

**UNIVERSITY OF KWAZULU-NATAL**  
**A REFORMED CRITIQUE OF PUBLIC HEALTH POLICIES AND  
PRACTICES IN KWAZULU-NATAL: A CASE STUDY OF  
GREYTOWN UNITING REFORMED CHURCH IN SOUTHERN  
AFRICA**

By

**NKOSINATHI LAWRENCE MBATHA**

Student number: 219083143

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Supervisor: Professor Simangaliso Kumalo

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## DECLARATION

I, Nkosinathi Lawrence Mbatha, declare that this thesis, except where otherwise indicated, is my original statement regarding a reformed critique of public health policies and practices in Kwazulu-Natal: a case study of Greytown Uniting Reformed Church in Southern Africa. The thesis has not been submitted for any degree or examination at any other university. It does not contain other people's data, pictures, graphs, or other information, unless specifically acknowledged as being sourced from other people. It does not contain other people's writing, unless specifically acknowledged as being sourced from other researchers. This thesis is submitted for the first time to the School of Religion, Philosophy and Classics, College of Humanities of the University of KwaZulu-Natal.

Name of Student: Nkosinathi Lawrence Mbatha

Date: 02 December 2022

Signature of Student



Name of Supervisor: Prof Simangaliso Kumalo

Signature of Supervisor:

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## **ACRONYMS AND ABBREVIATIONS**

AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
ARHAP	African Religious Health Assets Programme
ARV	Antiretroviral
CHC	Community Health Centre
CHW	Community Health Workers
CHWP	Community Health Worker Programme
COVID-19	The Novel Coronavirus Disease
DHS	District Health System
DOH	Department of Health
DRC	Dutch Reformed Church
DRCA	Dutch Reformed Church in Africa
DRMC	Dutch Reformed Mission Church in South Africa
RCA	Reformed Church in Africa
FBO	Faith-Based Organisations
HAART	Highly Active Antiretroviral Therapy
HPCSA	Health Professionals' Council of South Africa
HIV	Human Immune Virus
HIS	Health Information System
KZN	KwaZulu-Natal
KZN DoH	KwaZulu-Natal Department of Health
NCS	National Core Standards

NGO	Non-Governmental Organisation
NHI	National Health Insurance
NHP	National Health Plan
NHS	National Health System
NIV	New International Version
NSP	New Strategic Plan
PHC	Primary Healthcare
PIRHANA	Participatory Inquiry into Religious Health Assets, Networks and Agency
PIRASH	Participant Inquiry into Religion and Adolescent Sexual Health
PPE	Personal Protective Equipment
PrEP	Pre-Exposure Prophylaxis
RA	Religious Agents
RCC	Roman Catholic Church
RCSA	Reformed Church in South Africa
RE	Religious Entities
RHA	Religious Health Assets
SANDF	South African National Defence Force
SCM	Supply Chain Management
STI	Sexually Transmitted Disease
TB	Tuberculosis
UNICEF	United Nations Children's Fund
URCSA	Uniting Reformed Church in South Africa
USA	United States of America

UTT	Universal Test and Treatment
WHO	World Health Organization
WCC	World Council of Churches
WARC	World Alliance of Reformed Churches

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## **ABSTRACT**

This study examines the relationship between religion and health. It aims to establish a common framework of strengths, barriers, and recommendations for positive church responses to public health issues in order to inform an improved collaborative strategy between members in the Greytown Uniting Reformed Church in Southern Africa. Many churches are currently successfully involved in community development and empowerment, providing health workers and agencies with support and helping meet tangible needs of the people.

In responding to the reformed critique of public health policies and practices in KwaZulu-Natal, this study undertakes a detailed analysis of key areas, namely the prospects and challenges for interchange and partnership between the worldviews guiding action of Reformed theology and public health in KwaZulu-Natal, the public health policies and practices in KZN, the role of Reformed Theology in public health, the opportunities and challenges of public health and reformed theology, a model that can be implemented to shape activities, formations and consequences to strengthen collaboration between public health and reformed theology, and ways the state and the church can collaborate to improve the public health system.

The study is rooted in a theoretical framework of the African Religious Health Assets Programme (ARHAP) which has developed a theory to help establish the link that exists between religion and health in healthcare. The conclusions from the ARHAP theoretical framework are engaged in this study to identify tangible and intangible religious health assets and how they contribute to health promotion and care.

### **Key terms:**

Reformed theology, Public health, Uniting Reformed Church in Southern Africa, KwaZulu-Natal, and African Religious Health Assets Programme.

## CHAPTER ONE

### GENERAL INTRODUCTION TO THE STUDY

#### 1.0 Introduction

“Accept the authority of every human institution, including the head of state in his role as ultimate leader and the governors he appointed to punish wrongdoers and commend good deeds, for the sake of the Lord.” (1 Peter 2:13-14) Governments have a responsibility to safeguard individuals from disease and to assure the treatment, care and safety of the ill, their families, and the public’s general welfare. Because of this, the Bible asserts that authorities are appointed by God and are to be regarded and obeyed (Romans 13). Churches endorse and adhere to government regulations designed to stop the spread of disease, even when those protocols limit how people typically practice their faith. Kimble (2017) states that as the government takes extraordinary steps to stop the spread of illness, the Church has a prophetic responsibility to remind the public and make sure that justice and fairness are upheld. Instead of being viewed as acts of disloyalty and disobedience on the part of the Church; advocating for the weak to be given lives of dignity, denouncing violence against the public, and exposing abuse and corrupt practices should be considered as part of the Church’s prophetic duty.

Overall, this study looks into the connection between religion and health. To this end, the Greytown Uniting Reformed Church in Southern Africa’s project that focuses on meeting the community health needs in KwaZulu-Natal is used as a case study. The research problem as identified, articulated, and motivated for in the study has attracted wide attention and promoted insightful ongoing debate in the public domain. This is understandable, since immediate societal changes have an influence on the public understanding of reformed theology. Hence, this study is positioned within the theological perspective, which characteristically informs pragmatic theological praxis in contextualised settings.

The study used, as a theoretical framework, the African Religious Health Assets Programme (ARHAP) which is a research programme involving scholars at the Universities of Cape Town, Witwatersrand and KwaZulu-Natal in South Africa, working in partnership with scholars and practitioners from other universities and institutions in the United States of America, Europe and Africa, and religious organizations in several different countries.

According to this programme, religious organizations have assets, known as Religious Health Assets that can help promote health and care. These assets can be both tangible and intangible. James R Cochrane (2011) states that the ARHAP has been attempting to map and evaluate religious objects involved in health prevention, support, treatment, and care for some time now. This has led to the development of tools for positioning religious and community health assets alongside recommended health services and systems. Using this framework, the study investigated the Church's intangible religious assets, which were analysed to establish how they contribute to people's well-being.

Thus, as gleaned from the above explication, the study contributes to the growth of public health policies and practices through reformed theology. In the following sections of the study, the researcher introduces the scope of his examination, places it against the background of the study, and explains the motivation for the enquiry upon which he embarked. This is accompanied by his clarification of the main research question, and outlines the sub-questions which guided the investigative inquiry. Lastly, the researcher explores the literature on public health in the Greytown congregation as it relates to reformed theology.

### **1.1 Background to the research problem**

According to Leavey et al (2007: 548-559), the contribution of the Church and church-based organisations towards the health and well-being of communities is indisputable. Churches have built and run healthcare centres and facilities. Its ministers are also involved in praying for and counselling the sick. Churches and faith-based organisations play a major role not only in the public health delivery system of any country, but also at the level of public health policymaking. Church-based health-promotion programmes have the potential of reducing inequality in terms of access to healthcare services in emerging nations and developing regions such as South Africa and KwaZulu-Natal (KZN).

This study investigated the connection between religion and health. To this end, it examined the role that religion and religious entities play in contributing to health in communities. In particular, the study examined the direct contribution of the Church and religious institutions to health in the Greytown Presbytery of the KZN Uniting Reformed Church in Southern Africa (URCSA). As an ordained minister of the Word and Sacraments working in a local congregation in Greytown, the researcher interacts with people suffering from various illnesses and offers counselling services to both the sick and dying.



A common trend among those suffering from illnesses and other health crises is to resort to religion for help and answers. Furthermore, many health challenges, including HIV and AIDS as well as the COVID - 19 pandemic, are no longer mere medical issues but challenges to development and the well-being of communities. As such they require multi-sectoral responses that rise above the health sector.

It is clear from the influence that health issues have in society that the response to health problems demands an inclusive and holistic approach. Therefore, there are theological and moral demands placed on the Church, which oblige it to respond in a holistic manner to people's health needs, based on the belief in a loving God who is interested in the well-being of His people. The Church then enters the stage to respond to this challenge.

## **1.2 Motivation to the Study**

The background to the study and the researcher's motivation for undertaking it is twofold: scholarly motivation and personal experience

### **1.2.1 Scholarly Motivation**

The researcher's interest in undertaking this study began during his academic studies of practical theology. The scope of the discipline in practical theology includes matters of public importance beyond the Church, and is often directed towards shaping public policy and social transformation. It is reflecting about Christian life and encountering God in moments, contexts, situations and practices. Roest (2020), asserts that the challenges, worries and experiences of practitioners, such as pastors, pastoral workers, parish evangelists, pastoral counsellors, and ministers have been central to the research issues in practical theology over the years. Despite the fact that the rest of society was always visible, practical theology offered insight into their actions, knowledge and instructions on 'know why, knowing what and knowing how'.

Today projects are increasingly being created in direct consultation with practitioners rather than just being carried out for, or on behalf of, practitioners. Common problems encountered by church congregations, mission organizations, educational institutions, church councils, or chaplaincy teams give rise to questions. Ministers are interested in learning from practical theological experiences on topics like sermon listener experiences, innovative church practices, and expectations about the role of the minister held by congregations or church councils.

Local churches seeking rejuvenation encourage practical theologians to conduct local audit studies to determine what services are lacking and what needs are unmet among the populace, community centres, and other organizations.

Practical theologians carry out diverse research programs and make their own constructive, scholarly contribution to theological enterprise. They reflect on Christian life (practical faith) and encountering God in moments, contexts, situations and practices. It also processes understanding the situation, reflection in light of the gospel, and reaction in faith.

The researcher was motivated to conduct this study by Richard Osmer's (2008) four tasks:

### **Descriptive – the empirical task - what is going on?**

Osmer (2008:31) asserts that for theology to be contextual and local, you need to insert yourself into a particular context of ministry, to ask what is really going on, to wrestle with the meaning of fleshing out the Gospel in real places and with real people. Keep your own focus area in mind. In this study, the researcher will be relating his experience on his insertion into the local context. He will discuss reformed theology and public health policies and practices and will reflect critically on his own (in) ability in terms of the challenges that both context and congregation seem to present.

### **The interpretative task – why is this going on?**

Osmer (2008:79) asserts that once you have inserted yourself deeply into the context or congregation, identifying what is going on, you can then go deeper and ask why. This is the moment of analysis, interpretation or sense-making. The researcher will be drawing relations to reformed theology and public health policies and practices.

### **The normative task – what ought to be going on?**

Osmer (2008: 129) asserts that this moment of doing theology is creating a space for reflective imagination: asking together and under the guidance of the Holy Spirit, and in conversation with Scripture, confessions and other sources, what ought to be going on. The researcher will bring into dialogue the questions raised from reformed theology and public health, in ways that are critical and creative, paving the way for new decisions and visions of what ought to be.

## **The pragmatic task – how might we respond?**

Lastly Osmer 2008: 175) asserts that this moment requires strategic action – once we discern what we ought to do, we then have to decide and plan how it will be done. This moment is essential in terms of an ongoing transformative ministry praxis (being transformed and being transformative). The researcher will then present the recommendations and conclusions of the study.

### **1.2.2 Personal experience**

The researcher was also motivated to conduct this study by the following three main reasons:

Firstly, as an ordained minister working in a local congregation in Greytown, my personal journey of faith as a Christian and professional experience as minister of the Word and Sacraments led me to question the nature and purpose of the Church as it relates to health issues. Our perceptions are influenced and formed by the community in which we belong. The Christian perception is moreover influenced and shaped by Scripture and the Church. The perception is the broader context, which partly influences the type of a leader that one turns out to be. Religious leaders are called to let their perceptions be changed as Paul attests:

“Do not conform to the standards of this world, but let God transform you inwardly by a complete change of your mind” (Romans 12:2).

That question is pushed further by pastoral interactions in the congregations who the researcher serves, where there is a gap between what he ought to believe and what he does believe. “The thief comes only to steal, kill and destroy, I came that they may have life and have it abundantly” (John 10:10). The abundant life that this text speaks to health concerns as well. The text derives from a context where many sick people were given their health back in Jewish Palestine as recorded in the New Testament. The researcher interacts with people suffering from various illnesses and counsels both the sick and dying. His ministerial experiences in pastoral counselling have exposed him to the serious health issues that confront people and challenge their religious assumptions and faith. As alluded to earlier, a common trend among those who are suffering from illnesses and health crises is to resort to religion for answers as to what beset them. This phenomenon places a challenge on the Church and her ministry, who have to be responsive to the well-being of people, which is one of the principal goals of its work.

Snodgrass (2015:3) argues that the term “pastoral” refers to the metaphor of the shepherd present in Jewish and Christian scriptures, as shepherds are key figures throughout these sacred texts. Moses spent time as a shepherd. God chose David, a youthful shepherd, to be a monarch. In Psalm 23, God is compared to a shepherd, emphasizing God’s compassionate and forgiving character. Christ, the “Good Shepherd”, led, cared and gave his life in the service of His sheep. Abel, Abraham and Rachel also spent time tending to their herds in the meadows. The word “pastoral” refers to this rich religious tradition and describes how a pastoral counsellor leads sheep into new grazing areas and leads them to calmer waters by paying close attention, gentle understanding, and compassionate regard.

Secondly, the theological and moral demands placed on the Church and her contribution to the plight of people in the world, also serve as a motivation for this study. Jesus says: “Love the Lord your God with all your heart, with all your soul, and with your entire mind. This is the first and greatest commandment. In addition, the second is like it: Love your neighbour as yourself. All the law and prophets hang on these two commandments” (Matthew 22:37-40). Jesus saw his followers as his friends, as seen in Luke 12 and John 15. Surprisingly, the word “friend” connotes companionship, togetherness and unity and is a synonym of kindness and affection (Bennet 1993:46). In John 15, Jesus says that following his teachings as an act of love constitutes true friendship. As a result, religious leaders must submit to God. The Good Shepherd is a healer and a comforter as well (Ps. 23:4). The Church is obliged to respond in a holistic manner to the needs of people’s health based on the teachings of a loving God who is interested in the well-being of people. This theological and moral response founded on the biblical witness also serves as a motivation for this study: “You are the light of the world” (Matthew 5:14). Thirdly, many health problems, including HIV and AIDS, are no longer merely medical issues, but are challenges to the development and the well-being of communities, requiring multi-sectoral responses that rise above the health sector. It is clear from the influence that health issues have on society that responses to health problems demand an inclusive approach that is complete in nature.

Franklin Payne (1985) comments on the role of medical doctors and theologians:

“By the nature of what they do, physicians make pronouncements, personally and professionally, about what people may or may not do. For the Christian ‘full range of human moral responsibilities’ is the prerogative of the church to define principle and implement practice. A dialogue between physicians and theologians who are solidly convinced that the Bible is the ultimate source of truth, is imperative if we are to arrive at biblical principles and practice. Until that occurs, the following discussion will act as a catalyst. The unity of the body and spirit and the relationship between sin and illness commands that the church play a central role in and outside the church (Payne, 1985: 126).”

On the 14<sup>th</sup> of June 2004, the Ecumenical News Service of the World Council of Churches reported that religious leaders from 39 nations gathered in Nairobi to declare war on AIDS and poverty, two issues that threaten to uproot the continent’s population. Africa has thus made a heartfelt appeal to stop the pandemic that has driven her people into exile. Affiliates of the All Africa Summit of Churches are said to have made this sombre appeal in a joint statement at the conclusion of a three-day conference.

### **1.3 Relevance of the Study**

This study explored and examined the relationship between the Church and health. It acknowledges the direct contribution of the Church and religious institutions to health in Greytown Presbytery of KZN URCSA. Campbell (2007: 2014) remarks that Church-based health-promotion programs have the potential of reducing inequality among racial groups. Although the positions of these groups may be as firm as those of the people, the people may differ significantly in terms of a variety of influences, ranging from the people’s health and demographic concerns. Therefore, it cannot be assumed that strategies that have been successful in one ethnic or religious group will be successful in another. To avoid a “one-size-fits-all” approach to Church-based health promotion, health groups must conduct extensive, constructive research and collaborate when creating and organizing initiatives.

Payne (1985) challenges the World Health Organization’s definition of health as a state of whole physical, psychological and social well-being and not just the absence of disease or infirmity:

“The broad definition [of health] will either be withdrawn or else consistently applied. The latter would mean that professional medical judgements assume the responsibility for the full range of human moral consideration. This is an alarming suggestion from which the medical profession should draw back in the direction of a stricter construction of medical judgements as such. Between the health meaning and the religious, moral, or human-focused sense of significant and potential difficulties, there should be a continuity difference. The role of the men who are their clients, their families and their spiritual counsellors should be considered by the doctors when making ethical decisions about human behaviour (Payne 1985:126). “

#### **1.4 Research gap**

When the researcher was working on his literature review, he discovered that many scholars have done studies on Reformed Theology and Public Health respectively. What he find to be missing in the literature is how these two traditions could be used to comprehend one another, and this is the gap where he wish to make his contribution. He will critique the reformed theology on public health policies and practices in KZN.

#### **1.5 Location of the Study**

The study was conducted in the Greytown congregation of the KZN Regional Synod of the Uniting Reformed Church in Southern Africa (URCSA). The Uniting Reformed Church was founded in 1994 after the merger of the Dutch Reformed Church in Africa (DRCA) and the Dutch Reformed Mission Church in South Africa (DRMCSA). The Greytown congregation falls within the boundaries of Greytown Presbytery (circuit), together with eight other congregations, which include Mandleni, Machibisa, Pietermaritzburg, Table Mountain, Kwazanda, Imbali, Umngeni, and Woodlands. It is demarcated into eight wards, which are: Nhlalakahle, Shane, Matimatolo, Ntembisweni, Mbulwane, Mbuba, Ngome, and Mpalaza. The congregation is dominated by people of Zulu descent who speak isiZulu and practice Zulu culture.

## **1.6 Practical Theology**

In this study, the researcher highlights the diverse relationships each individual encounters in their various ethical and religious aspects. In setting a context for the discussion of these diverse relationships, the researcher reflects on religion, particularly the concentration now frequently called “practical theology”. Usually, theology has been described, as “faith seeking understanding.” According to Migliore (2014: 02), faith seeking understanding has an extensive and valuable practice. In the words of Augustine of Hippo (a theologian and philosopher of Berber) it brings the form, “I think so that I may comprehend”. Augustine believes that while having faith is a prerequisite for understanding God, having faith also drives one to continually seek out new information.

Christians are interested in knowing what they should believe, hope for, and love. Anselm of Canterbury; an Italian monk, abbot, philosopher, and theologian who served from 1093 to 1109 and is credited as the creator of the expression that faith pursuing considerations; agrees with Augustine that devotees should enquire not for the sake of reaching to faith by means of reason, but that they may be gladdened by understanding and contemplating those things that they trust rather than to reach faith.

According to Anselm, sympathy raises faith and faith raises enjoyment. But Karl Barth, a Swiss Calvinist theologian, disagrees with Anselm’s and Augustin’s idea that theology’s role is to assess the community’s beliefs and practices, testing and evaluating it in the light of its enduring basis, purpose, and content. Theology is distinguished from sightless acceptance by its unique character as faith seeking insight. There are various specialized fields included in this thorough explanation. In a similar manner, there are numerous specific fields of analysis within this broad field of knowledge.

Gerard Mannion (2009:122) state that theology only exists within a specific practice of philosophy, both public and background, like with any discipline. According to Lonergan (1971), Practical theology aims to clarify the function and relevance of spiritual belief in the cultural context with a focus on the significances and standards that convey a certain way of living. There is a particular philosophy of community health inside the larger area of modern philosophy, active from a whole compound of connotations and standards explaining and inspiring its structure, establishments, concept and exercise.

Religion, along with community health itself, has the difficulty of concentration in trying to support this ideology. However, for those with extensive experience in community health, it's possible that they lack the scriptural or devotional vocabulary necessary to effectively communicate their practices.

While some researchers may speak accurately about religion and values, others lack knowledge of community health, particularly events and activities associated with the various actions that currently provide the qualifications and training of community health. These boundaries are clearly discernible, for instance, when community health authorities find that their actions no longer follow a clear line of logic.

The other extreme is when academics are so certain of the unsolved problems in public health that they tend to be overly academic and appropriative. If both sides acknowledge that successful multiset oral collaboration is feasible, these difficulties are not insurmountable and can be minimized by prioritizing both the public's welfare and basic human health. Without an ethical, spiritual, or philosophical foundation, public health is reduced to looking at the misery as an examiner on which its expertise is focused.

Theology, however, is essentially inaccessible if it is unresponsive towards the real practice, necessities, and complications involved in public health.

This study is anchored in the discipline of practical theology. The space of the discipline contains objects of public significance outside the Church and is often focused towards determining open strategy and shared conversion. The space of the discipline therefore requires reflecting on Christian life and encountering God in moments, settings, circumstances, and practices. Therefore, the practice of doing practical theology consists of, among other things, understanding the situation, considering the Gospel, and responding in belief.

### **1.7 Description of Reformed Theology**

Christian religion consists of many different church traditions; Catholic, Reformed, Evangelical, Pentecostal, Charismatic, to African-Initiated Churches, Bible Churches, Ministries, and Mega Ministries, to mention but a few. Each church tradition is influenced by its history, culture, doctrines, creeds, and beliefs. Reformed tradition is based on the ideas of John Calvin, a Geneva Reformer who was initially a Catholic.



He was among those who were influential in the initiation and amalgamation of the Protestant Reformation. de Gruchy (2009:21) claims that while some historians may prefer to ignore or undervalue John Calvin, with enough persistence, this weak and serious Frenchman emerges to impede their research. At his own request, no rock represents his tombstone, although just a small portion of him is actually interred there. His places of recognition and inspiration will endure through oblivion and time. Prejudice and admiration both have stumbled together. He was neither a perfect saint nor a role model with an archangel's mentality. Furthermore, he was not a cold-blooded tyrant. Rather, he was very gifted and dedicated individual whose moral significance was undermined by serious flaws, of which Calvin himself was too aware.

The basics of reformed theology are the Bible (Old and New Testament), two sacraments (baptism and Holy Communion), ecumenical creeds (Apostles', Nicene, and Athanasian Creed) and four confessions (Belgic, Canons of Dordt, Heidelberg Catechism, and Belhar). Sproul (1997) asserts that people frequently receive an answer that can be summarized as the five solae principles: standing on Scripture alone, we are saved by grace alone; through faith alone, in Christ alone; or they may hear the five points of Calvinism: the doctrine of human depravity, unconditional divine election, Christ's death for the elect, God's sovereignty in saving them, and their final perseverance in grace to eternal life and glory (Sproul 2016:28). However, a review of reformed theology shows that there is much more to reformed theology than the doctrine of salvation. In summary, TULIP is what this reformed theology could be encapsulated by: **T**otal Depravity, **U**nconditional Election, **L**imited Atonement, **I**rresistible Grace, and the **P**erseverance of the Saints.

One needs to bear in mind that in South Africa, Dutch settlers brought with them reformed tradition when they landed in the Cape under the leadership of Jan van Riebeeck in 1652. According to de Gruchy (2009:22), between Switzerland, Holland and the Transkei in South Africa, the tradition we now associate with the Geneva reformer has influenced societies, cultures, churches, and institutions.

In conducting this study, the researcher has drawn ideas from the following reformed theology sources: John Calvin's *Institute of Christian Religion*, *Geneva Confession*, *Ecclesiastical Ordinances*, *Reformed Confessions of Faith* (Belgic, Canons of Dordt, Heidelberg Catechism and Belhar), and *KZN Regional Synod Church Order and Stipulations*, 2018.

## 1.8 Descriptive definition of Public Health

In this study, the phrase “public health” is a recurring feature. The phrase is used by the researcher to denote that aspect of human requirement and inability that motivates curative activities and the institutions and organizations into which they are organized. When discussing “health”, Callahan et al (2007:04) note that while these occupations have a long history of treating illness, overcoming injuries and curing diseases, their primary objectives is to achieve the best physical and mental function for people whenever and wherever this is practical given their commitment to “health and consideration in the face of humanity”. This statement has no impact on how public health is defined or how its structure and values are established.

Many nursing organizations make it clear that the care and attention that have inspired communities and individuals to stand with people on the verge of tragedy are what make healthcare real. The engagement of the patients and communities, to whom the entire activity is focused – the person who suffers from illness, a disease or a problem and who must now deal with health challenges- is therefore of the utmost important in this study. Therefore, despite the fact that it seems crucial, the concept of “health” is not the main focus. Regarding this word, the researcher acknowledges two broad, but in-depth explanations as appropriate for his conclusions.

