Religious assets, health outcomes and HIV/AIDS: a challenge and an opportunity for St Paul's Anglican Church, Pietermaritzburg

By

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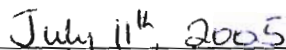
DEDICATION

I dedicate this research work to Susan and our lovely children – Paul, Patricia and Peter, and my mother Oripa whose support has been instrumental in my study, and Getrude Bako for accepting her situation of living positively with AIDS.

DECLARATION

I, Bill John Akutoko hereby declare that this thesis, unless specified in the text, is my original work. I also declare that I have not submitted this research project for any other purpose at any other institution or University.

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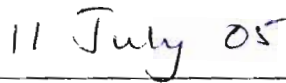Bill John Akutoko   Date

As supervisor, I agree to the submission of this thesis

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Dr S.M. de Gruchy   Date

ABSTRACT

The study examines the role religious institutions play in responding to health crises in the community with particular focus on HIV/AIDS. The thesis argues for the importance of focusing on *health outcomes* rather than the traditional "economic" models for assessing health sector in time of AIDS crisis. *Health outcomes* measures: good practice, increases accountability of services, quantifies the values of interventions where traditional research data may be impractical or lacking. It even assists in determining resource allocations and help to monitor and improve standards of care. This opens the door to focus on religious institutions, where selecting and measuring outcomes could be deeply connected to a community's or institution's mission and be able to describe a specific desirable result or quality of institution's services.

The role of religious institutions has not been well recognized in dealing with health issues, and in particular within the religious community itself. Religious communities have not recognized their enormous assets, which they could mobilize in an effort to create good health conditions while facing the challenges of the HIV/AIDS pandemic and other diseases. The study examines the involvement of a local Anglican Church, St Paul's in health in the urban context of Pietermartzburg, KwaZulu-Natal.

The asset-based approach guides the study in capturing the basic notion that assets carry value and may be used to create greater value. The research findings show that the worshippers of St Paul's Anglican Church seem to have little understanding of their religious asset portfolio, which can be used effectively to improve the health conditions and health prospects of those in need in order to build healthy communities.

The study argues that religious congregations and other faith-based organizations can play a vital role in local public health systems and community-based health improvements initiatives. In addition, faith communities can act as conveners and mobilizers of community residents and other faith-based groups around issues of health policy and interventions for health promotion and disease prevention (e.g. nutrition, care, VCT, etc.).

ACKNOWLEDGEMENTS

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ABCD	Asset-Based Community Development
ACCT	AIDS Counseling, Care and Training
ARHAP	African Religious Health Assets Programme
AIC	African independent churches
ATICC	AIDS Training and Information Counselling Center
CADRE	Centre for AIDS Development, Research and Evaluation
CBR	Community based research
CBA	Cost benefit analysis
CBHPP	Church-based Health Promotion Programme
CEA	Cost effectiveness analysis
CDC	Centre for Disease Control
CMS	Church Mission Society
CUA	Cost utility analysis
DHS	District Health System
ECAP	Evangelical Christian AIDS Programme
FBO	Faith-based organization
GEAR	Growth, Employment, and Redistribution Programme
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
NACWOLA	National community of women living with AIDS, Uganda

NGO	Non Governmental Organizations
PASCA	Pietermaritzburg Agency for Christian Social Awareness
PHC	Primary health care
QALYs	Quality adjusted life years
SAP	Structural Adjustment Programme
STD	Sexually transmitted disease
TAC	Treatment Action Campaign
RHA	Religious Health Assets
VCT	Voluntary Counselling and Testing
UN	United Nations
WB	World Bank
WHO	World Health Organization
YFC	Youth for Christ

CHAPTER ONE

INTRODUCTION

This chapter seeks to discuss the nature of and the possible role for religious institutions in responding to the health crisis as a result of the HIV/AIDS pandemic in Pietermaritzburg, KwaZulu-Natal, South Africa. It focuses on the background, motivation and theoretical framework of this study, its findings and the nature of the methodology used. The chapter also deals with the literature review, the limitations of the study, and identifies various aspects of the research problem. Finally, it gives an overview of the various chapters in this study.

1.0   Background

Religious institutions have a role to play in responding to health crises by creating the individual, communal, cultural, socio-economic and environmental conditions that enhance and maintain health.[1] The role of religious institutions has not been well recognized in dealing with health issues, and this is so particularly within the religious community itself. Religious institutions have not recognized their enormous assets which they could mobilize in an effort to create good health conditions while facing the challenges of HIV/AIDS and other pandemic diseases. Coupled with this there seems to be sporadic knowledge about these assets, and even at times difficulty to find and get access to them by key decision makers.

In response to this, this study will have an "asset-based" focus, so that it captures the basic notion that assets carry value and may be used to create greater value.[2] Because of this, it will be necessary to identify what is already there to work with, and locate strengths and

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[1] Gary R Gunderson, "Executive Summary" in African Religious Health Assets Programme (ARHAP) colloquium, unpublished ARHAP document, (Pietermaritzburg: University Of Natal, 2003).

[2] Kretzmann J P and McKnight J L, *Building Communities from Inside Out: A path toward finding and mobilizing a community's assets*, (Chicago: ACTA Publications, 1993), p.5-10.

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capabilities, rather than starting with needs.[3] In this dissertation, the asset-oriented frame of reference will provide a means of acknowledging that religious health assets can effectively improve the health conditions and health prospects of those in need in order to build healthy communities and institutions that will mitigate the effects of diseases on individuals, families, communities, and the nation at large.

Even though St Paul's Anglican Church is currently doing very little in the area of HIV/AIDS, it can be argued that it has a role to play in improving the health conditions of the community in which it is located. This church is located in the city of Pietermaritzburg, KwaZulu-Natal, and is under the jurisdiction of the Church of the Province of Southern Africa (Anglican) within the Diocese of Natal. The city has a growing population of about 500,000 people.[4] This has been as a result of the massive migration of people from rural areas to urban areas forming large informal settlements on the periphery of the city following the collapse of apartheid and the institution of a democratic government. The majority of people in this city speak English and Zulu and they belong to different religious groups: Christian, Hindu, Islamic and Buddist.

As a result of this massive migration, the city and the churches face great challenges in coping with the problem of unemployment, AIDS, health, and poverty. For example, the quarterly statistics report of October-December 2003 in Pietermaritzburg shows that 513 women out of 946 attending antenatal clinics in public health centers tested HIV positive.[5] HIV/AIDS issues have been contentious, spawning debate in the media and South African government regarding effective strategies for prevention, conflicts over discrimination, access to health care and confidentiality.[6] This debate impedes the development of effective policies to lessen the threat of the disease to public health. For health care to be socially

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[3] Gary R Gunderson, Executive Summary.
[4] World Gazetteer, Current Population for Cities and Towns of South Africa 2004.
 Source: www.world-gazetteer.com/c/c_za.l   Accessed on 08/05/2004.
[5] KwaZulu-Natal Department of Health, District HIV/AIDS statistics for October-December 2003 summary report, unpublished, Pietermaritzburg: Department of Health office, 2003.
[6] J O Kromberg, "A cover story about TAC's Zackie Achmat,"in *Leadership Magazine*, May 2004, p.12-16.

acceptable, it needs to be of good quality as well as being cheap to an ordinary person in the community. Health care has become expensive to the general populace, and the most affected person is an HIV patient who needs health-related services. St Paul's Anglican Church's compassionate and caring ministry could be helpful in improving the conditions of the vulnerable in the city. This is because of the tangible and intangible assets it possesses, which it could use to constructively promote and influence health.

1.1   Motivation for the research

I was motivated to undertake this study for the following reasons: firstly, as a Ugandan, my desire to deal with issues of HIV/AIDS can be traced to my niece Gertrude Bako, living with HIV/AIDS. This has personally challenged me to question what best can be to done to reduce the HIV/AIDS pandemic. In addition, my experience of training and raising AIDS awareness in communities has influenced my thinking about the way Christians contribute in helping people living with HIV. As a Church worker, I am further motivated by the efforts of the government and other institutions such as NGOs in trying to reduce the infection rate of the disease in Uganda and South Africa. However, I believe we can offer a great deal as a church alongside what the government and other NGOs are doing to care for people living positively with AIDS in our communities. This can only happen if Christians can understand their role as an "asset" in the community in supporting the marginalized such as orphans, widows, people living with HIV and others who need them most.

Secondly, the "asset-based" development process that identifies the capacity of both individual and community associations and organizations and assets has provided me with insight to undertake this study because it can regenerate community life.[7] Understanding religion as an asset could help bring life to a devastated community. Therefore, this approach, which is capacity-focused, will replace the one concentrating on needs and deficiencies, will help the community (church) to understand, enhance and align its assets

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[7] Kretzmann J P and McKnight J L. *Building Communities from Inside Out*, p.1.

and capacities (gifts, skills) in new combinations and new structures of opportunities to deal with the challenges of South African health crises - in particular HIV care in Pietermaritzburg, KwaZulu-Natal, and elsewhere in the country.[8]

Thirdly, it is the silence of the church on HIV care that has propelled me towards this study. The church has the available resources to support the vulnerable. HIV/AIDS is a health problem. Health care is something that touches all of our lives. Yet it seems to be in almost permanent crisis – with limited facilities and drugs. The worst affected groups of patients are those living with HIV who receives the least services and support, both in health centers and churches. Reflecting on this makes the researcher thinks that if the church could utilize a good percentage of its assets for HIV care, then this would drastically reduce the infection rate and prolong the lives of HIV positive Christians and others, hence making HIV care cost effective.

Fourthly, my studies in Theology and Development at the University of KwaZulu-Natal have to a large extent led me to challenge the naïve attitude of churches and religious institutions towards their existing (and unrecognized) tangible and intangible assets, which they could use to reduce the costs of health-related activities (see Chapter 3). This would provide opportunities for the vulnerable to find their identity within the churches as a place where they could feel at home. This has its roots in the Christian faith, where to be loved means to have a sense of belonging to a community.

1.2 The literature review

The review of the literature on "assets" (religious assets), health and the effectiveness of HIV care in religious institutions provides the basis for an overview and discussion of the challenges and opportunities for St Paul's Anglican Church, Pietermaritzburg covered in Chapter 2. This has the objective of providing a methodological context for the asset-based method employed in this study.

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[8] Kretzmann J P and McKnight J L. *Building Communities from Inside Out*, p.5.

References were sourced from the University of KwaZulu-Natal library, the Natal Society Library and the internet. The materials used include published and unpublished essays, books, journals articles and dissertations. In addition, literature on the faith - health link i.e. public health and faith collaborations was sourced from the Interfaith Health Programme based at Emory University, USA.

Primary source materials were sourced from the files of St Paul's Anglican Church and via interviews of key informants from religious institutions, including St Paul's Anglican Church members, and government officials.[9]

1.3   Research problem

In practice, health is usually defined negatively as the absence of illness or disease. However, this ignores the positive aspects of being healthy. The definition of health used by the World Health Organization (WHO) tries to capture these positive aspects by defining health as: "a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity."[10] Health is a fundamental right of everyone, including those who are HIV positive, and people have the right to adequate food, water, clothing, housing, health care, education, and security in the event of unemployment, sickness, disability, or lack of livelihood in circumstances beyond the individual's control. This seems to concur with Gunderson's view that it is "ameliorating the suffering, preventing the wounds and maladies that can be prevented and advancing the health and wholeness of communities" which needs our attention.[11]

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[9] Some of the institutions I visited included: Evangelical Christian AIDS Programme, (ECAP), AIDS Training Information and Counseling Centre, (AITCC), Pietermaritzburg. These seem to provide spiritual and community HIV care around Pietermaritzburg. They provided for me some insight in understanding HIV care activities in the city.

[10] Derek Yach, Health and Illness: The definition of World Health Organization,
Source: www.medizin-ethik.ch/publik/health_illness.htm   Accessed on 3/24/2004.

[11] Gary Gunderson, Concept paper for design process of The Institute for Public Health and Faith Collaborations, June 4, 2002. Unpublished.
Source: http://www.ihpnet.org/IPHFCdesignprocess.pdf,   Accessed on 21/03/2004.

A vision of attaining health for all is not possible, due to limitations in the availability of resources to ensure that people attain the highest level of health, and the fact that our scientific knowledge remains incomplete with regard to the determinants of health and the effectiveness of interventions. This can not happen without proper health systems.

Churches could provide better health services since they are community gathering centre for spiritual, social and cultural activities, reach the complete family, have an established organizational structure through which mutual support for healthy behaviour development can be facilitated, and have permanence and prestige, which contribute to their influence and can make them effective promoters of healthy behaviours. But not all churches can understand "health language as a lens to bring the needs and opportunities of the community into focus so that the appropriate connections can be recognized", and systematically and intentionally "weave a web of relationships, associations, structures and individuals to a build a community."[12] It was upon this premise that St Paul's Anglican Church was selected for this study. The study was further informed, firstly, by the fact that St Paul's Anglican Church is doing very little in areas of HIV/AIDS. Secondly, as a member of the church, the worshippers are known to the researcher. Thirdly, this study provides a platform to motivate the church to do more by showing the potential that lies in its congregation. It is upon these that the research problem was formulated as:

> To what extent can a local religious institution (like St Paul's Anglican
> Church) understand itself as an asset so as to be able to help the
> community to deal effectively with health–related issues, in particular the
> HIV epidemic?

The research seeks to identify and align these religious assets to address the struggle for sustainable health in the community with pragmatism and hope. It will be argued that it is

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[12] Gunderson, G. R. *Deeply Woven Roots: Improving the Quality of life in your community*, (Minneapolis: Fortress Press, 1997), p.62.

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vital that religious institutions seek to apply the Asset-Based Community Development (ABCD) approach as they seek to implement development programmes in their communities.[13]

1.4   Theoretical Framework

The theoretical framework of this study is "asset-based," and is outlined in chapter 3. It is based on discovering and analysing community-building stories, as these stories carry a set of methods for community mobilization, which can be used as a strategy for community-based development. It acknowledges that a healthy community depends on the strengths, gifts, talents and assets of individuals in the community, unlike in an unhealthy community, which focuses exclusively on needs and problems.

The framework recognizes any local religious institution, such as a church, as being one of the key assets in the community.[14] The faith-based institutions and health systems share, as a general principle, a sense of real responsibility for stewardship of their assets. These assets can enhance the process of rebuilding the community in a way that supports community health improvement. The church can contribute to the community's basket of assets some common resources it has such as personnel, space and facilities, materials and equipment, expertise, rituals and symbols, and moral authority.[15] This is further discussed in Chapter 3.

Work done in the African Religious Health Assets Programme (ARHAP) provides insights into the framework for understanding that the contribution of a community to public health is important, and that interventions work best when they are rooted in the assets (values, knowledge, expertise, and interests) of the community itself. In other words "communities

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[13] Kretzmann J P and McKnight J L, *Building Communities from Inside Out*, p.5-10.

[14] John P Kretzmann and John L McKnight, *Building Communities from Inside Out,* p.143.

[15] John P Kretzmann and John L McKnight, *Building Communities from Inside Out, p.144.*

are the starting points for positive change; we must recognize the unlimited assets of communities before we focus on their problems."[16]

The study structure is enveloped in the Christian notion of "See – Judge - Act" techniques.[17,18] The notion engages us as Christians in the concerns of this world as we do social analysis to "See" the gravity of a health crisis around us. This helps to us to "Judge" this crisis in the light of God's word. This is because a crisis and an opportunity confront us everyday as we live. For example, health care is changing in the way it is delivered and its control by the private sector, as well the way public funds are being channeled to faith-based organizations in the struggle against HIV/AIDS. This now raises basic questions about the role of religious institutions in nurturing and providing social support for the well-being of our communities. This helps us understand "the link between faith and health which is evident in thousands of local congregations and community organizations that are discovering in parallel the face of God in the hungry, the sick, and the marginal, as well as the face of God in those children who need not be hungry, sick, or marginal at all."[19]

This model finally invites us to join God in transforming the world- as we "Act." Foege writes "public health and religious faith can be used to create a lens for viewing holistic communities. In such a milieu, 'my neighbor' becomes not only the family next door, but

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[16] Len Duhl, "On strength & Health: Recognizing Strength, Choosing Health" in *Strong Partners: A report on realigning religious health assets for community health,* (Atlanta: The Carter Center, March 1997), p.24.

[17] Margaret Nash, "See-Judge-Act," in *Christians Make Peace*, (Durban: Christian Printers, 1982), p.81-85.

[18] Des van de Water and Steve de Gruchy, "See-Judge- Act: A method for Mission, "in *Transform: A Manual for Mobilizing Leadership,* (Brixton, South Africa: UCCA, December 1993), p.24-34.

[19] Gary Gunderson, "On Faith, Science & Hope: Linking Faith and Science" *in Strong Partners: A report on realigning religious health assets for community health,* (Atlanta: the Carter Center, March 1997), p.20.

also everyone who will ever be born."[20] This seems to challenge us to get involved in "working for a system that treats people like neighbors and encourages good health."[21]

The study uses this theoretical framework to:

- Map and analyse the assets and strengths (capacities, talents, interests, experience, gifts and skills) of St Paul's Anglican Church so as to align and enhance them to meet the challenges of a disease such as HIV/AIDS.
- Explain the effectiveness of HIV care in the community, from the point of view of health outcomes.
- Help to improve the quality of life and health care in the congregation by putting new knowledge in the hands of the congregation to make changes.
- Bring the congregation into the study as partners, and not just subjects.

Theories related to community health "are neither isolated nor independent; rather, they are an amalgam of theoretical propositions drawn from a wide range of writers and augmented from practical experience."[22] These seem to include theories of public health, religious health assets, epidemiology, health interventions and outcomes. "Each proposition is brought to life by a number of principles, which are derived from theory and informed by experience."[23] These can provide leverage to constructively address the issue of HIV care in the community. One needs to systematically identify those contexts that are positive, as well as those that are negative, with a view of accomplishing the goal of improving HIV prevention programmes.[24]

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[20] William Foege, "On Our Future Neighbor: Who is My Neighbor" in *Strong Partners: A report on realigning religious health assets for community health,* (Atlanta: the Carter Center, March 1997), p.30.
[21] William Foege, On Our Future Neighbor, p.31.
[22] Mark S Homan, *Promoting Community Change: Making It Happen in the Real World,* (London: Thomson Brooks/Cole, 2004), p.42.
[23] Mark S Homan, *Promoting Community Change: Making It Happen in the Real World,* p.42.
[24] Olive Shisana, Sc. D and Leickness Simbayi, D. Phil, *Nelson Mandela/HSRC Study of HIV/AIDS: South Africa National HIV Prevalence, Behavioural Risks and Mass Media Household Survey 2002,* (Cape Town: Human Sciences Research Council, 2002), p.10.

1.5   Research methodology

This study uses a qualitative methodology. As people construct their social lives and find meaning to everyday life, they require interpretation; as a result an interpretation paradigm was adopted.[25] The qualitative method "allows doors to be open for unexplored or distorted aspects of relational aspects."[26] The individual units of analysis were used as the object of this study, where the individuals were studied as individuals, as members of groups, or as representatives of the church and other organizations. This made the data collection process of individual assets: gifts, skills, talents, group assets (their roles, ministry), and of church or organizational assets (such as care it provided, partnerships, public spaces, library, etc) visible.

Furthermore, this approach tied in with the purpose of the research, which is to rediscover local religious institutions, in particular St Paul's Anglican Church, as an asset within the community (Chapter 4). A purposive sampling method was employed to map the religious assets within this local Anglican Church. Fifty questions were used to collect information from the sampled participants. These questions addressed issues of skills, health, HIV/AIDS programmes such as prevention, care and support, and advocacy. In addition, respondents were asked to identify resources they used or would wish to be used in their HIV/AIDS programmes, also to state their current challenges and their views on the future of HIV/AIDS activities. The majority of initial responses for each question were closed multiple-choice responses, with additional space for qualitative comments for some questions.

Key faith-based organizations and the government health department within Pietermaritzburg were identified because of their engagement in health and HIV/AIDS activities.

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[25] Martin T Blanche and Kevin Durrheim, (ed.), *Research Practice: Applied methods for Social Sciences,* (Cape Town: University of Cape Town Press, 1999), p.35.
[26] Katherine R. Allen and Alexis J. Walker, "Qualitative Research" in Clyde Hendrick and Susan S. Hendrick, (ed.), *Close Relationships: A Sourcebook,* (London: Sage Publications, Inc., 2000), p.27.

1.6   Limitations

In spite of the study's strength in producing the expected results, it has several limitations. First, although the data may have been fairly considered to be representative of the congregation of St Paul's Anglican Church, it cannot represent all the religious institutions in Pietermaritzburg, and or even those in the country.

