Date	Signature

Copies: All participants will receive a copy of the signed and dated version of the consent form and information sheet for themselves. A copy of this will be filed and kept in a secure location for research purposes only.

Researcher:	Supervisor:	HOD:
Rev Desmond Lambrechts	Dr . Miranda Pillay	Prof .Ernst Conradi

Appendix 8: Quantitative Questionnaire

WHAT ARE THE MOST SIGNIFICANT REASONS FOR THE LIMITED IMPACT OF THE ISISEKO SEKOMOLEZA HIV/AIDS PROGRAMME INTRODUCED BY THE ANGLICAN AIDS OFFICE IN THE DIOCESE OF FALSE BAY - 2003-2015

1. GOVERNANCE STRUCTURES

1.1. Does your Church have a HIV/AIDS ministry? YES / NO

1.2. If yes, do the parish leadership, clergy and organizations support the HIV/AIDS outreach programmes? YES / NO

1.3. Is there a person responsible for coordinating the HIV/AIDS ministry in your congregation? YES / NO

1.4. Is the HIV/AIDS ministry part of the overall programme of the congregation? YES / NO

1.5. Does your parish have a workplace policy in place for its members who are HIV/AIDS positive members? YES / NO

1.6. Is there a special task team in the parish to provide oversight, leadership and direction to the programme, if any? YES / NO

1.7. Are you familiar with the Isiseko Sekomoleza Programme? YES / NO

1.8. If yes, where did you hear about the Programme?

1.9. Have your parish introduced the programme? YES / NO

1.10. Were you as a parish involved in the process towards the implementation of the programme? YES / NO

1.11. Have you received funding for the Isiseko Sekomoleza Project? YES / NO

1.12. Did you receive training in programme management, financial management or writing reports? Please elaborate. YES / NO

1.13. Name a few programmes you have introduced since the implementation of the Isiseko Sokomoleza Programme in your congregation.

1.14. What in your opinion were the changes or impact brought about by the programme?

1.15. Why did the programme come to an end?

2. COMMUNICATION AND INFORMATION ABOUT HIV/AIDS

2.1. How often do you here sermons preached on HIV/AIDS?

2.2. Is stigma and discrimination being highlighted in the sermons with special reference to HIV/AIDS? YES / NO

2.3. Have your routine liturgies incorporated and addressed HIV? YES / NO

2.4. Are special prayers being offered for those living with HIV and affected by it? YES / NO

2.5. Are members living with HIV/AIDS included in the planning of programmes for the care and support groups?

2.6. Have your congregation mainstreamed information on HIV/AIDS in the following organizations?

- Sunday Schools? YES / NO
- Youth Programmes? YES / NO
- Women's groups? YES / NO
- Men's groups? YES /NO
- The whole congregation? YES /NO
- Other? YES /NO

3. MEANINGFUL PARTICIPATION OF THOSE AMONG YOU WHO ARE HIV/AIDS+

3.1. Does your Church have safe spaces for people who want to share their experiences? YES / NO

3.2. Do you know of people in your Church are HIV positive? YES / NO

3.3. Are you aware of any Church leaders who are HIV/AIDS positive? YES / NO

3.4. Do they feel supported and welcomed in the congregation? YES / NO

3.5. Are members being encouraged to undertake the HIV/AIDS test? YES / NO

3.6. Does your parish provide on-going counselling and support to those who have declared their status? YES / NO

3.7. Are you having discussions on HIV/AIDS in your congregation? YES / NO

4. PROGRAMMES

4.1. What, in your opinion, is the Church?

4.2. Do you see a link between your programmes for HIV/AIDS and the Church? YES / NO

4.3. Should the Church get involved in matters of poverty, gender, care and support? YES / NO

4.4. Should the Church reach out to the vulnerable groups in the congregation or do we behave as if they do not exist? YES / NO

4.5 Do you talk about cultural differences and practices within your communities that are harmful, or protect its members? YES / NO

4.6. Does your Church write reports about its HIV/AIDS programmes? YES / NO

4.7 Are those reports shared with the members of the congregation? YES / NO

5. CARE AND SUPPORT

5.1 Do you have home based care groups? YES / NO

5.2 How often do they visit the homes of the members in need of care?

6. COUNSELLING AND TESTING

6.1 Are their opportunities for testing in your support group or Church? YES / NO

6.2 Do the leaders or members know where the testing is being done? YES / NO

6.3 Is the congregation connected to the testing site and do they refer people to the sites? YES / NO

6.4 Do members feel their information is being kept confidential by the Church leadership or the care group? YES / NO

6.5 Can couples where one member is positive receive advice and support from the Church? YES/ NO

7. FINANCES AND RESOURCES

7.1 Do we use our Church buildings for the promotion of AIDS related work i.e., schools, clinics and hospitals? YES / NO

7.2 Is there a budget devoted to the work for HIV/AIDS in your congregation? YES / NO

7.3 Did you receive donor funding from sources inside and outside SA to sustain your AIDS ministry? YES / NO

7.4 Has the lack of resources closed down your care and support ministry? YES / NO

7.5 Have you received funding for the Isiseko Sokomoleza Project? YES / NO

7.8 Is your care and support group reporting to the parish council, social development department, health committees or any other body? YES / NO

7.9 Can you sustain your project without funding? YES / NO

7.10. Do you need funds to reach out and care? YES / NO

8. HISTORY

8.1. When did you start the care and support group?

8.2. How many members was part of the original group?

8.3. Why have they left the group?

8.4. Why are you still continuing with the group?

8.5. What would you consider as achievements of the care and support group?

8.6. What do you consider as challenges for your HIV/AIDS ministry in your congregation presently?

8.7. What would be your recommendations for future HIV/AIDS programmes in the Church?

Appendix 9: Confidentiality form

UNIVERSITY of the
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OPEN DIALOGUE CONFIDENTIALITY FORM

Title of Research Project: The implementation of the Isiseko Sekomoleza HIV/AIDS Programme in the Diocese of False Bay 2003-2015: Critical Theological Investigation.

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits. I understand that confidentiality is dependent on participants in the Open Dialogue group maintaining confidentiality. I hereby agree to the following:

I agree to uphold the confidentiality of the discussions in the Open Dialogue group by not disclosing the identity of other participants or any aspects of their contributions outside the group.

Participant's name.....

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Appendix 10: Editorial Certificate

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31 January 2017

To whom it may concern

Dear Sir/Madam

RE: Editorial Certificate

This letter serves to prove that the thesis listed below was language edited for proper English, grammar, punctuation, spelling, as well as overall layout and style by myself, publisher/proprietor of Aquarian Publications, a native English speaking editor.

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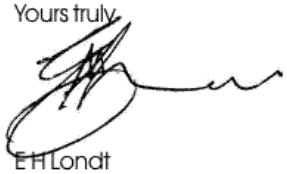
Author

Desmond J. Lambrechts

The research content, or the author's intentions, were not altered in any way during the editing process, however, the author has the authority to accept or reject my suggestions and changes.

Should you have any questions or concerns about this edited document, I can be contacted at the listed telephone and fax numbers or e-mail addresses.

Yours truly,



E H Londt
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