The best functioning of the human being, on the other hand, is defined as meeting active, psychological, interpersonal, and spiritual demands. The WHO defined health, however, as “a position of full physiological, emotional, and societal welfare and not merely the absence of illness and incapacity”, in 1958. The knowledge of healthcare that is crucial to this inquiry is evidently supported by these descriptions. However, the researcher’s goal was not to investigate these definitions of health beyond how they related to the idea of the person in question. The researcher has also drawn ideas from the following public health sources: *The Constitution of South Africa*; *National Department of Health, Strategic Plan 2020/2021*; *White Paper on Transforming Public Services Delivery, 1997 (Batho Pele principles)*; *South Africa’s Health System*; *KwaZulu–Natal Department of Health Policies and Practices*; and *Health Professions Council of South Africa, Guidelines for Good Practice in Health Care Professions*.

## **1.9 Aim of the study**

The main aim of the study was to assess and critically assess the following:

Investigating the prospects and challenges for interchange and partnership between the action guiding worldviews of reformed theology and public health in KwaZulu-Natal. The challenges under study within this thesis is interdisciplinary, will therefore examine it through the lenses of the two disciplines of religion (reformed theology) and health (public health).

The Objectives of this Study were to:

1.9.1 Critically examine KZN's public health policies and practices considering reformed theology doctrines (Descriptive – empirical task - what is going on?).

1.9.2 Recognize the public health policies relevant to reformed theology (Interpretative task - why is this going on?)

1.9.3 Identify opportunities and challenges that emerge from public health and reformed theology (Normative task - what ought to be going on?)

1.9.4 Create a reasoning model that shapes activities, formations, and consequences to strengthen collaboration between public health and reformed theology (Pragmatic task - how we might respond?)

1.9.5 Create a self-assessment procedure on how dialogue may be initiated between the state and the church (Pragmatic task - how we might respond?)

## **1.10 Theoretical Framework**

This study was built on the African Religious Health Assets Programme (ARHAP) model. The model seeks to define assessment tools for four distinct, though interrelated, areas of investigation. The four are:

### **1.10.1 The role of human agency in health (those who seek it and those who provide it)**

Agency is the capability to perform, to move into action, to apply the belongings one has, or to pursue and attain preferred objectives within the context of social and environmental conditions. This goes hand in hand with an asset-based approach to development or health mitigation, because it focuses on the capacity to utilize what is already present to create positive change. ARHAP, in its approach to health and well-being, puts the emphasis on people's capacities as agents of change with the ability to bring about desired outcomes in matters of health. Schmid et al (2010:146) argue that health providers are important role players in the health systems of countries as they exert their agency according to their view of health needs, which justifies the call that the agency of health seekers also be taken seriously. The health-seeking behaviour of individuals and communities is informed by their understanding of what causes ill health and what makes for a healthy life. This complex belief system informs their choices and directs their actions. The researcher identified tangible and intangible human agencies and their role in the healthcare, those who provide it (healthcare professionals), and communities that seek it.

### **1.10.2 An appreciative inquiry into the capabilities of religious health assets**

In Schmid et al (2010:137)'s study of the interface of religion and public health, the term "religious health assets" (RHA) has proven itself useful, particularly for understanding the character of faith-based organizations (FBOs) and religious communities', networks', and organizations' impact on health in a way that allows for better integration with public health systems and more effective implementation of funding initiatives and programs. Perspectives adopted on health in relation to development rest on an appreciation of the assets that religious groups bring to public health. This study evaluated the public health practices in KZN - infrastructure, hospitals and clinics, holistic support, chaplains, traditional leaders, FBOs, and Non-Governmental Organizations (NGOS) around the Greytown area.

### **1.10.3 A mapping of material assets**

Schmid et al (2010:148) assert that ARHAP proposes to collect and map data on religious health assets. The term “assets” refers to what communities and people already have. In ARHAP research projects, the positive contribution which religion brings to health is referred to as an asset. This specifically relates to what things religion has which can impact positively on people’s lives and well-being. In the context of contemporary development systems on maintainable livelihoods and people-oriented improvement techniques, the term “assets” refers to what individuals have available to them, regardless of how disadvantaged they may be substantially, politically, or in other ways. This study mapped the capabilities, skills, resources, links, associations, and institutions that can be built on to enhance better health in the community.

### **1.10.4 The alignment (or not) of religious health assets with public health structures and policies**

Schmid et al (2010:146) note that one of the key motives for lack of recognition of RHAs and their under-utilization is that these assets are usually held by a diversity of religious groups who work in relative isolation from each other and from other health service providers. Often, they are invisible to the government. This results in a fragmented health system with separate parts operating alongside each other without mutual interaction, creating unnecessary duplication of services, and competing for a diminishing pool of health workers.

In cases where alignment of religious organisations and workers in the health field has been achieved, the health system is strengthened.

## **1.11 Layout of chapters**

### **1.11.1 Chapter One: Background and Orientation**

The chapter presents the general introduction, background, location, motivation, relevance, and rationale of the study. The objectives of the study, theoretical framework, methodology and the limitations of the study are also highlighted in this chapter.

### **1.11.2 Chapter Two: Greytown Uniting Reformed Church in Southern Africa and Historical Development of Health Provision in KwaZulu-Natal.**

This chapter places the study in its geographical, historical, religious, economic, and social context. It presents the historical development of health and the causes of decline in health provision in Greytown.

### **1.11.3 Chapter Three: Literature Review**

This chapter presents the review of relevant literature.

### **1.11.4 Chapter Four: Theoretical framework**

This chapter introduces the African Religious Health Assets Programme (ARHAP), including its background, objectives, and historical and current activities. Detailed working definitions of ARHAP terms and concepts and how they relate to the study are presented.

### **1.11.5 Chapter Five: Research Methodology**

This chapter interprets and analyses data. Direct references supporting the explanation of the report findings are provided. Interviews are used to complement the overall discussion.

### **1.11.6 Chapter Six: Effective South African Public Health Policies and Practices.**

This chapter focuses on effective South African public health policies and practices.

### **1.11.7 Chapter Seven: Discussion of the Findings and Recommendations.**

This chapter deals with general reflections on the study's objectives and gives recommendations and conclusions on the overall study.

## **1.12 Conclusion**

This chapter highlights the general introduction, background, motivation, and location of the study. Also, research problem(s), research question(s), relevance, rationale, and objectives of the study are presented. The chapter also discusses practical theology, descriptive definitions of reformed theology, and descriptive definitions of public health, reviews literature, theoretical frameworks, research methodology, and chapter layout. The next chapter locates the study in its context, probing the development and the decline in health provision and the impact of health reforms on health provision, with a specific focus on Greytown.

## DEFINITION OF TERMS

To gain a clearer understanding of the research questions and study, key terms need to be defined. The concrete definitions of several terms used in this study have broad or multiple meanings. Therefore, the following definitions clarify how the terms have been implemented for the purpose of this study:

1. **BATHO PELE PRINCIPLES (BPP):** refers to an official national document formulated to improve public service delivery in South Africa, including the health-care service (South Africa, 1997:9).
2. **CONSULENT** means a reformed Minister of Word and Sacraments nominated for a congregation that does not have two or more Ministers of the Word and Sacraments, to act in the place of the Minister of the Word and Sacraments during a vacancy. The vacancy could have been caused when there is a dismissal, a long illness, or any other absence, and whenever necessary in other circumstances (Stipulation 30 of the KZN Regional Synod URCSA church order and supplementary stipulations, 2018).
3. **CALVIN'S INSTITUTE OF CHRISTIAN RELIGION** means John Calvin's seminal work of systematic theology. This is regarded as one of the most influential works of Protestant theology. It is a core reference for the system of doctrine adopted by the reformed churches, usually called Calvinism (Bruce Gordon, 2016).  
**DISTRICT HEALTH SYSTEM** is a programme that has been adopted as the vehicle to deliver comprehensive primary healthcare services in South Africa. These services include community-based services as well as services available at mobile or fixed clinics and community health centres. District hospitals also form part of the district health system in the new policy (National Department of Health Strategic Plan, 2020/2021).
4. **ECCLESIASTICAL ORDINANCES** mean the title of the foundation rules, or Constitution, of the reformed church in Geneva, written by John Calvin (Chung Sung, 2002)
5. **GENEVA CONFESSION** was credited to John Calvin in 1536 by Beza who alleged that Calvin wrote it as a formula of Christian doctrine suited to the church at Geneva (Herman Speelman, 2016).

6. **GENERAL SYNOD** means the representatives of regional synods, consisting of the four members of the executive committee of each regional synod and one Minister of the Word and one church council member from every presbytery within the boundaries of each regional synod who meet as a general synod at times and in manner decided by the general synod (Article 11 of the KZN Regional Synod URCSA church order and supplementary stipulations, 2018).
7. **KZN DEPARTMENT OF HEALTH** is the executive department of the provincial government that is assigned to oversee healthcare in KwaZulu-Natal (National Department of Health Strategic Plan, 2020/2021).
8. **MINISTER OF THE WORD AND SACRAMENTS** means a member of clergy who takes charge of the church. The term can also refer to anyone who serves the community of worshippers by ministry (Johannes Kritzing, 2000).
9. **MODERAMEN** means the elected executive committee of a synod within a reformed church. It consists of the moderator, assessor, scribe and actuaries of the synod (Stipulation 50. 1 of the KZN Regional Synod URCSA church order and supplementary stipulations, 2018).
10. **NATIONAL DEPARTMENT OF HEALTH** is the executive department of the national government that is assigned to oversee healthcare in South Africa (National Department of Health Strategic Plan, 2020/2021).
11. **PUBLIC SERVICES AND SERVICE DELIVERY** is defined as services rendered by government to its citizens either directly or indirectly through the financing of private provision (Mathebula, 2010: 21).
12. **PRESBYTERY** means a number of neighbouring congregations that are grouped together. Representatives of congregations meet as a presbytery at times and in a manner as decided by the regional synod. There are seven presbyteries in KZN Regional Synod: Vryheid, Utrecht, Thukela, Zululand, North Coast, Greytown, and eThekweni (Article 09 of the KZN Regional Synod URCSA church order and supplementary stipulations, 2018).



13. **QUALITY** means the degree to which a product or service meets requirements and expectations (Harman, 2006:634).
14. **QUALITY OF SERVICE DELIVERY:** means to act or multiphase collaborative action carried out by a team in one moment or situation, the dimensions of which are assertion of capability, active focus, distribution of data, well-mannered behaviours by team and flexible effectiveness, which add appreciated sense to patients' healthcare practise (Hiidenhovi *et.al*, 2002:60).
15. **REGIONAL SYNOD** means presbyteries that are grouped together and meet every four years after the general synod has met. The representatives of congregations meet as a regional synod at times and in a manner decided by the regional synod. There are seven regional synods: Cape, Free State & Lesotho, KwaZulu-Natal, Namibia, Northern Transvaal, Phororo, and Southern Synod (Article 10 of the KZN Regional Synod URCSA church order and supplementary stipulations, 2018).
16. **SOLA GRATIA** means one is only saved by grace of God through the work of Jesus, the only mediator between God and man (Pieter Kriel, 2010: 14).
17. **SOLA FIDE** means one is only saved through faith in Jesus, not by the works of the law (Pieter Kriel, 2010: 14).
18. **SOLA SCRIPTURA** means the Bible is the only authoritative revelation of God, not human traditions (Pieter Kriel, 2010: 14).
19. **SOLI DEO GLORIA** means the only purpose of our lives is to glorify God (Pieter Kriel, 2010: 14).

## **CHAPTER TWO**

### **GREYTOWN URCSA AND HISTORICAL DEVELOPMENTS OF HEALTH PROVISION IN GREYTOWN, KWAZULU-NATAL PROVINCE**

#### **2.0 Introduction**

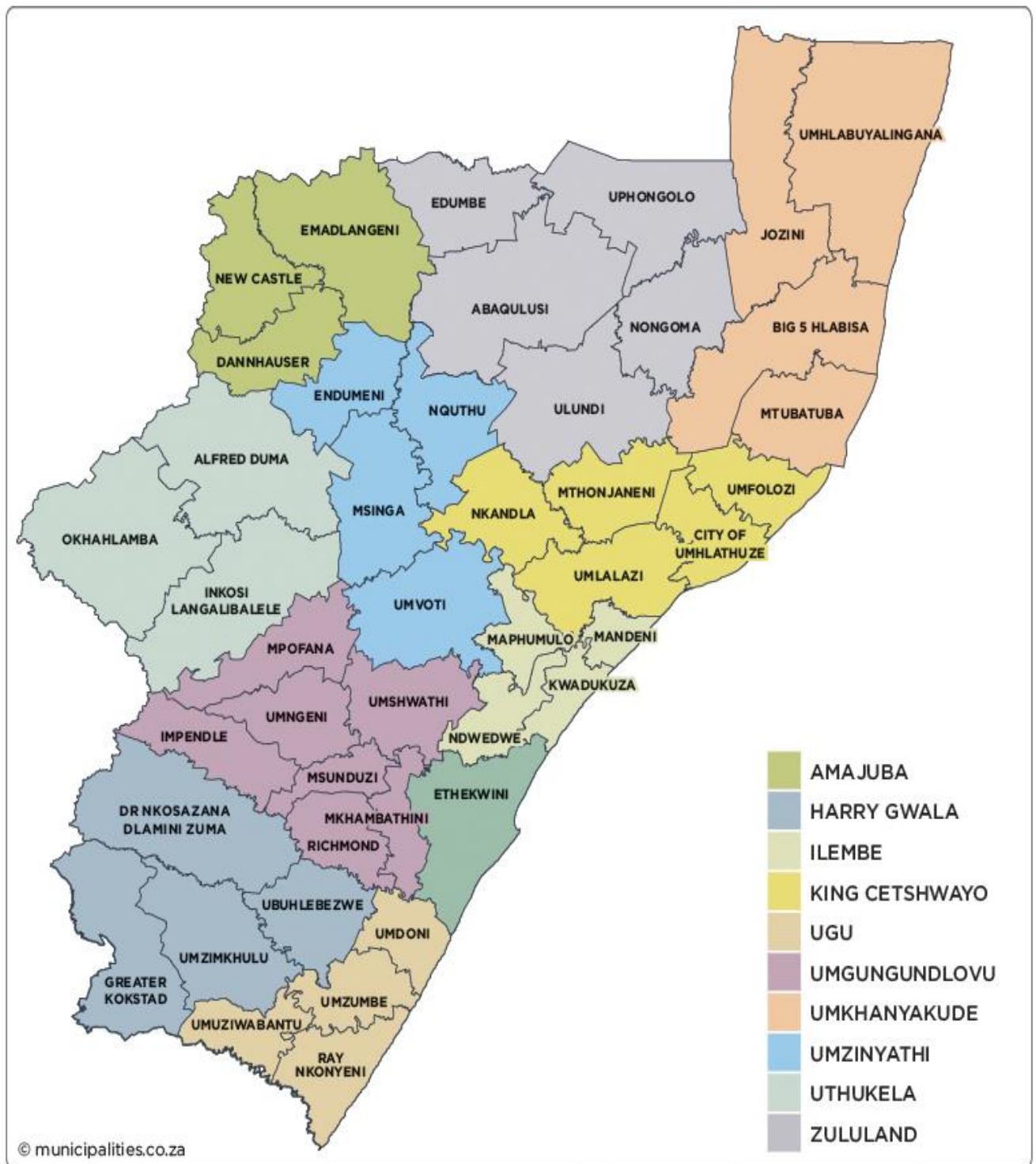
The previous chapter laid the foundation for this study by providing the problem that has been investigated and methodology used to discover the outcome of the study. This chapter focuses on the geographical, religious, economic, and social context of the study. An overview of religion and religious health services in the province of KwaZulu-Natal (KZN) is foregrounded as a way of preparing for Chapter Four, which focuses on the ARHAP. The historical development of health provision in KZN, with a special focus on Greytown, is explored. Thus, the chapter shows how the National Health Plan (NHP) has over the years impacted the development of health services and how other issues such as HIV and AIDS and Covid-19 have affected the church and the provision of health. The activities of religious health institutions in KZN are highlighted to show the relationship between religion and health.

#### **2.1 KwaZulu – Natal - A British Colony**

Graff and Campbell (2014:88) assert that KZN was formed by combining the Zulu Kingdom with the province of Natal, which, while once a British colony, was named by Portuguese navigators who landed on the site on Christmas Day, 1497. The province has international borders with Lesotho to the west and Swaziland and Mozambique to the north.

It also has several district regions. The north and south coast define a coastal belt centred on Durban. The central interior is the Midlands region, with Southern Natal and East Griqualand to the south and the uKhahlamba Local Municipality to the west. In the northwest is northern Natal with its battlefields, and in the northeast are Zululand and uMhlabuyalingana Municipality. Graff and Campbell (2014:24) argue that religion plays an important role in KwaZulu-Natal, as it is a melting pot of spiritual faiths. While almost 80% of the residents practice a form of Christianity, there are also many followers of Islam, Hinduism, Judaism, and African traditional beliefs as well as a smattering of adherents of Buddhism.

Figure 1: Map of KZN Municipalities



There are 11 district municipalities in KwaZulu-Natal, namely: Amajuba, eThekweni Metropolitan, Harry Gwala, iLembe, King Cetshwayo, Ugu, uMgungundlovu, uMkhanyakude, uMzinyathi, uThukela and Zululand.

## **2.2 Greytown**

Greytown is remotely situated 74 km away from Pietermaritzburg, the capital and second-largest city of KwaZulu-Natal. It is part of the uMzinyathi District Municipality and is located in the prosperous timber-producing region along the banks of the Umvoti River. It was founded in the 1850s and was given the name in honour of the Governor of the Cape Colony Sir George Edward Grey, who eventually rose to the position of Premier of New Zealand. Greytown is surrounded by eight rural and deep rural areas; Rietvlei, Eshane, Amatimatolo, Mbuba, Mbulwane, Ntembisweni, Ngome, and Nhlalakahle Township.

## **2.3 Demographics of Greytown**

Greytown falls under Umvoti Municipality. According to the *Census Municipal Fact Sheet*, published by Statistics South Africa, Umvoti Local Municipality has a population size of 103 093. The age breakdown is as follows: under 15 years 35.80%, 15 to 64 years 58.90%, and over 65 years 5.30%. Dependency ratio per 100 (15-64) is 69.70. 79.3 Men per 100 women. Population growth per annum is 1.11%. Unemployment rate (official) is 30.40%, Youth unemployment rate (official) 15-34 is 38.00%. Education (aged 20+): people with no schooling is 26.60%, higher education is 4.80%, and matric is 22.80%. There are 27 282 households, with an average size of 3.70. There are 57.60 female-headed households. The percentage of formal dwellings is 53.50%, and housing owned 58.70. Household Services percentages are as follows: flush toilet connected to sewerage is 23.40%, weekly refuse removal is 24.90%, piped water inside dwelling is 20.20%, and electricity for lighting is 58.30%.

## **2.4 Economic Context of Greytown**

Most people living in Greytown survive on daily small-scale activities. Some work in the four community shopping centres selling clothes, food, building material, furniture, and other useful items. There are also four petrol filling stations and four big supermarkets which provide employment.

Hawkers set up regularly on the main roads and in front of shopping centres, with other people coming to town from neighbouring rural areas once a month when patient, orphan, pensioner, and child grants are distributed. Other people work in the offices of the Umvoti Municipality and in different government departments like correctional Services, Home Affairs, Health, Education, Justice, and the South African Police Services. There are also many farms surrounding Greytown which provide employment to low-skilled people. An industry that is growing very fast in Greytown is funeral services. There are more than five funeral parlours run by local people which open every day. Bar lounges and liquor outlets are the major entertainment venues. According to the report from 2000 SAPS<sup>1</sup> these, however, add to the high crime rates in Greytown.

## **2.5 Religion in Greytown**

Greytown is a multid denominational community with Christianity<sup>2</sup> being the major religion practiced. However, this does not mean that other religions are not practiced. Various beliefs and different church organizations are found all around the community, from mainstream to independent, African-initiated churches, Pentecostal, and Charismatic churches. There are significant communities of Hindus and Muslims, smaller communities of Jewish people and other religions, and a growing number of those that do not espouse any formal religious belief. Characteristically, therefore, Greytown is not a purely Christian community but a mixed faith community of faith. The focus of this study is on reformed tradition and theology as it relates to healthcare services.

## **2.6 The Reformed churches**

The reformed churches align to the doctrines of John Calvin which are, the institute of Christian religion, the Geneva confession of faith and ecclesiastical ordinances. One of the churches that subscribe to the teachings of the Reformed tradition is the Dutch Reformed Church, which is the mother church to other Reformed churches in South Africa, including URCSA, which is a unification of Dutch Reformed Church in Africa (DRCA), Dutch Reformed Mission Church in South Africa (DRMCSA), and Reformed Church in Africa (RCA).

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<sup>1</sup> Department of Community Safety and Liaison. (2000). *A manual for community based crime prevention*. <https://www.csir.co.za/sites/default/files/Documents/Making%20South%20Africa%20Safe.pdf>

<sup>2</sup> Schoeman, W.J., 2017, 'South African religious demography: The 2013 General Household Survey', HTS Teologiese Studies/ Theological Studies 73(2), a3837. <https://doi.org/10.4102/hts.v73i2.383>

Veldsman (2000:34) states that South Africa's story has, for many years, been the well-known "tale of two cities", or more precisely, the tale of many cities. South Africans live worlds apart. The separation of black and white reflects the "success story" of Apartheid. Its architects and social engineers wanted complete and absolute separation which they achieved.

Reformed theology played a major role in this development. The story of Apartheid is thus part of the story of South African Reformed theology. White, Black, Indian and Coloured Reformed Christians also share this experience.

### **2.6.1 The Dutch Reformed Church in South Africa (DRCSA – White church)**

According to Plaatjies and van Huffel (2017: 01), Johan van Riebeeck, a representative of the Dutch East India Company in Holland, arrived at the Cape of Good Hope on April 6, 1652. His objective was to build a refuelling station for vessels traveling between Europe and Asia for trade. The introduction of Christianity to the Cape of Good Hope's native population and the establishment of the Reformed faith in Southern Africa were both ushered in by Jan van Riebeeck's arrival (Van der Watt 1977:4). Native people and slaves were active members of the Dutch Reformed Church in Southern Africa (DRCSA) and actively participated in the sacraments up until the end of the eighteenth century. Concerning the inclusion of black Christians at the Lord's Table, many issues occurred in 1828 in Stellenbosch, Calvinia, Caledon, Riversdale, and the Swartland (Loff 1981:18-19). Bentura Jones, a black man, for instance joined the DRCSA in Somerset West that year after being baptized. His appearance posed a challenge to the congregation's DRCSA members on the presence of black people at the Eucharist.

In the DRCSA, it was common practice for such persons to only partake in the Lord's Supper after the so-called born Christians had been invited in the manner of Stellenbosch and Caledon (Loff 1981:18-19). Since these few white people were initially considered to be Amsterdam's church members, there was never any idea of starting a congregation. Wiljlant was in charge of caring for the sick and providing them with spiritual support. The first congregation was founded in Cape Town in 1665. Under the Presbytery of Amsterdam, this congregation reverted. Johan van Arckel served as the church's first minister. The minister worked for and was paid by the state. A political representative served as the state's representative at church council meetings. In 1686, a second congregation was founded in Stellenbosch and in 1691, a third congregation was founded in Drakenstein (Paarl).

Two congregations were started thereafter: one in Tulbagh in 1743 and another one in 1745, another in Malmesbury.

After 50 years, two other congregations were founded: one in 1792 at Graff – Reinet and one in 1798 at Swellendam. Between the year of the arrival of the Dutch at the Cape (1652) and the synod of 1857, all “non-white” and white Christians worshipped God under the same roof irrespective of their colour and race.

According to de Gruchy (1979:7), during the early days at the Cape Colony racism practiced between whites and blacks, free man and slave, was apparently centred more on religion than race. Though discrimination and a European sense of cultural dominance were common, everyone was sternly warned and told to display every kindness and amiability to the native population, according to a proclamation made by the first Dutch commandant at the Cape. de Gruchy (1979:7) goes on to say that the issue of separate structures for non-whites was brought up once more at the synod of 1857. The proposal, which was endorsed by the synod, stated as follows:

“The synod believes it is both desirable and scriptural for our branches from the Gentiles to be assimilated into our current churches. “

Wherever they may be, but where this measure in consequence of the weakness of some, the promotion of the house of Christ under the Gentile should stand in the way, the congregation of the Gentiles established, whether to erect, Christian privileges in an underlying building or style will be enjoyed. The proposal was accepted by most of the synod.

Although de Gruchy (1979:8) argues that the proposal was not simply for racist reasons, it is nevertheless important to take into consideration its racist consequences in the political ecclesiological history of South Africa. Before 1963 the different regional synods of the then-Bantu DRC functioned as independent synods under the control of the white DRC. In 1963 the four regional synods of the African church; the Cape, Transvaal, Orange Free State and Natal; formed one general synod. The new church became known as the Dutch Reformed Church in Africa (DRCA). However, it remained under the patronage of the white DRCSA, financially, theologically, politically, and psychologically.

### **2.6.2 The Dutch Reformed Church in Africa (DRCA – Black church)**

The DRCA was the result of mission work of the Dutch Reformed Church in South Africa (Whites). Nyatyowa (1999:11) asserts that the Cape DRC started mission work in Bechuanaland (now Botswana) in 1877, Nyasaland (now Malawi) in 1889, and Mashonaland (Zimbabwe) in 1891, and in Nigeria in 1908. In Natal, the first mission was founded in Greytown in 1887 (Crafford 1982:158-173). In 1874 mission work started in the Orange Free State at Witsieshoek, to be followed in 1885 by work in the Transvaal (Crafford 1982:128-132). In 1889 the Dutch Reformed Church in the Orange Free State started its own missionary work in then-Northern Rhodesia (now Zambia) (Crafford 1982: 310). This work was also extended to Lesotho, Kenya, and Swaziland. This church grew rapidly, especially during the nineteenth century. Four theological seminaries within the boundaries of South Africa were established, one in Umtata (Decoligny) for the amaXhosa, Witsieshoek for the Basotho, Turfloop for Batswana and Dingaanstat for the amaZulu.