Secondly, the data on assets, health promoting behaviours (e.g. exercises/nutrition), and demographic information, which were self-reporting through filling out a questionnaire seem to carry some bias hence making it difficult to judge or assess the level of congregation involvement in community health. It will require that experimental and/or longitudinal studies be done to determine the direction of any such effects of the assets.

1.7   Outline for the rest of the study

Chapter 2 provides a review of existing literature dealing with health and the effectiveness of HIV care, and it also argues that *health outcomes* is a better way of measuring health because of its holistic approach.

Chapter 3 presents the Asset-Based Community Development, (ABCD) approach to health by examining the key concepts and principles of ABCD which are relevant for health practice. It also presents the idea of religious health assets which could be used as a means to increase the effectiveness of HIV care.

Chapter 4 describes the engagement of the members of St Paul's Anglican Church in health and HIV/AIDS activity, and their altruistic concerns for the poor, including people living with AIDS, in the communities of Pietermaritzburg. It also presents the church as a community asset: what it has and what it could offer to the community in relation to health and the HIV/AIDS crisis in Pietermaritzburg.

Chapter 5 presents the contribution of religious health assets to *health outcomes* with some practical strategies for a local church namely St Paul's Anglican Church. These strategies could also be useful for other religious institutions in Pietermaritzburg.

Chapter 6 concludes the study and also provides recommendations for the future which could be a guide for St Paul's Anglican Church.

CHAPTER TWO

HEALTH CARE AND HEALTH OUTCOMES IN A TIME OF AIDS

2.0   Introduction

This chapter reviews the literature on health and the effectiveness of HIV care so as to establish the basis of the study. It seeks to present the traditional health measurement tools and use this to analyse HIV care, and argues that these tools are not suitable in a time when health care is under threat from the AIDS pandemic. The chapter then argues that *health outcomes* is a better alternative measurement tool because it looks at health issues more holistically.

2.1   The AIDS crisis in South Africa and Pietermaritzburg

South Africa, with a population of 44.8 million people, continues to have the highest number of people in the world living with HIV. By the end of 2003, an estimated 5.3 million (4.5 million – 6.2 million) South Africans were infected with AIDS.[27] The national HIV infection rate among pregnant women attending antenatal services in 2003 was 27.9%, with a variation among the country's nine provinces from as high as 37.5% in KwaZulu-Natal to as low as 13.1% in the Province of the Western Cape. This has become a big challenge to health care services in the country.

In KwaZulu-Natal the HIV/AIDS prevalence rate is an aggregate and so does not reflect individual districts and municipalities' rates. For example, in the Msunduzi Municipality, Pietermaritzburg, the estimated prevalence rate is 18%, but it could be higher than this

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[27] UNAIDS, AIDS epidemic update: December 2004, Geneva: UNAIDS Publication, 2004.
Source: www.unaids.org/wad2004/report_pdf.html   Accessed on January 10, 2005.

because people are in constant denial and silent about the disease.[28]   In addition, Pietermaritzburg's strategic position along the Durban-Johannesburg route for heavy traffic might, to some extent, be contributing to the spread of the disease. As a result of this, the municipality has made provision for care for at least 100,000 people living with AIDS, and built a broad partnership with a number of institutions, including faith-based groups e.g. Evangelical Christian AIDS Programme, (ECAP) to fight the disease.[29] All these are efforts used to fulfil the national strategic framework for reducing the HIV/AIDS pandemic. This pandemic raises a whole series of challenges for society at large; but it also challenges our framework for understanding health care and health policy.

2.1.1   Health care and health policy

The health and well-being of individuals and communities in developing countries is in crisis. Not surprisingly, however, where the needs are greatest, the means tend to be the least, because of poverty, policies, and many other issues within developing nations. There is no way to fix all problems, cure all diseases, or patch up all injuries in all these nations. For example, globalization trends, the HIV/AIDS pandemic, the imposition of Structural Adjustment Programmes (SAPs) on some Sub-Saharan African countries, and the Growth, Employment and Redistribution programme (GEAR) experienced in South Africa, have all drastically affected the health care services of these nations.[30]

The GEAR policy of South Africa is the key redistribution mechanism for government spending on social services, including health.[31] After the end of the apartheid era in 1994,

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[28]Msunduzi   municipality   health   department.   Municipality   Strategy   on   HIV/AIDS, (Pietermaritzburg: The Built Environment Support Group, 2002).

[29] Msunduzi municipality health department. Municipality Strategy on HIV/AIDS 2002. Brochure.

[30]Brooke G Schoepf, Claude Schoepf and Joyce V Millen. "Theoretical Therapies, Remote Remedies: SAPs and Political Ecology of Poverty and Health in Africa" in Jim Yong Kim, Joyce V Millen, Alec Irwin and John Gershman. *Dying for Growth: Global Inequality and Health of the Poor,* (Boston: Common Courage Press, 2000), p.91.

[31] Di McIntyre, Stephen Thomas, Sandi Mbatsha and Luvuyo Baba. "Equity in public sector health care financing and expenditure," in Nicholas Crisp and Antoinette Ntuli (ed.). *South Africa Health Review 1999*, (Durban: Health Systems Trust, 1999), p.9&29.

the health sector underwent a massive shift from curative care towards preventive, easily accessible primary health care. In order to guide restructuring, the government adopted the principles of the primary health care (PHC) approach as the central tenet of future health practice and the benchmark against which all health policy and planning could be measured.

The primary health care approach is a conceptual model for health care planning and health systems development.[32] Its guiding principles provide an integrated and holistic framework for addressing the health needs of the population, particularly those living in poverty and who are marginalized. It is upon this that the district health system (DHS) model was developed as the means to achieve the end of an equitable, efficient and effective health system in the country.[33] These two models (PHC and DHS) emphasize the importance of comprehensive health care. In practical terms, this means that community-based and facility-based health care services should be planned and implemented as different components of a single health plan for a given population and area. Though the DHS makes policies and plans, these policies and plans apply to both the private and public health sector in any given locality or region within the country. In these policies and plans, HIV/AIDS issues are also considered.

Since the health system inherited fragmented health care services from the apartheid era, its decentralization has been relevant to HIV/AIDS, notes Hickey.[34] Its relevance has been the planning and implementation of programmes and community-based support initiatives and home-based care promotion. McCoy et al. argue that the decentralization of the health system made some contribution to the improvement of health services in Durban, Richard's

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[32] Anso Kellerman, "Health and Development" in Frik De Beer and Hennie Swamepol, (2nd ed.), *Introduction to Development Studies*, (Johannesburg: Oxford University Press, 2000), p.187-190.
[33] David McCoy and Beth Engelbrecht, "Establishing the District Health System", Nicholas Crisp and Antoinette Ntuli (ed.) *South Africa Health Review 1999*, (Durban: Health Systems Trust), 1999, p.132.
[34] Alison Hickey, "Governance and HIV/AIDS: Issues of public policy and administration" in Kevin Kelly, Warren Parker and Stephen Gelb (ed.), *HIV/AIDS, Economics and Governance in South Africa: Key Issues in Understanding Response,* (Johannesburg: The Center for AIDS Development, Research and Evaluation (CADRE), 2002), p.48.

Bay and Pietermaritzburg.[35] However, this does not rule out the disparities that exist between the public and private health care services. For example, the private sector bristles with sophisticated technology serving just 20% of the population: those with private health insurance.[36] Meanwhile public health care is free to pregnant women and children under six; others pay on a means-tested user fee, fee-for-service basis.

The gross inequity between the public and private sectors led the government to set health regulatory instruments to manage the health system. Notably, the Medical Schemes Act reviews have been set to regulate "cost effectiveness, health policy developments, and the impact of medical scheme viability and its affordability to members."[37] One of its objectives is to encourage improved efficiency in the allocation of private and public health care resources. The regulation aims at redirecting scarce resources to areas of greatest need through the rationalization of the health care system in order to increase health productivity.

On the other hand, the substantial inequity has posed challenges to the financing of the public health sector. The politicking and policies have made a shift in social welfare provision and even undermined South African policy designs to meet the basic needs of the poor people. These have a prolonged effect on health and health care, as noted by Ford et al. around the focus of the GEAR policy.[38] "Disease epidemics result from social processes; the spread of infection is propelled by history, political economy and culture."[39] Policies are seen to accelerate the socio-economic burden on the poor, making them greatly affected by disease epidemics, in particular HIV/AIDS.

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[35]David McCoy and Beth Engelbrecht, Establishing the District Health System, p.140.
[36] Love life, *Impending Catastrophe Revisited: An update on the HIV/AIDS epidemic in South Africa,* (Parklands: Henry J Kaiser Foundation Publications, 2001), p.16.
[37] Di McIntyre, Stephen Thomas, Sandi Mbatsha and Luvuyo Baba, Equity in public sector health care financing and expenditure, p.15.
[38] Claudia Ford, Gregory Lewis and Bronwynne Bates, "The macroeconomic impact of HIV/AIDS in South Africa" in Kevin Kelly, Warren Parker and Stephen Gelb (ed.), *HIV/AIDS, Economics and Governance in South Africa: Key Issues in Understanding Response,* (Johannesburg: The Center for AIDS Development, Research and Evaluation, (CADRE), 2002), p.18.
[39]Brooke G Schoepf, Claude Schoepf and Joyce V Millen, Theoretical Therapies, Remote Remedies: SAPs and Political Ecology of Poverty and Health in Africa, p.91.

It would require a clear strategy and tool to solve this health crisis, which includes the HIV/AIDS pandemic. Hickey argues, "The initial response by the governments was to deal with HIV/AIDS as a health issue."[40] They had to change this strategy because the pandemic affects all sectors of the population. To achieve this, a social movement is vital, a movement towards prevention and connection.

This challenge made the government develop a multi-sectoral approach to address the crisis of the disease. In this approach, some ministries are drawn to incorporate HIV/AIDS issues into their work instead of sitting back and providing advice on the best way the ministry of health ought to tackle the disease. This meant that the available resources had to be used equitably and efficiently to support health and health care as well as HIV/AIDS care.

2.1.2   Role of government and agencies in responding to the AIDS crisis

The appropriate role of government in facilitating the treatment of people living with HIV/AIDS could be guided by the desire to: (a) make the best use of scarce public funds (the people's money) to benefit as many people as possible and ensure equitable access, (b) have HIV/AIDS preventive activities be cost-effective, (c) emphasize selective financing and /or the provision of highly desirable health goods and services that the private sector is unlikely to undertake, like prevention, (d) target public subsidies as well as NGOs in ways that help the poor, and (e) have a regulatory authority to monitor the quality of drugs, quality of treatment, and compliance.[41]

Following the above logic, it can be argued that the government and other agencies should mobilize and allocate scarce financial resources, and utilize public and private health care providers, to alleviate as much pain, suffering, and death as possible through prevention, treatment of opportunistic infections, and palliative care. These are precisely the kinds of

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[40]Alison Hickey, Governance and HIV/AIDS: Issues of public policy and administration, p.49.
[41] World Bank Policy Research Report, *Confronting AIDS: Public Priorities in a Global Epidemic, (revised edition)*, (Washington: Oxford University Press, 1999), p.132.

care that most urban, and even peri-urban and rural people living with HIV/AIDS require when they seek relief from the pain and suffering associated with HIV/AIDS, which is, as yet, incurable.

This threat goes beyond individual interest, or individual gain, to affect everyone whether they have HIV/AIDS or not. The above approach seems to contain a strong, positive external rationale. Substantial new resources are becoming available for prevention, care, and support.[42] It would require visionary governments (both at national and local levels) to take up the baton offered by international agencies, for example, in the form of new sources of funding proposed like the Global Fund to fight AIDS, tuberculosis and malaria.[43]

There are challenges that lie within this approach. Designing and implementing an HIV/AIDS national programme is complex and important. Prevention, treatment, and palliative care costs are significant components of the health budget. Faced with the growing HIV/AIDS pandemic and the limited resources for prevention, policy makers need to decide how to distribute funds between different HIV prevention interventions to achieve the maximum impact on the pandemic. The decisions they make may have important implications for *health outcomes* and the choice of HIV prevention strategies as a result of inappropriate models (see subsection 2.3 below). However, it would seem that there is overwhelming evidence of HIV prevention strategies that can reduce the incidence of new infections and be effective in the communities. This strategy will not require much funding, because it will depend on how well community assets are given recognition in the fight against HIV. It is imperative that resources be effectively used in designing and implementing strategies for prevention, care and support.

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[42]Andrew Creese, Katherine Floyd, Anita Alban and Lorna Guinness, "Cost-effectiveness of HIV/AIDS in Africa: a Systematic review of the evidence" in *The Lancet*, 359: 1635-1642, 2002, p.1635.
Source: www.thelancet.com   Accessed on 09/06/2004.
[43] Alison Hickey, "HIV/AIDS spending policy and intergovernmental fiscal relations" in *The South African Journal of Economics,* 70(7):1262-1281, 2002, p.1279-1281.

An effective response to the AIDS crisis depends on the evaluation of prevention and care programmes so that the questions on resource allocation and cost-effectiveness of drug treatment and HIV vaccines can be answered. Because the major burden of AIDS falls on the limited resources of the poor nations, the need for low-cost, effective interventions is paramount.[44] As a result the decision makers are faced with the challenge of allocating the limited resources among health intervention programmes. AIDS is much more than just a health problem. It's a problem that brings challenges to many aspects of people's lives. Hence this calls for sensitivity, acceptability, equity and efficiency in scaling up the response towards the AIDS crisis. The two key areas of intervention are prevention and care.

2.1.3   Costs of prevention

Although one might discern overall efforts to reduce HIV prevalence trends, the AIDS epidemic coursing through KwaZulu-Natal is highly varied, both between and within rural areas and urban areas. Because the epidemic is heterogeneous in terms of its intensity, pace and impact, locally appropriate prevention, treatment and care, and strategies to cushion the impact need to be developed. Prevention is much less expensive than treatment, and avoids the sickness, death, and socio-economic impact that will ultimately result.

An appropriate prevention strategy would require an expanded, multi-sectoral, and local response, including both secular and faith-based organizations to extend the reach of current prevention efforts to those who are vulnerable in order to reduce the impact of the epidemic on all sectors. This would address the biological, behavioural, and social factors that determine the profile of the epidemic, not only in Pietermaritzburg but in the nation as a whole. Prevention strategies, for example, to influence behaviour and the sexually transmitted disease (STD) treatment have been widely implemented, but structural interventions designed to alter the social and policy environments have been few and far

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[44] UNAIDS Information Center, *Cost-effectiveness analysis and HIV/AIDS*, UNAIDS Technical update, Geneva: UNAIDS, August 1998, p.3.

between. Such interventions change laws, policies and the environment as, for example, demonstrated in Thailand, where nationwide condom advertising, a 100% condom use policy for all commercial sex establishments, and the wide availability of STD services and over-the-counter antibiotics were highly successful.[45] It has been and is supported by a strong alliance with the private sector, communities, NGOs, and people infected and affected by HIV who have been leading the fight so far.

Although much has been learned about how to curtail the epidemic, most countries are slow to act and have not been able to scale up successful interventions to reach all at-risk individuals. Kelly argues "there have been no comprehensive attempts to understand the reach and impact of governmental, private sector, non-governmental organizations, faith-based and other institutional and community-based responses to HIV/AIDS in South Africa."[46] This makes it difficult to assess the general trend of AIDS activities of these organizations and institutions. However, the organizations such as, Soul City and LoveLife in South Africa have lessons for health agencies to learn from their HIV prevention efforts.[47] But their efforts are just a drop in an ocean, and more energy from the religious institutions and groups is needed to accept challenge to scale up and intensify the actions from local to national level.

2.1.4   Costs of HIV care and support

Notwithstanding the continuum of prevention and care, the burden of caring for people living with AIDS has increasingly become a priority, and is competing with prevention programmes, especially in an environment where prevention programmes have failed. This requires a strategic and coherent approach, not only to address prevention, but to provide care, which is a burden to the society as well.

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[45] World Bank Policy Research Report, *Confronting AIDS*, p.159.
[46] Kevin Kelly, Behavioural and social responses to HIV/AIDS, p.101.
[47] Soul City: www.soulcity.org.za and Lovelife: www.lovelife.org.za   Accessed: Jan 20th, 2005.

The context of understanding HIV/AIDS care and support may depend on the health and socio-economic status of a country's population. Care and support tends to strain the available resources of households, these resources are then redirected for treatment, transport, and other activities. It may be defined as "care for those uninfected and at risk; asymptomatic HIV-positive individuals; those with early HIV disease; those with late HIV disease or AIDS; and those who are terminally ill."[48] The need for care and support vary because of the different stages of the HIV pandemic.

What this means in the local context, for example, is that the primary objectives of care and support should be to deal with the increasing levels of illness and death as well as those infected and affected by the constantly increasing levels of the HIV pandemic in Pietermaritzburg and the country at large. This is greatly affected by the uncertainty of HIV/AIDS policy at national and provincial level.[49] In "South Africa health and welfare agencies (including faith-based) are struggling to deal with this uncertainty, which inevitably includes provision of different forms of care and support, and, the consideration of how to accommodate the different forms of HIV/AIDS management strategy."[50] With the decentralization and integration of HIV/AIDS services, it has been argued that the community-based approach to care and support could be sustainable and cost-effective. It would seem effective if it is linked with prevention, and has a high involvement of community members, who should be in full control of the initiatives.

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[48] Rose Smart, *AIDS Analysis Africa* 10(5), Feb/March 2000, p.13.

[49] Martin Hensher, "Economics aspects of HIV/AIDS prevention and care: the Challenges" in *AIDS Analysis Africa* 13 (4) December 2002/January 2003:5-6.

[50] Chris Desmond and Tim Quinlan, "Costs of care and support" in Kevin Kelly, Warren Parker and Stephen Gelb (ed.), *HIV/AIDS, Economics and Governance in South Africa: Key issues in understanding response,* (Johannesburg: CADRE, 2002), p.123.

What Broomberg et al. have argued in terms of prevention is true also for care.[51] It can be argued that:

> Ideally, an approach to estimating global resource requirements for HIV prevention should take full account of the cost-effectiveness of alternative strategies. In the case of HIV prevention efforts, however, there remains very limited information on the relative costs and effectiveness of the large number of different strategies currently in use.[52]

Creese et al. show that "evidence for cost-effectiveness of interventions for HIV/AIDS in Africa is fragmentary."[53] This could be due to the fact that "interventions oriented towards developing behavioural and social responses are the least satisfactorily researched or understood in economic and financial terms, of all areas of response to HIV/AIDS."[54] Practically, based on resource allocation, the inclusion of a theoretical model combining economic analysis such as cost-effectiveness and social epidemic modelling is very insightful. But all these depend on allocation formulae used to allocate "discretionary" resources across risk groups based on population size, seroprevalence, risk behaviour and access in order to increase effectiveness in intervention strategies.

2.1.5   Measuring the impact of HIV prevention programmes

It has been pointed out that it is important to understand how the impact of AIDS on households can be reduced to some extent by putting programmes in place to address specific problems. Programmes can translate ones aims, desires, plans and purposes into physical, social, economic, political, artistic and spiritual goals. In practice, there are many different measures that can be taken to monitor how well an HIV prevention project is

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[51] Jonathan Broomberg, Neil Sóderlund and Anne Mills, "Economic analysis at the global level: A resource requirement model for HIV prevention in developing countries" in the *Health Policy* 38: 45-65, 1996, p.46.
[52] Jonathan Broomberg et al., Economic analysis at the global level, p.46.
[53] Andrew Creese, Katherine Floyd, Anita Alban and Lorna Guinness, Cost-effectiveness of HIV/AIDS in Africa, p.1635.
[54] Kevin Kelly, "Behavioural and social responses to HIV/AIDS: Value for money?" in Kevin Kelly, Warren Parker and Stephen Gelb (ed.), *HIV/AIDS, Economics and Governance in South Africa: Key Issues in Understanding Response,* (Johannesburg: The Center for AIDS Development, Research and Evaluation, 2002), p.100.

being implemented, and the extent to which it is likely to impact on HIV and STD transmission. Terminologies such as "processes," "outcomes" and "impacts" with regard to indicators can help one to understand the effectiveness of an approach to HIV/AIDS interventions.[55] Often there are many methodological challenges associated with compiling such indicators and assessing what may be attributable to one or more forms of prevention activity. In general, process indicators are the easiest of the three to monitor and compile over time, and impact indicators are the most difficult to estimate.