### **2.6.3 The Dutch Reformed Mission Church in South Africa (DRMCSA- Coloured church)**

According to Nyatyowa (1991:10-11), the new Mission Commission of the DRC, elected at the synod of 1857, did well in its mission within the country. On Friday 12<sup>th</sup> November 1857, the synod agreed to establish a separate “Dutch Reformed Mission Church”. The overwhelming majority accepted this proposal (Crafford 1982:99). On the acceptance of this proposal, the Inland Mission Commission arranged the establishment of the Mission Church. The synod of DRMC consisted of four congregations, namely George, Zuurbraak, Wellington, and Wynberg, and the very first moderator of the newly established church was formed by four missionaries. The Mission commission of the “mother” church remained operative as a link between the “mother” and the “daughter” church. The new church grew rapidly (Kriel 1961:63-67). Two congregations, St Stephens (Cape Town) and Stockenstrom (Eastern Cape) decided to unite with the DRC. The St Stephens congregation remains a member of the DRC in South Africa until this day, but Stockenstrom later decided to become a member of the DRMC. By 1981 this church had 200 congregants (Kriel 1981:55). In March 1981 the Dutch Reformed Mission Church was a hundred years old and celebrated its birthday at Wynberg in Cape Town (Kriel 1981:26). It expanded throughout South Africa until 1994, when it united with the DRCA to form the new Uniting Reformed Church in Southern Africa (URCSA).



Before 1963 the different regional synods of the then-Bantu DRC functioned as independent synods under the control of the white DRC. In 1963 the four regional synods of the African church, the Cape, Transvaal, Orange Free State, and Natal, formed one general synod. The new church became known as the DRCA. However, it remained under the patronage of the white DRC, financially, theologically, politically, and psychologically.

#### **2.6.4 The Reformed Church in Africa (Indian church)**

Dionne Crafford (1996) asserts that among the Indians, the DRC started its mission work in 1996 through the efforts of the Reverends MW Theunissen and CWJ Pretorius of the DRC. At a later stage, the DRC took over the mission work from Theunissen and Pretorius. In 1951 Mr A Murugun was given the status of an evangelist and worked among his people for the DRC. In 1957 Rev CWJ Pretorius was appointed to work full-time among the Indians in Natal. In Transvaal, mission work was started by Rev Chris Greyling in July 1957. In 1959 Charl du P le Roux was ordained to assist Rev CWJ Pretorius. By 1961, Gopal Moodley had already been working as the first student evangelist in the Transvaal (Crafford 1982:449). A second evangelist, Bunyan Peter, came to his assistance.

In November 1961 a church building in Germiston was inaugurated. In 1963 Mej Eringa was appointed to work in Pretoria (Crafford 1982:450). In Cape Town, mission work among Indian people was started by Rev DJ Pypers in 1960 on the Cape Synod's request. In 1965 a church building was erected in Rylands and in 1966 the first Indian congregation in the Cape was established.

The first convention of the Indian congregation was held on 27 August 1968. This convention accepted the church order and constituted as the Indian Reformed Church. It changed its name in 1976 to Reformed Church in Africa. This church was independent from the onset. The DRMC, DRCA and RCA were initially independent churches in association with the DRCSA. All these mission churches were established by the DRCSA. It was not the will and desire of the "non-white" churches to establish separate churches.

### **2.6.5 The foundation of the Uniting Reformed Church in Southern Africa (URCSA)**

Fouche (2000:176) asserts that the Uniting Reformed Church in Southern Africa (URCSA) is a product of the amalgamation of the black Dutch Reformed Church in Africa and the Coloured Dutch Reformed Church in 1994. According to Bosch (2011:168), the amalgamation was aimed at uniting all the Dutch Reformed Churches to make one church, though the White Dutch Reformed Church is still out of this unification. Regarding the reformed church's position, the Geneva Confession states:

“We always accept that necessity forces groups of the faithful to be distributed in different regions, even though there is only one Church of Jesus Christ. Each of these gatherings is referred to as the Church. We believe that the proper mark by which we were rightly discerned the Church of Jesus Christ is that his holy gospel be purely and faithfully preached, proclaimed, heard, and kept, that his sacrament be properly administered, even if there are some imperfections and faults, as there always be among men. But in as much as all companies do not assemble in the name of our Lord Jesus Christ, but rather to blaspheme and pollute him by their sacrilege. On the other hand, we do not recognize the structure of the Church if the Gospel is not preached, heard, or received. Thus, rather than being Christian churches, the church regulated by the Pope's commandments are synagogues of the devil. “

It should be noted that the White Dutch Reformed Church was in support of racism and Apartheid policies. de Gruchy (2009:41) notes that one of the leading theologians of the Dutch Reformed Church in South Africa in the latter half of the twentieth century, Frederick Potgieter, and defended Apartheid to the end on “Calvinist” principles. Potgieter also rejected any lasting humanist influence on Calvin's theology, other than as a tool for preaching the gospel. Bosch (2011:169) argues that outsiders are immediately tempted to ascribe this situation solely and exclusively to racism. This is partially correct. It is, however, not the whole story and unless we realize this, we shall not be able to understand this entire phenomenon fully when commenting on the Dutch Reformed Church's policy of racially separate churches.

### **2.6.6 African Reformed Praxis**

URCSA believes in an African reformed praxis, since the majority of its members are Africans. According to Bujo (2009: 113), the question as to whether a specific African ethic exists arises because the African version of Christianity is largely the consequence of the battle of African culture and religion with an absolutist Western form of the religion. Many features considered as fundamentally Christian were purely features of Western culture, and the African world view hardly managed to contribute anything positive to this extended form of Christianity.

African reformed praxis is sometimes misinterpreted, because some people associate it with ancestral worship. African reformed praxis is the way Africans worship God in a way which includes singing, dancing and praising. It can also be called African Reformed Theology. According to Engelbrecht et al (2000; 45), African Reformed Theology is the vocalisation of the Reformed Christian faith by African Reformed Christians, both theologians and lay people. They explain that there are four sources and tools for doing theology in Africa: Bible, Christian heritage, African culture, and African history.

#### **2.6.6.1 The Bible**

The Bible is one of the four sources for doing theology in Africa. There is an argument among theologians whether the Bible is the Word of God or a book that contains the Word of God. Those who say it is a book that contains the Word of God, argue that there is no power in it when it is not used, but if used correctly it can change people's lives. According to Engelbrecht et al (2000; 74), the word "Bible" derives from the Greek *biblia*, which means 'books'. After the invention of printing, the Bible came to be known as just one book, but actually there is a whole library of no fewer than 66 books between its covers. These represent a wide variety of literary types, all combining to form the Holy Scriptures of the Jewish and Christian communities. The Bible is the religious book of both synagogue and church, except that when Jews speak of the Bible they are referring only to the Hebrew and Aramaic works which Christians call the Old Testament.

The authority of the Bible is central in Reformed theology, followed by church doctrine and church order. Both church doctrine and church order are founded on and based in the Bible, which means that church order or doctrine must not be in conflict with the teaching of the Bible. One of the highlights of the Reformation was the authority of the Bible. The Reformers believed that the Bible alone gives a guide to salvation (*sola scriptura*- Scripture alone, 2 Peter 1:20-21). Next to it is faith alone (*sola fido*, John 3:16) and grace alone (*sola gratia*, Ephesians 2:8-9). In other words. The Bible contains everything about salvation. It has the authority to give guidance. It cannot be disputed and nothing should be added to its teachings (All Christian traditions use the Bible as their source of reference). In actual fact, most of these Christian traditions are the result of different interpretations of the Bible.

#### **2.6.6.2 Christian heritage**

According to Engelbrecht et al (2000; 48), Christianity was first practised in Hebrew culture but soon spread to the Greek, Roman and eventually European and American cultures. It was covered in the clothing of those cultures when it arrived in modern day Africa, but it is rich in spirituality, theological ideas, art, music, liturgy, symbolism, etc. The church in Africa has been enriched by this Christian heritage.

Most church traditions in South Africa are the result of an inheritance from missionaries and their place of origin: e.g. URCSA is the result of missionary work from the Dutch Reformed Church, which originated from the Netherlands, and it is still maintaining the Dutch Reformed Church practices such as church council members wearing black suits and white ties and the terminology still used, which is Afrikaans, in black and coloured churches. The church council is usually called “*Kerkrade*”, ministers clerical gowns “*togas*”, pulpit “*preek- stoel*”, Holy Communion “*Nag maal*”, etc.

The first settlers at the Cape, whether Dutch, German or French, were Protestants, according to de Gruchy (1995:28). Jan van Riebeeck, the first commander, saw it as part of his duty to contribute to the development and spread of the Reformed faith. By 1579, when Holland gained its independence from Catholic Spain, Reformed Christianity, which had its roots in the early sixteenth century Swiss Reformation led by John Calvin, had already become the country’s official religion. It should come as no surprise that the Dutch East India Company specifically forbade Roman Catholicism in its societies.

Therefore, the Dutch Reformed Church (DRC), which was governed by the church authorities in Amsterdam, served as the traditional church in the Cape of Good Hope.

### **2.6.6.3 African culture**

Culture is central to every human being, because it identifies a person. Culture also explains how people do things, how they cook and eat food, how they dress, how they raise their children, and the language they speak. It has been said before that though there are many different ethnic groups and clans in Africa, in most cases their culture is unique. They all celebrate similar ceremonies, such as wedding preparations and marriage, funerals, etc. According to Englebrecht et al (2000, 48), the most significant factor in influencing the development of an African worldview has been African religion. Even if it is frequently in the background or just below the surface, it is nevertheless a significant factor. Since African belief is predicated on the faith in the existence of the one God, creator of all things, God, rather than the missionaries from Europe and America, brought them to Africa.

The Christian Old Testament and African religion are similar in many ways. Some theologians have even referred to African religion as the Old Testament of Africa, which is an unjustified claim. Despite the diversity of African civilizations, according to Munyaka & Mothlabi (2009:63), there are some shared value systems, beliefs, and behaviours among them. These regions essentially represent the perspective of Africa. This worldview's guiding idea is referred to as *Ubuntu* (humanism or humanness). The researcher, as an African Reformed Calvinist Christian, strongly believes in the teachings of Reformed tradition, especially on salvation, because they don't clash with my African culture, instead both support each other as they promote the notion that we are all accountable for the life that we are living and that one day we will answer to God.

Reformed tradition encourages people to worship God in their language by practising their culture; e.g. singing, dancing, and poems. Contrary to modern morals, African philosophy does not view morality as a separate discipline because it is implicit in all aspects of African social life, claims Richardson (2009:131). It is a frustrating journey to go out on to discover and comprehend African ideas through abstract ethical principles. As an alternative, one must observe and consider how individuals interact in their social environments – their rituals, practices, events, and connections.

#### **2.6.6.4 African history**

According to Engelbrecht et al (2000; 48), it goes back, if we so wish, three million years to when the first ancestors of human beings began to wander the grasslands of eastern Africa. More recently however, we take up precolonial, colonial, and post-colonial history. Each of these phases has had its impact on the life and thinking of the people. Modern history is branded by fast social, economic, and political change, for better or for worse, and by mass media, modern technology, and contact with other nations. African theology is taking place in a multi-historical context, which affects theological reflection and output. Millard (2001:11) articulates that North Africa is part of the Mediterranean world, so the growth of Christianity there was influenced by the growth elsewhere in the Near East. People travelled from Africa to Rome and other cities to trade and to visit friends.

The spread of Christianity in North Africa can therefore not be studied in isolation, due to the influence of the dominant Greek and Roman cultures. On the other hand, the influence of Africa was felt all over the world where Christian message was preached (Oden 2007:44). Millard further articulates that Greeks lived in Egypt from the seventh century BC and their history there had a great influence on the development of Christianity, especially in Alexandria (Isichei 2004:17). In 331 BC when Alexander the Great of Greece conquered Egypt he founded the city that bears his name. After his death, one of his generals, Ptolemy, built it up into one of the greatest cities in the world. Egypt became part of the Roman Empire in 30 BC when Cleopatra, the last of the Ptolemies, committed suicide. Greek remained the language of scholarship and the cities while the ordinary Egyptians, especially in the rural areas, spoke Coptic. Indigenous Egyptians were called upon to pay heavy taxes to Rome. This caused great hardship.

#### **2.7 Greytown Uniting Reformed Church in Southern Africa**

Greytown URCSA is one of the congregations of the presbytery of Greytown (the presbytery is named with the name of this congregation, because it is the first congregation that was established in this presbytery), KZN Regional Synod of the General Synod of URCSA. The congregation subscribes to all doctrines of reformed theology, including the *KZN URCSA Regional Synod Church Order*. While there is only one church of Jesus Christ, the Geneva Confession of Faith states this regarding the status of the congregations of Reformed churches:

“We always admit that necessity demands groups of the faithful to be distributed in different areas. Each of these gatherings is referred to as the Church. We believe that the proper mark by which we richly discern the Church of Jesus Christ is that his holy Gospel be purely and faithfully preached, proclaimed, heard, and kept, that his sacrament be properly administered, even if there are some imperfections and faults, as there always will be. However, in as much as all companies do not assemble in the name of our Lord, but rather to blaspheme and pollute him by their sacrilegious deeds. On the other hand, we do not recognize the structure of the Church if the Gospel is not preached, heard, or received.”

Article 1 of the *KZN Regional Synod Church Order and Stipulations*, 2018 also affirms the status of a congregation: “A group of Christians who have been brought together by the Word of God and the Holy Spirit is known as the Church of Jesus Christ. This Church of Christ is made up of those who have been called and comprise the Uniting Reformed Church in Southern Africa, along with other churches that affirm Christ. This church has been designated as a nation as the people of God who are His and who are obliged to share the salvific works of the One who called them out of darkness and into the light, making them a new creation that dwells in the light as He is the light.”

### **2.7.1 Greytown URCSA leadership succession from 1947 to date**

According to the updated 2021 membership register, the congregation was started in 1947 under the leadership of the late Rev Dr Thamsanqa Zondi, who was followed by Rev Simon Thela from 1983 to 1986, Rev Peter Khanyile from 1990 to 1993, the late Rev Michael Zikhali from 1995 to 1997, Rev Nicholas Chamane from 1998 to 2000, and Rev Kgoabosele Sekgokgoba from 2000 to 2005. Currently the congregation is under the leadership of Rev Nkosinathi Mbatha, who was installed in 2019 as its congregation minister. The congregation has seven branches with a total membership of 230.

NAME OF BRANCH	WOMEN	MEN	TOTAL
Amatimatolo	25	14	39
Eshane	07	05	12
Mbuba	13	04	17
Mbulwane	08	04	12
Ngome	27	02	29
Nhlalakahle	68	35	93
Ntembisweni	19	09	28
Total	167	73	230

### 2.7.2 Church governance

Governance is in accordance with John Calvin's doctrine, which states that Paul calls the apostles, prophets, evangelists, pastors and teachers in that order to preside over the administration of the Church in accordance with Christ's Institution ( Eph 4:11). Only the last two, the pastors and teachers, hold regular positions in the church. The apostles, prophets and evangelists were the first three that the Lord raised forth at the start of his Kingdom and periodically brings back to life as the situation calls for (Calvin, 1559:1056).

Article 7 of the KZN Regional Synod Church Order and Stipulations, 2018 states this on governance of the congregation:

“Through the power of the Holy Spirit and His Word, Jesus Christ controls his Church. All other offices in the church are built upon the office of believers. For this reason, a church council made up of elders and deacons is chosen by the congregation itself from among its practising members. The leadership of the congregation's many ministries as well as the management (governing), oversight, and discipline of the congregation fall within the purview of the church council. The church council oversees all activities related to worship, instruction, shared care and witness, and community service.



It also imposes discipline on congregation members, with the exception of elected office holders, establishes procedures and rules for tasks entrusted to it, and, if necessary, may call a meeting of the congregation in a manner agreed upon by each congregation.”

Stipulation 28 of the KZN Regional Synod Church Order and Stipulations, 2018 states this on composition of church council:

“The church council shall consist of the minister(s), evangelist(s), and at least three elders and at least two deacons. The church council itself shall determine the number of the church council members. The posts for elders may not be fewer than those for deacons. The church council shall meet at least four times a year.”

Calvin (1539:58) articulated that the minister and the teacher form part of the four orders of the Church, ministers, doctors, elders, and deacons, each of which fulfils a particular role in the Church.

#### **2.7.2.1 Ministers**

According to Ecclesiastical Ordinances, the duty of the minister is:

“To publicly and covertly preach the Word of God, to explain, warn, encourage, and reprimand, to administer the sacraments, to give brotherly admonitions alongside the elders or other helpers.”

The Geneva Confession of Faith states the following regarding the Ministers of the Word:

“We acknowledge no other ministers in the church but faithful ministers of the Word of God, feeding the sheep of Jesus Christ on the one hand with instruction, admonishment, consolation, exhortation, and deprecation, and on the other, resisting all false doctrines and deceptions of the devil, without mixing with the pure doctrine of the Scriptures their dreams or their foolish imaginings. These have only the control and authority to lead, rule and manage the God-given people who have been entrusted to them by the same Word, in which they have the power to command, guard, assure, and warn, and without which they cannot or should not attempt anything. ”

“It is crucial in the Church that we accept the genuine ministers of God’s Word as His messengers and spokesmen. However, we view their position as a mandate from God that is necessary in the Church. But according to our beliefs, no tempting or false prophets who are not the ministers they claim to be should ever be tolerated or retained because they turn away from the purity of the gospel in favour of their own discoveries. Instead, they should be alarmed and banished from God’s people like greedy wolves. ”

Stipulation 13 of the KZN URCSA Regional Synod concurs with the Ecclesiastical Ordinances and Geneva Confession by stating the following responsibilities of a minister: a) Preaching God’s word and practicing prayer. b) Giving forth the sacraments. c) Directing the worship services. d) Assuming accountability for catechetical instruction. e) Excellent public religious expression. f) Governing and disciplining the congregation in collaboration with the church council. g) Pastoral care for the congregation and appropriate home visits. h) Preparing all disciples for their offices, especially those holding special offices and other positions of leadership in the congregation, as well as those who have the capacity to do so. i) Presiding over church council sessions. j) Extending an invitation to non-Christians and non-churchgoers. k) The marriage blessing in Christianity. l) Going to church services.

#### **2.7.2.2 Doctors / Theology Lecturers**

According to Ecclesiastical Ordinances, the duty of the doctors’ or theology lecturers’ responsibility is: To impart good theology to the faithful so that their ignorance and unfounded beliefs do not taint the purity of the Gospel. As things stand, every person helping to uphold God’s message is included, preventing the Church from experiencing challenges due to a shortage of pastors and ministers. This is the order of teachers in everyday language.

Theology lecturers are closest to the minister and most directly associated with church leadership. The URCSA’s ministerial training program (General Synod Agenda 2005, pages 304-307), give the following guidance for student ministers:

“A student with full matriculation exemption will complete their education in five academic years. An institution of higher education will require a student with Senior Certificate (or similar) to finish an academic ‘bridging or access’ programme before granting entrance to degree studies. This process will take (at least one year) longer for this student.”

The precise requirements that a student must meet may vary from area to region, but the GS MFTT must accept the species. The following framework will be followed by all regional MFTTs:

“The first four academic years will be made up of either a three-year B.Th. (or equivalent), followed by a broad-based B.Th. Honours, or four-year B.Th. (or comparable broad-based qualification at NQF level 9) or equivalent. The fifth year will include a one-year M.Div. (or equivalent) or a specialized research MTh, provided that the following conditions are met: a) the student earned an average of at least 65% in the Honours degree; b) .The student finds a theological department that will accept him or her into a specialized Master’s programme on the basis of a broad-based Honours degree; c) the student has complied with all other curriculum requirements for practical and spiritual formation, During the first four years, all students are required to take a few basic subjects, but they are also free to select from a wide range of electives. They are able to properly base themselves in an ecumenically open and African Reformed theology. The electives give the student the chance to build a feeling of focus or specialization, as well as expertise in a subject that might lead to a supporting profession for a part-time minister. At least one year each of Hebrew and Greek are required for the core subjects, as well as a minimum of one year in an African language other than the student’s mother tongue. Missiology, Practical Theology, Ecclesiology (Church History and Church Polity), Systematic Theology, and Theological Ethics. ”

#### **2.7.2.3 Elders**

According to Ecclesiastical Ordinances, the duty of the elders is to keep an eye on everyone’s behaviour. They should gently caution individuals who have strayed and those who lead chaotic lives. When required, they should then report to the church council, which will make arrangements for fraternal reprimand. As our church is now arranged, it would be most suitable to have two elected from the council of 24, four from the council of 60, and six from the council of 200. They should be men of good repute and conduct, and should be chosen from each quarter of the city so that they can keep an eye overall area.

#### **2.7.2.4 Deacons**

According to Ecclesiastical Ordinances, there are two duties of deacons which are:

“The first step is to collect, distribute and take care of the poor’s goods (i.e., daily alms as well as possessions, rents and pensions).The second is to administer the poor people’s allowances in the traditional manner while tending to and caring for the sick. Since we have officials and hospital personnel, one of the four officials of the aforementioned hospital should be in charge of all of its assets and revenue in order to prevent confusion, and they should be paid enough to do their duties effectively. ”

What is significant of Calvin’s role in the Church is that he viewed the two offices (minister and theology lecture) in Ephesians 4:11 as separate. Calvin writes:

“The Church can never function without ministers and teachers, so they come next. There is no distinction between them: teachers are only tasked with interpreting the Scriptures in order to maintain doctrine that is complete and pure among believers, not with enforcing rules, delivering the sacraments or giving out cautions and encouragements. However, the pastoral office itself performs all of these duties (Calvin, 1559:1057).”

Consequently, according to Calvin, the theology lecturer functions as “a scholar” of the church. This is also basic in the Geneva Confession (2006:63) where Calvin orders that the instructors must be educated to be able to interpret the Scriptures and explain to others the correct doctrine, a role expected from scholars.

Calvin did also expect the ministers to be educated, because the role of the minister matched with the instructor’s role.

The congregation of Greytown is under very good leadership, comprising mature men and women mixed with the youth. It is governed by 13 church council members (one elder and one deacon from each branch): seven elders, seven deacons, and a Minister of Religion who holds a position of chairpersonship as per the ruling of the Church Order of URCSA.

A few of the church council members are well-educated, whereas the majority are not. The member's sense of their responsibility as custodians of the administration of the church that has been handed to them is somewhat weakened by this observable fact, and those who are unaware of the church order tend to avoid active engagement, especially during the discussion of concerns. It should be mentioned that the minister faces a significant challenge in educating council members about their tasks and equipping them with the confidence needed to navigate the path due to this lack of awareness. According to Article 01 of the *KZN URCSA Regional Synod Church Order and Supplementary Stipulations* (2018), through the power of the Holy Spirit and his Word, Jesus Christ rules his church. All other offices in the church are built upon the office of believers. For this reason, a church council made up of elders and deacons by the congregation itself from among its practicing members. The church council is in charge of the following:

- a) The direction of the church's many ministries, as well as the management, supervision and discipline of the congregation.
- b) Everything having to do with worship, instruction, shared (communal) care, witness, and service to the neighbourhood.
- c) Discipline of members of the congregation, except for elected office bearers (their discipline is entrusted to the Presbytery commission).
- d) Establishing policies and guidelines for the tasks assigned to the council.
- e) Additionally, they have the option to hold a congregational meeting as they see fit.

### **2.7.3 Denominational practices**

#### **2.7.3.1 Church tradition on membership**

Membership in the congregation of Greytown URCSA is in line with article 3 of the *KZN Regional Synod Church Order and Stipulations*, 2018:

“The only requirement for membership in the Uniting Reformed Church in Southern Africa is faith in Jesus Christ. Those who want to join this church must publicly profess their faith in front of the congregation and for members of other recognized reformed churches; they must do so by submitting a membership certificate. By virtue of the covenant of grace, baptized children of communicants (practicing members) are members of the church.”

Such members will publicly proclaim their religion in front of the congregation to confirm their membership in the church. Stipulation 10 of the *KZN Regional Synod Church Order and Stipulations*, 2018 state this on the office of the believer:

1. Church members are ordained into the office of believer at baptism and nurtured by the church to become confessing members who are equipped to exercise their responsibilities and use their gifts as servants of God in the church and society.
2. Based on this general office of believer (or “priesthood of all believers”) and to make the services in the congregation more effective, some members of the congregation are appointed to serve in special offices.
3. The office of believer includes the following responsibilities:
  - a) A caring acceptance of one another to build up the Body of Christ as an inclusive fellowship of believers.
  - b) A priestly rendering of service to one another and to the society in which they live, through sacrificial sharing and intercession.
  - c) A royal lifestyle of victory over every form of sin, by striving for personal righteousness and compassionate justice in church and society.
  - d) A prophetic preparedness to declare God’s truth by being witnesses to people and by speaking truth to power.