There is need to improve the understanding in general terms of regulatory analysis of HIV disease and AIDS, so that the increasing cost burden on health care systems with limited resources is justified. Within this environment, well designed HIV/AIDS programmes that capture effectiveness and use of health care resource are urgently required. This can be supported by data collected in observational studies which reflects the "real world" effectiveness of interventions, which cannot be accurately captured within the programme. By ensuring that these evaluations create impact, policymakers should be in a position to evaluate and deliver appropriate care in future to people with HIV. It is clear then that government strategies in both the prevention of HIV/AIDS and care for people with AIDS raise questions to do with effectiveness. How health is measured will be examined, and a shift from the traditional "economic" models to a more holistic approach will be suggested.

2.2   Measuring health

Formal regulatory analysis tools (or traditional tools) such as risk analysis, decision analysis, cost-effectiveness analysis and cost benefit analysis are used to accomplish health care decisions at less cost than would occur when decisions are made without them. In this section, a brief account of how economically oriented health policy has influenced health care decisions, and a general overview of some of the regulatory tools used to make

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[55] [Unknown author], Methods and Models: Cost-Effectiveness Analysis for HIV prevention. Documenting the effectiveness of HIV prevention: What measure to use?
Source: www.iaen.org/costs/stages2.htm   Accessed August 6th, 2004.

decisions are discussed. It can be argued that traditional tools are not suitable at a time when the health sector is threatened with the AIDS crisis (section 2.3).

2.2.1   Traditional cost analysis.

The health crisis has given rise to greater health care costs. The rising cost of health care provision coupled with the heavy emphasis on quality and value for money, has undoubtedly caused a steady increase in interest in medical technologies more generally.[56] This has placed responsibility on the health planners and public sector agencies to allocate health care resources in reasonable ways so as to create equity and efficiency in the health care services. Such an economic approach to analysing health and health care has often been used to provide information for health care decision makers to allocate scarce resources efficiently within the health sector.

To make health care decisions that are effective, an appropriate method has to be employed. Various ways have been used to assess quality of life based on welfare economic theory models such as Cost Benefit Analysis (CBA) or Cost Utility Analysis (CUA), Cost-Effectiveness Analysis (CEA) and others.[57] An extraordinary interest in cost-effectiveness analysis was developed because it doesn't require placing a dollar value on health outcomes. The "benefits of any health care intervention are measured in terms of quality-adjusted life years of survival (QALYs) so as to allow benefits for different medical interventions to be compared in a single unit of measure."[58] However, analysts and researchers seem not to have a consensus view in the use of the cost-effectiveness approach

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[56]Christopher Evans, ManoucheTavakoli and Bruce Crawford, "Use of Quality Adjusted life Years and life Years Gained as Benchmarks in Economics Evaluations: A Critical Appraisal" in *Health Care Management Science* 7: 43-49, (The Netherlands: Kluwer Academic Publishers, 2004), p.43.
[57]David Meltzer, "Accounting for future costs in medical cost-effectiveness analysis," in the *Journal of Health Economics* 16:33-64, 1997, p.34.
[58]Margaret L. Brandeau, Gregory S. Zaric, and Anke Richter, "Resource allocation for control of infectious disease in multiple independent populations: Beyond cost-effectiveness analysis," in the *Journal of Health Economics* 22:57-598, 2003, p.576.

in evaluating health and health care.[59] "Of the challenges facing scholars, economists have been especially concerned with the welfare economics foundation of CEA (Garber and Phelps, 1997; Garber, 2000), including the consistency between CEA and CBA (Dolan and Edlin, 2002; Blomvquist, 2002).[60] Despite these controversies, cost-effectiveness analysis has been agreed to be a fair way of analyzing the health sector and HIV/AIDS programmes, if it includes all future medical and non-medical expenditures. As such, it aids decision-making, but is not a complete prescription for social choice.

However, as has begun to be apparent, the AIDS crisis is involving the community in health care decisions, with a general feeling that the more community participation, the better (Chapter 3). Community involvement can provide good value-for-money or effectiveness of health care interventions since communities have the assets, which they can use to improve health care outcomes. However, this has led to a questioning of the traditional measurement tools, as to whether they are suitable to evaluate health outcomes in the face of the AIDS pandemic.

2.2.2   A critique of the traditional model of health measurement

Regulatory tools, as described above, have so far been used primarily to feed into management, planning and policy decisions taken at various levels within countries. Agencies working on health have a need for advice provided by these tools. On the one hand they need to identify which health interventions and strategies are the more cost-effective and should be promoted by them; on the other hand they need to identify the magnitude of resources required to implement such interventions and help mobilize funds. Despite these needs, the cost-effectiveness model has a limited ability to cope with the ever-changing or emerging health care system environment, especially in the time of the AIDS crisis. Five criticisms have been made.

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[59] Milton C. Weinstein and Willard G. Manning, Jr. "Theoretical issues in Cost-effectiveness analysis" in the *Editorial of Journal of Health Economics* 16:121-128, 1997, p.127.
[60] Rajiv Sharma, Miron Stano and Mitchell Haas, "Adjusting to changes in health: Implications for cost-effectiveness analysis" in the *Journal of Health economics* 23:335-51, 2004, p.335-336.

The first problem is that the model has made people working on health and human care adopt the language of economics, which overemphasizes efficiency, and the model has failed to "recognize the most important ethical and social values that underlie medical practice. Medicine as a profession rests on the dignity and sanctity of life, a philosophy and practice that resists overt commercialization."[61]

The traditional method cannot measure values which have wider meaning for health care and the HIV/AIDS pandemic. Viewing this from a religious angle, values entails lessons and moral codes that drive our lives and our work, and which provide the appropriate guide for us to be involved in health care. We are loved and valued by God, and we are obligated to take necessary precautions to safeguard this gift that has been lent to us. For example, our involvement in health and HIV activities exemplifies our attention to the value of prevention – specifically early identification and access to care to avoid further risks, as well as our allocation of resources and efforts to improve the length and quality of life for those living positively with AIDS. Tied to this is the principle of responsibility which teaches us that every human life, no matter how frail, is of infinite value. Our commitments to improve the lives of the disadvantaged, to support the chronically ill, to help those living with HIV are examples of living out this tradition of caring for the most vulnerable among us. It means that we need a model which can accommodate the values of people in health care.

Secondly, HIV prevention efforts have very limited information on the relative costs and effectiveness of the large number of different strategies currently in use. This makes it difficult to determine important relationships between programme scale and cost, or to identify other important determinants of cost.[62] This makes the data on effectiveness of interventions further limited. There are several reasons attributed to this, and it includes the fact that most assessments of effectiveness have relied on *process indicators*, on the basis

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[61]Thomas E. Getzen. *Health Economics: Fundamentals and Flow of Funds*, (New York: John Wiley & Sons Inc, 1997), p.46.
[62] Creese et al. "Cost-effectiveness of HIV/AIDS in Africa," p.1638.

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of which effectiveness assumptions may have been made, rather than on measures of *outcome*. The former suffer from the obvious problem of uncertainty as to the causal links between the measured indicators and reduced HIV transmission. Secondly, despite the fact that several interventions are often implemented simultaneously, information on interactions between these interventions, and on their relative contribution to outcomes, remains scarce.

A third problem with the traditional measurement model is that there is the enormous challenge of assessing the likelihood and severity of a health threat, particularly an emerging health threat, of communicable or infectious diseases.[63] Sometimes there is ample basis for public or clinical concern about a hazard, but there may be very limited historical basis for determining the precise magnitude, whether measured in probability or severity. Take cholera as an example: in order to perform good risk assessment of the threat, we need much better information about the most susceptible subgroups in society because exposures in these groups may determine the overall public health significance of an emerging hazard.

The question which needs to be asked is which institutions in society should be responsible for research into applied risk assessment? One might think that medical university-based scientists could offer analytic solutions to these challenges and they often do. Yet these emerging health issues, including the identification of sources and causes, often require collaboration of scientists from multiple disciplines.[64] This is not always the case because of intellectual and institutional differences leading to inconsistent study of the method and its reporting systems. In a similar way, public health agencies are disoriented as they move from providing technical interventions to building community capacity and dealing with the mysteries shaping human choices. This calls for hard work to strengthen the scientific

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[63] Brandeau et al. Resource allocation for control of infectious disease in multiple independent populations, p.576.

[64] Gary Gunderson. "On Outcomes and Hope: Measuring what matters," in Gary Gunderson, *Strong Partners: Realigning Religious Health Assets for community Health,* (Atlanta: The Carter Center, 1997), p.72-73.

quality, credibility, and policy relevance of these applied research organizations to inform the public and private sectors.

Fourthly, a cultural approach is of crucial important in the valuation process, for it raises acutely the issue of whose values are to count, and how. The family is the center of community as well as culture. It is here that family values are taught through a strong parenting agenda, and even wider community issues, which leads to social and family support of the communities. Traditional economic tools cannot capture the real community spirit and culture of volunteerism that exist in every culture.

Inconsistent principles and varied expressions is a fifth drawback of this method.[65] It is important to raise methodological issues about the objectivity of some of the technical measures of illness severity, because of political issues concerning the authority of the respective parties when it comes to deciding on treatment (i.e. resource use). This creates technical difficulties over the application of economic models of resource allocation, including semantic problems over "need" versus "demand", and the problems of getting people to reveal their true preferences.[66]

These five criticisms suggest that a new paradigm is needed which recognizes that the traditional measurement tools are poorly suited for analysing health outcomes. Redefining the meaning of community and adopting a new starting point for evaluation is necessary steps towards implementing this new paradigm of health. This leads one to a consideration of *health outcomes.*

2.3   Health outcomes as an alternative for measurement

Today, outcomes measures have become increasingly important in determining the allocation of health care resources. Gunderson explains "in today's economic and political

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[65] Christopher Evans, ManoucheTavakoli and Bruce Crawford, Use of Quality Adjusted life Years and life Years Gained as Benchmarks in Economics Evaluations, p.43.
[66] Thomas E. Getzen, *Health Economics*, p.27.

environment we account for our time, financial resources and allegiance" which require enforcement of protocols and accountabilities for health care processes.[67] Health outcomes are used to define the functions to be measured as well as to monitor and improve the quality of care. The approach is deeply connected to a community or organization's mission, and is able to describe a specific desirable result or the quality of an organization's services.[68] When compared to the traditional approach, health outcomes research is more comprehensive, has a greater focus on the patient, and measures what is often of greatest concern to the patient. It looks beyond the clinical success or failure of an intervention to define success by the effects of a treatment on various areas of a patient's life.

A focus on outcomes carries certain responsibilities as well, and this can be described as "nothing more than deciding what to keep track of, what to pay attention to in a systematic way."[69] It has been argued that like the larger field of health services research, the study of health outcomes is multidisciplinary in that it is a collaborative science that encompasses the work of boundary leaders who have the opportunity to influence the strategies of other institutions, such that these organizations can be accountable for long-term health improvement rather than just cost.[70] This means that the process recognizes that health has to do with human experiences of what matters and what hurts; and also it provides a lens through which people can describe themselves and see their communities better.

The principle of *health outcomes* incorporates the community in its analysis by recognizing that the community is the center of delivering health services. The community is often only defined from health care providers' view as the legal jurisdiction that regulates their work and by the market area they hope to serve. Legal boundaries may encompass social networks and critical issues affecting health such as poverty, environmental degradations and others. On the other hand, redefining the community as being primarily voluntary

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[67] Gary Gunderson. "On Outcomes and Hope", p.61.
[68] Alan Clarke and Ruth Dawson, *Evaluation Research: An introduction to principles, methods and practice,* (London: SAGE Publications, 1999), p.13-14.
[69] Gary Gunderson. "On Outcomes and Hope,"p.62.
[70] Gary Gunderson. "On Outcomes and Hope,"p.63.

associations of people will offer a better understanding of where health is formed. It would provide new starting points for a new paradigm for evaluating health and HIV/AIDS programmes.

Many health care activities such as caring take place outside the health system. This involves great costs in providing nutrition, transport to health centers, clean bedding and clothes for the sick, and others. These intangible costs are often borne by parties who are not in a position to control infections[71]. Hospitals cannot control risky social and behavioural trends that normally lead to HIV infection. Instead, communities have the answer through their social linkages. Changing roles and responsibilities in the interface between communities and service providers brings new challenges and new opportunities. This calls for a shared language and negotiation as one recognizes these linkages, and, if possible measures them in order to understand the degree of their power to influence decisions. In other words, it would mean that one needs to emphasize non-monetary information or activities in health and HIV care when reporting on the overall effectiveness of programmes. And this is typical of religious health assets that have indirect health outcomes (see Chapter 3).

It would seem that a new language for health needs to emerge, and it is about how a community works in order to achieve healthy individuals in a community. Socio-economic status often influences the health conditions of an individual and even the community. In South Africa, most health disparities are associated with racial and socio-economic trends of the country. This does not ignore other factors such as the cultural and biological ones. All these have a negative effect on the health outcomes of the country. But there is a poor understanding of exactly how this happens, which should encourage humility when community-based programmes are designed. Blaming somebody for what has happened or is happening will not solve health and HIV problems. Developing a dialogical process can

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[71] Gary Gunderson. "On Outcomes and Hope," p.70.

make the community interpret and project meaning onto the reality of health-related issues they see.

Community health campaigns will not necessarily need outsiders' knowledge to design programmes to address the problem at hand. Members of the community will use their wisdom to allocate finance, time and energy, to choose with whom to collaborate in solving infections' problems within the community. The success of this is the result of community resilience.[72] At the same time collaboration can contribute data, knowledge or wisdom and support the language of accounting, strategy, ethics, and spirituality. These elements are all legitimate and vital to an articulated strategy of dealing with health issues.

Programmes evolve and deepen the level of learning among the people. The success of any programme depends on the language used. Programmes must firstly be simple and consistent, so that the community can capture its activities, its perceptions of quality and value, its principles used in designing and presenting its outcomes, and its monitoring mechanism - which can be described as "result mapping".[73] The traditional approach seems not to be sensitive to people's needs for understanding health programmes' impact on the whole society, as a key concern in time of AIDS. Information gleaned from health outcomes analysis can be used in a shared decision making model to help patients and the community make more informed choices about health care.

Thus *health outcomes* have implications for every aspect of the health care system, including clinical practice, treatment, quality of life, health care delivery, information on health policy, and health care financing. Outcomes can affect decision making on health policy at local, provincial, and national levels, and in both the private and public sectors. The wide scope of this discipline allows it to become one of the most important means by which policymakers, clinicians, managers, and tax payers can learn more about the most

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[72] Community resilience is based on three points when dealing with the of wellness community health. It is about prevention of illness, an act of intervention in times of illness or an attempt to cure the illness through remedial medication or therapy.
[73] Gary Gunderson. "On Outcomes and Hope", p.72.

effective and efficient ways to provide high quality health care in this time of AIDS. In other words, this measurement helps one think more holistically about health and it enables one to look at wider community involvement. And when we do this in Africa, it leads one to look specifically at the role of religion in the community, and its contribution to health care.

CHAPTER THREE

RELIGION AS A HEALTH ASSET

3.0   Introduction

In this chapter, some key concepts and principles of community organization and community-building are examined for their relevance to health care professionals and others working at the interface of health systems and communities.[74] A number of new approaches and change in strategies have been developed and adopted by health systems in recent years, but the principles and methods of community organization have remained a central method of practice. Many questions about health system performance have not been clear because *health outcomes* are hard to measure and as was noted in Chapter 2, it is hard to disentangle the health system contribution from other factors. Using the fundamental principles of community organization and community-building for health care services, this chapter suggests a need for a further refinement of theory, methods, and measurement techniques in assessing health system performance. The study asserts that this approach can help health providers, and faith-based organizations, to assess their performance, improve it, and respond better to the needs and expectations of the people they serve.

3.1   Community-building for health

Community-building has emerged as an alternative to a service-based approach to address not only developmental problems, but also persistent health needs in local communities.[75]

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[74] World Health Organization, "Why do health systems Matter?" in *World Health Report 2002: Health Systems improving performance,* (Geneva: World Health Organization Publication, 2000), p.5.
The World Health organization defined health system as including all the activities whose primary purpose is to promote, restore or maintain health.
[75] Meredith Minkler and Nina Wallerstein, "Improving Health through Community Organization and Community Building: A Health Education Perspective," in Meredith Minkler (ed.), *Community*

The rationale is that despite an increasing volume of resources allocated to address the symptoms of poor health, the basic infrastructure of local communities has nevertheless declined greatly. Service-based approaches are costly; not only in financial terms, but also in that they have the tendency to undermine the ability of residents to solve local problems. Service-based approaches view communities as problem areas that serve as sites for services delivered by qualified professionals, and they view residents as passive consumers or clients of health commodities.

The community-building approach views neighborhoods as dynamic environments with a diverse array of assets that can be mobilized, and with community residents as partners who can be engaged in an ongoing process of problem solving.[76] Service provision remains vital, but a key premise of community-building is that direct actions by local residents, with the strategic support of institutions, may yield a more cost-effective and sustainable impact on health status and quality of life.

For many public health agencies, a new approach can transform traditional needs assessments into more comprehensive processes that include the identification of assets that serve as entry points for health improvement activities.[77] An outstanding example of this new approach is in the provision of Primary Health Care, which is based on full community participation on health matters, and is accessible and affordable to the community. Though difficult to implement, Primary Health Care has become the basis of health care for the majority of the world population. Its failure has often been attributed to a lack of use of community assets such as service-based organizations, local businesses, faith-based organizations, advocacy groups, coalitions, and the skills and talents of individual residents.

Organizing and Community Building for Health, (New Brunswick, New Jersey: Rutgers University Press, 1997), p.32

[76] John P. Kretzmann and John L McKnight, *Building Communities from the Inside Out*, p.6-8.

[77] Christoph Benn, "Why religious health assets matter: Past, Present and Future of Faith Based Health Institutions in Africa," in a Report of African Religious Health Assets Programme Colloquium, unpublished, (Pietermartzburg: University of Natal, August 2003), p.5.

Once community assets have been identified, health providers and other community stakeholders can determine the best configuration of resources that will mobilize and/or enhance the capacity of those assets to address the symptoms and causes of health problems. Resources invested in this process include financial support, technical assistance, human capital, physical resources (e.g. space, equipment), and advocacy. A health provider that is committed to a community-building approach to health improvement would:[78]

a) Engage community members as partners rather than simply as consumers, with shared accountability for improving health and the quality of life in the community.

b) Identify existing assets that serve as an entry point for efforts to address the causes and impacts of health-related problems.

c) Build enduring resources that individuals can acquire, develop or improve to exert control over their lives and to participate in their society in meaningful and effective ways. To achieve this, the health care provider has to make strategic investments in existing community assets to increase their effectiveness, efficiency, and sustainability.

d) Emphasize community problem solving through direct action by community stakeholders to address the underlying causes of persistent health problems. The intention is to stress internal focus with primacy of local definition, investment, creativity, hope and control.

e) Make long-term investments in community quality of life which can enhance the security of the vulnerable communities by reducing the poor's vulnerability not only to adverse shocks such as ill-health alone but also to crop failure, natural disasters and policy induced shocks.[79]

Many faith-based organizations are trying to demonstrate their commitment to partner community residents to address the underlying causes of health problems. In

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[78] John P. Kretzmann and John L McKnight, *Building Communities from the Inside Out,* p.9-10.
[79] Department for International Development, DFID, Sustainable Livelihoods Guidance Sheets, (London: DFID Publications, 2003), p.17.

Pietermaritzburg, examples include the Evangelical Christian AIDS Programmes, Youth for Christ, (YFC) and Pietermaritzburg Agency for Christian Social Awareness, (PACSA). Given the growing financial pressures that most of the faith–based organizations face, sustaining this commitment requires visionary leadership and willingness to take risks.[80] This, Nicolson argues, is very important for South African leaders as they "rediscover some of the original vision of religiously motivated health care."[81] Community-building initiatives are unlikely to produce improvements in health status or major financial returns for health care providers in the short-term. However, they offer considerable potential to create local environments that produce a wide array of long-term benefits, financial and non-financial, for community residents and institutions.

In the situation of uncertainty and incomplete information that has plagued the health sector, have faith-based health care providers sustained their commitment to community health? If so, what factors have contributed to promote effectiveness and sustainability? These were some of the questions addressed in a recent ARHAP colloquium concerning health care providers as leaders in the community health improvement field.[82] The present study takes up this question as it investigates how and why a church such as St Paul's Anglican Church, with a weak commitment to improving community health, may seek to sustain these efforts over a long period. By means of building synergy between health and Asset-Based Community Development, the study suggests that religious health assets can help by way of improving health care given by religious institutions.