### **2.7.3.2 Liturgy**

According to de Gruchy (2009: 178), the earliest Sunday worship for most Christians has been shaped by a common life of prayer, Scripture reading and teaching, within the context of sharing in the Lord’s Supper (cf Ac 2:42). This is apparent in the structure of all the classic liturgies of the Church, where the liturgy of the Word, derived from synagogue devotion (scripture reading, sermon, prayers, and hymn singing), has always been set within the context of the liturgy of the upper room or the Lord’s Supper. The liturgy is the order of the service. In some churches it is prescribed exactly what should be done, when, and how. The tradition of the Church, especially its theological tradition, plays a very important part. For example, in the Roman Catholic Church they understand the Lord’s Supper as a sacrifice that is repeated at every service.

Therefore, it becomes the most important part of the service, rather than the preaching of the Word. In Reformed churches, the Sacraments are seen in a different way, where the preaching of the Word is the central part of the service. Reformed churches also regard the liturgy as the two-way communication between the congregation and God. The liturgist represents God to the congregation and the congregation responds to the liturgist.

Greytown congregation again adheres to the Reformed liturgy when conducting Sunday service, as prescribed by the URCSA General Synod. When one observes the liturgy in Greytown URCSA, it is still inherited from the Dutch Reformed Church practices. The service is very formal, where the liturgist stands in front of the congregation and acts as a programme director. The liturgist speaks and directs the congregation to sing songs from the hymn book, pray politely, and the liturgist preaches, then the service is over. However, in the African context the liturgy is done differently. Mbiti (2015:20) state that Africans are known for their dancing, singing loudly, and poetic recital. For the service to be relevant, all these activities need to be involved during the service. In addition, we think that African liturgy and theology needs to be understood in relation to African life and culture as well as the creative efforts of African people to forge a new future distinct from the colonial past and the neo-colonial present. A new theological and liturgical methodology that departs from the prevailing Western theologies and liturgies is necessary to address the African context. The prefabricated conceptions of North Atlantic theology must therefore be rejected by African theology, which must define itself in light of the struggles of the populace in opposition to the structures of dominance.

African people must be at the centre of the theology we develop for them (Accra, Ghana Conference of African Theologians, 1979:193). So being African in the church is beyond loud singing, but the thought of African liberated worship or liturgy. The African form of liturgy seeks to be liberated from the chains of European liturgy and songs which express this Europeanisation and corrosion of things African – culture, dance, politics, and freedom of worship. There is a story about Martin Luther, the father of Reformation, where he composed the songs through the tunes he got from people drinking at the bars and only changed the words to be about Christ and salvation, because he was contextualising the worship service.

### **2.7.3.3 Proclamation of the Word**

URCSA in general subscribes to the pure proclamation of the Word. In Greytown URCSA congregation the Word is proclaimed in accordance with the teachings of the Reformed tradition.

The Geneva Confession states this on proclamation of the Word:

“First, we affirm that we desire to follow Scripture alone as rule of faith and religion, without mixing with it any other thing which might be devised by the opinion of men apart from the Word of God, and without wishing to accept for our spiritual government any other doctrine than what is conveyed to us by the same Word without addition or diminution, according to the command of our Lord. ”

Article 4 of the Belgic Confession concurs with the Geneva Confession on proclamation of the Word:

“We believe that the Holy Scripture contains the will of God completely and that everything one must believe to be saved sufficiently taught in it. For since the entire manner of service which God requires of us is described in it at great length, no one—even an apostle or an angel from heaven, as Saint Paul says ought to teach other than what the Holy Scriptures have already taught us. For since it is forbidden to add to the Word of God or take anything from it. It is plainly demonstrated that the teaching is perfect and complete in all respects.”

In addition, we think that African liturgy and theology must be understood in the context of African life and culture, as well as the innovative efforts of African peoples to create a new future that differs from the colonial past and the neo-colonial present. A new theological and liturgical methodology that departs from the prevailing Western theologies and liturgies is necessary to address the African context. The prefabricated conceptions of North Atlantic theology must therefore be rejected by African theology, which must define itself in light of the struggles of the people in their resistance to the structure to the structures of dominance. African people must be at the centre of the theology we develop for them (Accra, Ghana Conference of African Theologians, 1979:193).



Article 3 of the Canons of Dordt states this on the Preaching of the Gospel:

“God mercifully sends the preachers of this highly joyful news to the people He chooses and at the time He chooses in order to help people come to faith. People are called to repentance and faith in the crucified Christ through this ministry. Since they haven’t heard of him, how are they supposed to believe in Him? And without preaching, how will they be able to hear? And how will they be able to preach if they are not sent? (Rom 10:14-15). ”

Cochrane *et.al* (1991: 80) clarifies that listening to the Word, and reflecting on its meaning, brings together both the powerful and often hazardous memory of Jesus, the crucified and risen Lord, and our life in the world.

de Gruchy (2009:144) also explains that, while the Reformers emphasised that the Scripture was itself inspired by the Holy Spirit, they were not fundamentalists in the contemporary sense of that word whereas Luther was doubtful about certain books in the Bible, like the Letter of James, and Calvin used the results of humanist scholarship in his approach to the Bible, admitting that there were some errors of fact in its pages.

Kritzinger (2015: 6) asserts that preaching or proclamation of the Word is a public act that takes place in a worship service of a Christian community, where someone presents a message that is based on a passage of the Bible. Preaching of the Gospel is central in the Greytown URCSA. When anyone is preaching, it is a tradition that Christ should be put into the centre of the message, because the Gospel without Christ is not regarded as the proper Gospel. Preaching is also one of the three marks of the living church, as outlined by the teachings of the Reformed tradition i.e., preaching pure gospel, administration of Sacraments (baptism and Holy Communion), and discipline among church members. According to de Gruchy (2009: 141), in our modern world, where we are inundated with words in ways that so often devalue them, it is difficult for us to grasp the importance that the recovery of the Word had for the Reformers. Not just the words of Scripture or of the preacher, but the Word as vibrant power by which God creates and redeems the world; the Word as the Wisdom of God “made flesh” in Jesus Christ – all of which is captured in the foreword to John’s Gospel. Preaching should include the daily challenges of the people in today’s context, which includes chronic diseases (message about healthy living and diet),

HIV/AIDS (message about abstinence, being faithful to your partner and adherence to treatment for those who are already infected and are in treatment), poverty (empowerment and importance of education), forgiveness, love of one another, dangers of using drugs, etc.

Calvin's preaching was the fundamental role of the pastoral office, as is evident in his account of the office of the ministers in the Ecclesiastical Ordinances. "The role of ministers, also known as elders in the Bible, is to preach the Word of God, instruct, forewarn, encourage, and condemn in both public and private, administer the sacraments and issue commands" (1541:58). It is obvious from this that all these instructions involved a great deal of scholarly engagement with the Word of God, written in the Holy Scriptures, to be carried out. Calvin's preaching when dealing with his ministry by means of understanding can thus not be ignored, since this was the key way in which he pastored.

Concerning Calvin's view of preaching, Herman Selderhuis (2009:110) pronounces that Calvin believed in such a great interpretation of preaching and took his preaching so seriously that his pulpit was physically elevated. Nonetheless, this was not to elevate the preacher, but it was so that the Word of God might descend upon the listeners. Olivier Fatio (1986:1) reasons that this reflects Calvin's theology of preaching because he believed that when he spoke as the preacher, God himself was speaking. His insistence upon the importance of the preaching role of the minister was because he believed preaching was like a visitation from God, through which he reached out to people. According to Calvin, the ability of the Word of God to transform people's lives was twofold: first, it turned God's enemies into his children and second, it taught God's children to further honour their Father. Selderhuis (2009:111) draws attention to this.

#### **2.7.3.4 Sacraments**

The Greytown URCSA congregation also subscribes to two Sacraments as per the teaching of the Reformed theology: Baptism and the Holy Communion. The Geneva Confession of Faith states that:

"We hold that the sacraments that our Lord established for his Church are exercises in faith for us strengthening and confirming our faith in God's promises as well as serving as a witness to others. Only two of them, baptism and the Lord's Supper, were established by our Saviour and are thus recognized by the Christian church.

We reject as fantasy and lying everything the Pope claims to have established as seven sacraments.”

Article 33 of the Belgic Confession also concurs with the Geneva Confession:

“We believe that our good God, mindful of our crudeness and weakness, has ordained sacraments for us to seal the promises in us, to pledge the good will and grace of God toward us, and to nourish and sustain our faith. God has added these to the Word of the Gospel to represent better to our external senses both what God enables us to understand by the word and does inwardly in our hearts, confirming in us the salvation imparted to us. For they are visible signs and seals of something internal and invisible, by means of which God works in us through the power of the Holy Spirit. So, they are not empty and hollow signs to fool and deceive us, for their truth is Jesus Christ, without whom they would be nothing. Moreover, we are satisfied with the number of sacraments that Christ our Master has ordained for us. There are only two: the sacrament of baptism and the Holy supper of Jesus Christ.”

#### **2.7.3.5 Baptism**

Baptism is another one of the two sacraments that is practised in the Reformed tradition churches. It is done inside the church building in front of the congregation. Along with Holy Communion, it is done by an ordained minister. There are two groups of people who are baptised: both young children and adults can be baptised. According to the Geneva Confession, baptism is an outward manifestation of our Lord’s willingness to accept us as members of his family and as children of his Son, Jesus. As a result, it serves as a representation of our forgiveness of sins by the humiliation of our flesh and the blood of Jesus Christ through his death, so that we may live in him through the power of the Holy Spirit. Now that our children are a part of this alliance with our Lord, we know that the external sign is being applied to them correctly.

Regulation 63 of the URCSA General Synod states on baptism:

- Children 0 to 6 years old: Children of confessing and participating members of the church will receive holy baptism. Parents must acquire written consent from the church council of their own congregation if they want to have their children baptized in a congregation other than the one they are members of.

- Baptism may, by means of high exception, be served to the children of members of recognised Protestant churches on condition that they have received written permission from their own minister or the responsible representatives of their congregation. Children of believing parents but born out of wedlock may be baptised after discipline has been lifted. After providing evidence of adoption, believing foster parents may baptize children whose parents have relinquished all claims to them.
- Children aged 7 to 15 years of age: The church council will consent to the baptism of children in this age range with great freedom and choice, particularly when the entire house has become converted and desires baptism. Only if the church council is persuaded that the child from this age group has a personal trust in and love for Christ, as well as understanding of the Bible and the Confessions, can they be baptized. The baptism of these kids will be reported by the church council to the presbytery.
- Adults (16 years and above): Un-baptised adults are baptised after confession of faith and with the prescribed form being used. Polygamists who are converts from heathendom may be admitted to the confession of faith and baptism after Presbytery has carefully investigated the grounds of an application of the church council, has given its approval. Polygamists may not be elected to offices.

Article 34 of the Belgic Confession states this on baptism:

“We hold on to the conviction that every previous act of bloodshed intended to atone for or satisfy for sins has been abolished by the death of Jesus Christ, the fulfilment of the law. Christ abolished the bloody practice of circumcision and instituted the sacrament of baptism in its place. It is how God’s Church receives us and how we are separated from all other people and other religions so that we might be fully devoted to the one whose mark and sign we bear. It also serves as a witness to the fact that God as our Father will always be our loving Father and our God.”

Because of this, God instructed that everyone who is part of Him be immersed in clean water in the names of the Father, the Son and the Holy Spirit. Stipulation 5 of the KZN Regional Synod church order and stipulations, 2018 states this on baptism:

- The minister or consolent of a congregation or another URCSA minister officially invited by the church council administers baptism by sprinkling water on children and adults or by submerging them in water.
- Based on God's covenant of grace, a minister baptises the children of confessing members after counselling and instructing the parents to ensure that they understand the significance of baptism and the responsibilities it places on them.
- Parents must acquire approval from the church councils of both congregations if they want to have their children baptized in a congregation of which they are not members.
- In special circumstances, baptism may be administered to children of members of a recognised Protestant church, provided that the parents have written permission from their own congregation and minister.
- Children of foster parents who are members of a congregation may be baptised if the biological parents of the children have renounced all legal claims to the children.
- A child of a confessing URCSA member, living permanently with a grandmother or other family member who is also a URCSA member, may be baptised under the care of that person, provided that the parent(s) (if alive and contactable) have given written permission, and provided that the church council is convinced that those family members will be able to fulfil their baptismal promises.
- A single parent may present his or her child for baptism, provided the church council has counselled him or her and after any disciplinary steps that might have been taken by the church council were completed.
- The church council may, with care and discernment, authorise the baptism of children older than seven years, for example when an entire family wishes to join the congregation and the children have not been baptised previously. When such cases are recorded in the Baptismal Register it should be specified in the Comments column as follows: "With the permission of the church council".
- The church council may allow close relatives of the parent(s) to stand with them during the baptismal ceremony to act as witnesses of the baptism to vouch that the baptismal promises will be carried out.

- The church council will strive, when possible, to give instruction to parents and witnesses before baptism.
- Unbaptised adults who wish to become members of the congregation shall be baptised after appropriate instruction and a public confession of faith.
- The church council shall see to it that all baptisms are recorded in the baptismal register.

The Geneva Confession of Faith states that:

“Baptism is an external sign by which our Lord testifies that he desires to receive us for his children, as members of his Son, Jesus Christ, the mortification of our flesh which we have by his death that we may live in him by his Spirit. Now since our children belong to such an alliance with our Lord, we are certain that the external sign is rightly applied to them.”

The Church encourages its members to have children when they are married. *Lobola*, which is an African cultural practice, makes it difficult for most couples to get married. In most cases couples end up having children out of wedlock because of the barriers in place for them to be married. Other couples decide not to get married, especially in the urban areas because each person prefers to be independent but chooses to have children. Christian religion rejects this idea, but it is a reality that cannot be ignored even if those couples are not married. As they do not want to deprive their children from being children of God through baptism, because they value and honour baptism.

#### **2.7.3.6 Holy Communion**

Sharing the body and blood of Jesus, who is the cornerstone and basis of our salvation, is the purpose of Holy Communion. In the URCSA, each participant receives his or her own cup of wine when receiving Holy Communion. According to the Geneva Confession, the Lord's Supper is a sign through which he symbolizes the genuine spiritual communion we enjoy with his body and blood through the use of bread and wine. We agree that it should be distributed in the presence of the faithful in accordance with his ordinance, so that everyone who desire to follow Jesus in life may partake of it. Regarding Holy Communion, Article 35 of the Belgic Confession declares the following:

“Since the Pope’s mass was a reprobate and demonic ritual that undermined the significance of the Holy Eucharist, we declare that it repulses us and is an act of idolatry that God has condemned. In fact, the mass itself is so highly regarded as a sacrifice for the redemption of souls that God takes the bread and adores it. Additionally, there are additional repulsive blasphemies and superstitions mentioned here, as well as the abuse of the Bible that is used ineffectively and without benefit or edification. We hold fast to the conviction that the Holy Supper is a sacrament that our Saviour, Jesus Christ established in order to nourish and maintain those who have been reborn and grafted into his family, which is his church. Those who have had a new birth now possess two lives. The one is bodily and temporal, everyone has it and has had it since the moment of their first birth. The other, which is spiritual and heavenly, is given to them at their second birth and is only available to God’s elect. It comes through the Word of the Gospel in the fellowship of the body of Christ. Therefore, God has prescribed for us an appropriate earthly and material bread, which is as common to all people, as life itself also is to support the corporeal and worldly life. God, however sent a living bread from heaven, namely Jesus Christ, who feeds and sustains the spiritual life of believers when eaten that is, when taken and received spiritually by faith in order to preserve the spiritual and heavenly life that belongs to believers. We are inspired to a fervent love of God and our neighbours by this holy sacrament. ”

Stipulation 6 of the *KZN Regional Synod Church Order and Stipulations*, 2018 states this on celebrating the Holy Communion:

- The Holy Communion may only be served by an ordained minister of the URCSA or of a church recognised by it. It will normally be served either by the/a minister of the congregation, or the consulent, or another URCSA minister duly invited by the church council.
- A congregation will celebrate the Lord’s Supper as frequently as possible, with four times per year an absolute minimum, depending on the number of wards, the distances between them and the availability of the minister or consulent.

- Only members who are not under church discipline are admitted to the Lord's Supper. In congregations that welcome children to the Lord's Supper, this applies to both baptismal and confessing members.
- The church council may, at a particular occasion, allow members of other URCSA congregations or Reformed churches to partake of the Holy Communion as guests. The same applies to members of other recognised churches.
- A church council may allow the serving, at their home or in hospital, of the Holy Communion to a member who is too ill to attend worship services. The format will be that of a worship service, presided over by the minister or consulent, and some church council members, in which both the words of institution and the Eucharistic prayer are said.
- All baptised children may be admitted to the sacrament of the Holy Communion.
- Before serving the Holy Communion to children, the church council officially announces the decision of General Synod and the formal decision of the Church Council to the congregation.
- Including children in the celebration of the Holy Communion is guided by the principle of the Supper as a family meal, so that parents and children participate together as a covenant family.
- The church council implements a programme of catechism that: (a) enables parents to educate their children on the meaning of the sacrament and (b) helps children to understand the meaning of the Supper and the responsibilities that it entails.
- The church council ensures that non-alcoholic wine or grape juice is used when children are included in the celebration.
- Congregations that welcome children at the Lord's Table report annually to the Presbytery about their experiences in that regard.

Cochrane et.al (1991: 80) again explains, sharing in the bread and wine highlights the fact that Christianity is grounded in the Incarnation, in the Word becoming flesh, in the material world. This leads also to a new awareness that the Eucharist celebration is for the life of the world.



That the sharing of bread and wine is empty unless it relates to reasonable sharing of material resources within society. Without this it becomes insincere and even irrelevant. The bread and wine are served by an ordained minister of the Word and Sacraments. It is believed that the wine and bread does not change to be the body and blood of Jesus like the Catholics and other church traditions believe, but the bread and wine will always be like that bread and wine. But this is a sermon of remembrance of Parousia (the second coming of Christ) as Christ advised His disciples that they must always do it in His memory, until He comes back.

When the minister of the Word and Sacraments administers the Holy Communion, he says these words:

“The Lord Jesus, the same night he was deceived, took bread and when he had given thanks, He broke it and gave it to them saying, ‘Take, eat, this is my body which is given for you, do this in remembrance of me’. After the same manner also, He took the cup when they had supped, saying ‘this cup is the New Testament in my blood, do this, as often as you drink it, in remembrance of me’ (Worship book of URCSA: 2014:15).”

de Gruchy (2009:183) articulates that while Luther was very serious towards the Mass understood as a sacrifice and rejected the doctrine of transubstantiation (the bread and wine literally becoming the body and blood of Christ on the altar) in favour of consubstantiation (Christ being present in, with and under the bread), he was even more serious towards Zwingli’s doctrine and practice of the Eucharist.

#### **2.7.3.7 Church discipline**

Church discipline is not a penalty, but a promotion by the Church for living a decent Christian life. One of the responsibilities of the congregation and church council is to promote a Christ-centred life to the congregants. No sin is better or more minor than another sin. Sin is sin, therefore every church member; including leaders i.e., elders, ministers and deacons; are under the watchful eyes of the church council. The URCSA went the extra mile because it even encourages the church council to investigate rumours if they are reported, as the aim is promoting purity in the church. Article 32 of the Belgic Confession regards this as discipline:

“We also hold the view that while it is useful and beneficial for people in charge of the churches to establish a certain order among themselves in order to preserve the church as a whole, they should always be on the lookout for ways that stray from what Christ, our one and only master, has established for us. Therefore, in our worship of God, we disapprove of any advancements made by humans as well as all regulations that coerce our conscience in any way. Therefore, we acknowledge that there is only one suitable approach to maintain peace, unity, and everyone’s submission to God. ”

For this reason, it is necessary to exclude the Word of God, with everything that it entails. The Geneva Confession of Faith states this on discipline:

“Because there are always some who hold God and his Word in contempt, who take account of neither injunction, exhortation, nor remonstrance, thus requiring greater chastisement, we hold the discipline of excommunication to be a thing holy, and salutary, among the faithful, since truly it was instituted by our Lord with good reason.

“This is in order that the wicked would not, by their damnable conduct, corrupt the good and dishonour our Lord, and that though proud they may turn to penitence. Therefore, we believe that it is expedient according to the ordinance of God that all manifest idolaters, blasphemers, murderers, thieves, lewd persons, false witnesses, sedition-mongers, quarrellers, those guilty of defamation or assault, drunkards, dissolute livers, when they have been duly admonished and if they do not make amendment, be separated from the communion of the faithful until their repentance is known.”

According to de Gruchy (2009:105), the modern-day reader will note how, time and again, John Calvin stresses that the aim of discipline is not to hurt, but to heal and restore. His intent is always pastoral, arising out of a concern for the well-being of both the guilty person and the church community. Even those guilty of “dishonourable and public immoralities” are to be objected in a “responsive” way, and if they amend their ways, no harm is to be done to them.

#### **2.7.4 Church Ministries of the Greytown Congregation**

Children Christian Ministry (CCM), Christian Youth Ministry (CYM), Christian Women's League (CWL), Christian Women's Ministry (CWM), and Christian Men's Ministry (CMM) are the five ministries in the Greytown congregation. To maintain adherence to the church order, the church council oversees all of these ministries. The president of the CWM is in charge of overseeing all aspects of CCM, CWL and CWM, including catechism class and Sunday school.

The primary goal of ministries is to frequently gather in their home cells to discuss the Bible and consider all of its facets (URCSA KZN Church Order, 2018). The purpose of all these events is to inspire participants to want to comprehend God's word. The gatherings in the home cell also work as a vehicle for evangelization, drawing both churchgoers and non-churchgoers to join these ministries and avoid feeling left out. The only organizations still operating in the last 20 years were the CWM and the CYM. They consistently made a noticeable impact on the church as a whole.

Before they were created in 2016 and 2019, the Greytown congregation did not have the CMM and the CWL. As specified and directed by their constitutions, the goals of individual ministries can be summarised as follows:

##### **2.7.4.1 Children Christian Ministry (CCM) – Sunday school**

Every youngster in the church receives a solid foundation at Sunday school. Children learn about the Bible in this setting, and how to dramatize Bible stories in order to apply them to their own lives. Children have the chance to interact with church leaders and ask questions during this time. The church council seeks to raise up good kids who are eager to study Christ and how His teachings apply to their life. They must also comprehend the importance of studying Christ's acts. Children should be given leave to learn about the church's activities (Matt18:4-6; 19:14-15; Deut 4:5).

Sunday school is where the next generation of leaders is raised. The most delicate group in the Sunday school has a variety of difficulties, from parents who are unwilling to cooperate to those who neglect to support their children. Single parents who have children who were born out of marriage frequently suffer.

Since there is no attempt being made in these households to teach the Bible, Sunday school is the only place some of these kids can learn about Jesus or God. The church council of the Greytown congregation faces an additional hurdle, as Bible instruction is no longer taught in schools. The church council urges all parents to support their kids and participate in all Sunday school events on a rotating basis. Some ladies and young people have devoted their time and energy to making sure that Sunday school is held, that parents' engagement is given time, and that the Greytown congregation as a whole becomes active in order to ensure that the goals of the church council are accomplished (Church council minutes 5 June 2019).

#### **2.7.4.2 Christian Youth Ministry (CYM)**

The CYM places a high priority on teaching young people about loyalty, submission, and a host of other virtues. The Bible's lessons and Reformed principles are actively emphasized and taught. Members are urged to cherish the church and to participate in all of its events. The CYM members learn to genuinely love Christ and to live as His witnesses in every area of their lives. In order to evangelize their classmates who are not actively interested in Christian concerns, the youth are encouraged and offered support. In order to advance the CYM's operations and their most significant effort to expand the church in order to enlighten, educate, teach, and instruct the youth, the Greytown church council has created a clear and structured plan of action, which is overseen by an elected elder (Church Council minutes, 12 February 2019). To ensure that these young people will be able to lead the church of Christ to new heights, the training that takes place in this ministry is highly inclusive. In other words, the council draws leaders for various ministries and leaders of the church as a whole from this group.

#### **2.7.4.3 Christian Women's league (CWL)**

A fresh idea from the Greytown congregation is this ministry. It is primarily made up of young women who have advanced from the youth ministry but who do not identify with the rigorous mission of the CWM, since they see themselves as still being energetic and young. In accordance to Jesus's command to His disciples to go forth and teach the nations all that He had taught them and to baptize everyone who comes to believe in the name of the Triune God, the CWL and the CWM likewise, carry out home visits and evangelize those who have not yet found their faith (Matt 28:19).

By ensuring that meetings and other church activities go well, CWL supports the church council as well. It actively participates in all church activities, including catering, and accomplishes these tasks through fundraising efforts motivated by those of their counterparts. The CWL, like the other league, is overseen by Mrs Phumlile Victoria Mbatha, the presiding congregation minister's wife, who is very competent and diligent in her work. The CWL ladies adhere to their commitment to their work and their belief in action (Acts 2:42) at all costs.

#### **2.7.4.4 Christian Women's Ministry (CWM)**

Within the Greytown congregation, the CWM is regarded as the foundational organisation of the church. It is made up of strong, accomplished women who take satisfaction in being a driving force in the Greytown church. The CWM visits the elderly and sick to console them and encourage those who have fallen along the way who do not routinely attend services (CWM URCSA General Synod Constitution).

During the visits, they first check on the visitor's and their family's well-being before talking about the Bible. This is done to show the individual that the church cares about them on a holistic level and to ascertain what needs the ministry might be able to meet. Every Thursday, the CWM has prayer meetings for the congregation, the local community, the church leadership, and the government. The CWM helps the Greytown congregation in a variety of ways, including through fundraising. The church council's ability to launch projects, like caring for the spouses of pastors who passed on while still employed by the congregation and those who served in the classis, is made possible by its fundraising efforts. In May 2022, throughout the holidays and winter, the CWM also provided food and blankets to flood victims in Durban, KZN. This was done in response to Jesus' command, in which He also controversially included table fellowship with the pariah and the marginalized in society (Acts 6:2).