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[80] Christoph Benn. "Why religious health assets matter", p.4.
[81] Ronald Nicolson. "Why Religious Assets Matter: A Response" in *African Religious Health Assets Programme Colloquium*, (Pietermartzburg: University of Natal, August 2003), p.13.
[82] The Promoters of African Religious Health Assets Programme organized this colloquium to discuss some of these questions raised in this study at the University of Natal, Pietermaritzburg in August 2003.

3.2 Asset-Based Community Development as a theoretical approach for the study

An asset-based approach focuses attention on the productive, social and locational assets of households (or individuals), with the understanding that the quantity, quality and productivity of their portfolio of assets determine the potential for the long-term improvement of community development. Kretzmann and McKnight have collected many stories of successful initiations to build communities.[83] The stories present the role played by particular individuals in catalyzing the development process in their communities, and the strong base of their social networks that are mobilized to enhance the process. The catalysts may be community leaders, because of their formal education or influential ideas with which they have come from outside. The approach recognizes the potential within the community, as well as the potential outside of it: "sons and daughters" living elsewhere, sometimes in larger urban areas, and also opportunities available through linkages with external institutions.

Such community-building stories are relevant for the low income communities of South Africa, and particularly those in Pietermaritzburg, KwaZulu-Natal. In communities across Pietermaritzburg, families ravaged by the AIDS pandemic have turned to some sources of strength and fellowship their forebears have counted on for centuries: their local churches, mosques, and other houses of worship for all kinds of assistance. Though South Africa's religious communities have, understandably, often struggled to come to terms with the behaviours that put adults at high risk for HIV infection, they have responded wholeheartedly to the medical, financial and educational challenges the pandemic has created for children and families who are losing loved ones at an astonishing rate.

Far from being silent on HIV/AIDS, women have progressively taken on a leadership role in trying to speak and fight against the consequences of AIDS in their families, and also in attempting by all means to reduce the impact of the disease on their communities. For example, the Circle of Concerned African Women Theologians has done a lot of work on

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[83] John P. Kretzmann and John L. McKnight, *Building Communities from the Inside out*, p.1.

HIV/AIDS in the areas of theology and ethics, prevention, care and counseling, education, training, support and other matters.[84] The work of the National Community of Women Living with HIV/AIDS, (NACWOLA) in Uganda has helped to build community resilience through its programme called "memory boxes" in the children of families affected by HIV/AIDS. In South Africa, the Memory Box Agency in Soweto working in partnership with AIDS Counselling, Care and Training (ACCT) uses this concept.[85] A Memory box contains the stories of those infected and their affected family members; it functions as therapy for them. It has become a way of building community competence, where people with HIV/AIDS work together for change with their family members, friends, relatives, and stakeholders at various levels to achieve competence.

Healthy communities depend firstly on citizen participation and their investment in local problem solving capacities; secondly, on their taking responsibility; and thirdly, on their working together to create better local conditions, which can, in turn, enhance a sense of togetherness and increased opportunities for personal growth. Much of contemporary citizen participation practice is built on principles that focus upon building relationships, involving people in a process, and the full utilization of existing strengths, assets and capacities of community members. This process seems to be good for South African communities, as they try their best to come to terms with issues of diversity in building the nation.[86] A parallel perspective utilizing similar themes and already hinted in the present work is the asset-based community development programme advocated by Kretzmann and McKnight, in their book called *Building Communities from the Inside out: A path toward finding and mobilizing a community's assets.*[87]

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[84] Isabel Apawo Phiri, "African women of faith speak out in an HIV/AIDS era" in Isabel Apawo Phiri and Beverley Haddad, and Madipoane Masenya (ngwana' Mphahlele), (ed.), *African women, HIV/AIDS and Faith Communities,* (Pietermaritzburg: Cluster Publications, 2003), p.7.
[85] Phillippe Denis, "Memory Boxes: Helping AIDS orphans to remember" in *Bulletin for Contextual Theology in Africa: Church and AIDS in Africa,* Vol. 7, No.1 March 2000, p.34-35.
[86] Koos Bekker (ed.), *Citizen participation in local government*, (Hatfield, Pretoria: J.L. van Schaik Publishers, 1996), p.2.
[87] John P. Kretzmann and John L. McKnight, *Building Communities from the Inside out: A path toward finding and mobilizing a community's assets,* (Chicago: ACTA Publications, 1993).

The basic tenet of the ABCD approach is that, although there are both capacities and deficiencies in every community, a development process can be driven by communities as they identify and mobilize their existing (but often unrecognized) assets, thereby responding to and creating local opportunities.[88] Such unrealized resources include not only personal attributes and skills, but also the relationships between people that fuel local associations and informal networks. Through mobilizing these social assets and formal institutions, a process of community development can be sustained and scaled up, because local associations have been recognized as the driving force, the means by which community assets can be identified and then connected to one another in ways that multiply their power and effectiveness.

The approach helps communities not only to recognize and map their assets: individuals, associations and institutions, but also seeks to build relationships among and between them, so as to strengthen the community's own capacity to enhance its well-being. It is important to note at this point that individuals (both employed and unemployed) have strengths and capacities, and uncovering these is a key to taking action pro-actively. Going beyond the dominant picture of a needy person can encourage these individuals to act progressively in building healthy families and communities.

Second, ABCD stresses the key role played by formal and informal associations, networks and extended families at the community level, and by the social relationships that connect local initiatives to external windows of opportunity. In this way, all types of assets are taken into consideration. Particular importance is attached to identifying, strengthening, and mobilizing what others have called "social capital" located in this associational base, precisely because this is the key to accessing the other assets needed for community development (or health). It is normally in this context that people's skills are encouraged, their problems are shared, and their vision extended. The role played by associations is often ignored by development professionals including service providers, who see society in terms of isolated individuals and large institutions.

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[88] John P. Kretzmann and John L. McKnight, *Building Communities from the Inside out,* p.5-8.

The third asset in the community is its formal institutions, and the

the most visible and formal part of a community fabric. These ins

interests of outsiders, and it is important these institutions are "ca

themselves as key players in local development. Amongst the lo

by Kretzmann and McKnight are the local religious institutions,

form part of these religious institutions.[89] The task of the community builders is to build relationships between these institutions and the individuals and associations in the community.

To sum up, an asset-based process offers a set of principles and practices for communities to drive their own development by maximizing their assets and establishing strategic linkages. This process has it starting point with what the community has, rather than with what it lacks; it offers a new capacity-oriented option for communities that are in danger of being paralyzed by the "deficit mind-set"; and it always seeks the paradigm shift of building relationships between and amongst individuals, associations and institutions for the good of the community.

This process provides the basis for Christians to speak of the church as a community asset. The church brings diverse and potent webs of gifts and assets which include personnel, space and facilities, materials and equipment, expertise, rituals and symbols, moral authority, and it even has the capacity to hire residents of the community for their on-going programmes and activities. The approach, which seems to echo the Christian perspective, affords one an astounding variety of creative ways to promote community-building. It signifies that the process recognizes the God-given potential and vocation of each person in the congregation.

Although the approach is internally-focused, external resources are necessary. However, they will only be effective if the local people are themselves investing and mobilizing their

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[89] John P. Kretzmann and John L McKnight, *Building Communities from the Inside out,* p.115 & 145.

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own resources, and are able to set the development agenda for outsiders. Thus, this simple community-building path is: asset-based, internally-focused, and relationship driven.[90] The approach seems to present convincing evidence that when communities focus on their assets rather than their needs, they can often:[91]

- ✓ integrate marginalized citizens into productive community life,
- ✓ strengthen their infrastructure,
- ✓ create new business opportunities, and
- ✓ improve local health and service delivery.

With this in mind, we turn now to examine the challenges that this approach places before faith-based organizations in health.

3.2.1   Challenges to the role of faith-based organizations in health

Across the country, health care systems, including faith-based organizations, reach out to their communities as part of their mission to improve the health of their communities. Through collaborations with other community organizations, these efforts to improve community health have evolved to include a focus on improving the quality of life.[92] While these efforts vary in terms of scope, health priorities and structure, many health care systems nationwide have demonstrated their commitment to reach out to their communities and address health issues through collaborative, rather than a single organizational approach.

Committed to addressing the root causes of health problems, these health care systems invest their financial, human and technical resources in areas such as: basic health needs, education and economic development, to strengthen the ability of communities to create

[90] John P. Kretzmann and John L McKnight, *Building Communities from the Inside out,* p.9-10.
[91] John P. Kretzmann and John L. McKnight, "Mapping Community Capacity", in Meredith Minkler (ed.), *Community Organizing and Community Building for Health*, (New Brunswick, New Jersey: Rutgers University Press, 1997), p.169-172.
[92] Nancy Coulson, "Health Promotion", in Nicholas Crisp and Antoinntte Ntuli, (ed.), *South African Health Review 1999,*(Durban: Health Systems Trust, 1999), p.291.

and sustain a healthy environment. Some of the most outstanding examples include Evangelical Christian AIDS Programmes, Youth for Christ and Pietermaritzburg Agency for Christian Social Awareness all in Pietermaritzburg. In many cases, community stakeholders play a leading role, and local health organizations such as hospitals and faith communities are supportive partners.

As we have seen above, the strategic investment of resources in local communities referred to as "community-building," has been advanced as an alternative to the emphasis on professional service delivery.[93] Kretzmann and McKnight explain that community-building approaches include building upon existing community resources or assets, reducing duplication of effort, and increasing the ability of residents to solve local problems.[94]

In many cases, a community-building approach grows from existing partnerships between health providers and local community members. As health providers and community stakeholders assess local needs and explore alternative approaches to health improvements, they may conclude that large investments in human services are both impractical and unlikely to produce a sustainable impact on persistent health problems. Partners may agree that all local stakeholders need to take actions in order to build a strong neighbourhood infrastructure that will support community health and well-being.

The significance of community-building as a community health strategy emerges in an environment in which faith-based health care systems must balance their mission with competing financial and political demands. This is seen in the way public funds are channeled to faith-based health care systems in their fight against HIV/AIDS in South Africa. In the course of this process, they are often required by the stakeholders to justify their identity, mission, and hopefulness before being approved for funding for their health care initiatives. This results in their charitable obligation being narrowly defined by the

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[93]Meredith Minkler and Nina Wallerstein, "Improving Health through Community Organization and Community Building", p.32

[94] John P. Kretzmann and John L McKnight, *Building Communities from the Inside Out,* p.5-6.

public. Therefore, such challenges of current financial pressures have led many of the faith-based health care systems to decide not to use donor resources even if these could be used for extending medical care for preventable illness.[95] The strategic investment of resources to address the underlying persistent health problems may be the expression of a faith-based health care system's charitable mission, one that sets aside issues of financial returns or competitive advantage. Yet many community advocates and legislators view religious institutions as an immediate resource to address the health care needs of four million South Africans affected with HIV/AIDS and even those having no medical aid, and this has increased the pressure on religious health providers to increase charity care.[96]

In the light of current financial and political pressures, faith-based health providers, private and public hospitals, health care associations, and community advocates need to build greater public awareness of the idea that investing in community-building is an important component of the charitable commitment of faith-based health providers. In the face of these challenges, this study argues that religious institutions have a real responsibility for the stewardship of assets which can be used to improve community health. Therefore, a model of health promoting behaviour derived from principles of faith (or religious principles) may help one understand religion as a health asset which can influence health practices within the community.

3.3   Religion as a health asset

People have known about the close relationship between health (and illness) and religion for centuries. This is reflected in many ancient texts. The Jewish and Christian Bibles, for example, make many references to disease, from the description of a major epidemic in the book of Exodus to the association of plagues with the social crisis in the book of

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[95] Barbara Schmid, JR Cochrane, CA Wanamaker, Hajira Khalfe and Lyn Holness, "Health Services provided by religious communities", in Nicholas Crisp and Antoinette Ntuli, (ed.), *South African Health Review 1999*, (Durban: health Systems Trust, 1999), p.123.
[96] Lovelife, *Impending Catastrophe Revisited*, p.6.

Revelation. This shows that "the ultimate context of health and health care is religious."[97] It is about "ameliorating the suffering, preventing the wounds and maladies that can be prevented, and advancing the health and wholeness of communities," which is crucial for the society.[98] All faith groups to some extent address the issues of illness and wellness, of disease and healing, of caring and curing amongst their congregations. This is because religious institutions nurture and provide social support for the well-being of their congregations and even reach out to those in need within their neighbourhoods and throughout the world. Through these they seek to improve the well-being of the community. As congregations, they represent the values of the gospel, which is a key to addressing many of the social health issues of today. Such interventions would change risky behaviours of communities and influence the underlying faith practices in the community.

Religious institutions can achieve this change in risky behaviour when they recognize that socio-economic status is a powerful determinant of health and disease. This could provide an opportunity to address the health needs of the lower socio-economic segments of the population, as religious institutions recognize and understand the expanded definition of health, which "integrates concepts of curative medicine (absence of disease) with public health (absence of excessive mortality, morbidity, and risk factors of disease), and productive functioning and well-being."[99]

The well-being of a person would mean the wholeness that encompasses mental and physical well-being as a result of the absence of physical threats like war, disease and famine.[100] It would seem that social facilities are necessary in order to experience well-being. These facilities, such as schools, health centers, and so on, influence the individual's

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[97] Gary Gunderson, *Deeply Woven Roots*, p.4.

[98] Gary Gunderson, Concept Paper for Design Process for the Institute for Public Health and Faith Collaborations, June 4, 2002.

[99] Charles Grosel, Melinda Hamilton, Julie Koyano and Susan Eastwood, *Health and Health care 2010:The forecast, The challenge,* (2nd ed.), (Princeton NJ: The Institute for the Future, 2003), p.338.

[100] Perry Yoder, *Shalom*, (London: Faith and Life Press, 1987), p.13.

substantive freedom to live better.[101] Denial of or lack of these facilities to an individual or society will increase the preventable morbidity and mortality of people, and even further their illiteracy and reduce their participation in economic activities and politics. Therefore the well-being of an individual or society should not be narrowly understood; instead it should encompass working for just and health giving relationships between people and nations.

The notions of 'well-being' (Chambers 1997) and 'capability' (Sen 1999) provide a wider scope for understanding the concept of livelihoods strategies. Sen sees capabilities as being "what people can do or be with their entitlement", a concept which encompasses far more than the material concerns of food intake or income.[102] This made Sen suggest that developing human capabilities provides a better way of dealing with well-being and lack of well-being. For example, "personal health and the capability to be healthy can depend on a great variety of influences. (And) an alternative to focus on means of (well-being) is to concentrate on the actual living that people manage to achieve (or, going beyond that, on the freedom to achieve actual living that one can have reason to value)."[103] Such ideas represent more than the human capital which allows people to do things, but also the intrinsically valued elements of "capability" and "well-being." Chambers argues that the criterion of a well-being as an approach to poverty and livelihoods analysis may allow people themselves to define the criteria (assets) which are important. "Unlike wealth, well-being is open to the whole range of human experience: social, mental and spiritual as well as material. This may result in a range of sustainable livelihood outcome criteria (or the household's revealed behaviour); including diverse factors such as self-esteem, security, happiness, vulnerability, power, exclusion, as well as more conventionally measured material concerns."[104] It is important to note that Chamber's ideas of well-being provide the

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[101] Amartya Sen, *Development as freedom*, (New York: Anchor Books, 1999), p.39
[102] Amartya Sen, *Development as freedom*, p.70.
[103] Amartya Sen, *Development as freedom*, p.73.
[104] Robert Chambers, *Whose Reality Counts? Putting the First Last*, (London: Intermediate Technology Publications, 1997), p.10-11.

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"space for both spiritual well-being and value change."[105] This can be looked at in another way as being embedded within religious health assets, which are vital for pursuing livelihood strategies such as health care including HIV/AIDS prevention strategies.

The ability to pursue different livelihood strategies is dependent on the basic material and social, tangible and intangible assets that people have in their possession. In order to create livelihoods, therefore, people must combine the "capital" endowments that they have access to and control over. These may be made up of personal capabilities, tangible assets (e.g. stores and material resources) and intangible assets (e.g. claims and access).[106] The question which needs to be asked is: what are assets? and why religious assets? There are various ways of defining assets. However, for simplicity, one can say that "an asset is anything somebody can make decisions about: things, processes, culture, techniques, knowledge and relationships. Understanding assets clarifies the differences between what to endure, what to simply lament, what to complain about, what to work on, refine, build, reinforce and hope for."[107] To a large extent, naming assets plays a vital role in all dimensions, because naming embeds meanings, logic, context, purpose, utility and value.

Gunderson explains:

> It is appropriate to ask of an asset and those responsible for it, that both functions in ways enabling the asset to produce its optimal return, to play its fullest intended role in the system God makes possible. This is especially true of those most sacred assets, those that are religious because their "utility" is accountable to a more complex standard. Religious assets are more accountable, not less.[108]

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[105] Bryant L Myers. *Walking with the Poor: Principles and Practice of Transformational Development*, (Maryknoll, New York: Orbis books, 1999), p.106.

[106] Robert Chambers and Gordon Conway. *Sustainable Rural Livelihoods: Practical Concepts for the 21st century,* (University of Sussex, Brighton: Institute of Development Studies Publications, 1992), p.10.

[107] Gary Gunderson. "The Least we can do: Why an African Religious Health Assets project? in *Africa Religious Health Assets Programme Pietermaritzburg colloquium report*, (Pietermaritzburg: University of Natal, August 2003), p.17.

[108] Gary Gunderson. "The Least we can do", p.17.

The religious health assets matrix below presents the religious values which are sacred in value. A full list of the religious assets includes: Congregations, Connectional systems, ecumenical and interfaith social systems, owned things (hospitals, schools, foundations, etc...), influenced things, and others.[109]

Figure 1: Religious health assets matrix

		Direct	Indirect
Religious Health Assets ↑	**Intangible**	▪ Prayer ▪ Resilience ▪ Health-seeking behaviour ▪ Motivation ▪ Responsibility ▪ Commitment/sense of duty ▪ Relationship: caregiver & "patient" ▪ Advocacy/Prophetic ▪ Resistance-Physical/and/or Structural/Political	▪ Individual (sense of meaning) ▪ Belong-Human/Divine ▪ Access to Power/ Energy ▪ Trust/Distrust ▪ Faith-Hope-Love ▪ Sacred space in a Polluting world (AIC) ▪ Time ▪ Emplotment (Story)
	Tangible	▪ Infrastructure ▪ Hospitals- beds, etc ▪ Clinics ▪ Dispensaries ▪ Training-Para-medical ▪ Hospices ▪ Funding/Development agencies ▪ Holistic Support ▪ Hospital Chaplains ▪ Faith healers ▪ Traditional Healers ▪ Care groups ▪ NGO/FBO- "projects"	▪ Manyano and other fellowships ▪ Choir ▪ Education ▪ Sacraments/ Rituals ▪ Rites of Passage (Accompanying) ▪ Funerals ▪ Network/ Connections ▪ Leadership skills ▪ Presence in the "Bundu" (on the margins) ▪ Boundaries (Normative)
Continuum →		**Direct**	**Indirect**

Health Outcomes →

Adapted from ARHAP Suite of Assessment Tools: A framework model, draft, March 2004.

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[109] Gary Gunderson. "Public Health and Social Health: Identifying common tasks and shared infrastructure".
Source: http://www.ihpnet.org/sld017.jp   Accessed on 09/08/2004.

These religious health assets (RHAs) can be distinguished as being: "tangible and measurable assets; and intangible and difficult to measure along the vertical axis. The horizontal axis represents the impact of religious health assets on health outcomes, which has either direct or indirect health outcomes." [110] A particular religious health asset may cross the quadrant, and as such these axes are assumed to be continua. However, most existing tools survey only the tangible and direct quadrant because it contains assets which can be physically counted, unlike love which people experience, but find difficult to measure. This makes the linkage between health and faith a multi-level, complex, and dynamic phenomenon. This seems to concur with the World Health Organization's definition of health, which encompasses spiritual aspects of health. [111]

In Figure 1 above, the interconnectedness between health and faith seems to provide room to consider religious health assets as a means by which to understand the community health building process. Such religious health assets, both tangible and intangible, have a vital impact on health promoting and health sustaining qualities. At a time of threat and stress, these intangible qualities are important, since they have good measurable indicators like long life expectancy of a person, mental, and physical disease prevention and the development and maintenance of healthy practices.