#### **2.7.4.5 Christian Men's Ministry (CMM)**

A broad organization within the URCSA is the CMM. After its founding in 1994, the CMM went dormant for some time. Given the lengthy hiatus, its official re-establishment in the Greytown congregation on September 25, 2020, was a historic occasion. Rev NN Chamane, who oversaw this event, administered the oath and confirmed 18 men as CMM members. In topics pertaining to congregational activity, the CMM acts as the leader. The role of a father is the main goal of this ministry.

The ministry is in charge of keeping the church grounds tidy, secure, and well-maintained. It looks out for the congregants' security during church events and makes sure the caterers have access to suitable resources or facilities. It is widely acknowledged that men avoid going to church and, unlike women, tend to favour amusement to religion. The CMM struggles to raise money, in contrast to the other ministries, but is more than happy to accept financial aid and support.

## **2.8 Historical developments of health provision**

In 1994, a new government was elected to office due to the first democratic elections in South Africa. Nelson Rolihlahla Mandela became president under the African National Congress (ANC). The challenge of the new democratic government was to address many problems created by the Apartheid-era National Party government, which promoted racial discrimination, gender inequality and white supremacy. Through its Apartheid policies, the former South African government created a healthcare system that was maintained over time by the adoption of racial laws and the establishment of institutions like political and statutory authorities for the control of the healthcare professions and facilities. These organizations and facilities were created and run specifically with the intention of upholding racial segregation and prejudice in the medical field. The new administration's goal was to develop fresh health regulations to deal with the effects of the Apartheid system.

## **2.9 The Constitution of the Republic of South Africa (Act 108 of 1996)**

The Constitution of the Republic of South Africa, 1996 created a way for a truly democratic dispensation. This dispensation was founded on ideologies such as fairness, choice of expression, privileges to have access to health, education, as well as upholding elegant standard and discipline. The 1996 Constitution, preceded by the 1993 temporary Constitution, certainly reveals an important political thought compared to the separate development policies of the earlier Apartheid government. The difference being that in the earlier Constitution, parliament was the highest authority. Parliament is now secondary to the Constitution and the 1996 Constitution is certainly the highest law in South Africa. Constitutional improvement of such greatness certainly leads to change and transformation in almost all scopes of government and its management. Such changes affected almost all efficient fields of government, and therefore redefined the role of policy and decision-making as it pertains to healthcare.

Seeing that government was dedicated to changing the state from a tool of discrimination, government approved the following ideas:

“To constantly improve the lives of the people of South Africa by a changed public service which is typical, clear, transparent, well-organized, active, responsible, and approachable to the requirements of all. (White paper of transformation of the Public Service: 1995).”

The Constitution of 1996 provided additional support for the objectives outlined in the Paper. The following fundamental principles and core values that guide public administration are outlined in the Constitution. The Constitution’s guiding principles must be used to administer public administration, including the following ones:

1. Support and uphold a high standard of professional ethics
2. Asset practices that are financially sound, well-organized and active must be promoted.
3. Public administration must be focused on improvement.
4. Services must be provided impartially, evenly, fairly, and on an independent basis.
5. The needs of the populace must be met and citizen participation in policymaking must be promoted.
6. The public sector must exercise responsibility.
7. Communities must be given pertinent, accessible and accurate information, in order to encourage transparency.
8. To maximize human potential, good human resources management and career development methods must be smart.
9. To achieve comprehensive demonstration, public administration must be mainly reflective of the South African population, with service and worker management centred on competency, objectivity, equality, and the requirement to replace historical disparities.

## **2.10 White Paper on Transforming Public Services Delivery, 1997 (*Batho Pele* principles)**

Government wants to encourage the delivery of unified, continuous services. The *Batho Pele* principles provide a framework for strategy and processes that public service is expected to follow (Reddy 2002:59). It involves building a public service capable of gathering data for an experiment to enhance how South African citizens gain access to public services.

As a result, the *Batho Pele* principles are predicated on the idea that a reformed public service will be judged on its success by the following criteria.

The amount to which it prospers in successfully providing services which encounter the basic requirements of all South Africans (Singh 2003:03). *Batho Pele* entails creating a framework for the delivery of public services, making people more like consumers and empowering them to hold public employees accountable for the quality of the service they give. It demands a shift away from rigid systems, methods, and approaches in favour of a new working style that prioritizes the requirements of the public and is enhanced, quicker, and more approachable to those needs. (Singh 2003:04) In terms of *Batho Pele*, the main goal is to enhance governance.

To enable all public service agencies to adopt *Batho Pele's* seven guiding principles in their particular contexts, the following principles were established:

**1. To consult with customers on a regular basis.**

Singh (2003:04) states that when possible, citizens should be given options on the services that are provided and should be consulted about the quantity and quality of the public services they receive. Several methods of user consultation are suggested, including customer surveys, user interviews, and consultation groups. The Republic of South Africa's 1996 Constitution particularly emphasizes the need for public consultation in section 195(1) (e). There are many ways to consult service users, including customer surveys, interviews with specific users, consultation with groups, and meeting with consumer representative organizations, NGOs, and CBOs, according to the Health Professionals Council Association (HPCA) guidelines on consultation from 2007. To guarantee thoroughness and representativeness, it will frequently be necessary to use more than one type of consultation. The Integrated Development Plans (IDPs) and their implementation in the local government realm are only two examples of how consultation is a potential tool that enhances and shapes government policies.

**2. To set service standards**

Singh (2003:04) states that it is important to inform the people about the degree and calibre of the services they can expect from the government. The amount and calibre of services offered by federal, state, and local agencies must be standardized and new services must be made available to people who were previously excluded from them.



Once authorized, service standards must be made public, visible at the point of delivery, and distributed extensively to all potential customers so that they are knowledgeable about the kind of service to which they are entitled and have the opportunity to voice complaints if they do not. The principle emphasizes the necessity for benchmarks to continuously monitor the degree to which individuals are satisfied with the service or products they receive from departments, according to the HPCA guidelines on defining service standards from 2007. It is crucial for the creation of plans to improve service delivery and guarantee a higher quality of life for all South Africans. Service standards should be developed with input from the public. To enable customers to determine for themselves whether they are receiving what was promised, criteria that are explicit and measurable are necessary.

Some standards will address procedures including how long it takes to approve a housing claim, provide a passport or other form of identification, or simply react to letters. Standards should be benchmarked (where relevant) against those used internationally, taking into account South Africa's existing level of development in order to achieve the goal of making South Africa globally competitive.

### **3. To boost access to service**

Singh (2003:04) states that equal access to the services that all citizens are entitled to is important. All federal state and local agencies must outline and establish goals for gradually expanding access to their services for people who have never used them. The ideal scenario would be to guarantee that a public service of first-world calibre or standards is enjoyed and equally accessible by all South Africans or, at the very least, a majority of them.

This principle emphasizes the necessity to recognize promptly and precisely when services are not meeting the promised standard and to have mechanisms in place to correct the situation, according to the HPCA Guidelines on Enhancing Access to Services from 2007. In respect to the complete service delivery programme, this should be done at both the organizational level and the individual transactional level with the public. Public employees are urged to treat complaints as a chance to provide better service and to take action so that flaws can be rapidly fixed for the benefit of the public.

#### **4. To offer added and improved information about services.**

Singh (2003:04) states that the public service to which they are entitled should be fully and accurately disclosed to the public. All customers need information in order to exercise their right to receive decent service. The requirements for truthful and objective public reporting supports an atmosphere of transparency and public accountability. According to the HPCA Guidelines (2007), information about services should be readily available at the point of delivery as a requirement, but for users who are far from the point of delivery, other arrangements will be required. Managers and employees should regularly work to make information about the organization and any other service-delivery-related matters available to other staff members, in accordance with the definition of customer in this document.

#### **5. To ensure higher levels of courtesy**

Singh (2003:04) states that people should be courteous and considerate to one another. Being polite and considerate to the public is one of the core responsibilities of public employees. Regular performance reviews of customer-facing workers should be conducted, and any performance that falls short of the required criteria should not be tolerated. Future training courses should incorporate service delivery. All supervisors should make sure they have direct input from frontline employees and should go see for themselves how things are done on a regular basis. Courtesy and ethical behaviour are related. The overall conduct of public employees should be impeccable while they are carrying out their official tasks. The HPCA Guidelines (2007) on upholding higher standards of civility states that this extends beyond a kind smile, and “please and thank you”. Service providers must have empathy for citizens and treat them with the same deference and respect that they would want from themselves. The public servant is dedicated to maintaining an open line of communication with the public. This calls for the sharing of goods, services, information, and issues that could impede or delay the effective provision of services at the levels that were promised. If effectively implemented, the principle will aid in dispelling the misconceptions that the general public has regarding the behaviour of public officials.

### **1) To increase honesty and transparency about services**

Singh (2003:04) states that the administration of national and provincial agencies, their costs, and their management personnel should be made public to the public. In another words, the management of the South African public service must be open and transparent.

A democratic system of governance is characterized by openness and transparency, which are essential for transformation and change as well as for enhancing service delivery. The Republic of South Africa's 1996 Constitution 195(1) (g) places a strong emphasis on the requirement for transparency in the provision of public services. A key component of openness and transparency, according to the HPCA Guidelines (2007) on Increasing Honesty and Transparency About Services, is that the public should be better informed about how national, provincial, and local government institutions function, how efficiently they use the resources they use, and who is in charge. The public is expected to take advantage of this idea and offer suggestions for improving the ways in which services are delivered. They may even hold government officials accountable and responsible by asking them questions.

### **2) To remedy failure and inaccuracy**

Singh (2003:04) states that public servants should be encouraged to welcome complaints as an opportunity to improve service and submitted concerns so that deficiencies can be found and fixed. If the promised standards are not met, citizens should be offered an apology, a complete explanation, and an effective remedy. Government errors occur, and as a result, when things go wrong, action must be taken. In order to avoid making the same mistakes again, it is also essential to learn from the past. This principle highlights the necessity to recognize promptly and accurately when services are not meeting the promised standard and to have mechanisms in place to correct the situation, according to the HPCA Guidelines on Remediating Failure and Accuracy from 2007. Both at the organizational level in relation to the complete service delivery programme, and at the individual transactional level with the public, this should be done. Public employees are urged to treat complaints as a chance to improve services and to take action so that flaws can be rapidly fixed for the benefit of the public.

### **3) To give the best possible value for money**

Singh (2003:04) states that to provide residents with the best value for money, the public sector should be economically and operationally supportive. Value for money is attained when a public body performs its tasks to a high standard at a reasonable cost. Achieving value for money is necessary to make the best possible use of limited resources. Many improvements that the public would want to see frequently do not require any additional resources and in certain cases, they can even cut expenses, according to the HPCA ((2007) Guidelines on Offering the Best Possible Value for Money. For instance, a wrongly filled-out application form that will take hours to repair may result from failing to provide a member of the public with a concise explanation that satisfies their inquiry.

#### **2.11 National Health Plan**

Durojaye et al (2013) state that the government of South Africa launched a National Health Plan (NHP) that was based on a Primary Healthcare (PHC) model after realizing the need for a complete change of the country's healthcare system. The NHP aspired to create fair social and economic development in order to ensure the health of all South Africans. The ANC-led government is devoted to the promotion of health, and this plan took into account that everyone has the right to get optimal health. The PHC method was used as the guiding principle for reforming the healthcare system. The PHC will play a crucial role in the community's overall social and economic development as well as the nation's healthcare system. The PHC approach places a strong emphasis on comprehensive community involvement in the design, delivery, control, and monitoring of services. The organization of the health services will be significantly influenced by democratically elected representatives. According to Marle de Haan (2005:23), the WHO primary healthcare principles serve as the foundation for South Africa's comprehensive healthcare coordination. A primary healthcare system is one that offers the greatest amount of health benefits to everyone at a fair price. It is a comprehensive healthcare system including elements for promotion, prevention, and treatment. It is a system that views each person as a member of a family, a community, and an unbreakable part of a particular social and physical environment that has a significant impact on their health. There are three degrees of promotion and preventative care: primary, secondary, and tertiary prevention.

### **2.11.1 National Health System**

Durojaye et al (2013) claim that the National Health System (NHS) must be unified into a single, all encompassing, equitable, and integrated system. Health policy will be handed by a unified governmental organization based on national standards, priorities, and recommendations. It will coordinate all facets of the provision of both public and private healthcare and be answerable to the South African people via democratic processes. The NHS will incorporate all current public health agencies, including local government, homeland security, military, and correctional services. There will be no more racial, ethnic, tribal, or gender prejudice. Both public and private providers will contribute significantly and work under a unified framework that promotes effectiveness and high standards of care. Health education is focused on sexuality, oral health, family planning, substance addiction, environmental health, and occupational health. Health professionals at all levels advocate healthy habits and general health. The government sets up the necessary frameworks for the integration of conventional and alternative practitioners within the NHS.

Health systems, as defined by the WHO in 2007, include all entities, individuals, and activities whose principal goal is to advance, restore, or sustain health. This includes more direct actions aimed at enhancing health as well as initiatives to affect health factors. Consequently, a health system is more than just a pyramid of publicly funded institutions that offer services to the populace. One example is a mother caring for a sick child at home, as well as private provider's behaviour change initiatives, vector control programmes, health insurance firms and rules governing workplace health and safety. Health professionals will need to engage in cross-sectoral activities, such as pressing the Department of Education to boost female education, which is known to improve health. Health systems are driven by multiple goals.

Overall health system outcomes or goals are described in the WHO report from 2000 as: "enhancing health and health equity in methods that are responsive, financially equitable, and make the best, or most efficient, use of resources. In order to get from inputs to health outcomes, it is necessary to increase access to and coverage of efficient health interventions, while sacrificing efforts to guarantee provider quality and safety."

### **2.11.3 Health-information system**

Durojaye et al (2013) maintain that an extensive health-information system that is necessary for NHS planning and management purposes systematically collects and analyses accurate and trustworthy data. Additionally, it enables the promotion of pertinent research to deal with the most significant public health issues. For the purpose of facilitating planning at the local, provincial, and national levels, both the public and commercial sectors are required to gather and submit pertinent data, in order to inform the entire system and boost its efficacy, the NHS's health-information system collects universal, sensible, trustworthy, straightforward, and action-orientated sorts of data. The WHO has long recognized the need of health-information systems for achieving health for all, according to Sauerborn and Lippeveld (2000:01). They lament the fact that most countries' health-information systems are insufficient for offering the required managerial assistance. The majority of healthcare professionals in developing nations associate information systems with compiling countless registers of patient names and addresses, compiling disease-related data on a weekly or monthly basis (e.g. patient sex and age), and sending out reports without sufficient feedback. Furthermore, because they are frequently unfinished, erroneous, out-of-date, timely, and irrelevant to the top priorities of local health staff, the data obtained is frequently not useful for management decision-making. In other words, rather than being "action-driven", information systems are typically "data-driven". A significant portion of the data gathered is sent to the national level without being examined and put to use. Instead, it typically ends up on the stale shelves of a Department of Health office. Current health-information systems are consequently frequently viewed as managerial barriers rather than as instruments, according to Sauerborn and Lipperveld (2000:03). They bring up the following issues listed below that create management challenges:

#### **1) Irrelevance of the information gathered**

Durojaye et al (2013) maintain that much of the data captured and reported by the health service workers is not necessary for the activities they are tasked with performing, according to a WHO Expert Committee (1994). Data gathering frequently concentrates on disease reporting and only partially addresses management goals at the patient/client level or at the level of the health unit. However, necessary data is frequently not gathered. For instance, health information systems infrequently offer suitable indicators to track the continuity of care of specific patients or clients.

The lack of agreement over the information required among data producers and users at each level of the healthcare system is the common denominator between these two observations.

## **2) Poor quality of data**

Durojaye et al (2013) explain that it is common practice to select data needs without taking into account the technical proficiency of the healthcare professionals collecting the data or the availability of diagnostic equipment in nearby healthcare institutions. Health services personnel's lack of enthusiasm is another factor contributing to poor data quality. In order to assure the quality of the data obtained and to adhere to reporting standards, health services supervisors and peripheral health workers infrequently receive feedback on the data provided to higher levels.

## **3) Duplication and waste among parallel health information systems**

Durojaye et al (2013) maintain that National reporting systems have historically been the outcome of fragmented efforts to meet the information needs of health planners and administrators, even in affluent nations. The Ministry of Health frequently saw donor organizations or national programs create their own specialized information systems, frequently under pressure and with financial support from outside donor organizations. These programs, which were created as vertically structured “empires”, replaced line managers with programme directors who oversaw distinct categories of staff, facilitated district training programmes, and produced distinct “programme information systems”. These systems intended to concentrate on a single disease (such as diarrhoea), as specialized service (such as “family planning systems”), or a management subsystem (such as “drug management information system,” for example), rather than addressing a variety of issues.

The general routine health-information system, which was deemed inadequate and unable to provide the data required for programme management, coexisted with and in addition to these programme-information systems. While the quality of the information produced tended to be better than that of the general information system, these distinct systems might in fact offer meaningful information assistance for programmatic decisions.

#### **4) Lack of timely reporting and feedback**

By the time a report is generated, the data is generally out-of-date and judgements are frequently taken without any information input, since the process of sending, gathering, analysing, and presenting the data is typically so time-consuming. Managers and planners must make decisions every day, while working under deadlines and time constraints. Even highly valuable outdated information has little value to them. Strong vertical programs frequently lead to data transmission delays and a lack of response at the district level. Health facilities provide data directly to national programme administrators and district level line managers receive any out-of-date feedback reports.

#### **5) Poor use of information**

There are still some usable data sets available, despite the evidence that much of the created data is irrelevant, of poor quality, redundant, or obsolete. Unfortunately, academics have not sufficiently assessed or recorded how information is used and the widely held belief that information is not used effectively is mostly supported by anecdotal evidence. A few recent studies do, however, identify some of the offenders. Given the centralization of many health systems and consequently health-information systems, it was discovered, for instance, that information utilization was particularly inadequate at the district, health centre, and community levels. Given the ongoing initiative to decentralize decision-making and strengthen district-level competence, this raises grave concerns. The difficult-to-bridge “cultural gap” between data people and decision-makers is another barrier to assuring the utilization of information. As a result, planning and management employees tend to make ad hoc judgements based more on “gut feelings” than on relevant data.

#### **6). Efforts to reform health-information systems**

The structural weakness of the system and lack of integration with the overall health system are related to the disorganized state and inefficiency of the majority of existing information systems in developing nations. This can be explained by the fact that information systems traditionally, like in the majority of developed nations, were not designed with the purpose of providing management support to the health services in an integrated manner.



## **7). Respect for all**

Health professionals recognize everyone's right to be treated with decency and respect throughout their time in healthcare. It introduces a Charter of Patient's Rights based on *Batho Pele* ideals. Additionally, it is legal for people, interest organizations, and communities to take part in the development and implementation of health policy. According to Yahia Salim Melhem et al. (2019), while respect is also relevant and fundamental in our daily lives and is necessary for human interaction and social relationships, it is also crucial for establishing a moral community. This is because trust is crucial for better organization outcomes and healthy interpersonal relationships. Everyone wants to be respected in both their personal and professional lives. People will rank respect and how they are treated at the top of the list when asked about the most important values in their professional lives. Respect is something that employees care about more than praise and adulation. Respect can be an attitude, a principle, a virtue, or attention, according to Dillon Respect (2007). It can be shown by acts of respect, appreciation and concern for another individual. Respect is the idea that someone is deserving in the eyes of one or more other people, according to Kristie M. Rogers (2014). A sense of psychological safety and a sense of belonging and support for members to feel comfortable can both be fostered by respect.

## **8). Coordination and decentralisation**

Healthcare delivery will be coordinated by the municipal, district, provincial, and national governments. As much as feasible, these will follow the limits of the province and local governments. It is intended to decentralize authority, accountability, and control over money to the lowest level that still allows for sane planning and the provision of high-quality healthcare.

The main entry points into the healthcare system will be clinics, health centres, and independent practitioners. Access to rural healthcare will be increased, with a focus on transportation. According to Martin Wittenberg (2003:34), there are currently four stages to the intergovernmental coordination process, with the exception of cities where there are only three:

- The national government is in charge of national economic policy, security (army and police), and overall management of the social service departments.

- The provincial government is in charge of overseeing the administration of important social services like grants, health and education (e.g. disability, pensions and childcare grants).
- In some circumstances, district councils lack a clear justification for their decisions, but in others they are in charge of bulk infrastructure like water and sewer reticulation. If their constituent municipalities are unable to carry out their missions, they serve as the last-resort municipal service providers.
- Municipalities are in charge of providing essential amenities including water, sanitization, garbage collection, electricity and town planning.

Wittenberg (2003:34) goes on to say that the district's function is unquestionably the system's most problematic element. The district can be viewed as a remnant of the Apartheid Regional Services Council to some extent. There needs to be framework in place to collect levy income. To be fair, though, some regions of the nation will require a lot of time for local authorities to build the necessary capacity. District councils may be able to improve local service delivery in several situations. However, in other areas where local councils do have the capacity, districts might just end being an obstacle, as the aforementioned quotation shows. The scope for district appears to have also been diminished as a result of municipalities being combined into bigger organizations.

## **9). Priorities**

The provision of basic healthcare to all South Africans shall be planned for and regulated to ensure that resources are used effectively and rationally, giving priority to the most vulnerable populations. Priority will be given to maternal and child health, environmental preservation, rural services, women's health, and the care of disabled. Young adults and adolescents will also receive the proper services.

The prevention and control of important risk factors and diseases will also receive attention, particularly AIDS, tuberculosis, measles, gastro-intestinal illness, trauma, heart disease, and common malignancies. According to Marije Versteeg et al (2013), 43.6% of South Africa's 49 million people live in the country's rural areas. Rural residents tend to be poor and rely heavily on the public health system.

The country is dealing with a quadruple disease burden (consisting of HIV & AIDS and tuberculosis (TB), chronic diseases, injuries, and maternal and infant mortality), and health results are low. The primary reasons the South African government opted to completely reform the system to fulfil its Constitutional commitment to ensure that all South Africans have access to high-quality medical care are the current health system's curative focus and high but unequal spending on health. Rural areas are among the least fortunate when it comes to access to high-quality healthcare. A child from Eastern Cape province (which is primary rural) is more than twice as likely to die in its first year of life than a child from the Western Cape (which contains large urban areas), despite the fact that a person with TB in the Gauteng province (which is predominantly urban) has a 19.9 % higher chance of being cured than a person with TB in the North West Province.

In South Africa, infant mortality rates were found to be 71.2 per 1 000 live births in rural areas against 43.2 in urban areas in 2007. Other emerging countries also experience health inequality between urban and rural areas. In the same year, India reported 39 fatalities per 1 000 new births in urban areas and 62 in rural ones (2007). The United Nations highlights that children in rural areas are more likely to die even in regions where overall child mortality is low.

#### **10). Accountability and community participation**

Accountability to community structures at the local, district, provincial, and national levels is a key concept in the primary healthcare approach. The selection of staff members and the management of budgets are tasks performed by elected representatives. This is a crucial method for expanding local authority and accountability over health-related issues. However, having executive control over the healthcare system is not the same as having community involvement.

In order for the Primary Healthcare (PHC) strategy to be effective, democratically elected community structures must work with representatives of all the diverse sectors and stakeholders involved in community development and health to make decisions about health-related matters. In order for the NHS to be fully functional, community participation is a crucial component that must be developed locally. This component cannot be mandated by law. Accountability is a crucial aspect of good government, and it is improved by citizen participation, transparency, responsiveness, and representatively, according to BH Sikhakhane (2009).

Democratic societies must include civil society. It offers a means for the local populace to take part in public affairs and monitor the use of state power. They have the power to hold the state responsible for the choices and directives made on their behalf. This is in line with the fundamental goals of local government, as outlined in Chapter 7 of the Constitution of the Republic of South Africa, 1996, which includes, among other things:

- Sections 41, 151, and 154 of the Constitution and Section 3(1) of the Local Government: Municipal Systems Act, 2000 (Act 32 of 2000) both provide that local governments must be democratic and responsible and that participation in decisions that affect their lives is encouraged.
- Community engagement is a focus of Chapter 7 of the Local Government: Municipal Systems Act of 2000, which also requires municipalities to implement structures, procedures and promotion plans.

This is crucial because the majority of previously underprivileged populations have low literacy rates and are unaware of their rights and obligations (Sikhakhane 2008:149). In order to hold politicians responsible for their actions and inactions, they must be encouraged to participate.

### **11). *Intersect- oral collaboration***

Health issues have several, intricate causes and addressing them requires a multi-sectoral strategy. The health sector has a significant lobbying role in making sure that other sector's policies, programmes, and strategies take health into consideration. It takes much more than bettering medical services to promote health. This is especially clear in South Africa, where decades of Apartheid have resulted in egregiously inadequate housing, income, educational prospects, and environmental conditions. All of these have a big impact on how most people's health is currently being undermined. Although it is crucial to increase access to healthcare, it should equally be acknowledged that doing so will only have a small influence on lessening the stark disparities in health status that now exist.

If the substantial role of other interventions in health promotion is to be acknowledged and encouraged, inter-sectoral strategy is required. The harmful impacts of numerous social and economic activities on health have not received much attention in the past.

According to Linda Rudolph et al (2013:10), the main goal of health in all policies is to enhance population health by working with partners who can influence the socioeconomic determinants of health through cross-sectoral collaboration. In order to promote health, equity and sustainability across all policies, it is necessary to break down silos, create new alliances, and improve government effectiveness. This is what is meant by health in all policies. Instead of irregular or focused project coordination, a health-in-all-policies approach emphasizes relationship building and collaboration. Partners must comprehend the group's vision and goals, as well as their own goals and ambitions. They must also be aware of each other's special views, areas of expertise, issues, constraints, and possible contributions. Collaborations for the benefit of all policies must be based on behaviours of trust, reciprocity or generosity, and mutuality in addition to having a clear vision and aims.

## **2.12 The impact of the National Health Plan**

The attainment of equal social and economic development, including the level of employment, the quality of education, the availability of housing, clean water, sanitation, and power will primarily ensure and improve the health of all South Africans. In addition, there should be a focus on lowering levels of violence and malnutrition, encouraging healthy lives and offering accessible healthcare services. Everybody has the right to achieve perfect health and it is the state's duty to make these conditions available.

Health and healthcare should not be permitted to suffer as a result of foreign debt or structural adjustment programmes, just like other social services, especially those that provide for women and children. According to Rispel (2016:17), South Africa has made great progress in the health sector and is overall a much better place than it was in the years prior to 1994. To bring about change and enhance population health, a primary healthcare philosophy was developed. This social justice philosophy combines legal, policy, and resource allocation strategies. It has put into effect a number of measures that clearly emphasize equity and work to make amends for those who were most negatively impacted by prior Apartheid laws. Examples include implementing a social-justice-based primary healthcare philosophy and using a combination of legislative, regulatory, and resource allocation levers to bring about change and enhance population health.

The 1997 White Paper for the Transformation of the Health System served as a backdrop for the first wave of transformation, which included the establishment of an enabling policy and legal framework for a complete overhaul of the healthcare system, the creation of an integrated national public health system from 14 disjointed, racialized, or Bantustan health departments and the elimination of racial barriers to accessing healthcare. In order to show the new government's commitment to providing services, free healthcare for expectant mothers and children was introduced within the first 100 days of the late President Mandela's inauguration. On paper, the district health system (DHS), which provides primary healthcare (PHC), became the cornerstone of healthcare policy. The 2003 National Health Act, which serves as the framework for PHC service delivery, formalized the DHS's legal standing. The clinic-building program and free PHC services both contributed significantly to lowering access barriers to essential medical care. The number of visits increased from 67 million in 1998 to 129 million by the end of March 2013, while the overall PHC cost per person in real terms nearly doubled.

### **2.13 Conclusion**

In this chapter, the geographical, religious, economic, and social context of the study with an overview on religion and religious health services in KZN were discussed. The historical developments of health provision in KZN, with a special focus on Greytown, were explored. Also, the National Health Plan (NHP), which impacted the development of health services, how other issues such as HIV and AIDS and COVID-19 have affected the church, and health provision and the activities of religious health institutions in KZN, were highlighted to show the relationship between religion and health. The next chapter locates the study in its context of ARHAP and presents the theoretical context and how it relates to the broader study of the religious assets programme. In addition, the chapter presents the religious health activities and institutions tasked with health programmes in KZN.

## CHAPTER THREE: LITERATURE REVIEW

### 3.0 Introduction

While it is true that there has been considerable literature regarding reformed theology and public health, this chapter focuses on what other scholars view is of these two world views. Robert Godfrey (2009:62), articulated that Reformed theology is rooted in the 16th-century Reformer, John Calvin. Calvin's views on some of the topics that were essential to establish the argument of this thesis, such as his observations on the reformed theology and public health and on his main vocation, are well-recognized in some of these main sources. A brief study of these provided understanding of Calvin's works in relation to public health. Wright (2009:5), points out that one can look at the many theological articles, church reformation and church order documents, the many letters, commentaries, and sermons that bear the name and works of Calvin, some of which were studied for this study. But because Calvin is probably known for his great work, the Institutes of the Christian Religion, then the first work to analyse, to be convinced that indeed, at heart, Calvin was a pastor and not just a cold, intellectual scholar, is the Institutes themselves. Wright is successful in emphasizing Calvin's pastoral heart in the Institutes, and if one reads the Institutes with Calvin in mind, this heart of his becomes evident. And thus, it may be concluded that Wright's focus on Calvin's pastoral theology in the Institutes is not inappropriate. He begins by stating and explaining the opening statement in the Institutes which is that, according to Calvin (cited in Wright, 2009:5).

"Nearly all the knowledge we have, that is, true and sound knowledge, consists of two parts: the knowledge of God and of ourselves. If this is the basis with which Calvin himself functioned, it is expected that the Institutes would be an appropriation of this basis and indeed according to Wright, this declaration became the introduction that Calvin employed in the rest of the Institutes" (2009:5). Wright goes on to reveal how Calvin did this, particularly in his pastoral vision, which concerns itself with the relationship between human beings and God and is actual in the different parts of the Institutes (2009:6). Smit's three volumes (2009 – 2013) deal with the question of what it means to be Reformed Christians and Reformed churches in the world today, as well as the concerns, convictions and questions that lie at the heart of Reformed identity. The volumes also address most contemporary issues, including being reformed and public health and outline the vision of John Calvin of strengthening public health in Geneva, which is something that can also be applied to the South African context.

Sproul's (2016) work makes it clear that there is much more to Reformed theology than "the five points of Calvinism" and "the five sola principles". Innes (1993) attempts to integrate reformed theology and public health. The importance of this work is that it deals with the question of public health from a Reformed point of view. In an article dealing with the HIV and AIDS pandemic, Okaalet (2006) criticizes the church in Africa and worldwide for failing to deliver assets, workforces, and management essential to deal efficiently with the disease. The importance of Okaalet's work for this study is that it discusses the role of the state in making and executing policies that directly legislate health concerns among the people.

Osmer, Richard R (2008: 223) in his book, *Practical Theology: An introduction*. He is teaching congregational leaders - including, but not limited to clergy-the necessary knowledge and skills to meet such situations with compassion and inspiration. The book is exclusive in its attention to interdisciplinary issues and the ways that theological reflection is grounded in the spirituality of leaders. Useful, accessible and lively – with lots of specific examples and case studies - Osmer's *Practical Theology* successfully prepares congregational leaders to guide their communities with theological integrity.

Writing about HIV and AIDS, Magezi (2007) notes that the congregation is the key to providing home-based pastoral care support to HIV positive people in developing countries like in the context of South Africa. In so doing, the Church does not only perform a social function to the affected families, but also acts in accordance with its calling of mediating God's Kingdom, thus spreading the Gospel and showing unconditional sacrificial love and compassion. Magezi's insights are important to this study, because they address the responsibility of the Church to the community in health-related issues. Covering a wide range of topics, ranging from international trends in the implementation strategies of primary healthcare to information regarding the transformation of the health system in South Africa, King et al (1998) argues that public health requires an interdisciplinary collaboration because it is public, diverse, and depends on a living religion for strength. The Church is that living religion. These authors add that public health is as old as the Church itself and that Jesus as founder of the Church is the exemplary healer who went about healing the sick. This thesis focuses on the strategies of public health in a social context and helps in unpacking public health policy and its relevance to the teachings of Reformed theology.



Kim (2011) shares insights on how theology can engage effectively with a variety of topics in the public domain, including public health policy.

Reflecting on the Reformed tradition as public theology, Vellem (2013) argues that Reformed faith is fundamentally public. He discusses two important doctrines of the Reformed tradition - only the Scripture and only by faith - within the decaying wounds of Black African colonialism, Apartheid, and the supremacy of the 21st century neoliberal pattern. Of these festering wounds caused by colonialism, Apartheid and neoliberalism, the health of the masses of the people were not taken as a priority.

This is exemplified by the privatization, commodification, and commercialization of healthcare. It is necessary that policy be made to nationalize and universalize healthcare for the benefit of the poor and marginalized of societies. Chapter one presented an introduction to the study. It presented the background to the study, research questions, research objectives, significance, and motivation of the study. The aim of this chapter is to review literature related to core understandings of the research so as to locate this study in the scope of the existing literature.

According to Shepherd (2021:01), a pivotal turning point in the history of the Reformation was the posting of the 95 Theses by German monk, Martin Luther, on the Wittenberg Church door. Madise (2009: 151) concurs and further explains that the Reformation was a movement that took place during the 15<sup>th</sup> and 16<sup>th</sup> centuries in Europe and brought about some changes in the Christian church. Some scholars see it as a transition in the Church from the medieval period to the modern world. Some Christian denominations, like Lutheran and Calvinist reformed churches, can trace their origin to this period. Reformers in the 16<sup>th</sup> century had one common objective, namely, to reform the Church.

The 16<sup>th</sup>-century Reformation encompassed more than only Reformed theology at that time. However, it is true that both this historical occurrence and its theological contribution are quite important. However, the Reformation was more than just a theological and ecclesiological development. Instead, it had and still has broader societal implications, such as changing the way people think, feel, and behave, including the current political climate.

Based on de Gruchy's (1991) assertions:

“A significant upheaval in the social, cultural and spiritual life of Western Europe during the sixteenth century included the Protestant Reformation. It was produced by a new practice and type of the gospel as well as several sociological government and commercial forces. With a focus on the salvation of the individual and the rebirth of the church, it had a significant impact on how individuals changed.”

Martin Luther, who was committed to the Reformation before Calvin, might also be regarded as a public theologian, according to Bedford-Strohm (2018). Luther's numerous accomplishments in the field of public health are actually only a small portion of his whole body of work.

Luther's admiration as a public theologian is based on his enthusiastic involvement in issues pertaining to social justice and the underprivileged. Calvin, a theologian, devout preacher, and clergyman, built on Luther's ground-breaking work in the Reformation and was a significant figure in Geneva's history. His work and ministry have had a significant and wide-ranging societal impact. In light of this context, Dreyer (2018:07) ends his brief but influential essay with a phrase that portrays Calvin as a public theologian. Understanding that Reformed theology is fundamentally, almost intrinsically, answerable to social commitment is crucial. Calvin qualifies as a public theologian who is still important in the twenty-first century because of his risky and theologically responsible reflections on justice, law, human dignity, kindness, and many other topics.

### **3.1 Reformed theology doctrines**

Reformed theology is fundamentally God-centred rather than human-centred, according to Sproul (1997:28). This God-centeredness does not diminish the value of individual in any way. On the contrary, it increases their significance. Because of its perseverance in promoting people's downfall and significant corruption, it has frequently been regarded as possessing a limited concept of tenacity. Because sin entirely absorbs God and humanity, it takes sin very seriously. Depravity disturbs both God and mankind. These serious issues are related. It upholds a high view of the worth and respect of individuals.

Finlayson (1963:13-14) asserts that, although it must be conceded that the term “God the Father” frequently refers to the supreme existence who is the architect and author of all things and does not necessary bring to mind a trinity.

The notion of a trinity of persons was not enshrined in the name Father, because it was the name of the living God. Paul engaged in a discussion with the Athenians along these lines (Acts 17:16-21), satisfying himself with the truths of commonplace faith, friendship, and God’s holiness as anchored in His universally good command and the impending life and judgement to come. The early Christians also offered the one Highest Existence divine, just, and virtue as a strong bulwark against polytheism. According to Finlayson (1963:50), the Reformers conveyed their remonstrance in the clearest and most forceful manner possible by fleeing from persecution because they opposed the development of power in matters of faith and life. However, the Reformers were not insensitive to the highest position of power in faith when they separated from a respected Church. One power was traded for another.

The theory of John of Geneva, who developed a Protestant doctrine through his scriptural interpretations, his pamphlets, but especially in the Institutes of Christian and Ulrich Zwingli, the first Reformer in Zurich, are revered as the foundations of the Reformed creed. Up until the present, many different individuals and organizations that sprang from the Reformation have adhered to Calvin’s principles, but they have not always taken the same path toward philosophical advancement. Because of this, according to the Reformed faith, Calvinists have distinct differences that are influenced by historical and even environmental factors, despite sharing many fundamentally agreeable traits. These variations have caused a variety of practices to take on various shapes or tensions. Pitikoe (2016) asserts that the Reformed church possesses all three of the characteristics of a congregation whose main mission is to proclaim that Christ’s true church of God is still and always will be. These three qualities are; (a) precise sacramental administration, (b) precise discipline implementation, and (c) precise Word preaching. One of the three marks, discipline, serves as a catalyst for the other two marks’ existence and proper continuation, and hence the existence of the real Church of Christ.

Therefore, discipline is a core component of the Reformed Church. However, as an instrument for regulation, its implementation and/or effect seem to be disregarded. This conundrum may be demonstrated by the overemphasis placed on democracy (related to the notion of majority rule) as opposed to theocracy (God as the supreme authority in our life), where even things of great spiritual consequence are subjected to human decision-making procedures. These factors have a crucial role in the decline and/or advancement of the Christian life as well as life in general. Reformed theology understands that human beings have both strengths and weaknesses.

Sproul (1997:138) asserts that the term “full immorality”, as opposed to “partial immorality”, describes the impact of sin and corruption on the entire individual. Being entirely immoral entails having corruption permeate every aspect of one’s being. Sin affects every aspect of who we are, including our body, soul, intellect, and resolve. Sin corrupts the entire or total person. No “island of righteousness” that is still standing is immune to the effects of the fall. Sin permeates every element of our life and cannot be protected by a single act of virtue. de Gruchy (2009:152) elucidates that, contrary to Jewish interpretations of the story of Adam and Eve’s disobedience (Gen 3), Augustine described it as the fall of humanity from grace to a state of sin. On this basis, he developed his doctrine of “original sin”.

Drawing on Paul’s teachings in Romans 5:12, Augustine concluded that because of Adam’s original sin, all succeeding generations have been born sinners and are, therefore, alienated from God. Moreover, Augustine, profligate turned ascetic, argued that the sinful virus was passed on through sexual intercourse. The human predicament was how to recover the lost state of grace and be reconciled to God. The medieval penitential system, building in part on Augustine, provided the answer. At baptism, original sin was washed away. Ongoing sin was dealt with by regular confession and works of penance.

### **3.2 How does the Bible define public health?**

According to Mahmood (2020), Biblically speaking, health is an integrated relationship with God in term of ideas of bodily, mental, relationship, and social wellness (Atkinson, 1993). This comprehensive understanding of health is derived from the concept of the Hebrew word “shalom”, found in the Old Testament (OT), which among other things relates to the philosophies of wholeness, soundness, welfare, peace, health, and well-being.

When all aspects of a person's being; emotional, physical, relationship, and environmental are open to God, there is shalom, which includes health. According to semantic analysis, the words sickness, disease, and their derivatives appear fifty-six times in the OT and forty-seven times in the NT, highlighting the Bible's emphasis on curing the sick. In line with OT prophecy, Jesus is identified in the NT as the source of complete well-being (Atkinson, 2011:9-11). As repeated in the texts in Isaiah (35:5-6), Jesus's healing and curing of disease and sickness (Matthew 9:35) revealed the health-giving indications of the Messiah age. Therefore, biblical notions show health as a multidimensional relationship with God, other people, and society rather than as a one-dimensional bodily trait.

Landa (2014) defines good health as a harmonious relationship in all aspects of a person's or community's life, rather than only the absence of disease or physiological or psychological dysfunction. The multidimensional oneness of life necessitates an intersection of oral, multidimensional ideas of health, illness and healing, but in a way that makes it clear that each dimension contains all the others (Tillich, 1961). As a result of this conception of health and illness, healing in the Bible is emphasized more as a renewal of the overall state of well-being and relationship of the self into the fellowship of God and the world, than as the functional restoration of diseased or damaged body parts (Hasel, 1983). Health, ailments, and recovery are hints that sin, disease, and healing are closely related throughout the OT. Divine law violations could result in illness as a penalty. In the OT, a large number of prophets were instrumental in creating and spreading the idea that sin (disobedience) and disease (punishment) go hand-in-hand. They regularly warned their populations not to disobey God's rules, lest they suffer the repercussions of societal, economic, or personal tragedy (2 Samuel 12:14). The OT also depicts God as the healer of his people, who can receive healing by having trust, obedience, and patience in God. But the hardship in Job's account also suggests that not all illnesses were brought on by committing sins. The covenant between God and his people is a central motif in the OT. It declares that God, who created mankind (Gen1-2), will bestow his favours upon those who observe and uphold his mandates and rules (Lev 26:3-13). However, disobedience and rejection of God's laws will bring about specific consequences such as wasting illnesses and plagues as well as social, economic, political, and ecological devastation (Lev 26:16-39). No sickness, illness, or even death is beyond the capability of God: "I will put to death and I bring to life, I have wounded and I will heal" (Deut. 32:39).

The wounding or suffering on an individual could be due to spiritual guidance and enhancement from God and therefore restoration. The more profound aspects of healing that go beyond the physical serve as additional examples of this comprehensive completeness (Psalm 41:3-4). In these areas, the prayer for physical healing frequently coincides with the confession of sin and spiritual healing. In this way, OT scriptural principles frequently did not distinguish between bodily and spiritual healing. Hasel (1983) defines healing as including aspects of redemption and forgiveness, in addition to the simple physical restoration of health. Health and healing in the NT offers theological assertions about individual and communal health in the NT built on precedents from the OT (Hill, 2007).

The act of pleading with God for assistance aids in the development of a connection with God, and healing offers a fresh start through consolation and strength. According to Wikinson (1967), God may use sickness to chastise his creation (Hebrews 12:6), but he may also use it to strengthen and elevate his people spiritually (2 Corinthians 4:17). Jesus spent a lot of time caring for the sick. The perspective on health and disease, a psychosomatic oneness between the body and soul as well as one's relationship to God, sin, and evil are all connected in Christianity. The concepts of health and wellness within Christianity have been various across time and denominations, much as they have been within public health, with the focus of the dedication to healing varying according to different eras and within different denominations.

Therefore, your identity and viewpoint on specific behaviours and beliefs will determine your level of Christian health, illness, and recovery. The use of contemporary medical technology and psychotherapy, as well as acts like prayer and anointing, can all have religious importance. This intersectionality is evident in the fact that, in some denominations, the focus is placed on the salvation of the soul rather than on physical treatment, while in others, miraculous cures for all diseases are expected (Atkinson, 2011:3).

Dissonances in theological views and the importance of Jesus's incarnation and worldly healing work are the root causes of the contemporary polemics surrounding the Church's curative (physical and metaphysical) role. The beginning of the Bible's story describes how God made the ideal, good world, including people who were made in his likeness (Genesis 1:1-31). Following the fall of man from heaven, sin, death, and suffering were defects that came to Earth (Romans 5:12).

The idea of personal accountability for disobeying divine commands is analogous to the idea that sin has a part in illness (Morgtate, 2002). Sin is often regarded to be the separation from God or to emphasize a rebellious heart. Individual sorrow and illness originate from this rebellion against God via sin, yet conversely in some circumstances, this suffering can foster spiritual growth, fortitude and an increased reliance on God in such vulnerable circumstances (Romans 5:3-5). Since salvation in the Bible reflects the ideas of soundness of bodily, mental, and spiritual health, there is also a strong correlation between salvation and healing (Olagunju, 2013). When viewed as a component of God's fight, disease and suffering can cause joyful sorrow for many Christians. Such pain and illness are seen as avenues of salvation or opportunities to participate in and rejoice in Jesus's resurrection and entry into the Kingdom of God (Hatfield, 2006). The theological concept of suffering is incompatible with health for many people and has little to no value, if any, in the age of contemporary biomedicine and therapies which aim to instantaneously eliminate illness and end suffering.

### **3.3 Jesus and public health**

According to Morgtate (2002), the synoptic Gospels' account of Jesus' healing miracles support God's desire for divine healing. Jesus's healing work served as a message of salvation and fresh hope in the heavenly kingdom (Atkins 2011:14). The healing miracles assisted in establishing the relationship and experience of God's presence via Jesus for the emerging Christians by bringing life and shalom to individuals (Kydd 1998: 10).

These healings were frequently witnessed by the entire town and served as tangible evidence of God's reign. Christians can feel a feeling of coherence and healing, thanks to the pattern and network of symbols that the Gospels' healing prescriptions offer. Additionally, it gives them the ability to understand this reality and offer humanity the prospect of salvation (Atkinson 2011:74). In the NT, Jesus's life and ministry of healing bring the context of salvation, which includes a person's health as well as the health of their community and the environment, to end. The story of redemption in Christianity is shaped by the healing ministry of the Church, whereby Jesus brought about the new age (the Messiah in the OT). Rarely do the accounts of Jesus' healing in the NT (Matthew 9:2, Mark 2:5, Luke 5:20, and John 5:14) mention sin as the direct cause of disease. The function of faith in the NT healing narratives is more important than sin since it becomes the unstated assumption for a long-lasting recovery and good health.

The Gospels attest to Jesus' pastoral concern for individuals who were ill or disabled (Matthew 20:34). As they were more concerned with breaking the Sabbath labour law than with the cure of the paralyzed man, the Pharisees' callous attitude toward those who were ill occasionally enraged Jesus (Mark 2:5). According to Morgante (2002), for Jesus, the Sabbath healing highlighted the fundamental purpose of the law, which was to uphold a connection of health and wholeness in order to sustain a condition of communion with God. Mahmood (2020) reiterates that the confirmation of Jesus' resurrection is the focal point of responses to health, illness, and healing from a Christian theological point of view (Acts 2:31-32, 4:2-33). From this time forward, all Christian life and ministry began. The fact that Jesus rose from the dead proves that he is the OT's Messiah who will bring peace, justice for the underprivileged, and healing for the sick (Isaiah 53:5).

Atkinson (1993) further articulates that through the casting out of demons and the healing of the sick, Jesus' ministry proclaimed the kingdom of God and also hinted at the coming of a brand-new restored Creation. The synoptic Gospels describe how Jesus overcame the forces of evil in this world and over the domination of Satan by performing exorcisms, establishing friendship with God, and giving people the gift of health. In contrast to the resurrection of the dead to eternal life, which represents salvation in the life after, Moltmann, (1990: 108) characterizes healings in this world as salvation this side of death. The restoration of all things' relationship with the divine is foretold by the healings performed by Jesus within this eschatological framework, "God's kingdom is Creation healed" (Kung, 1977:231).

### **3.4 Calvin's views on the relationship between the Church and the state**

According to Tuininga (2017:228), Calvin argued that Geneva owed it to society and its citizens to provide a minimal level of order. Calvin frequently looked forward to the government's free medical care for the underprivileged, regulation of the cost of food, wine and meat, and direction of working hours, salary rises, and re-equipment of the unemployed. According to Calvin, the state had to provide for its citizens in this manner. With his theological stance on the link between the state and the Church or the government and the general populace, Calvin's attitude toward government was trustworthy. Discovering his opinions on this subject is crucial, therefore, Calvin advocated for "twofold governance", which he divided into spiritual and secular administration.



The first kind, which is related to eternal life, “resides in the soul or inner man”. The latter is only concerned with the establishment of civil justice and external morality.

### **3.5 Public Health**

To discuss public health, one must first explain what health is. The World Health Organisation’s definition of health (as stated in the preamble of its 1948 constitution) state that; “Health is a condition of overall good physical, mental, and social welfare and does not only include the absence of disease or infirmity. General makes up for the lack of a universal definition of health.” (World Health Organization 1992).The imposing WHO definition, according to Griffiths et al (1999) reveals the intention to move beyond the narrow definition of ‘health’ as the absence of sickness and bodily disorder and instead emphasize “health” as a multifaceted and comprehensive concept. The Western medical tradition’s long-standing, albeit sometimes biased, emphasis on somatic symptoms and diseases has been abandoned in favour of an understanding of the mental, social, and supernatural foundations of health. This expansion of the concept of health is consistent with the majority of non-Western medical traditions, which are built on their comprehensive concept of health.

#### **3.5.1 What is Public Health?**

The term “public health” was first used in the nineteenth century to distinguish between the collective measures that governments may take to safeguard their population from disease and the measures taken by private citizens to enhance their health (Hetler et al, 2003). One of its enduring conflicts has been definition, where it runs the risk of becoming everything – the food we eat, the air we breathe, and sanitation - or nothing more than a collection of ideas (Griffiths & Hunter, 1999:1). Mahmood (2020) state that the main problems with this concept are the interpretation and open-endedness it fosters. Other shortcomings include the exclusion of the general public and the lack of any particular practices for those in charge of public health duties to comply with this definition. Other definitions abound:

- a) According to the UK Faculty of Public Health<sup>3</sup>, it is “The science and art of promoting and safeguarding health and well-being, preventing illness, and extending life through organized society efforts.
- b) According to the World Health Organization<sup>4</sup> it is “The science and art of extending life, preventing disease, and promoting health through organized social efforts”.

According to Powers and Faden (2006:10), public health has long acknowledged that there are many causes of both good and bad health. That policies and practices have an impact on other valued measures of life, and that health can occasionally be a basic concern about other important goods. It is important, therefore, that what the normal view on public health also gets wrong is that it structures public health as if the readiness was exclusively worried with health consequences and not problems of spreading.

### **3.6 Practice of public health evolving**

Mahmood (2020) state that while empirical methods (natural) were also used in ancient medical systems to explain disease, illness, and healing, these explanations were mostly based on supernatural (religious, magical, and mystical) explanations. The practice of spiritual exercise, propitiations, and libations was intended to purify the body and the soul before the god(s), and physical health was connected to moral well-being. In ancient cultures, good health and cleanliness enabled the patricians to get rid of spiritual impurity while simultaneously giving the ruling classes justification for their social rank.