As noted above, the determinants of health include physical, mental, social, cultural and spiritual factors. Different disciplines recognize all these different factors, but point to different methods of measuring the impact of these factors on health care. In Chapter 2, it was seen that the traditional way to assess performance uses the analytical paradigm which leaves out the contribution that many of these factors make towards health care success to a patient and the community, for example, religious or spiritual and also indirect factors to health care such as care. The religious or spiritual factor roots itself in the wholeness of a

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[110] Africa Religious Health Assets Programmes (ARHAP). Suite of Assessment Tools: A Framework model, Draft, University of Cape Town, March 2004.
[111] Derek Yach. "Health and Illness: The definition of World Health Organization". Source: www.medizin-ethik.chethik.ch/publik/healthillness.htm   Accessed: March 23rd, 2004.

person and even that of the community, which means that health and spirituality are no longer mutually exclusive. As such the outlook on life is integral to a new paradigm of assessing health care; which is *health outcomes* (Chapter 2). It looks at health care success in a proactive way rather than the traditional way; that is it approaches health assessment in a holistic manner. This makes room for all determinants of health to contribute to the well-being of a patient. It can be argued that it considers faith as a life-promoting factor, and as well as an asset for community health promotion. It is on this basis that we can locate a faith community, such as a local Church as a religious health asset, and consider its contribution to health to be vital to the community.

3.4 The local church as a religious health asset

Interventions on health promotion conducted in faith communities provide a promising opportunity to enhance emotional, physical and spiritual health. Churches have a strong foundation of caring, and can positively effect health behaviour changes in a safe, supportive environment. There are several reasons for their involvement in health promotion. These may include, first, churches have physical resources and spiritual influence that may not be available to other community organizations. Physical resources include large meeting facilities, groups of volunteers who value philanthropy, and media access. Spiritual influence is strong because churches are helping organizations by nature. Churches reach large numbers of entire families because they are community gathering centers for spiritual, social and cultural activities, and they are relatively stable and positive during the best and worst times. Significant life events, such as births, marriages, and deaths, center around the church. This makes the influence of the church significant because they can strongly influence health behaviour.

Second, churches are widely available to individuals of varying socio-economic status. The accessibility of the church enables church-based health promotion programmes (CBHPP) to reach individuals who are poor and underrepresented. It can also reach those individuals not accessible through health insurance, or school health promotion, or other means. Third, the

church can provide cost-effective services led by volunteers that are just as successful as those that are led by health professionals. The clergy, as the most influential members of the church community, have been highly receptive to CBHPP because most believe that spiritual and physical health are highly interrelated, and that health promotion activities are popular, so they have potential to attract new members or provide outreach opportunities. Examples include Archbishop Njongonkulu Ndungane and Bishop Kevin Dowling in their response to the challenges of AIDS.[112] Their acts provide opportunities for churches to bring order, meaning and purpose into the lives of people and communities, and assist communities in developing resources to improve health and well-being. This goes with establishing community norms and enforcing of community values through its organizational structure. It can be argued that these community norms and values form part of the church's assets which can be used to promote community health, thus making a church function as a religious health asset.

Recent research shows that the church continues to be a very important institution within a community.[113] The outcomes of this research reveal that the congregation's knowledge, skills, talents, gifts, attitudes, and values are important assets for promoting good healthy behaviors. The church's assets (as described above) can be aligned primarily to promote, restore or maintain health. Community-based health promotion ideally should reach an entire population. Places of worship like the church can reach out to serve effectively and efficiently often neglected, underserved populations within a context in which a healthy body, mind, and soul are equally valued. In a holistic approach to health, the mind, body, and spirit are intertwined, and every human experience has mind-body-spirit components.

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[112] Gideon Byamugisha, Lucy Y. Steinitz, Glen Williams and Phumzile Zondi, *Journeys of faith,* p.89.

[113] Gideon Byamugisha, Lucy Y. Steinitz, Glen Williams and Phumzile Zondi, *Journeys of faith,* p.106.
The authors write about various churches and Christian organizations in three southern African countries including South Africa response to the challenges of HIV/AIDS with imagination, courage and commitment based on their religious faith. For example, Hillcrest AIDS center near Durban under Methodist church, Orphan Haven of Tumelong mission established by Anglican Diocese of Pretoria, Duduza Care center, Ladysmith, KwaZulu-Natal, established by Catholic Church, and others.

Spirituality is an integral part of a person's well-being and is important when considering health promotion. Spiritual health provides a motivational factor in the difficult task of changing health behaviours and meeting the goals of health promotion programmes. In the language of assets, a spiritual health dimension can be considered as an intangible religious health assets (see Figure 1). When intangible RHAs are included in establishing new health behaviours and value systems, vital needs of the soul are met.

In each faith community such as a church, there may be a different rationale for reaching out to those in need, but in all faith communities there are tangible expressions of compassion. This compassion expresses itself in the multiple roles taken on as providers, consumers, contributors, and citizens (i.e. stewardship role). This makes the congregation realign their assets to take responsibility in the face of increasing crisis of health and HIV. For example, the St George's Anglican Cathedral, Cape Town congregation benefits from inter-faith services organized by TAC to raise AIDS awareness, and volunteers from this cathedral reach out to the community.[114] This is consistent with the asset-based approach to development, where people are at the center of any development initiative, both as medical and non-medical personnel who can be used to enhance health activities within the community.[115] This means that the congregation's gifts when identified can be utilized in community health promotion tasks.

Churches would certainly require strategic congregational strengths in bridging the schism between public health and personal care systems, a shared responsibility among health service providers and the operating domains of health systems. It is not only aligning these congregational strengths to accompany, pray, connect, endure, bless, convene, frame and give sanctuary, but it is also getting the churches and their leaders operating at boundaries to achieve better health[116,117] Congregational strengths seem not only to provide ways for

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[114] Byamugisha et al. *Journeys of faith,* p.91.
[115] Steve de Gruchy, "Asset-Based Community Development and the contribution of the church to community building", unpublished lecture notes.
[116] Susan Rans and Hilary Altman, *Asset-Based Strategies for Faith Communities*, p.111.
[117] Gary Gunderson, *Deeply woven roots*, p.22.

members to survive and receive, but also to grow and contribute to the health care system. This is because a healthy society needs a health system, where people's strengths can enhance communities to become healthy. The church can provide healthy system.

Community health would require modest medical professionals who would respect the integrity and knowledge of the poor, and their associations, because healthy communities believe in their abilities and assets as people who have the necessary capacities and information needed for designing and solving their problems. In a more significant way, the strength of the congregation to convene and to endure, offers an opportunity for the underprivileged to have a relevant understanding of community well-being as they seek access for health services.

As noted above the strength of the local church lies within its organizational structure and this is relevant for building community health. It can bring about meaning, hope and purpose to the creation amidst chaos. It connects people with one another in ways that multiply their power and effectiveness to account for community activities to achieve a long-term mission. Recognizing, mapping and mobilizing these clusters of local strengths, for example the power to bless, shows the power to say "yes" to where the future is emerging, and also the power to say "Not here."[118]

The strength of the church should encourage us to address a number of health-related disparities existing within the communities especially in the time of the AIDS crisis, where several approaches have emerged to address unmet needs in home-based health care and support services. One rapidly expanding approach involves volunteerism working through churches and faith-based organizations. Recognizing the unique capacities of congregations is important, because they are effective in delivering social services and they also offer material and volunteer infrastructure benefits for the good of the community. The congregation provides moral and spiritual capital to the community. The asset-based approach seems to recognize the congregation's assets, and its members' responsibility as

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[118] Gary Gunderson ."On Outcomes and Hope", p.66.

productive stewards in the world God made for them. This is because for Christians, Jesus Christ is the center of life. It would mean that Christian's ministry, development programmes, building, and very life as a church community should make a difference in the community. In essence, the church should be able to support strong and healthy individuals and communities.

At the same time, it should be recognized that because of issues of dignity, autonomy and confidentiality, there are many people who do not want to have their illness or vulnerability made known to the community or the church. In this context it becomes difficult to see the role that religious health assets can play in trying to embrace the triumvirate health concept of body, mind, and spirit. Thus, utilizing the assets, talents and gifts of the congregation to increase the effectiveness of its health activities is not as easy as it seems. It remains a hope, however, that the church can go beyond all these so that people can frame meaning in their lives and even rewrite shared narratives that give them hope.

It has been argued that community participation is essential in handling the challenge that is left mainly to them in the HIV/AIDS crisis. Gunderson explains that the congregation's (or community's) participation in more practical way expresses itself in the life-giving task of building the community through the congregation strength to: accompany, convene, connect, give sanctuary, context, bless, pray and persist.[119] It is through these strengths that we can see the great healing power of God working within our society, transforming it to a better place to live in. For example, the history of the South African community transformation from apartheid to democracy can give one a clear picture of community participation. This made Tutu picture the kind of South African communities making up society as being a: "caring, sharing, compassionate society."[120] This means that congregational involvement in community problems often brings healing of the soul, body and spirit.

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[119] Gary Gunderson, *Deeply woven roots*, p.22.
[120] Peter Barrett, "The quest for a uniting vision in South Africa- A question of beauty?" in the *Journal of Theology for Southern Africa*, Volume 119, July 2004, p.16.

The Church is embodied and at work in our homes, in the lives of Christians, and in the corporate expressions of the church locally, nationally, and internationally. Christians behave in the priesthood of all believers, and so all Christians are called to speak the word and to serve their neighbour in all of their daily relationships and activities. This means that the asset-based framework can be a tool to be used as Christians seek to minister in today's world. What this means to St Paul's Anglican Church is explored in Chapter 4.

CHAPTER FOUR

THE HEALTH ASSETS OF ST PAUL'S ANGLICAN CHURCH

4.0   Introduction

This chapter examines St Paul's Anglican Church's contribution to HIV prevention and care programmes in order that it might reduce the incidence and prevalence of the disease, based on developing and strengthening the congregation asset base within the communities of Pietermaritzburg. The data collected describes the outcomes of interviews, meetings, and brainstorming sessions. This now gives one the opportunity to evaluate the engagement of the church in HIV prevention and care in Pietermaritzburg in relation to the study theme. The present study will be examining the way this church makes use of existing resources and assets in the congregation to achieve positive health outcomes, and to enhance the general well-being of the congregation and/or community.

At the church, the congregation was interviewed to obtain information on health assets: skills, gifts, and talents (volunteerism). The data collected from the church consisted of the records of health promoting programmes, finance (budget reports), and vestry meetings

4.0   St Paul's Anglican Church

Within Pietermaritzburg, there are a number of religious institutions, which include the Anglican faith community. St Paul's Anglican Church is one of the faith communities situated in the city center, and is under the jurisdiction of the Church of the Province of Southern Africa (Anglican) within the Diocese of Natal. It is located between the corner of George Street and Longmarket Street in Pietermaritzburg, South Africa (see Figure 3 for a Map).

Figure 2: Map of study area within Pietermaritzburg

Extract from Pietermaritzburg city

KwaZulu-Natal

Pietermaritzburg

Eastern Cape

St. Paul's Anglican Church
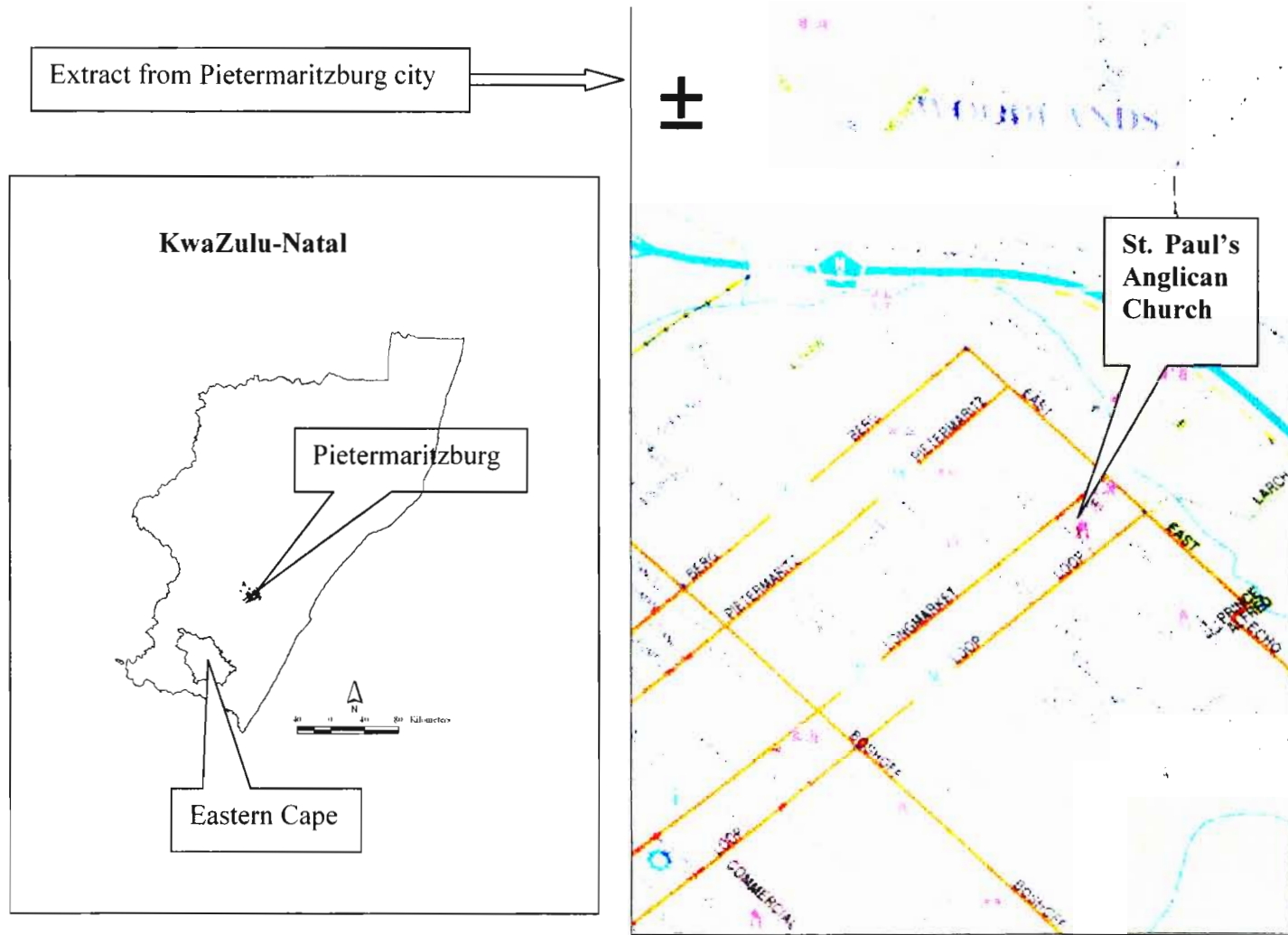
Built in 1894, it serves both the physical and spiritual needs of the Asian Anglican community in Pietermaritzburg. Writing in 1995, Alexander noted "the Anglican diocese of Natal was, and still is, divided along ethnic lines, with boundaries separating the Indians, the coloureds, the (Zulu-speaking) blacks and the whites."[121] Though it began as an Indian church, it has become a place of gradual healing of the hurt of past experiences. Different races are, to some extent, being integrated in the life and worship at this church, including foreigners who are either students, or doing business, or living in the city.

The legacy of history seems to have a significant impact on the development initiatives of the church as it aims to reach out to the community. This makes the congregation struggle to understand the fact that a church is a community of people with a common purpose, not only a place of worship but also a place where creating a healthy society takes place. The essence of calling it a congregation through which people assert their values of being human seems to lose it meaning as they engage themselves to meet the challenges of the AIDS crisis, poverty and unemployment in the city. For example, the congregation of St Paul's Anglican Church seems not to be challenged by these cutting edge issues which affect development practice from a Christian perspective when they do not even budget for their feeding programme. This is further discussed under the social ministry activity of the church (section 4.3).

4.1.1   Congregation structure

St Paul's Anglican Church began in humble way with a small number of worshippers, but has grown to a congregation with an estimated average weekly attendance of 150-200 under the leadership of the Reverend May Laban. The congregation comprises mostly women (both young and old), and there are few men in the church. The estimated structure of the congregation by age is 20% old people, 50% middle aged and 30% young and

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[121] Ronnie Alexander, "Indian clergy in the Anglican diocese of Natal" in Philippe Denis, (ed.), *The making of an indigenous clergy in Southern Africa,* (Pietermaritzburg: Cluster Publications, 1995), p.161.

children. In the language of development, this congregation should be an asset to the community because they have diverse talents, gifts and skills. The church, as an organization places considerable power in the hands of the local body of lay members even where the official polity invests authority in the hands of the clergy and this is often a remote hierarchy. This is seen through the Anglican tradition of Vestry where power radiates from and to the congregation through the hand-picked or elected lay members of the church. It is the laity who assist the priest in the running of some of the church activities, such as the weekly Wednesday prayer meetings, monthly Wednesday feeding programmes for the poor in the street, organizing outreaches and routine church meetings, choir practices, visiting the sick and bereaved families, counselling, organizing prayer meetings, secretarial work, bookkeeping, cleaning and maintaining the church building and fundraising planning programmes. But the full responsibility for all these activities lies with the Parish Priest, the Reverend May Laban, who is often assisted by foreign clergy students studying at the University of KwaZulu- Natal, Pietermaritzburg.

4.1.2 Socio-economic status of the congregation

The members who were interviewed have matric (or grade 12), but this does not mean that all the worshippers in the church are well educated.   The estimate shows that 10-20% of the worshippers of this church are unemployed. They can be characterized by high levels of socio-economic deprivation, and as having limited access to basic services such as health, education and employment. It is estimated that 60-70% of the worshippers are middle-income earners, with a further 10% are pensioners. Although the church has no record of the congregation's employment or educational status, there are some visible indicators such as a car, residential house, dress and others that can provide some guidance to judge a person's socio-economic status.

Church life has an important contribution to make to the socio-economic status of people. For example, the church advocates accountability, not only in financial terms, but also in moral terms. Good morals yield a good life. This tends to bring healing and wholeness into

the life of the people as they trust in their God. People begin to develop a relationship of trust and communication as they build social capital in which the disadvantaged members (unemployed and pensioners) find a connection to get access to socio-economic services. There have frequently been thanksgiving prayers for getting a new job or for the acquisition of a new vehicle among the congregation. This illustrates that members of the church often connect one another to social and economic opportunities, and even have projects where the unemployed and pensioners are kept busy in the church (see social ministry below).

This has made the worshippers consider the congregation to be not an occasional or adhoc meeting that requires intentional, regular assembly but a place where God invites them into a ministry. This is because they see themselves as people filled with talents, and assets, which are ever evolving (see Table 1). However, on deeper analysis they do not recognize, claim, develop, and share their God-given gifts with others outside the church, which in turn could invite others into God's given gift of grace that brings hope to humankind. The practice of participating in the sacrament in the Anglican tradition has the effect of making clear the sacredness of society.[122] This interaction amongst the worshippers has great influence on the socio-economic life of the church and the community, and this is a great asset for the (Anglican) Church life, which St Paul's Anglican Church must realize if it wants to bring hope to humanity.

4.2   St Paul's Anglican Church in the community

Whilst the church has the vision to reach the community with the gospel and social ministry, the focus of the social ministry seems to be fragile. The following are the reasons: firstly, because of the inadequate involvement of the congregation; secondly, the church has no documented plan for its social ministry. For example, the feeding project was conceived and born in an evangelistic meeting.

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[122] Martin E. Marty, "Health, Medicine and the Faith Traditions" in WH Foege and LJ O'Connell, *Healthy People 2000: A Role for American's Religious Communities,* (Chicago: The Park Ridge Center and The Carter Center, 1990), p.20.

4.2.1   The feeding project

The feeding project which is an avenue for reaching the community started in February 2002, after an evangelistic challenge to reach out to meet the needs of those outside the church. It is from this point that the Parish council decided that there should be a sit down meal for the street children instead of the handout, which used to be given to them. The church has continued to use this channel to reach the communities with God's mission of giving hope. It means that the worshippers not only come to worship and practise their faith, but also to extend their role beyond the place of worship to the community to provide some kind of social ministry to the disadvantaged groups of people within the city. It further means that the worshippers have to some extent a commitment to the project by praying for its success (see section 4.3 and 4.4). This they do in the face of a high level of need and limited formal health resources for those living positively with AIDS by providing care and supportive materials to them, and also feeding of the poor in the streets of Pietermaritzburg.[123]

The feeding project run by a few women volunteers in the church ensures that the poor, especially the street children and AIDS orphans, are fed once a month a Wednesday.[124] Like health professionals, St Paul's Anglican Church recognizes that a nutritional diet for the homeless is of great value. But the question one may ask is where do these street children get a meal for the rest of the days in the month as they wait for this particular Wednesday of the month? This question requires that the church recognizes and values these groups of people: the poor, the AIDS orphans and street children, as people made in God's image and who need more care and support. It is not good enough to provide assistance once a month to a hungry person while leaving him/her to continue trying to survive unaided until the next month for another meal.

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[123] St. Paul's Anglican Church warden's report 2003. Unpublished.
[124] The organizers of the feeding programme are familiar with the terminology "poor" which according to them means people who are helpless; and they need support. They use it to describe the street children, and old who come for a hot meal at the church.

Even though the support to run the project comes from the church's own members, the enthusiasm for the whole project is waning; firstly, in terms of financial support; secondly, the number of volunteers is decreasing; and thirdly, the language problem has made the mission focus become stagnant which cannot enable the volunteers to interact with the children. The effort of using nuns from the Cathedral of the Holy Nativity has not yielded good results in presenting the gospel to these disadvantaged groups. This has undermined the purpose or the goal of the project, which many in the church, including the researcher, have failed to understand from the initiators. It is in fact a struggling project which relies on the probability of funding and support because quite often an appeal is made in the church for the project. In interviews with members, it seems that the project has become a burden to some of the volunteers, but because of their faith and respect for their superiors they cannot complain of inadequate funding for the project. Despite all these problems, the project managed to collect and give the street children and AIDS orphans blankets to provide warmth for them during winter time.[125]

4.2.2   St Paul's Anglican Church and AIDS

Health activity, in particular HIV prevention and care, in St Paul's Anglican Church is fragmentary, in spite of the enormous assets it has. The church has both tangible assets (such as people, building space and finance), and intangible assets such as ability to care for the sick as revealed by the capacity inventory process. In the language of health terms both tangible and intangible assets constitute health assets, which are useful in enhancing the well-being of the community. The health promoting behaviour that the randomly selected participants exhibited included caring for the sick, in particularly those living positively with AIDS, the mentally ill, the physically disabled, children between ages of 1-13 years, and providing food for the disadvantaged people.

For St Paul's Anglican Church, holistic support should engage them in health activities to help the poor and those infected and affected by AIDS in the city. This has challenged the

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[125] *St Paul's Anglican Church: 110th Anniversary.* Brochure, 2004.

church to run a feeding programme on its premises for the street children and poor who basically depend on handouts from well-wishers they come across in the street. Yet as we have seen, the programme as described above is more of a relief programme than one which addresses the reality of HIV/AIDS pandemic within the community.

The engagement of the church in AIDS work is seen only in providing charity such as food and clothing to the orphans living in the Little Heart Foundation and Kyalisha in Pine street in the city, in promoting abstinence (i.e. faithfulness), and in spiritual support. This means that there are no intervention activities such as raising AIDS awareness and sensitization, voluntary counseling and testing campaigns (VCT), lifeskills training for the youth; resource mobilization specifically for AIDS' work, advocacy, and training of volunteers and outreach programmes for volunteers, and home care activities in the church programmme. In general terms both the feeding programme and AIDS support lacks theological-development, dialogical vision and organizational vision firstly, for the congregation and secondly, for the community. Although all these clearly explains the engagement of the church in humility, mercy and justice to the marginalized in the society, but the church would do better if it understands itself as religious health asset as articulated in section 3.4.

If one truly believes that all those infected and affected by AIDS need assets, that assets are shaped by all aspects of community, and that everyone in a community has something to offer, then it is difficult to think that one's work is defined by the walls of one's congregation, or by the boundaries of one's programmes. Asset building invites one to work with others to build the capacity of one's community to care for and contribute to the health care of those infected and affected by AIDS.

It is not easy for some churches to go beyond their walls and programmes because others in the community are viewed with suspicion. Some churches have different agendas and priorities from each other. Sometimes there is disagreement among and between churches. And sometimes one church is in competition with them for funding. One needs to move

away from these parochial battles, and find ways to work together, to find the common good, to talk with each other, to learn to respect and appreciate each other, even when there is disagreement on many things.

The asset-based framework offers one a tool of shared language and shared vision for many who are infected and affected by AIDS. Though, not well acknowledged, faith-based organizations can find in asset building common ground for recognizing that they have something to contribute to the lives of those infected and affected by AIDS.

In a time when the nation, province and district or the rural and urban areas are struggling with how to engage faith-based organizations as resources for society, asset building as a tool provides a shared vision for how a faith community (in particular the church) can participate in an authentic and meaningful way. If building assets is about building relationships, articulating shared values and norms, encouraging communities to take responsibility for those living with HIV, challenging policies and practices that are unjust, and valuing and caring for each and every person infected and affected with AIDS, then St Paul's Anglican Church has a great deal to offer.

St Paul's Anglican Church, if it recognizes itself as a religious heath asset, can play a vital role in *health outcomes*. As it has been noted above, this involves utilizing the community (or institution) assets effectively and efficiently to create good health outcomes. St Paul's church has the gift of trained, skilled and committed congregants, neighbourhoods, facilities and materials, leadership, linkages, and finances which can enhance *health outcomes*. The emerging assets profile and its significance to health and HIV care is important to assess the effectiveness of the church's health charity efforts to address the needs of those underserved in the city. As noted in Chapter 3, Kretzmann and McKnight suggest that there are three kinds of assets in a community namely, individuals, associations and institutions. Each in turn will be examined.

4.3 Assets of individual members of St Paul's Anglican Church

It is easy to see the assets of a professional such as a doctor, nurse, or teacher but it is so much more difficult to see the assets of an unemployed, disabled person or a pensioner. Yet it is essential to look beyond the dominant image of a needy person and to seek ways to encourage the use of gifts that people do have such as ability in music, art, crafts, driving, child-care, sharing, counseling, teaching, mentoring, and inspiring others.

In mapping the assets of individuals, four components of making a capacity inventory were considered: skills information, community skills, health-related skills and experiences; and personal information (i.e. name, address, phone number, age and gender). A congregational asset menu was designed with possible asset lists such as: community involvement, educational achievements, service to others, religious values, good health practices (exercise and nutrition), HIV programmes and others. With further definitions of some of these assets having been done, community involvement was refined as community assets which included: political campaigns, scouts (boys & girls), trips (field & camping), church associations/clubs, neighbourhood organizations; School-Parents associations; and sports teams (see details section 4.4). What the congregation can offer to the community is their individual gifts, talents and assets so as to encourage, heal and meet life's challenges rather than putting money first before helping in any way in the community. Hence a capacity inventory of any community is vital for any development initiative. The study reveals that the thirty randomly chosen participants from St Paul's Anglican Church have assets i.e. individual and community skills, and these assets embody in themselves health assets, which are useful for individual or community well-being. Sample characteristics of the assets can be as seen in Table 1 below.

These skills form individual or community assets and it is upon these skills that the livelihood of a community depends. This capacity inventory seems to reveal the life pattern of the participants. In Table 1 below; "other skills" represents the largest skills category. It could be that these skills are frequently being used by the participants as housekeeping

assets or survival assets: knitting, crocheting, dressmaking, sewing, tailoring, haircutting, assisting in a classroom, and moving furniture. This means that the congregation has tremendous potential to nurture faith and to do actual development work such as health care, education, housing and maintenance work (construction and repair works), create jobs with the disadvantaged groups of people and even for themselves because they have valuable gifts of trained, skilled and committed lay people. This should provide the impetus of engaging lay people correctly with ideas of what do to with their lives between Monday and Saturday, instead of constantly thinking that they can perform worship on a Sunday only. With these gifts, they can do a lot to help affected and infected communities in many ways. This is lacking in St Paul's Anglican Church. Out of 200 congregants, there were only 20 volunteers helping in the feeding project. Yet, these gifts can contribute tremendously to change the lives of vulnerable people who are constantly seeking a helping hand.

Table 1: Category of individual assets of some members of St Paul's Anglican Church.

Category of Assets	Emerging skills	Category of skills	Emerging skills
Office	taking phone messages	Transportation	driving light vehicle
			driving vehicle delivering
	receiving phone orders		goods
	entering information		general household
	into computer	Maintenance	cleaning
			planting and caring for
	operating calculator		gardens
	operating switch board		window washing
	keeping track of supplies		floor waxing or mopping
	typing (words per		washing and cleaning
	minute)		carpets
Construction and			pruning trees and
repair	painting		shrubbery
	wall papering	Others skills	knitting
	repairing locks		crocheting
	bricklaying and masonry		dressmaking
	plastering		sewing
	cleaning chimneys		tailoring
	furniture repairs		haircutting
Music	singing		assisting in classroom
	playing the organ		moving furniture
Security	ushering		

Source: Researcher

4.3.1   Community skills

Relationships do not occur in a vacuum. They form the essence of human existence. This relationship takes various shapes, sizes, forms and processes. The congregation relational model of St Paul's Anglican Church presents such a relationship process as community assets. Their involvement in community activities such as scouting, sports, church associations (e.g. youth groups, worship, feeding scheme committee, etc), neighbourhood organization, field and camping trips, School-Parents associations and political campaigns is important because it builds, strengthens and sustains *relationships* (see Figure 3). This is just a small sample, but their participation can go beyond this to include link with hospitals, universities, restaurants, libraries, small businesses etc. in the community as employees and employers in these places. It is this social capital building that improves the socio-economic life of people, and it allows them to be engaged in socio-economic activities. This emerged from the variety of community activities in which the respondents have participated. From the various activities, each respondent was limited to at least three best activities s/he had participated in.

Table 2: Frequency of Assets

Asset	St Paul's asset	
	Frequency	Percentage
	f	%
Political campaigns	3	03.30
Scouts (boys & girls)	9	10.00
Trips (field and camping)	15	16.70
Church activities	24	26.70
Neighbourhood organization	21	23.30
School-Parents association	12	13.30
Sports team	6	06.70
Total	90	100.00

In table 2, the frequency procedure provides the statistics and graphic display that is useful for describing many types of activities (variables) in the assets (or community skills) category.   Respondents are interested in church activities (26.7%), neighbourhood organizations (23.3%), trips (16.7%), School-Parents association (13.3%), scouts (10%), sports team (6.7%) and political campaigns (3.3%) respectively.

As seen in the above Table 2, the spiritual concern of this congregation seems to have little effect on community health, because they are more interested in their neighbourhood organization for various undefined reasons. It is further noted that the capability of the respondents to deal with the HIV crisis in the communities within which they are living is not evident. It could be that respondents in medium and high social support categories are much less likely to be sedentary than those in the no or low support categories. It means that some of them feel that physical or social support to vulnerable groups is not their concern. Research done by Chetty presents such as a claim among the Indian community where they feel HIV/AIDS is not their problem; which shows a lack of concern for the infected and affected communities.[126] This has a consequent effect on building community resilience through St Paul's Anglican Church for health and HIV care.

It is clear that attitude as denial and lack of concern for vulnerable groups as noted above contributes nothing to asset building and HIV prevention and care. Physical or social support can be considered as the strengths of the congregation to accompany, bless, give sanctuary, and connect the vulnerable groups in the society. This means that everyone pays attention to valuing vulnerable people including those living with AIDS. It further means that everyone, not just families and a few members of the congregation, starts becoming more articulate about positive values which are shared in a pluralistic society. Asset building calls one to reweave one's relationships and community so that those living with HIV are supported by a web of mutually reinforcing relationships and opportunities.

It should all start with one's personality. Knowing the power of assets, including religious health assets, is, by itself, an invitation to reflect on what each one does - or doesn't do – to contribute to vulnerable people's health care development. Thinking along the lines of race or ethnic group should change. The positive fact is that many of the congregation members are already doing many things to build assets, as seen in Figure 3, because many of them

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[126] Arumugam Perumal Chetty, *HIV/AIDS is not a threat to the Christian Indians of Northdale/Raisethorpe: Is this a myth? With special focus on identifying the absence of pastoral care for those infected and affected by HIV/AIDS in this suburb*, unpublished Masters thesis, (Pietermaritzburg: University of Natal, Pietermaritzburg, 2003), p.21.

belong to associations or clubs. The assets remind one of the importances of the everyday ways one shows love, sets boundaries, opens up new opportunities, encourages learning, and passes on values. They are all important elements to asset building. Regardless of our professional roles and responsibilities, we can each find large and small ways to be asset builders in the AIDS crisis.

Figure 3: Asset inventory for St Paul's Anglican Church
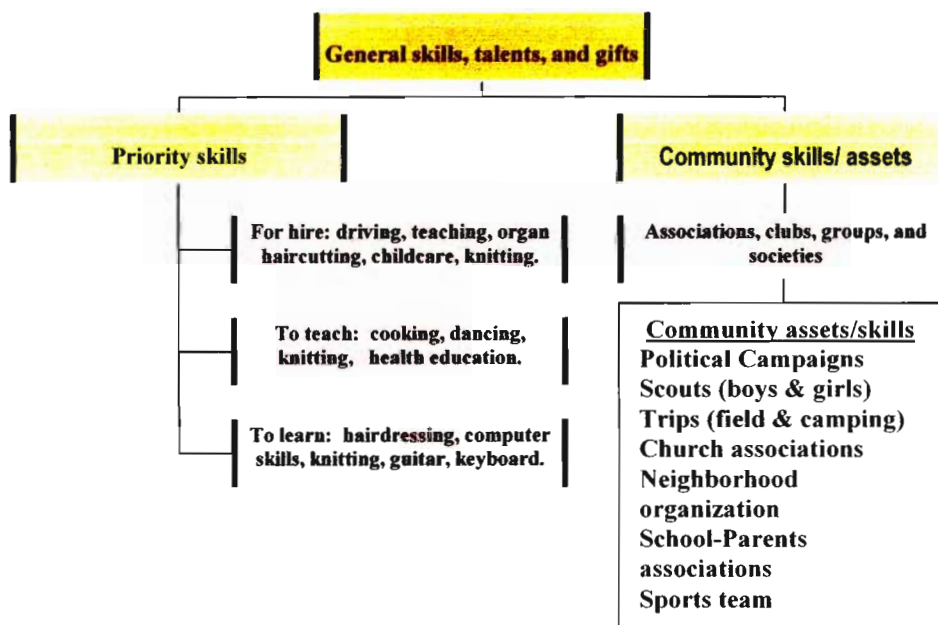
Source: Researcher

4.4   Assets of the church as an association

In all of this, there is an assumption that churches are important social assets that are not being fully leveraged. In an asset-oriented environment, many opportunities can be seized to promote the church as a source for community strength. Given this evolving interest in the church as a community asset, one can pay attention to role the church plays as an association in the community. Beyond what each one finds to do alone or in one's family, asset building invites each one of us in churches, organizations, and associations to examine how we nurture and care for vulnerable groups, specifically those living with AIDS. Although one's work as a church spans all sectors of community life, as a member

68

of a faith community, one is unique, but often overlooked, resource for asset building for health. From the asset building perspective, the church community can offer to those living with HIV...

- A sense of being welcomed, cared for, and valued;
- Multiple meaningful relationships with many caring volunteers and role models;
- A challenging, enriching environment for learning and growth;
- Clear boundaries about what is expected;
- Strong connections to friends and families;
- A sense of belonging in the intergenerational community of faith;
- The opportunity to educate and motivate people of all ages to see themselves as having a shared responsibility for affected and infected communities with AIDS, especially orphaned children, beyond their own family; and
- A prophetic voice that calls society to a shared responsibility for the development of health care and well-being of the affected and infected communities with AIDS.

It has been long known that at an individual level, connections, social participation, and supportive social relationships are good for a person's health. People do not just introduce one person to another; they bring a person into the web of associational life that can act as a powerful force in that person's life. As has been seen in Chapter 3, the strength of a church lies in the fact that as an association it can be physically present to pray, to bless, to care, to share stories, to mourn (or endure) and even to connect with others in times of crisis like this of AIDS. This is partly true with St Paul's Anglican Church, because of its prayer movements, youth groups, worship and praise groups, choir, parish council, lay ministers' group, feeding committee, and Sunday school: all these produce beneficial outcomes for the community's well-being. These groups represent the associational life of the church's closer association with the community (public) organizations. These groups bring thick webs of connections, which connect people into the web of community resources (both public and private) so that they can access services. In addition, connectedness is strongly linked with advocacy, community witness, and even protest. It is within the association that

advocacy can have meaning because it is the action towards people's care that often produces results.

Citing from *Health and Medicine in the Anglican Tradition,* Marty writes:

> No Anglican vision can require a particular set of priorities within health care. What it can demand is an acknowledgment of the public obligation. The church in its preaching and teaching can nurture an ideal life in which morality is accepted in hope and joy; it can be a community where service is offered in worship and at the bedside; and it can invest its monetary and human resources in the provision of care.[127]

In some communities, the church promotes physical and mental health for the community, as well as meeting the spiritual needs of the congregation. Historically, the church has played an important role as an advocate, encourager, and enabler of actions for advancement in the community. For example, the Anglican Church of South Africa has been at the center of some communities' social, political, economic, and educational functions. Church-based health promotion programmes can provide education, screenings, counseling, referrals, and group support for prevention of disease prevalent in the community population through its associations or clubs which exist within. This is demonstrated by the findings of this study that there is some degree of commitment by the church leaders of St Paul's Anglican Church and its few volunteers in the various association, for providing health support to the AIDS orphans and the poor in the streets of Pietermaritzburg. It can be argued that while these groups remain within the structure of the church, their ability to promote holistic health care is lacking, apart from pastoral care, food provision, and prayer to some selected orphanage homes in the city. This leaves a great gap of the church being at the center of connection to bring the needs and opportunities of the AIDS community into focus with governmental and other agencies.

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[127] Martin E. Marty, "Health, Medicine and the Faith Traditions," in WH Foege and L J O'Connell, *Healthy People 2000: A role for American's religious communities,* (Chicago: The Park Ridge Center and The Carter Center, 1990), p.20.

4.5   Assets of the church as an institution

Having examined the assets in St Paul's Anglican Church at both the individual and associational level, the third level of assets identified by Kretzmann and McKnight, namely, institutional assets will be examined.

4.5.1   Access to facilities

Resources provided by the church can facilitate health promotion programmes conducted in churches. The church has a direct connection with individuals within the community. Ethnically diverse people and minority individuals may feel alienated from traditional health promotion and preventive services, but feel comfortable in their place of worship. St Paul's Anglican Church is seen by some to promote the feelings of peace and care. Health care activities connected with the church often make services accessible and user friendly while providing better outcomes. When a church is divided along ethnic lines however it becomes difficult to reduce stigma and discrimination in the community. As a result of this not many non-Indians get access to St Paul's Anglican Church facilities nor are they aware of what the church is doing. Though the church has a space for workshops and seminars, the space is not hired by outsiders for conferences, which means its facilities do not attract public and private support.

4.5.2   Community-focused intervention

Churches are particularly effective in the promotion of community-focused health, since churches value helping people and value the spirit of volunteerism. With St Paul's Anglican Church, there is a huge, untapped, and valuable asset of trained, skilled and committed lay people who could be used for community health. But, there are now only six women volunteers who have devoted their time and energy to help to reach out to both the sick and street communities. This means that a widespread diffusion of health promotion can be

effected efficiently in the church when there is increased participation of its congregation in community-focused intervention.

4.5.3   Leadership

Church leaders need to value and demonstrate commitment to health promotion projects in order for the projects to be successful. St Paul's Anglican Church has the benefit of trained leadership in the person of the Rev Laban, who has a calling and desire to serve people. Clergy are respected by their congregation and can be an asset to health education and positive lifestyle changes in church members. The church as a faith-based center provides a model of caring in which the clergy can take an active role in assisting health care leaders to promote behaviour change that is necessary for health and the healing of mind, body, and soul. This is true with the Rev Laban, who is instrumental in St Paul's Anglican Church's engagement in AIDS work. The project is holistic: providing food and warm clothing as well as being spiritual in nature. Although she participates in the feeding project for the poor in the streets of Pietermaritzburg and AIDS affected persons, there is much more she could do to improve the project. This could include drawing up strategic health plans for the church, building partnerships between the church and health care providers in promoting positive health values in the community, counselling and training to improve this AIDS work. The strategic health plans open doors to train volunteers to promote health programmes in AIDS communities and within inner city dwellers where the church is located.

4.5.4   Linkage

Establishing collaborative linkage between the church and the Diocese and other organizations facilitates success in church-based programmes. In terms of health, the idea of linkage between health-related and religious institutions such as a church is not new. Churches and health care organizations have sometimes cooperated to implement health promotion programmes such as HIV/AIDS education, immunization and others,

particularly in vulnerable, underserved populations. Most church-based programmes have been administered within the community where the church is situated. Communities within which churches are located have been found to willingly participate in health promotion programmes to enhance the health of their congregations. Churches have a supportive influence on health promotion for individuals, groups, organizations, and entire communities. The findings of this study indicate that St Paul's Anglican Church apparently has no linkage with other organizations in relation to health promotion programmes. As such its engagement in AIDS programmes lacks theological and organizational vision (see Chapter 5). One could say that St Paul's Anglican Church lacks focus in the sense that it does not draw much attention from outside or inside the church.