According to Porter (1999:11-17), empirical classification of illness and disease was used, with environmental factors taken into account, and treatment based on clinical observation and suitable preventive routines including diet and exercise. The health of all the poor began to take greater significance than that of the patricians when social order started to change as a result of the population shift from agrarian to industrial urbanized cultures between the eleventh and fifteenth centuries. The population of Europe tripled as a result of the new agricultural techniques created during this time (Porter, 1999:27; Garman, 2007:23).

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<sup>3</sup> [https://www.fph.org.uk/media/1304/good-public-health-practice-framework\\_-2016\\_final.pdf](https://www.fph.org.uk/media/1304/good-public-health-practice-framework_-2016_final.pdf) - Accessed 21 June 2023

<sup>4</sup> <http://www.euro.who.int/en/health-topics/Health-systems/public-health-services> - Accessed 21 June 2023

As these social, demographic and economic elements changed and transitioned, it created new opportunities for infectious diseases like the plague, leprosy, and tuberculosis to spread. Since lepers were kept apart from the general population in Biblical communities (Leviticus 13:45-46 and Numbers 5:1-4), leprosy was the disease that caused the most agony. The stigma of excommunication was not always associated with the danger of spreading the disease, but rather with leprosy as a symbol of moral decay and a consequence of sins, so that the leper lived but was considered socially and legally dead. Municipal laws governing trash collection and commercial conduct (food hygiene) started to be implemented in many European cities by the late middle Ages.

The sporadic outbreaks of bubonic plague (also known as the “Black Death”) encouraged the development of bureaucratic government and the power of civil political authorities that sought to preserve social and economic stability as well as public order in the midst of the ravaging mortality such as the Great Plague, which claimed the lives of twenty million people in Europe, or about one-third of the continent’s population. These civil administrative systems developed during the Renaissance to lessen the consequences of the plague within the emerging European governments served as a template for public health management throughout Europe (Porter, 1999:30-37). According to Tognotti (2013), through public health authorities, boards, and health rules to regulate efforts to control the plague, the control of pestilence and plague across Europe during the late Medieval and Renaissance periods gave rise to current health politics and healthcare systems. Many of the health management techniques used to contain the plague required localized urban governmental organizations, which were not present in Renaissance England (14th through the 17<sup>th</sup> century), to implement measures.

The Plague Act of 1604 in England included European quarantine guidelines for controlling the plague as well as a series of instructions that complemented the objectives of the Poor Law and other policies to lessen social unrest (Porter, 1999:42). According to Voigtlander & Voth (2013), the “three horsemen of riches”; the plague, urbanization, and war; were responsible for the stability of Europe and the emergence of Early Modern European nation-states throughout the seventeenth century. The Treaty of Westphalia (1648), which followed the Thirty Years’ War or the European Wars of Religion established the framework for independent sovereign states in Europe by restraining the Pope’s claim to universal supreme power under the Holy Empire and confirming the diplomatic independence of secular rulers.

Since population health indicators determined the state's authority (Rosen, 1974), the relevance of bio-politics of the person, community, and society grew concurrently with the expansion of centralization of government inside nation-states. The development of national health systems during the eighteenth century in Europe's fledgling national governments was aided by initiatives like printing, which were used to address public health concerns like plague travel restrictions. Medical policy and monitoring served as an early example of state public health programmes throughout Europe and governments employed print to distribute and communicate public health plans to the general population in order to enforce laws and regulatory procedures. (Bamji, 2017).

Porter (1999: 51–53) elaborate that the population was viewed as the paternalistic property of European states during this time, and the well-being of the populace was seen as a measure of the health of the state. Because the body and behaviour of the individual were seen as the economic and political property of the country, this led to the growth of governmentality (Foucault, 1991:93). The improvement of the squalid conditions of the urban poor through methods reminiscent of Hippocratic miasma theory (relations between environmental factors and disease) to avoid and prevent disease as well as utilitarianism through welfare reforms for the poor and destitute are examples of how this civilizing process manifested in England in the late eighteenth century.

### **3.7 Public health since the 19th Century**

Since the Industrial Revolution (18th and 19<sup>th</sup> century), public health has undergone four waves that have paralleled changes in the governance of the contemporary state, according to Hanlon et al's (2011) explanation. It is thought that the first wave, which was structural in character, appeared around the start of the Industrial Revolution. It was acknowledged that crowded living conditions, a lack of clean water, and compact housing in developing urbanized areas constituted the perfect environment for the spread of infectious diseases. By creating the position of medical officers of health (MOH) inside municipal authorities, the Public Health Act (1848) recognized the fundamental contributions made by local and national governments to enhancing public health.

Since miasma theories of disease were being questioned and the germ theory of infectious diseases was being developed through the works of John Snow and Henry Whitehead (the cholera outbreak) and Robert Koch (*Mycobacterium tuberculosis*), scientific advances in discovery had a significant impact on this structural top-down approach (Davies et al : 2014). The second wave of public health was taking shape thanks to advances in our understanding of the aetiological causes of epidemics. The focus of this movement was on the biomedical causes of disease, its prevention, and its empirical treatment.

According to Davies et al (2014), all infants were required to receive a smallpox vaccination before the age of three months under the Vaccination Act (1853). This law served as an example of how wave one (structural) and wave two (biomedical) were connected. The third wave of public health; clinics; emerged as a result of increased knowledge of biological mechanisms, aetiologies, and analytical and descriptive epidemiological approaches. The development of the English welfare state and the establishment of the National Health Service in 1848 to address the emerging epidemiological shift from infectious to non-infectious communicable diseases defined this wave. The improvement in knowledge of the aetiology of and risk factors for chronic illness heart disease by the Framingham study (Stoke et al, 1989) and lung cancer by the British doctor's study (Doll, 1954) served as the paradigm for this age. Understanding risk stratification and screening to avoid disease has shed light on how diseases are distributed throughout society. The better understanding of risk factors allowed for the development of preventative strategies, such as changes in lifestyle (including smoking, physical activity and alcohol use) to lower the incidence of disease. According to Marmot et al (2010) in the WHO Ottawa Charter for Health Promotion (Who, 1986), member states vowed to develop sound public policies that prioritize and intersect oral action. In waves two and three, medical advancement like antibiotics, heart transplants, and kidney transplants may have helped to significantly lower mortality rates over the latter half of the 20<sup>th</sup> and early part of the 21<sup>st</sup> centuries. The effects and implications of waves one through three have significantly improved public health in the UK. However, the fourth wave's complicated backdrop has made it difficult to address to significant changes in the UK public's health. The first was the epidemiological transition, which involved a higher disease burden from non-communicable diseases compared to communicable diseases and the need for health services to deal with chronic sickness rather than a preponderance of acute events.

The second was the rise in chronic illnesses. Despite improvements in our knowledge of the aetiology of disease and proximal and distal causes of illness, there are significant health disparities in the UK. According to Davies et al (2014), because of societal changes and ongoing health inequalities, the current problems facing UK public health demand the development of a new (fifth) wave of public health. Instead of a top-down paternalistic approach, a more shared responsibility for health is proposed through increased and professional participation within local communities. In light of the current societal emphasis on individualism, a shift in community health culture is necessary. There is a need to develop a culture of health, in which health is considered from an interdisciplinary lens that incorporates health improvement interventions from civic service and community providers. (PHE, 2019)

According to Hanlon et al (2011), Individuals, communities, public and private healthcare professionals, as well as non-profit organizations must collaborate to address a variety of lifestyle variables and morbidities as a result of this wave. While earlier waves are open to top-down interventions and assigned relative unimportance to the person and the human spirit, the current wave of communitarianism is offered within a culture that idealizes individualism, materialism, and consumerism. Therefore, this new wave of growth cannot result from the accumulation of earlier waves. Rather, it necessitates a significant paradigm or worldview shift in order to be implemented to address existential public health challenges.

### **3.8 Current public health practice**

Since 2013, a variety of public health services have been transferred from the NHS to local councillors, from the national to the local level of government. To address the issues associated with an aging population (social care) and the ongoing spreading of health inequality, it was judged necessary to return some preventative public health tasks to local authorities after they were transferred to the NHS in 1974. The health and well-being agenda could be ingrained in local communities and across all policies that went beyond doctors and hospitals such as education, housing, and environmental health; if promoting health was included in the local council's statutory role (LGA, 2019). The financial resources that local public health teams have access to have significantly decreased, despite the fact that local government is required to perform these mandated health improvement duties.

The public health fund was reduced by £531 million in financial terms between 2015–2016 and 2019–2020 despite the fact that the government and NHS have laws requiring it to address inequality and direct the preventative agenda in local communities.

According to Maskovsky & Kingfisher (200: 105), a post-welfare state model that favours the market model of public service delivery and welfare due to its alleged economic effectiveness rather than solely state-delivered health provision, which is how public health is currently practiced in UK, is based on the dominant neoliberalism political ideology. Chapman and Middleton (2017) explain that recent years have seen significant structural, cultural, and identity disintegration in the field of public health, which is also functioning in a time of rising austerity, widening health disparities, and significant budget cuts in local government due to significant funding cuts. The NHS has also been suffering from similar erosion for almost ten years, which has negatively impacted its performance in terms of waiting times and staffing shortages. The new NHS long-term plan (NHS, 2019) is expected to address some of these issues through additional financing for the NHS and enhance population health and well-being through closer collaboration with local governments and communities.

Disparities in health status between communities in the UK remain a persistent concern that cannot be solved by current approaches in public health practice. Even after thirty years of a universal health service, the Black report (1980) showed significant health disparities and differences in health outcomes between social classes (Gray, 1982).

In the modern era, a healthy person or healthy body is portrayed as a morally upright citizen who exercises control over their bodies, whereas those who are sick or deviate from social norms are frequently stigmatized. Individualistic views of health are supported by the comparison of healthy, active citizens who are capable of managing their own health versus those who are unwell and require state intervention (LeBesco, 2011). Many of the current health promotion tactics function through the prevailing capitalised culture of today. This neoliberal rationalism-marked fundamentalism connects inequality with individual choice and is based on the ideas of limited governmental involvement and individualism.

Public health activities to improve health are supported by messages that emphasize the individual's autonomy, and neglect broader societal norms that may have an impact on people's health, well-being, and health outcomes (Ayo, 2012).

Additionally, they depend on people using their individual agency to follow normative and professional definitions of what constitutes health. However, cultural changes that can primarily be created through social contexts and networks, rather than top-down interventions, are necessary if an individual is to prioritize their health as a priority (Harrison et al, 2011). The 2019 NHS Long Term Plan (LTP) offers a ten-year road map for healthcare services. However, the plan's goals and objectives represent status quo continuity rather than substantial reform, which is necessary to address some of the NHS's most pressing problems (Kings Fund, 2019). It puts prevention at the centre of each of its core components, because it understands that good health entails more than just access to healthcare.

The strategy admits that the NHS must address broader social determinants of health in order to eliminate health disparities but it makes no specific commitments to utilizing local resources. Implementation plans are needed to shift the emphasis away from clinical services and disease treatment and toward a culture of health and well-being using an asset-based approach. To do this, civic and community partners must be involved (Chapman & Middleton, 2019). The strategy won't be able to realize its preventative objective without whole-system investment and meaningful vertical and horizontal engagement between partners across the business and public sector (NHS, 2019).

### **3.9 The Mission of Public Health**

According to Bouldin (2010:04), the goal of public health is to serve society's interest in preserving the health of the environment in which people live. Two components of this task are crucial to comprehending public health. The demands and pressures placed on the public by these factors greatly concern public health. The government sponsors many public health initiatives and those funded by taxpayer dollars are open to community feedback. Public health is a melted punishment as a result of this response to popular demand. Even while public health has fundamental goals and symbols, its scope and achievements are always subject to change. The second section of this task statement, which confirms that individuals live in healthy environments, emphasizes the beneficial role that public health plays in ensuring that people are healthy. Public health does not always provide medical care to people instead, it verifies that the environment promotes health.



### **3.10 Public Health as a System**

Turnock (2012:07) asserts that there are several public health viewpoints that need to be considered. The inquirer may already be aware of one or more of these. Public health is a broad social project that also aspires to disseminate the advantages of modern awareness in ways that will have a significant impact on people's health. It does this by identifying issues that require collaboration in order to defend, stimulate, and improve well-being, primarily through defensive measures. Public health is unique not just because of its interdisciplinary methods and approaches, emphasis on preventative measures, and relationship to political and governmental decision-making, but also because of how quickly it adapts to new issues that are brought to its attention.

Above all, it is a joint determination that identifies and addresses the incorrect realities that have unavoidable and unneeded negative effects on one's health and quality of life. As a result, people and systems of government that are devoted to these conclusions typically carry out a combination of hard labour and activities.

### **3.11 Foundations of Public Health**

Snellig (2014) identifies three primary public roles, including assessing the likelihood of communities' and populations' identified major health issues and local and national health issues, develop public health policies to address these issues, guarantee that all populations have access to appropriate and financially viable care, including health promotion and disease-prevention services and assess the efficacy of that care.

According to Powers and Fade (2006:09), securing essential health metrics for everyone is the progressive fact of impartiality for public health. The destructive fact of impartiality necessitates a commitment to monitoring organized forms of weakness that vigorously and persistently oppose well-being projections, and it focuses ethical determination on the health needs of oppressed and subordinated groups, as well as on individuals whose conceptions of well-being, including health, are so deficient that their life decisions are not even remotely similar to those of others. This includes children whose views on well-being, in general, are so constrained that their lifestyle choices are not even remotely similar to those of others, as well as children whose views on well-being, not just while they are young but throughout their lives, are in jeopardy due to the initial locking-in of controls.

### **3.12 Essential Dynamics of Well-being**

Policies, according to Eyler and Brownson (2016), are fundamentally linked to health improvement and illness prevention, because they open up opportunities for extensive and viable improvements in population health, which need to be made. Public health laws have played a fundamental role in advancing health through their role in encouraging behaviour and environmental change. Just because the policy is in place, however, does not guarantee compliance. Although health as a metric of well-being is portrayed as the primary ethical foundation for public health and health policy, Powers and Faden (2006:17) contend that there is no reason to anticipate that every policy choice that has an impact on public health or medical care rests on the single ethical foundation of health any more than any other logical discipline, occupation, or collective foundation. For instance, laws against female genital mutilation are based on health considerations, as well as the physical and psychological purity valued by what we refer to as personal security and self-determination.

### **3.13 Public Health Outcomes**

It has long been a source of concern for the field of public health, according to Albee and Gullotta (1997:10). It is safe to claim that public health initiatives consistently outperform traditional medical interventions that focus on “healing” strategies in terms of keeping the population healthy. Effective preventive measures have been used by public health for a very long time to minimize many of the major epidemics that have killed millions of people. Wills and Jackson (2014:15) identify five important public health domains that should always be considered in public health: “Health promotion and resilience (protection of the population from major emergencies and remaining resilient to harm), tackling the wider determinants of health (tackling factors which affect well-being and inequality), health improvement (helping people to live healthy lifestyles and make healthy choices), prevention of ill health (reducing the number of people living with preventable ill health), healthy life expectancy, and preventable mortality (preventing people from dying prematurely).

### **3.14 Health Promotion**

Arguably, the importance of health promotion is noteworthy when discussing public health domains. According to Wills and Jacksons (2014:16), health promotion essentially entails “going upstream” and implementing measures to prevent infections in the first place. Thus, health promotion aims to create a healthy environment through enhancing people’s overall health and well-being. In doing so, it overcomes significant health and societal barriers to promote active living. The Health Promotion Policy is based on the four competencies of the Negotiated Service Delivery Agreement (NSDA) and aligns with the National Department of Health’s policies and strategies. Combatting HIV, AIDS, and TB, lowering infant and maternal mortality rates, efficiently enhancing the healthcare system and extending life expectancy are some of these competencies.

Bloom and Gullotta (2003:18) remark that just as health promotion has progressed in reaction to alterations in the incidence and occurrence of diverse illnesses, it has also been formed by our altering systems of sicknesses. Through the past, people have varied not only concerning the circumstances they defined as diseases and the names they give to these diseases, but also in their beliefs about the fundamental practices that lead to the arrival of disease in a person or people.

### **3.15 Disease Prevention**

In the past, the primary, secondary, and tertiary subjects of the public health concept of disease prevention have been whether the approach stops the disease itself rather than the severity of the disease or a related disability. Primary prevention, as opposed to risk reduction, tries to delay the onset of diseases by altering risky behaviours through protection or teaching, according to Bloom and Gullotta (2003: 11). For instance, smoking cessation and government initiatives to make it easier to smoke in public places may reduce the incidence of respiratory disease. Bloom and Gullotta (2003:72) assert that the concept of primary prevention is largely focused on the notion of illness prevention, as opposed to disease enhancement. This has public health roots, and was first associated with cholera prevention and other infectious disease prevention.

According to Schinke and Cole (2003), different persons are demographically varied groups who, because of their racial or ethnic background, way of life, or physical, emotional, or societal qualities, require and justify carefully designed major preventative measures. Promoting health and well-being as well as preventing the occurrence of particular diseases, maladies, illnesses, or circumstances that may cause these are the two main goals of primary prevention. According to Boom and Gullotta (2003:11), secondary prevention includes steps that locate and address pre-clinical illogical alterations in order to avoid the spread of disease. Early interference can result from screening procedures (such mammography to find breast cancer in its early stages) or routine blood sugar checks for persons over 45 years of age.

According to Bloom and Gullotta (2003:11), tertiary intervention aims to lessen the disability or difficulty arising from an illness and enhance a patient's function, life expectancy, and quality of life. By helping a patient to decrease weight, cardiac rehabilitation following a myocardial infarction can work to change behaviours to lower the risk of a re-infection.

### **3.16 Social Justice and Public Health**

Powers and Faden (2006:18) contend that while many disparities cause harm to people's health, they also contain a great deal more that cannot be reduced to only the impact on health. Certain inequalities that cause harm include more obvious harms to other aspects of well-being. For instance, a broken arm sustained while being tortured differs from a broken arm sustained in an unsafe employment.

Criminal acts like rape and battery cause more than just physical injury. Even when they do not result in actual harm or bodily injury, assault and threats are nevertheless attacks on the individual's safety. If one is always afraid of being physically or emotionally abused, it is debatably incredibly difficult, if not impossible, to live a decent life. Regardless of who we are or what standards we may then consume, experiencing such abuse is unquestionably a delay to one's well-being. For those people and organizations who focus specifically on domestic violence, crime, war, and human rights abuses, destructions like rape, assault and torture are causes for alarm since they have a bad impact on health and even more so because they affect health negatively.

### **3.17 Moderate Essentialism**

Powers and Faden (2006:30) contend that the moderate essentialist view serves as a basis of appraisal for how well social structures carry out the obligations of social justice, despite it not being meant as a basis for making several other claims about individual lives. Our view does not claim that a life deficient in some important dimensions of well-being on our list is not a valuable life or not entitled to the same moral concern as others. It does not claim that such a life cannot be decent life. Indeed, lives full of pain, illness, and physical infirmity are familiar enough to all for us to know that lives lacking in good health can count as among the paradigm of decent lives. According to Nicholls (2009:23-41), essentialism is the designation of something as having two characteristics that are both necessary for it to be labelled as such: a fundamental and substantial trait shared by all things referred to as that “thing”. Up until the early 20<sup>th</sup> century, the essentialist concept, which was grounded in an objectivist sense of utility, governed the social sciences.

### **3.18 Interface between Reformed theology and Public health**

Cochrane et.al (2011: xxii– xxiv) argue that the interface between religion and public health is predicated upon an overt conviction that the task cannot be accomplished solely within any disciplinary boundaries or even by a merely additive assembly of perspectives from multiple disciplines. On the contrary, it is vital to comprehend, as far as possible, through a transdisciplinary orientation, the full complexity of the matter if any breakthrough insights are to emerge. The principles that guide Christians in their decision-making are invariably shaped by their religious convictions. This is also true with regards to their understanding of the Biblical viewpoint.

According to Powers and Faden (2006; 17), there are as many interpretations of the term ‘health’ as there are cultural practices and medical specialities. Notably, the account of health with which we are concerned was developed with a certain moral objective and from a specific viewpoint. In particular, we deal with what is essentially a common-language knowledge of the physical and psychological that is projected to capture the aspect of human prosperity that is commonly defined as the natural or organic function of the body. Although there is a great deal of support for the interconnection among Reformed theology and public health, there is a need to learn much more about the mechanism underlying these links as well as the outcomes of the interventions for their targeted purposes.

### **3.19 Theological Ethics and Pastoral Care**

In the end, theological ethics insists that the moral outcome of therapeutic interventions be considered as bearing the weight of God's own moral will. Jesus provided for this when he said: "Whatever you bind on earth will be bound in heaven, and whatever you loose on earth will be loosed in heaven" (Matthew 16:19 and John 20:22-23). This is a costly kind of advocacy. The caregiver must be prepared to suffer the judgement of those who feel it necessary to uphold legal and formal structures. The presence of the liberating of the moral will of God will often appear ambiguous, and even wrong, to those who find security in "being good" as defined by legal morality. For this reason, Dietrich Bonhoeffer insists that the task of Christian ethics is not to be good but to do the will of Christ.

### **3.20 Conclusion**

Thus, it is clear from this brief overview of the extant literature that a lot of work has already been done on the two legs of this study, namely Reformed theology and public health. This study used these insights to give a reformed critique of the public health practices and policies in KZN. Moreover, most of the literature for this study is predominantly North American. This study is a South African one, and so insights from the Western literature have been adapted to suit the South African context and perspective on public health. The researcher aims to write a book and an article which will be based on the Reformed theology and public health based on South African and African context.

## **CHAPTER FOUR: THEORETICAL FRAMEWORK OF THE STUDY**

### **1.0 Introduction**

This chapter explains the background of ARHAP before revealing its function. It describes the primary aims and objectives that direct ARHAP's research, so that readers can comprehend the inspiration behind it. It also introduces ARHAP's collaborators who have helped make its work known and valued. A summary of the actions that ARHAP has carried out in KZN will come after. African Religious Health Assets Programme is abbreviated to the acronym ARHAP. This initiative was primarily developed by academics to do research in Africa and the rest of the world to uncover the potential ways that religion could collaborate with secular health organizations to foster an environment in which communities may engage in public health improvement. Due to growing health crises, particularly in Africa, ARHAP sets out to identify participants who have the potential to improve the health and welfare of the populace. This chapter provides an overview of ARHAP, its historical background, vision, and objectives. It also defines the terms used by the ARHAP project; such as health, religion, assets, and agency. An explanation of the ARHAP conceptual framework of the theory matrix illustrating Religious Health Assets (RHA) is highlighted. The theory matrix seeks to identify religious health assets as both tangible and intangible and thus identifies their relationship to health outcomes.

### **4.1 Descriptive overview of ARHAP**

A group of academics with an interest in religion and health launched ARHAP. According to James R Cochrane, Barbara Schmid, and Teressa Cutts (2011), the initial objective of the Religious Health Assets Project (RHAP), which was established in Geneva in December 2002, was to develop a comprehensive database of religious health resources (RHAs). This would help religious health leaders, public policy makers, and other healthcare professionals better coordinate and advance their work as they work together to address major public health challenges. Christoph Benn (2011:02) argues that, since ARHAP was launched, there have been many remarkable developments. ARHAP has contributed to a much broader recognition of the role that the faith communities around the world have been playing and still play in international health.

Benn (2011:2) further asserts that, among many other things, ARHAP has conducted a major mapping exercise on the share of faith communities in the provision of healthcare with support from the World Health Organisation (WHO).

#### **4.2 The vision of ARHAP**

In order to better coordinate and advance the work of religious health leaders and public policy decision makers in their joint efforts to combat diseases like HIV and AIDS and to contribute to the creation of healthy conditions, especially for those who are poor, this program's objective is to establish a systemic knowledge base of religious health resources in sub-Saharan Africa (ARHAP 2015). Cochrane et al (2011: xx) note that one of ARHAP's important contributions is the development of language with which to address this field. Religious Health Assets<sup>5</sup> are at the core of this work. The term emphasizes not only the focus on assets, as opposed to needs, but also building on what is there. There is, therefore, invariably much even in the most marginalised community in opposition to paying attention to what may be missing. Many RHAs such as facilities and staff are tangible. It is noted, however, that equally crucial are the intangibles like trust and hope and the way these reinforce what is tangible. ARHAP seeks to align religion and its relationship to health, as these two worldviews have not been fully investigated and few health practitioners appreciate the positive contribution religious assets make to the easing of diseases.

#### **4.3 Goals and objectives of ARHAP**

The purpose of ARHAP is to provide assistance in improving the alignment of the work of religious leaders, public policy-makers, and other health professionals and institutions to meet the challenge of disease and to foster health in its holistic understanding, as defined by the WHO. ARHAP formulated its objectives to meet its vision as follows:

- a) To comprehend and unbiasedly evaluate the contribution and expansion of religious health resources in promoting health in all of its aspects, as defined by the WHO.
- b) To conduct studies that advance a deeper and more thorough understanding of how religion and religious institutions contribute to health promotion.

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<sup>5</sup> The term 'Religious Health Assets' refers to what communities and people already have, which are present in a given community or organization.



- c) To improve organizational capability and leadership in order to promote health and thus lessen suffering.
- d) To offer information that can affect how governments, religious authorities, intergovernmental organizations, and developmental organizations decide how to allocate resources for healthcare (ARHAP 2015).