The church is linked to the Diocese of Natal, Durban office and the Provincial office in Cape Town through its church ministry. The leadership of the diocese knows that churches are struggling to do something about the AIDS crisis in the diocese. Any financial support to run the AIDS programme and the feeding project does not come from either the diocese or the province. In broader terms, development activities of St Paul's Anglican Church have little to do with the diocesan support. An effort by the researcher to understand this gap was made by visiting the Suffrage Bishop's office to see if there was any organogram for the diocese so that the researcher could understand where social development activities of churches fitted into their other activities. But no information was available. It clearly demonstrated that there is an organizational problem which needs attention so that development linkages of various churches under the diocese can be made.

4.5.5 Economic power of the church

As an institution which receives and spends funds, the church can direct its purchases towards the community, rather than outside it. For example, the church spends money on buying food items for its feeding programme, altar flowers, office materials, on paying cleaners, on fuel and other minor items. However, the church has not been able to pool its resources with other organizations in order to create opportunities to expand its health

programmes; instead it has received money from organizations through it fundraising drive for its development activities.

Building community requires a different approach. It requires recognizing and respecting the strengths and capacities of others, even when one disagrees. It requires one to learn as much as one teaches, to listen as much as one talks. It requires that one goes onto people's turf, learns their language, and understands their world; and one invites them into one's or own world, too. In short, it requires that one takes time to be in mutual relationship with others, recognizing the common commitment one shares to the health care development in this time of AIDS crisis, even if one approaches it in different ways from other people.

4.6   Conclusion

The finding of this study shows that St Paul's Anglican Church is doing some small community work with its feeding project for the poor and AIDS orphans. Though small, it could have been a valuable instrument to reach the underserved populations in the city. The church as a community asset at individual, associational and institutional levels could have influence in the delivery of effective health promotion, prevention and care programmes, hence creating good *health outcomes*. It could have benefited a diverse population of individuals and neighbourhoods, and even reached groups of persons that other faith-based agencies and health care organizations may not be able to reach with health care services. Additionally, charity-based projects have the ability to focus on a wide range of health issues. These projects, when properly constructed, help individuals and families adopt healthier behaviours and attitudes, as well as assist persons in navigating health systems or obtaining appropriate referrals for care and support. Because St Paul's Anglican Church could have greater impact with its health promoting strategies, Chapter 5 suggests some principles which the church and other faith-based institutions, which are also struggling with their health work, can use in building good *health outcomes*.

CHAPTER FIVE

THE CONTRIBUTION OF RELIGIOUS HEALTH ASSETS TO HEALTH OUTCOMES

5.0   Introduction

As the challenges to community-based organizers and developers escalate, so also do the creative new responses, which community builders discover. Many of these organizers now recognize that rebuilding low and moderate income communities from the bottom up requires the mobilization and the participation of all of the assets at hand and that prominent among those assets are the religious institutions. At the same time, local religious leaders are recognizing that successful religious programmes rest on the rock of the well-being of the communities.

This chapter provides some theological and organizational principles as a guide to St Paul's Anglican Church and other religious institutions in their health care work. These principles present with a greater specificity their commitment to the guiding principles set out in the new approach to health assessment, the *health outcomes* in Chapter 2. The principles also provide the foundation for effective programming based on religious health assets, and the contribution of RHA to good *health outcomes* as outlined in Chapter 3. Some of these principles apply specifically to the work of St Paul's Anglican Church as a local church, while others are applicable to any faith-based organization that has engaged or may wish to engage in health-related activities, in particular the care for those living with HIV.

5.1   Organizational mission and management

Religious institutions including FBOs and local churches need to have an understanding of their mission and their stewardship responsibility (management). This would require having a clear mission, supported by strategic objectives and a statement of values that can

underpin their work. The principles underlying stewardship are vital in this case as religious institutions seek to use religious health assets to address the needs of health in the communities.[128] Effective use of assets begins with strategic planning, together with effective human resources and financial systems which are essential to ensure the success of a mission. Instead of looking for feel-good, quick fix solutions, St Paul's Anglican Church and other religious institutions might need to change long-term plans to focus seriously on those assets that can best be used to increase community health, and in particular caring for those living with HIV, through the promotion of behavioural changes. This will make them focus their time, energy and resources in areas which have been identified as being able to offer maximum benefit to the community.

5.2   Learning to accept strengths and weaknesses

Achieving behavioural change requires death and rebirth. To seek intimacy with the God who encounters us Christians in the person of the crucified Jesus is to accept our strengths and weakness as a corporate body of Christ, and as an individual who has a role to play in this world. Standing in solidarity with those infected/affected by AIDS, and even with the poor who cannot afford to meet health care costs; this is our humble journey of fearful vocation. Only when we go through this contemplative journey of dying and receiving new life, we can practice learning to accept our weakness and strengths. And we will also learn to accept those infected and affected by HIV/AIDS in our communities. This will give opportunities for those living with HIV to be involved in a variety of roles at different levels in our communities. This is exactly what St Paul's Anglican Church is expected to do in its effort to help those infected with and affected by HIV/AIDS.

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[128] George W. Trimble, (2nd ed.) *Stewardship: Managing God's resources*, (Durban: The Methodist Church of Southern Africa, 1999), p.1.

5.3   Breaking the silence

One needs to break the silence surrounding the subject of HIV/AIDS, which often leads to stigma and discrimination. The faith community could continue to raise its voice against these kinds of attitudes if it wants to have a healthy community, as God desires for the faith community. Where silence has been broken, progress has been made. For example, "the experience of a country like Uganda demonstrates that when the culture of silence is broken, combined with strong leadership and comprehensive plans to combat HIV/AIDS, the spiraling new infection rates can be reversed."[129] This makes faith-based programmes non-discriminatory, accessible and equitable to both individuals and communities. It further reminds us that a church, like St Paul's Anglican Church has social workers, counsellors, dieticians, doctors and nurses, who have assets that can be used to break the silence. The outpouring of love and support as a church, as individuals and as a congregation keep many people going through the most difficult first few months of mourning for the loved ones who has died of AIDS. This brings real hope in their lives.

5.4   Access and equity

Accessibility of services alone is not enough to respond to the diverse needs of those living with HIV and affected communities. Programmes that are generic in nature often reflect and entrench social inequities. To ensure access and equity, programmes need to be tailored to meet the particular needs of those infected and affected, depending on the context of population vulnerability. For example, HIV prevention programmes for men and women, need to address gender stereotypes, norms, attitudes and practices in order to address underlying gender inequities that increase the vulnerability of women and girls to HIV infection.

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[129] Church Mission Society (UK). "Action against AIDS", (London: Church Mission Society Publication, 2003), p.3.
Source: www.cms-uk.org   Accessed: 30th July 2003.

The faith-based programmes need to create an enabling environment of being respectful to the culture of individuals, minorities, peoples and communities, and of being sensitive to gender and family planning requirements. For example, regarding the usage of condoms, Richey writes, "men in Tanzania, as elsewhere (including South African men), often make the final decision on condom usage, and men are almost universally absent from family planning clinics."[130] As matter of fact, equity of and access to services and programmes are best achieved by actively involving women, even those infected with and affected by AIDS, not only in the designing and delivering of programmes, but also in a wide variety of roles within religious institutions and community-based organizations. Thus creating such an enabling environment will empower them to be agents of their lives. St Paul's Anglican Church needs to refocus its attention on improving its programmes so that many vulnerable groups can access them.

5.5 Advocacy

Religious institutions need to advocate an enabling environment that protects and promotes the rights of people infected and affected in the communities, and religious institutions need to support effective programming. They play a vital role in vision-casting and facilitating development of the congregation and the community ministry. They can pursue a listening, learning, consulting and information-gathering approach.[131] This can draw more human resources from various backgrounds to participate in the planning, monitoring and evaluating process for outreach (advocacy) programmes of the church, as they focus together on creating and sustaining an environment where laws and public policy protect and promote the rights of those living with HIV and affected communities with effective programmes that reduce the vulnerability to HIV/AIDS. In this way the religious institutions such as St Paul's Anglican Church can develop a sense of responsibility for

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[130] Lisa Ann Rickey, "HIV/AIDS in the shadows of reproductive health interventions," in the *Reproductive Health Matters* 11 (22):30-35, 2003, p.32.
[131] Dan and Kathleen Sheffield, "Ubunye church and community ministries," in T. Yamamori, Bryant L. Myers and K.L. Luscombe, (ed.), *Serving with the urban poor*, (Monrovia: MARC Publications, 1998), p.46.

their various church activities to be undertaken willingly and voluntarily by its congregation. Successful advocacy depends on identifying the assets of the congregation so that people are placed in the right place to advocate, with the right message, to the right audience. This is what St Paul's Anglican Church needs to do and this could lead to identifying the right people for the task ahead.

As the congregation becomes more involved in the work, comprehensive volunteer training could be undertaken. However, the challenge that lies in advocacy work is the monitoring and evaluating of advocacy programmes. It is difficult to measure the changes in social norms and laws, whether religious or public, in advocacy efforts. But this should not stop one from advocating for the protection and promotion of the rights of those living with HIV and affected communities.

5.6   AIDS as a discipleship issue

HIV/AIDS is not only a health issue, but it is also a socio-economic issue. Health is related to the economy and individual wealth. People need good nutrition to maintain their immune systems, which protects them from AIDS-related illness: Drugs used to prolong the quality of life for people living with AIDS are costly, so poverty associated issues such as the high level of unemployment, crime, and illiteracy need attention. Thus, AIDS is an issue of social justice. St Paul's Anglican Church, though on the right track, needs to move a few more steps in its feeding programme to address the real issues of people who are at risk. The most vulnerable are the young people. Building community resilience will require St Paul's Anglican Church to engage itself with these young people at an early stage so that as they mature, they can endure the unpredictable difficulties that all humans experience. This then becomes the mission of concern as the church; and it will enable the congregation to help stem the tide of the AIDS pandemic. Creativity in presenting the message about lifestyle leads one to be multidimensional – through the use of material, psychological and spiritual approaches to the young people.

The psychological goal could be used to increase the feelings of value, self-efficacy and control through consciousness raising and analysis of the forces that have reinforced vulnerability in the past. With renewed vision for their future, the vulnerable can begin to embrace new possibilities for themselves and their communities. A spiritual approach leads to the realization of one's worth, a direct relationship with God, and a belief that behavioural change is possible which requires a change of values and attitudes.

5.7   Information, education and communication materials

Behaviour change requires much more knowledge and providing awareness on HIV/AIDS. People need information and education to stop them from being infected with AIDS. They also need information and education about contagious diseases. The church needs to change its focus in designing and translating information materials from being those of information-for-decisions to those of behaviour-influencing kind; with a primary aim of influencing people to make the desired change.[132] This could help to reduce the incidence and prevalence of HIV/AIDS within the community. Most of the present HIV/AIDS IEC materials: pamphlets, newsletters, stickers, leaflets and posters, to mention are few, have little to do with religious values. If one wants to influence behaviour changes one needs to have "spent time on our knowledge of people (e.g. trained theologians) to improve standards, processes and systems; which is rewarding to the society."[133] Where people are unable to read, one could develop religious audio tapes in the local dialect which could be used over community public address systems, as well as video tapes which could be shown at community meetings. This would take the message closer to the people and widen the target group. St Paul's Anglican Church could engage the vulnerable group its feeds to create ways to develop informational materials. The youth group and the Sunday school children have a lot to present to the congregation and community in their creative drawings and writings. That is what the church could develop.

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[132] Tony Hope and Jeremy Hope, *Transforming the bottom line: managing performance with real numbers,* (Boston, Massachusetts: Harvard Business school Press, 1999), p.185.
[133] Tony Hope and Jeremy Hope, *Transforming the bottom line*, p.185.

5.8   Access to barrier methods of prevention

The Anglican Archbishop of Southern Africa, Njongonkulu Ndungane, has said the following about getting access to methods of HIV/AIDS prevention: "The church must teach and promote faithfulness, (but)…the use of condoms must be promoted. Our vocation is to save souls, but we must also save lives."[134] Some Christians are against the use of condoms as a preventive measure for AIDS, but it could be seen as being the same as not using nets to avoid a bite from anopheles mosquitoes which spreads malaria. This should not raise an argument, but the reality is that condoms help those who cannot do without sex for long. Building behavioural change does not happen overnight. The concern needs to aim at increasing wider accessibility and consistent use of condoms as a strategic prevention approach. One could do this by directing the congregation to the relevant health centers for advice and support. More still, the church leader of St Paul's Anglican Church could learn to speak openly to her congregation about the use of condoms. There are people within the congregation who need to hear the church's stand on condom use.

5.9   Creating an enabling environment

Non-governmental organizations, including religious institutions, are playing an important role in health issues within communities. The social environment constructed through public policy efforts has been recognized as playing a role "in trying to prevent the spread of HIV/AIDS through achieving behaviour change."[135] This offers an enabling environment for home care, support and networking for sustainable behaviour change. The strategy is aimed at enhancing the healing process for those infected by and affected with AIDS, and also aimed at incorporating an appropriate home health plan that addresses the needs of the infected person. The healing process in the spirit of *ubunye* (a Zulu word meaning unity, together, harmony) can improve community health as the importance of intangible assets within religious institutions is recognized.

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[134] Church Mission Society (UK). "Action against AIDS", p.9.
[135] Matthew Clarke. "Achieving behaviour change", p.625.

5.10   Scaling up

The devastating impact of HIV/AIDS on communities needs a sustained response of sufficient scale that can affect the dynamics of the epidemic. The scaling up response needs to be a significant priority for communities where prevalence is low and where it is still possible to prevent epidemics from spiraling out of control.

As much as there are a number of institutions providing home care and support around Pietermartzburg, the challenge is that many of these programmes have yet to become comprehensive in their coverage. Much more has to be done in mainstreaming HIV/AIDS in order to respond more effectively to the causes and consequences of HIV/AIDS. Scaling up can be readily applied to existing HIV/AIDS programmes, and to integrating HIV/AIDS work into health and other related programming, such as development and humanitarian programmes. This is ideally what St Paul's Anglican Church should have done. However, it can still refocus its programmes.

There is much that can be learned from smaller scale initiatives that have wider relevance and application. Uganda and Thailand offer a national and co-coordinated response to the scaling up process.[136] In South Africa, a good example of the health benefits may be found among Zionist African Initiated Churches.[137] Scaling up faith-based programmes is complex. It is critical to recognize and address the new challenges involved in the process of scaling up. Resources need to be made available in a manner that supports the complexity of the process. Careful planning is needed to determine what programmes are capable of being scaled up, given the nature of the epidemic in a given context. A home-based resource approach (i.e. asset–based) would be sufficient, but it might need additional resources from outside to boost the scaling up programme. Broader community

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[136] Lilani Kumaranayake and Charlotte Watts. "HIV/AIDS prevention and care interventions in Sub-Saharan Africa: An econometric analysis of the costs of scale-up" in *The South African Journal of Economics,* 68(5):1012-1032, December 2000, p.1013.

[137] Jim Cochrane. "Religion as Social Capital in the context of health: Mapping the field" in *African Religious Health Assets Programme Colloquium,* (Pietermaritzburg: University of Natal, 2003), p.44.

programmes such as health clubs and associations within religious institutions, like St Paul's Anglican Church, can scale up health and HIV/AIDS activities. For example, the Mothers' Union groups in Anglican churches would not require many resources in the scaling up process.

In similar manner, the assets of individuals of St Paul's Anglican Church identified in Table 1 have significant contribution to scaling up process if properly planned and utilized by the church. The driving skills, for example, can speed up the transportation of the sick to the health centres. In addition to this "pick up point" can be established by the church for these drivers to get information about the sick so that they can assist the sick, particularly those living with HIV. It is the responsibility of the church to manage this place because it has a body of volunteers, telephone services; space to keep the sick for a while and its position is strategic for road networks and health services connections.

Voluntary skills and talents development can be started by the church for those living with HIV and the poor in the street instead of providing them with hand-outs of food and clothing. The individuals who have the gifts, skills and talents of painting, repair works, knitting, crocheting, sewing and sing can teach those living with HIV and the poor in the street. This can empower them to be good citizens instead of underrating their ability to function as useful citizens. Such a scaling process embodies in itself a hope for better living because it has the strength to re-orient the minds of those living with HIV and street people, as they see themselves participating in a learning process. This process could make them fit in society with more ease because they can to some extent pay for their medical bills and also buy some handy items for themselves.

In general, the scale up process aims at balancing the need to maintain community ownership of the HIV/AIDS prevention efforts by government and institutions and a realistic assessment of the capacity of the organizations to scale up.

5.11   Research

Religious institutions need to undertake and/or advocate for adequate and appropriate research to ensure that the responses to HIV/AIDS are informed by evidence. The results of good quality, appropriate and up to date research data can guide religious institutions' actions to enable an effective response to HIV/AIDS. Research must be interdisciplinary, such as that of epidemiological and community-based research, (CBR), or social and behavioural, or basic and clinical trials and other programmes that can help in advancing the research on causation, prevention and treating of the disease. A successful experience of community-building against HIV/AIDS could require a small epidemiological study undertaken with the community members and for the community. Haddad explains the importance of, "Community education and participation (agency) as well as acknowledging, and recognizing their cultural, socio-economic, gender, and religious factors may fuel the epidemic."[138] In this regard culture, sexuality and agency (of the community) are important factors in preventing HIV/AIDS.[139]

It would seem that "linking the research to community-based organizations, parallel calls for AIDS interventions themselves to be community-based."[140] A successful community-based research model seems to depend on care, improvement and learning.[141] The model built on care seems to recognize that "development of partnerships takes into account

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[138]Beverley Haddad. "Synergies between bio-medical and social science in the context of HIV/AIDS" in *African Religious Health Assets Programme Colloquium,* (Pietermartzburg: University of Natal, August 2003), p.24.

[139] Ida Susser and Zena Stein. "Culture, Sexuality, and Women's Agency in the Prevention of HIV/AIDS in Southern Africa" in Ezekiel Kalipeni, Susan Craddock, Joseph R Oppong, and Jayati Ghosh. *HIV/AIDS in Africa: Beyond Epidemiology,*(Cowley Road, Oxford: Blackwell Publishing Limited, 2004), p.133-135.

[140] Carolyn Baylies. "Community-Based Research on AIDS in the Context of Global Inequalities-Making a virtue of necessity? in Ezekiel Kalipeni, Susan Craddock, Joseph R Oppong, and Jayati Ghosh. *HIV/AIDS in Africa: Beyond Epidemiology,*(Cowley Road, Oxford: Blackwell Publishing Limited, 2004), p.230.

[141] Claudia R. Baquet, MD, MPH; Olivia Carter-Pokras, PhD; and Barbara Bengen-Selter, MA, MBA. "Health care Disparities and Models for Change" in *The American journal of Managed care,*10:.5-11, September 2004, p.6.

community resources and policies" for health.[142] It further acknowledges that communities have both tangible and intangible assets, which are useful for reducing health disparities and for HIV prevention and care programmes. Certainly, the insights, perspectives, rituals and symbols of the community contribute a lot to the very vision of the future that is being sought by them i.e. a vision of having a healthy community. With adequate social opportunities, individuals in the communities can effectively shape their destinies and help each other with the health care crisis.

5.12   Conclusion

Several advantages come with implementing a health-related programme within a faith community. Broadly as neighbourhoods decline many businesses, including health care organizations, tend to move away from these communities. However, places of worship usually remain in these distressed neighbourhoods and exist as ideal agencies to reach uninsured and underserved populations. Beyond their involvement in existing health activities, churches and other faith-based institutions have much to offer to health promotion planners: they have credibility and roots in urban low income communities. In many devastated neighbourhoods, churches are among the most established community institutions, having served several generations of parishioners and non-parishioners with their charity services. Additionally, faith communities have assets (both tangible and intangible) that can benefit health-related programming, including facilities, volunteers, and an extended tradition of health ministry, outreach and support.

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[142] Baquet et al. "Health care Disparities and Models for Change", p.7.

CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.0   Summary

In summary, the potential of religious communities to provide resources that can enhance the quality and length of life people enjoy is vast. This is seen clearly when religious congregations are willing to face squarely the need to become involved in health care ministries, and they are willing to accept the challenge of being involved, which is line with theme of this study: "Religious assets, health outcomes and HIV/AIDS: a challenge and an opportunity for St Paul's Anglican Church, Pietermaritzburg." Even more importantly, congregations must understand they have a special role to play as a religious community and they have distinctive resources and assets to offer in responding to the challenges of health care and the HIV/AIDS pandemic. The potential for providing resources has wide implications, particularly in HIV/AIDS prevention and care, where cost effectiveness is at premium and where reaching large numbers of individuals in many communities is a necessity.

As was noted in previous chapters, the establishment of health promotion programmes assures long-term maintenance of the desired behaviour changes with the potent social support networks churches may offer. Few other institutions in society allow such convenient access to entire families as do churches. Thus, the positive behaviour change being advocated for the primary prevention of chronic diseases (including HIV/AIDS) that require major socio-economic support and other types of proximal environment change should find churches to be the appropriate catalysts of change, not just religious institutions, as they are narrowly understood to be at present.

Chapter 2 makes an attempt to explain the difficulties of assessing health care activity in time of AIDS. It was noted that traditional methods measuring health have pitfalls. This can

centuries: the resource of faith - embedded in their individual, associational and institutional assets (Chapters 3 and 4). This makes a great contribution in influencing *health outcomes* as we have seen in Chapter 5. The chapter presented the key elements that facilitate Church-based health promotion programmes (CBHPP) but notes that evidence-based health promotion interventions in churches remain sporadically implemented. Various reasons exist as to why church-based interventions have been hampered. This study, for example, seems to demonstrate that there has been little research into health-based activities in faith-based communities, in particular the Anglican community in Pietermaritzburg. In spite of barriers, church-based health promotion programmes continue to hold promise in enhancing the health behaviours of diverse populations.

The number of CBHPPs continues to grow. Although CBHPPs are making some progress in the time of AIDS, the assessments of these programmes have often not been properly recorded and as a result the outcomes of these programmes are either unknown or vague. Despite CBHPP limitations, the research has shown that health promotion and prevention and care activities established in faith communities could be effective at addressing a range of health behaviours and diseases, including HIV/AIDS using the *health outcomes* principle. The *health outcomes* principle offers holistic foundation based on assets and has a spiritual message to encourage behaviour change.

When the *health outcomes* programmes are designed well, they can promote physical and social support activity within the context of existing church groups by utilizing the congregation's assets and church structure for successful CBHPP. The key elements to promote success in CBHPPs are partnerships, availability of services, positive health values, community-focused interventions, access to facilities, and supportive relationships (Chapter 4). Applying these key elements to the *health outcomes* programme, partnerships will exist between clergy, church leaders, and community outreach programmes. It will in turn enforce the theological-development dialogue and organizational vision of the church for health care and HIV prevention and care, not only in Pietermaritzburg but the whole of South Africa (Chapter 5).

only be addressed with a new approach using *health outcomes*. It measures: good practice, increases accountability of services, and quantifies the values of interventions where traditional research data may be impractical or lacking. It even assists in determining resource allocations and helps to monitor and improve standards of care, thus making it holistic in approaching health care and HIV/AIDS assessment. This gives an opportunity for religious assets to be used in assessing health programmes. It means that religious communities ought to have as a core concern the existing health care disparities and the AIDS pandemic as they advocate for justice in the distribution of health care services. Gunderson writes:

> Brokenness draws God's attention. Broken communities, bones, promises, families, hearts, nature systems, and cycles draw god's attention. ....eyes of faith recognizes brokenness as the incompleteness that will be made whole one day.[143]

Health care would appear to be an entirely new arena of ministry for the vast majority of congregations; but congregations can discover the new opportunities the current crisis in health care represents by becoming expert at what they do best, namely, ministering and serving. Chapters 3 and 4 have presented an argument as to how a congregationally based ministry can be created for health care - and specifically HIV prevention and care - using religious assets at: individual, associational and institutional level of a local church. Many congregation members share a climate of concern without realizing it. In fact, health care activities may be the most significant inadvertent activity occurring in the congregations today, if the congregation members know their responsibility. These chapters 3 and 4 argue that this could intentionally move health care activities to the centre of the congregation's life and surrounding communities, and at the same time enhance church-based health promotion programmes effectively.

More than any other institution in our society, the local congregation has a claim and a call to minister to people in need. The single most distinctive resources the modern congregation can offer is the same resource that has served the healing process for

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[143] Gary Gunderson. *Deeply woven roots*, p.122-123.

6.1   Conclusion

In conclusion, church-based health promotion programmes can effectively encourage health behaviours within certain communities. To promote health and wellness in light of our diverse society and health needs in a time of AIDS, health promotion professionals and churches can be partners. Communities without access to or resources for traditional health promotion programmmes may benefit the most from CBHPPs. Successful CBHPPs have been found to have utilized congregational assets to leverage the health programmes. These assets can be simultaneously incorporated into new health programmmes of the church to foster future success in promoting health behavioural change. In general, unless faith-based organizations, such as St Paul's Anglican Church consider themselves to be a community asset, and specifically a religious health asset, then they will loose the possibilities of contributing effectively in delivering health-related programmes, in particular in the time of AIDS.

6.2   RECOMMENDATIONS

The findings of this study could fuel broader use of assets measures in multiple settings for serving the community. Nonetheless, the congregation asset survey presents an important initial step toward establishing a standard, valid measure of the congregation's assets that could help to focus on the health care and HIV care problems. This means that the elements of successful religious health assets could be recommended for simultaneous incorporation into church's programmes to foster future success in promoting health behaviour changes in time of AIDS. It would require research, practice and continuous education as future recommendations.

6.2.1   Research

Future research could compare the effectiveness of health interventions through local faith communities, like St Paul's Anglican Church and other faith community areas. Programme

evaluation of the effectiveness of interventions needs to be done, factoring in costs to the congregation and the community. Effective programmes would encourage ongoing funding for the health-education and disease-prevention components of the ministry. Evaluation and community intervention studies with faith communities need to become a high priority in public health and in health ministry. Using valid instruments such as Participatory Rural Appraisal (PRA) tools or similar community/congregation interaction type exercises to establish best practices and reports could strengthen the interventions. Additional training, increased emphasis on documentation, and outcome identification and evaluation will be necessary for congregational ministries to examine the effectiveness of their interventions. This will encourage an increasing focus in the evolving practice. Interesting areas of research could involve investigating questions about quality of life and religious health assets, spirituality in health and healing, and health care practices within a religious community.

6.2.2   Practice

The success of theological and organizational principles as a guide for better practices for religious institutions involved in health programmes could be promoted (chapter 5). Recommendations for advancing the practice could include more-systematic communication between the volunteers, clergy (s) and health collaborators in the community. This will engage all parties involved in health programmes to discuss factors affecting health service delivery, in particular HIV interventions strategies. The theological programmes could assume a pivotal role in supporting health programmes. Developing and using financial resources, updates on best practices in health promotion and education, and evaluation strategies and processes are ways that would support the developing practice. As a Christian, one needs to develop a good attitude towards those living with HIV with an understanding that:

> Life is like a long-distance car trip, with detours, potholes, intermittent audio reception, strange sounds under the hood, and the eventual need to replace worn parts. But there are road maps to plan trips, gauges to monitor engine performance, and trained mechanics to fix problems.

(However), Life itself has no maps no gauges expert internal emotional reactions, and no skilled life technicians to call in when lives goes awry. Instead, people have each other. And people try, as best they can, to help each other maintain a spirit of love and laughter when hitting bumps in the road and to pull each other out when they roll into ditches,(as the Good Samaritan did.)[144]

Thus a congregation's participation in life-giving tasks depends in the most practical way possible through recognizing their unique capacities or strengths for delivering effective health services as they offer material and volunteer benefits for the good of the community. The congregation could provide moral and spiritual capital to the community since they have the strength to "accompany, convene, and connect. They have the ability to give sanctuary and context and even to bless, to pray and to persist" in times joy, trouble, disease and death.[145] Through this practice, the vulnerable could see the great healing power of God working within their lives and environment - transforming it to better place to live in.

6.2.3 Education

HIV/AIDS presents the church with its uniqueness in competence, an opportunity to respond, addressing the spiritual, physical, mental, social and emotional needs of those infected and affected by HIV/AIDS. The position of the church in the community and its Christ-like endowments should ideally let it be what God intended it to be in the hurting world. There are various reasons as to why the church is uniquely positioned to serve the spiritual and physical needs of people infected and affected with HIV within their community including those noted in chapter 5. But this section emphasis the fact that continuing education for religious leaders, and volunteer members of health ministry could continue, with the interdisciplinary, interdenominational approach using a variety of media. Offering education in pastoral counseling and lay ministry for volunteers of the health ministry teams could strengthen preparation for roles in the congregation and wider

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[144] Clyde Hendricks and Susan S. Hendricks (ed.). *Close relationships: A sourcebook*, (London: Sage Publications, Inc., 2000), p.285.
[145] Gary Gunderson. *Deeply woven roots*, p.22.

community. The official preparation course for health and HIV/AIDS volunteers is an essential beginning for this developing practice area. Interdisciplinary learning experiences for volunteers and recruitment volunteers from faith communities for health professions are ways that volunteers and educators could become involved in health ministry.

In addition, education takes various forms, either formal or informal. Health education as health information is all people need to be healthy in their communities. Godlee et al. argue that although people are in revolutionary information age, there is little if any evidence of major successful health information achieved in the developing world.[146] Reliable and usable information to improve community health services would require cooperation among health care providers like the church which has diverse assets of people, infrastructure and others to communicate health education. Lack of health education can be compared to a lack of drugs and infrastructure to run health services. Prevention is better than cure which is necessity for the vulnerable. This made Shisana et al. to argue that an information gap is a barrier to dissemination of health and HIV/AIDS programmes for the communities.[147]

Although, there are challenges to providing continuing health education which might be because of a lack of understanding about how various actors are working together more effectively, this could be solved through collaboration and consultation. The church could champion this campaign of improving education system through its liturgy, hymns, prayers and sermons. This makes the vulnerable to understand health education in their own language and develop a correct interpretation for their lives, hence creating the potential benefits of reaching the sick/patients and populations at the centre of health care services. John the apostle writes "Dear friends, I pray that you may enjoy good health and that all may go well with you, even as your soul is getting along well" (3John 2). This means that

[146] Fiona Godlee, Neil Pakenham, Dan Ncayiyana, Barbara Cohen, and Abel Packer. "Public health: Can we achieve health information for all by 2015?" in *The Lancet* 364: 295-300, 2004. Source: www.elsevier.com   Accessed on 30/10/2004.
[147] Olive et al. *Nelson Mandela/HSRC Study of HIV/AIDS,* p.88.

learning programmes for health and HIV/AIDS needs to build the soul, mind and body of a person in order to create a healthy society.

It's is not impossible to have thousands of congregations working alongside public health structures, sharing an understanding that health is a seamless whole – physical, mental, social, spiritual because church based health promotion programmes have a positive effect on individual and community health. Respect and "limited domain" collaborations are ways that faith communities and health agencies may partner to address common goals. Additional efforts to evaluate, collaborate, and communicate could strengthen effectiveness of programmes.

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Questionnaire

Religious assets, health outcomes and HIV/AIDS care in religious institutions in Pietermaritzburg.

Hello, I am ....I am a student from University of KwaZulu-Natal, doing Theology and Development. I am requesting you to participate in this survey of skills, talents, gifts, resources and assets of this congregation. If you can assist, please can you answer few of these questions that should not take much of your time?

You are not required to give your name and all information is confidential and anonymous. Should you not wish to answer any of the questions, please indicate this to me. The responses to these questions will be captured with the responses of 50 other participants in the survey and the data will be analysed and interpreted for Master thesis of Theology and Development research report.

A. General

1. Please indicate in which area you live.

Northdale	
Scottsville	
Central	
Imbala	

2. Are you?

Male	
Female	

3. Is your age?

16-24	
25-34	
35-44	
45-54	
55-64	
65+	

4. Population group

Black	
Coloured	
Asian	
White	

5. What is your martial status?

Single	
Married	
Widow	
Divorced	

6. Are you presently studying or learning any skills?

Yes	
No	

7. What is your highest educational qualification?

Non-schooling	
Primary school	
Secondary school	
Matric	
Post-matric	

B. Skills information

Now I'm going to read to you a list of skills. It's an extensive list, so I hope you'll bear with me. I'll read the skills and you say "yes" whenever we get to one you have. I am interested in all your skills and abilities. They may have been learned through experience in the home or with your family. They may be skills you've learned at church or in the community. They may also be skills you have learned on the job.

Health

Caring for the elderly	
Caring for the mentally ill	
Caring for the sick including HIV+ person	
Caring for the physical disabled	

Now, I would like to know the kind of care you provided.

Bathing	
Feeding	
Preparing special diets	
Exercising and escorting	
Grooming (cleaning, massaging etc.)	
Dressing	
Making the person feel at ease	

Office

Typing (words per minute_____)	
Operating adding machine/ calculator	
Taking phone messages	
Writing business letters (not typing)	
Receiving phone orders	
Operating switchboard	
Keeping track of supplies	
Bookkeeping	
Entering information into computer	

Construction and repair

Painting		Kitchen modernization	
Porch construction or repair		Furniture making	
Knocking out walls		Plastering	
Wall papering		Soldering & Welding	
Furniture repairs		Concrete work (sidewalk)	
Repairing locks		Installing floor covering	
Building garages		Repairing Chimneys	
Bathroom modernization		Heating/Cooling system installation	
Building room additions		Installing windows	
Tile work for roofing		Building swimming pools	
Installing drywall & taping		Carpentry skills	
Plumbing repairs		Roofing repair or installation	
Bricklaying & Masonry		Cabinetmaking	

Maintenance

Window washing		Fixing leaky faucets	
Floor waxing or mopping		Mowing lawns	
Washing and cleaning carpets/rugs		Planting & caring for gardens	
Routing clogged drains		Pruning trees & shrubbery	
Using a hand truck in a business		Cleaning/Maintaining swimming pool	
Caulking		Floor sanding or stripping	
General household cleaning		Wood stripping/ refinishing	

Food

Catering	
Serving food to large numbers of people (over 10)	
Preparing meals for large numbers of people (over 10)	
Clearing/setting tables for large numbers of people (over 10)	
Washing dishes for large numbers of people (over 10)	
Operating commercial food preparation equipment	
Meat cutting	
Baking	

Child care

Caring for babies (under 1 year)		Caring for children (1-6years)	
Caring for children (7- 13 years)		Taking children/youths on field trips	

Transportation

Driving light vehicle	Driving heavy vehicle	
Driving a vehicle delivering goods	Hauling	
Operating farm equipment	Driving a Ambulance	

Operating equipment and repairing machinery

Repairing radios,Tvs,VCRs Tape recorders	Repairing heating and air conditioning system	
Repairing other small appliances	Operating a dump truck	
Repairing light vehicles	Fixing washers/dryers	
Repairing trucks/buses	Repairing elevators/lifts	
Repairing auto/truck/bus bodies	Operating a crane	
Using a forklift	Assembling items	
Repairing large household equipment(e.g. refrigerator)		

Music

Singing	Play an instrument (which one?)	

Security

Guarding residential property	Ushering at major events	
Guarding commercial property	Installing Alarms or security systems	
Guarding industrial property	Repairing Alarms or Security systems	
Armed Guard	Firefighting	
Crowd control		

Other

Upholstering	Sewing	
Dressmaking	Crocheting	
Knitting	Tailoring	
Moving furniture or equipment to different locations	Managing property	
Assisting in the classroom	Hair dressing	
Hair cutting	Phone surveys	
Jewelry or watch repair		

Are there any skills that you have which we haven't mentioned?

_____

_____

_____

C.   Priority skills

When you think about your skills, what three things do you think you do best?

_____

_____

_____

_____

Which of all your skills are good enough that other people would hire you to do them?

_____

_____

Are there any skills you would like to teach?

_____

_____

What skills would you most like to learn?

_____

_____

_____

Community skills

Have you ever organized or participated in any of the following community activities?
Read the list, then say
Let me read the list again. Tell me in which of these you would be willing to participate in the future.

Have already done this (participation)		Would do it again (future participation)	
Boy Scouts/Girl Scouts		Boy Scouts/Girl Scouts	
Church Fundraisers		Church Fundraisers	
Bingo		Bingo	
School-Parent Associations		School-Parent Associations	
Sports Teams		Sports Teams	
Camp Trips for Kids		Camp Trips for Kids	
Field Trips		Field Trips	
Political Campaigns		Political Campaigns	
Block Clubs		Block Clubs	
Community Groups (e.g. Stock-fell group)		Community Groups (e.g. stock-fell group)	

Rummage Sales		Rummage Sales	
Yard Sales		Yard Sales	
Church Suppers		Church Suppers	
Community Gardens		Community Gardens	
Neighborhood Organization		Neighborhood Organization	
Other Groups or Community Work?		Other Groups or Community Work?	

Section B: Types of interventions

1. What you understand being healthy mean to you?

_____

_____

2. What role do you think the church plays in health?

_____

_____

_____

3. Is your Church involved in any HIV/AIDS activities?

Yes	
No	
Don't know	

4. If yes, what HIV/AIDS activities are your church doing? Please tick the appropriate box.

Prevention

General awareness and sensitization		Lifeskills (youth)	
Voluntary counseling and testing (VCT)		Condom distribution	
Prevention of Mother to Child Transmission of HIV/AIDS (PMTCT)		Promoting Abstinence (Faithfulness)	
Others			

Care and Support

Provision of Home care	
Counseling support	

Treatment of opportunistic infections	
Income generating activities	
Shelter construction	
Vocational skills	
Linkage with health units and other service providers	
Resource mobilization	
Spiritual support for those affected and infected by HIV/AIDS	
Social support groups	
Material support to those infected and affected	
IEC support (educational, material)	
Other	

☼Information, education, communication. (IEC)

Advocacy and training

Lobbying	
Capacity development	

5. If no why?

Lack of human resources	
Lack of financial resources	
Lack of material resources	
No interest at all	
HIV/AIDS is not a problem in our church	
Others are doing it	
Others…	

General Challenges/Problems/Gaps in Implementation

6.   What challenges does your church face in implementing its HIV/AIDS initiatives?

Inadequate resources/funds	
Limited staff/personnel capacity	
High expectations from the congregation/ community	
Discrimination and stigma	
Limited appropriate skills	
No vision about HIV/AIDS	
Poor accountability of resources	
Too much workload	
Others/ specify	

7. What does your church suggest/adopt to overcome these challenges?

Access to funding/resources	
Training in technical skills	
Sensitization to the church to death with stigma and discrimination	
Facilitating staff/personnel	
Training in financial management skills	
Training in organizational management skills	
Others/specify	

G. Identification of resources

Financial resources

1. Do you receive any HIV/AIDS funding?

Yes	
No	

2. How do you fund your HIV/AIDS activities?

International donor	
Sister churches overseas	
Members' contributions	
Government	
Private sector contributions	
Other (please specify)................................	

3. What successful methods/strategies have you used to get funds for your work?

Submitting proposals to donor partners	
Local fund raising events	
Contacting private companies	
Using individual contacts	
Going through a network	
Going through denomination contacts	
Other (please specify)	

4. Have you had any problems in getting funds? What were the problems?

No problems	
Proposal not accepted	
Delays in receiving funds	
Lack of information on where to go for funds	
Mis-match between donor priorities and church priorities	
Too many donor requirements	
Other	

5. Which of your activities are funded and which still require funding? (Please tick)

Activities	Receiving funds	Need more funding	Would undertake as a priority if funding were available
Prevention activities			
Home-based care			
Lifeskills training			
Counseling			
Income generating activities			
Resource materials			
Volunteer incentives			
Organizational development			
Core support (operational)			
Infrastructure			
VCT			
Training			
Other			

6. Do you have any recommendations on how churches could get more funds for HIV/AIDS
activities?_____

_____

7. Does your church use members as volunteers?

Yes	
No	

How many? _____

8. Do the volunteers receive any incentives?

None		Regular financial incentive	
Gifts (Christmas/ Easter)		Food parcels	
Other material (bicycle,umbrella,shoes)		Recognition	
Certification		Travel allowance	
Other (specify)			

9. Do you have any staff working on HIV/AIDS programs?

Yes		No	

10. If yes,

Full-time		Part-time	
Local		Expatriate	
Consultants		Other (specify)	

11. What training has been received and what is still needed. Please tick

Area	Volunteers trained in this	Volunteer need training
Basic HIV information & awareness		
Prevention interventions		
Home-based care		
Psycho-social support		
Counseling		
Developing IEC materials		
Financial management		
Mobilization		
Other (specify)		

thank you for answering