In an effort to create a structured knowledge base regarding religious health assets, the ARHAP program is driven and directed by these goals and objectives, according to Cochrane et al (2015). It is important to reiterate that these are intended to support religious health leaders and public policy decision-making efforts to combat diseases and contribute to the development of healthy communities. de Gruchy et al (2006)'s statement places ARHAP's tasks inside its clearly stated vision in order to achieve this. It is backed by the following purposes:

- To assess the quality of the baseline data sources currently available and to conduct an inventory (mapping) of the networks and institutions for religious health in Africa.
- Using conceptual frameworks, analytical tools, and measures, to define and adequately capture religious health assets from African perspectives across geographical regions and various religions, to coordinate and enhance the work of religious health leaders and public policy decision makers in their cooperative efforts.
- To create a network including nodes of academics, leaders in religion and public health, as well as academics from outside of Africa, leaders in religion and representatives of important financing, development and policy-making organizations in sub-Saharan Africa.
- To impart knowledge of religious health asset-assessment techniques to upcoming public health and religious institution leaders (capacity-building).
- To offer information that can be used to influence decisions about health policy and resource allocation made by governments, religious authorities, intergovernmental organizations, and development organizations.
- To routinely and widely publish and convey findings and lessons learned.

#### **4.4 Conceptual framework of ARHAP on religious health assets and health**

There are two basic kinds of RHAs, namely tangible and intangible. These RHAs contribute to direct and indirect health outcomes. The theory matrix is developed in a manner that provides a tool to assess religious assets and how they impact these health outcomes. The matrix illustrates possible avenues, which show how RHAs interplay at various levels such as the intangible and the tangible. RHAs and how they function and impact on health in either direct or indirect outcomes. It is important to understand that this theory matrix has, at this stage, only been proposed. ARHAP is undertaking field research to illuminate and develop it. This study is part of the process of evaluating the understanding and contribution of religious assets to health outcomes. Therefore, while this study assumes this theoretical framework as its starting point, its findings may also lead to further development of the same framework.

#### **4.5 Definition and understanding of terms used in this study**

This study adopted the definitions used by ARHAP. These encompass a specific understanding of the terms in the ARHAP research project such as African, religion, health, agency, and assets. These terms are defined in a manner that helps to facilitate a wider framework and appreciation of the concepts ordinarily understood in a narrow, traditional way. The terms described below elaborate the concepts and understanding of certain terms in the language of ARHAP.

##### **4.5.1 Religion**

It is worth noting that the use of the term “religion” in this study embraces the general understanding of the word, which is wide and inclusive in nature. Religion, according to Geertz (2004:04), is a system of symbols that works to instil strong, persistent, and pervasive sentiments and motivations in men by conceiving ideas of a general order of reality and wrapping these ideas in an air of factuality that makes the moods and motives seem especially realistic. Religion, therefore, includes any system of sacred beliefs and practices, upheld by various religious groups such as Christianity, African traditional religions, Hinduism, Islam, and other religious formations. The understanding of RHAs is, therefore, determined by this broader and inclusive definition of religion, which impacts various aspects of human, social, and spiritual life. Religion is understood in terms of relationship to and with a being or beings that is outside the person and is perceived to be higher and powerful.

Religion is, therefore, presented as something more than a set of beliefs, but a lived relationship. Although religion has a broader and inclusive understanding, this study focuses on Christianity as a religion with its religious assets. Slider (2000:212) argues that there is no theological source for relating specific illnesses with exact types of immorality. Going by this definition, any facilities, organizations, beliefs, practices, and networks that have a religious orientation are termed as religion in ARHAP.

#### **4.5.2 Health**

According to Baxter (2010:04), the WHO defines health as a state of whole human flourishing, and not only the absence of disease or disability. The WHO definition clearly demonstrates that health is supplementary to more than just the bodily well-being of an individual. This understanding of health is what the ARHAP research endeavours to show. Germond and Molapo (2006:27-47) state that in Africa the meaning of health is broader than mere physical well-being, as it refers to the comprehensive well-being of an individual and everything that sustains his or her health. Therefore, a broader perspective on health is embraced including the personal, communal, social, economic, environmental, and spiritual dimensions of health. This understanding of health incorporates everything that contributes to the well-being of people such as hospitals, medical facilities, and all medical therapies. This broad understanding of health, which is more than the absence of illness given its inclusivity of the well-being of an individual and everything that contributes to the same, is what ARHAP defines as health in its research study.

#### **4.5.3 Assets**

The term “assets” refers to what communities and people already have, and these are present in each community or organization. This kind of approach to enhance human life engages the community and the institution’s assets and not their needs or deficits (ARHAP 2015). The concept of assets would include things such as the capabilities, skills, resources, links, associations, and institutions that can be built on to enhance better health. In the ARHAP research project, the positive contribution which religion brings to health is what is referred to as an asset. This specially relates to the ability of religion to improve people’s lives and general well-being. Cochrane (2006:7) states that ARHAP places strong emphasis on this assets-based approach. When Cochrane states, “by assets, we mean something pretty distinctive”, he elaborates on this.

The language of assets refers to what individuals have available to them, regardless of how significantly deprived they may be, politically and in other ways, in the context of modern improvement ideas concerning maintainable lives and people-centred improvement approaches. These resources are mapped, gathered, and coordinated with the purpose of promoting human health and well-being.

#### **4.5.5 Religious Health Assets (RHAs)**

The asset language provides a framework upon which ARHAP builds its focus on RHA, which is different from the traditional approach that focuses on deficits or needs. It is these religious assets, according to de Gruchy (2003) that can be mobilized to help mitigate diseases in proactive preventative measures. De Gruchy et al (2006:39) further emphasizes that religious health assets are norms based on people and physical resources that are always available to be employed. They are held by religious organizations with the goal of enhancing people's health and welfare, and can be found among the adherents of any religious organisation

#### **4.5.6 Agency**

Kretzmann and McKnight (1993) define agency as the ability to take initiative, use one's resources, and seek out and accomplish desired goals while taking into account social and environmental factors. This goes hand in hand with an asset-based approach to development or health mitigation, because it focuses on the capacity to utilize what is already present by local agencies to create positive change. ARHAP, in its approach to health and well-being, puts emphasis on people's capacity to do things as agents of change with the ability to bring about desired outcomes in matters of health.

#### **4.5.7 Religious Entities**

The term "religious entities" (RE) addresses a broad range of tangible RHAs, such as clinics, dispensaries, hospices, hospital beds, and care groups such as Home-Based Care support groups. Religious entities include religious facilities, organizations, and medical practitioners, from both the bio-medical and the traditional. According to ARHAP glossary (2007:123), the all-encompassing understanding of religious entities provides a platform for addressing both the conventional religious entities, such as faith-based organizations (FBOs), as well as those that are less recognized entities such as traditional healers.

ARHAP feels that FBOs are not broad enough to include national church organizations, worshiping congregations, small projects, and key individuals, etc. So, the use of the term RE to refer to this wide range of assets helps to address any activity that goes on under the name religion.

#### **4.5.8 Tangible and Intangible Religious Health Assets**

The terms “tangible and intangible” health assets mention to detectible and undetectable health assets. Both tangible and visible resources as well as tangible and intangible physical resources are included here. Amos (2015) asserts that the ARHAP’s intangible assets are Christian principles, which, when met, can enhance the health of health-seekers. According to her, intangible assets have both direct and indirect consequences on people’s health. Tangible assets are those that are physically present and can be seen, felt, or touched by a person. Buildings like church structures, church-related buildings, hospitals, and health facilities are examples of tangible religious health assets. They may also consist of both current and stationary assets. These assets include, among others: furniture, goods, computers, structures, and machinery. There is no physical reality or sensation for intangible assets. Depending on the type of asset, intangibles can either have definite or indeterminate lifetimes. Unseen resources that support the same goal of enhancing the health of health-seekers are intangible religious health resources. These assets include, but are not limited to, goodwill, patents, copyrights, trademarks, the company’s brand name, etc. when both tangible and intangible assets are combined, religious health assets work together. One illustration is when many (tangible) followers of a certain faith unite to support (intangible) and show their love to health-seekers.

#### **4.6 ARHAP activities in South Africa**

ARHAP was a research programme that involved scholars from the Universities of Cape Town, Witwatersrand, and KwaZulu-Natal in South Africa. These scholars worked in partnership with scholars and practitioners from universities and institutions in the USA, Europe, and the rest of Africa. The research programme was aimed at engaging religious health institutions and health policy-makers on the understanding of how religion functions as an asset for the well-being of communities. The activities of ARHAP were made possible with its collaborative partners and other participants such as non-governmental organizations and the Centres for Disease Control and Prevention. Others who remain anonymous, are professionals in the health community.

#### **4.7 The role of the faith community**

While the dominant view of faith comes mainly with religious traditions, its fundamental moral objective is to be the light in the world within communities through different methods of teachings, development, and philosophies. Traditional Christian teaching includes Biblical teaching, as well as the Church's teaching and practice over the years as a guide of becoming the light of the world. Anthony Butler (2004:36) argues that if language continues to be a force for division, religion performs a more equivocal role. Benn (2011:02) asserts that ever since ARHAP was launched, there have been many remarkable developments. Without any doubt, ARHAP has contributed to a much broader recognition of the role that faith communities around the world play in international health. Among many other things, ARHAP has conducted a major mapping exercise on the share of faith communities in the provision of healthcare with support from WHO (ARHAP 2006). Karecki (1999:30) concurs with the view that Christian life has been described as an inner and outer journey, which always means movement and growth. Thus to be human is to be an explorer who is always on the move, always on the way. The inner and outer dimensions of our human journey cannot be separated. Notably, therefore, the inner journey leads the explorer into a deep relationship with God, while the outer dimension enables the explorer to cross the boundaries of human relationships and enter communion with other explorers. Therefore the journey for all of us Christians is one and the same with the only difference being that we take different paths on the road. The Christian journey always leads us to ongoing conversion and transformation, and at the same time to dedication in furthering the control of God in the actual situation in which we live and work.

#### **4.8 The challenge for religion**

Whenever we think about issues that impact negatively upon the community, health comes to mind as number one. Whenever health is discussed around the community, most community members believe that the only solution to health is clinics and hospitals. From this perspective, the issue of clinics and hospitals is thought to be a remedy for the problem of health. But the question that arises from this relates to how health can be achieved in a community that is overwhelmed by issues such as diseases. Some people in the world, including South Africa, are Christians. Smit (2007) argues that the story of South Africa is filled with the activities of Christian churches. A rich diversity of religions exists in South Africa and most of the population professes faith.

During the 2015 census the number of faithful was 86%, with 77% being Christians. What can be gleaned from the history of PHC is that despite its strong Christian input and the fact that many RHA organisations did play prophetic roles in developing community-based models of healthcare, PHC turned out in practice to be an obstinately secular movement. This is a result of the fact that PHC did not generally recognise the motivational link between health, healing, and the grassroots spirituality of communities and families.

#### **4.9 Mapping religious entities engaged in health**

Keane (2005:45) is of the view that the Church, as we know, is the body of Christ but it cannot share in his applause until it has first followed him in the path of humble, persevering service and in the suffering that often accompanies such service. Keane further quotes the Scriptures to the effect that “the Son of Man came not to be served but to serve, and to give his life as a payment for many” (Mark, 10:45). In this sense, the ‘Son of Man’ was a man for others, as he came to minister, to heal, to reconcile, and to bind up wounds. According to Olivier (2011:24), there are many different types of faith-based actors, such as clergy, faith-based organizations, local faith communities, religious congregations and religious institutions. Engagement efforts must take into account the various roles and responsibilities of these many actors. As shown in the following description, those engaged in collaboration and inquiry are conscious of this difference and are making an effort to be considerate of it. To enable comprehensive programming and excellence in HIV and AIDS prevention, care, and support, the CORE initiative brings together important stakeholders, including people living with HIV and AIDS, church and faith-based organizations, non-governmental organizations, private voluntary organizations, and donors.

#### **4.10 Participatory Inquiry in the interface between religion and health**

According to de Gruchy et al (2011:54), the African Religious Health Assets Programme aims to conduct research into RHA through the development of participatory inquiry, a technique that integrates multiple concepts into one. The pertinent toolbox, known as PIRHANA (Participatory Inquiry into Religious Health Assets, Networks, and Agency), was originally employed in the research conducted for the WHO (ARHAP 2006) and has since been applied in a variety of different international settings. Its usefulness for obtaining particular types of data has been frequently attested to, and its deep participatory nature has notable launching effects in drawing important actors together around shared problems.

#### **4.11 Challenges and possibilities of RHAs**

Sayed (2011:105) asserts that since the launch of the ARHAP, there has been a plethora of literature on the interface between religion and public health, especially on one of the biggest public health challenges, the HIV and AIDS pandemic. Religious traditions are often considered to possess the ability to contribute positively to the struggle against HIV and AIDS, while at the same time posing certain challenges. According to Ndinga Mulumba (2008:03), the South African government unveiled a new strategic plan for combating HIV and AIDS in April 2007. The plan included recommendations to increase access to appropriate treatment, care, and support to 80% of all HIV-positive individuals and their families by 2011.

#### **4.12 The influence of religious leaders on the limits of public health**

On the edges of public health, religious agents play a crucial role. The ARHAP has been attempting to map the religious organizations involved in health prevention, care, support, and treatment for some time, according to Cochrane (2011:150). In order to achieve this, it created methods for integrating religious and community health resources with established health services and systems. In the process, ARHAP has demonstrated how numerous and diverse in scope and kind religious organizations engaged in health work are (ARHAP 2006). According to Lupton (1996:26), British Reformers were the driving force behind the modern “public” health movement, which emerged in the early nineteenth century in response to issues in the towns brought on by rapid industrialization and urbanization, such as squalor, dirt removal, inadequate water supply, traffic congestion, and unsafe housing. By this period, it was endemic illnesses; like smallpox, typhoid, and chronic illnesses brought on by hunger and poor living conditions; rather than epidemics which had significantly improved public health.

#### **4.13 Religion and Sex in Culture and in Human Lives**

To understand the role of religion regarding adolescent sexual health, Paul Germond and Tessa Dooms developed a new research tool: Participant Inquiry into Religion and Adolescent Sexual Health (PIRASH) (Blevins 2011:119).



Drawing on the insights of the Participatory Inquiry into Religious Health Assets, Networks, and Agency (PIRHANA), an earlier suite of research tools developed by ARHAP scholars, the PIRASH research initiative consisted of two workshops in local communities – one with young people and the other with community leaders – to understand the social forces that impact young people’s emerging sense of sexuality, sexual identity, and sexual decision-making. Grenz (2000:168) argues that there is simply no other way to be a created human being except as an embodied person. Embodiment means existence, and being male or female in keeping with the discovery of modern psychology that identity formation is closely connected with our sexuality.

#### **4.14 On the Pedagogy of HIV and AIDS**

Molapo (2011:134) notes that the dominant pedagogy of HIV and AIDS which serves as the backdrop against the understandings of HIV and AIDS among indigenes, emerged in South Africa prior to 1994. However, it was only after 1994, within the post-Apartheid dispensation, that its operation became pronounced to curb the proliferation of HIV and AIDS. This pedagogy entailed, and continues to entail, mass education concerning HIV and AIDS biomedical information on what it is, how it is contracted, and how people can protect themselves against contracting the virus (using condoms, for example), or slow its progress (immune-boosting nutrition and avoidance of alcohol, for example). According to Butler (2004:165), the problem of HIV and AIDS affects society, the economy, and politics equally since it burdens managers and employees, raises absenteeism and turnover rates, and lowers productivity. The social fabric of the poorest areas and democratic political institutions have both been put to the test thus far. The epidemic is a unique challenge that calls for increased cooperation between the public, private sector, and citizens as well as stronger political leadership if it’s worst possible effects are to be avoided.

#### **4.15 The Relevance of Health Worlds to Health Systems**

Gilson (2011:165) argues that although widely used in health policy debates, approaches to understanding and evaluating access remain elusive. Indeed, although utilisation is often presented as a measure of access, the two notions are generally understood as distinct from each other. Aday and Andersen (1975), for example, distinguish between “having access”, denoting the potential to use a service if required, and “gaining access”, meaning initiation into the process of using a service.

Notably, Thiede (2005:1453) defines access as a precondition to health services utilisation where such services are needed. Bryant (2019:39) remarks that the great weapon of modern medicine is aimed at the pathos-physiology of disease and its susceptibility to pharmaceutical, immunological, or surgical attack. This weapon is intended to be delivered primarily by doctors using health services. The sad reality is that these weapons cannot combat the major causes of child mortality, such as diarrhoea, pneumonia, and hunger.

#### **4.16 Challenges facing Christian health association in the next decade**

According to Dimmock and Cassidy (2011:179), Christian healthcare professionals have contributed significantly to the public's access to preventive and curative healthcare services for more than a century in sub-Saharan Africa. Motivated by compassion and the moral imperative, religious communities provided holistic care before colonial or government health services were developed. Estimates of their direct contribution to national health systems vary widely due to the absence of standard indicators.

Poku and Sandkjaer (2008:17) concur with Dimmock and Cassidy. And further explain that the gap between human security as a concept and its policy relevance is a paradox. On the one hand, there is a debate about the analytical rigour of the concept, since virtually all economic, food, health, environment, personal, community, and political upheavals can conceivably constitute a threat to human security.

#### **4.17 The church in the context of HIV and AIDS**

Pick (2003:15) asserts that the call to the Church is to follow the example of Christ. If the Church in South Africa is to uphold its mission, it must first accept that HIV has caused the crisis which humanity is experiencing. Secondly, it must make the crisis its own in solidarity with God's world. The relevance of the Church in the battle against HIV and AIDS will be determined by how actively the Church combats this much-feared disease. The crisis induced by HIV and AIDS also challenges the Church to renew its focus on some of the inhumane conditions which promote the spread of the pandemic and to make people aware of their inhumanity to others and the dire results of damaged relationships and unjust structures. Foster et al (2011: 86) argue that governments and their partners now recognize the important role played by faith communities regarding HIV and AIDS initiatives and look to them and their leaders for help in formulating responses.

According to Nicholson (1995:19), it is theologically and morally necessary for the Church to address the situation and participate in the national AIDS strategy. A multi-sectoral strategy to combat AIDS has been recommended by the National AIDS Coordinating Committee. It would suggest that God, Jesus, and Christianity are unimportant and do not provide salvation if the Church does not address a matter of this importance. Churches are in a unique position to educate the public and hence organize aid, thus failing to do so would be a failure of love. Nicholson also lists the following tasks for the Church in relation to the HIV virus: to create a theological solution to the issue, encourage Christians and, if possible the entire community, to adopt an ethical perspective that will enable individuals to abstain from actions that endanger their lives and will motivate us to provide care for AIDS patients, contribute to this common ethical perspective in order to assist the state in directing its response, question the government and the community when it is believed that their solution to the issue is unethical, and aid in educating and raising awareness of the virus and its containment among the people of South Africa. To participate in efforts to rebuild society in order to lessen conditions that aid in the spread of the HIV virus, assist in ministering to AIDS patients, their families, and anyone else who depends on them, and promote collaboration with other ministries dedicated to healing,

Additionally, to help direct contributions received from foreign organizations toward the appropriate recipients. Geographic disadvantages, disorder, and relative deprivation, inequality, and poverty, according to Barnett and Whiteside (2004:152-156), are all traits of a risky environment where vulnerability is high. The horsemen of the end of the world in the twenty-first century are HIV and AIDS. The AIDS epidemic reflects the history of the region. Sub-epidemics or local epidemics with different epidemic curves reflect the history of one place, village, or township and the forces by which it was shaped and the powers that brought it into being. According to Richardson (2009:136), since the mid-1980s, much has been discussed and written about the church and its part in respect of HIV and AIDS. Some of this work focuses on the disease itself and its terrible consequences. The members of the congregation, as part of the community, have either been infected with or affected by HIV and AIDS. Richardson further elaborates that while calls have been made, even by government, for the Church to be involved in the fight against HIV and AIDS, it is unlikely that the role of the Church will be of central concern to the public in a secular state. For Christians, however, it should be of central concern.

Nicolson (1995:74) argues that for many rural people the Church is the only educational agency in their community. For most South Africans, the Church is an important agency for consciousness-raising.

#### **4.18 The impact of COVID-19**

COVID-19 is a group of deadly viruses that have arrived in South Africa. Shocking information regarding the extent and impact of COVID-19 in South Africa came to light when the first victim was identified in February 2020 in Pietermaritzburg. Many ordinary citizens became aware for the very first time that some of the South African population were already infected with Covid-19. Within a very short period, numbers of positive cases and deaths started going up.

Cyril Ramaphosa, the president of South Africa, gave a speech to the country on March 23 2020, announcing a 21-day national lockdown that would begin at midnight on March 26 and last until April 16, along with the deployment of the SANDF to help the government. The president extended the lockdown by two weeks through the end of April 9. The following individuals were exempted from the lockdown because they were necessary for an efficient response to the pandemic: health professionals, pharmacy and lab staff along with emergency personnel, security services; including law enforcement, the armed forces and private security; individuals deemed crucial to the economy's fundamental operations (supermarkets, logistics and transportation services, gas stations, banks and other vital financial and payment institutions); and those employed in sectors of the economy that could not shut down (such as mines and steel mills). Excerpt for funerals, no gatherings were allowed while the country was under lockdown. All establishments that didn't sell necessities were shut down during the lockdown, including restaurants, bars, bottle shops, and other businesses. A week prior to the lockdown, schools had already closed and they wouldn't reopen until after the lockdown. During this time, non-exempt citizens were only permitted to leave their houses to receive healthcare, collect social benefits, attend small funerals (no more than 50 people), and buy necessities. While the country was in lockdown, South Africans were instructed not to walk their dogs outside of their homes or apartment complexes.

The URCSA General Synod issued a statement on COVID-19:

“During the COVID-19 pandemic period, we have learned that we need to wait for God’s response through His people by using God’s creation. We now chorus with Paul in 2 Corinthians 1:8-11; we were crushed and overwhelmed by this pandemic beyond our ability to endure, and we thought we would never live through it. We expected to die. But as a result, we stopped relying on ourselves and learned to rely only on God, who raises the dead. And He did rescue us from mortal danger, and He will rescue us again. We placed our confidence in Him, and He will continue to rescue us. Therefore, the Executive of the Uniting Reformed Church in Southern Africa has taken note of the developments regarding the COVID-19 pandemic. (*URCSA News-Nuus*, March 2021).”

The Church was very affected, because church services were suspended, including the 2020 Passover festival, which is a very fundamental church service to most Christians. Church leaders who are above 60 years of age and with comorbidities could not perform their functions because of their vulnerability to the virus. A “new normal” emerged because of many deaths, as funerals were now conducted during weekdays to reduce the number of people in the mortuaries and graveyards. Corpses were wrapped with plastic, which is not common in the African context. Churches, including Greytown URCSA, were very much affected as they depend on congregants’ contributions for survival.

The URCSA General Synod Moderamen (cited in *URCSA News-Nuus*, March 2021) recorded 17 ministers and hundreds of congregants from different ministries (Christian Youth Ministry, Christian Women’s League, Christian Women’s Ministry, and Christian Men’s Ministry) who passed on due to COVID-19-related complications. Church leaders and members rightly gave much attention to dealing with the coronavirus pandemic. In-person church services were cancelled. Small groups met digitally, if at all. Church leaders urged members to support the Church financially through digital giving. Churches sought ways to minister to their communities during the pandemic.

#### **4.19 KZN Department of Health**

de Haan (2005:22) asserts that after the elections in 1994, the health authority was transferred from the former provinces and the so-called self-governing territories to nine new provincial administrations that function as independent structures, each with its own budget. Each provincial structure has its own elected body, known as legislature that determines the law or legislation appropriate to the needs of that specific province. de Haan (2005:22) adds that the Municipal Structures Act (No. 33 of 2000) and the Municipal Systems Bills (2000 and amended in 2003) outline a proposed framework for the operation of this level of government and explicitly define the role local government in the provision of District Health System Services.

The KZN Department of Health provides health services at the local, district, and provincial levels. Amajuba, eThekweni, iLembe, Harry Gwala, King Cetshwayo, UGU, uMgungundlovu, uMkhanyakude, uMzinyathi, uThukela, and Zululand are the eleven health districts.

#### **4.20 Theoretical background on policies in KZN**

Rakate (2005) asserts in his study that administration is the practice of achieving goals, or else the provision of goods and services to meet the requirements of people. In light of this, it follows that the administrative procedures that deal with need identification and goal-setting for need fulfilment must be carried out first. These are referred to as the policymaking processes (Cloete 1975:24). In situations when two or more people collaborate to accomplish a specified goal, such as the manufacture of goods or the provision of services, administration refers to a collection of procedures that must, always and everywhere, be carried out. It is desirable to categorize these processes into six groups in order to comprehend and carry out those activities in a knowing manner. These are namely: the policymaking process, which is followed by the planning and programming processes, the financing process that must be carried out in order to secure funds for achieving the given objectives that are required to achieve a policy statement, the process of putting together the institution and other organizational needs necessary to accomplish goals, the process of supplying and using staff to make it possible for the institution to run, the process of deciding on work processes to allow the staff to work in a systematic manner to meet the policy objectives, and the process of monitoring people's performance to ensure that they are on track to accomplishing the goals in a way that enables them to account for the fact that all relevant processes have been carried out successfully and efficiently at the lowest feasible cost (Cloete 1975:1).

#### **4.21 Objectives of the Department of Health in the Province of KwaZulu – Natal**

As a public institution, the Department of Health in the province of KwaZulu–Natal is mandated to achieve its objectives by fulfilling the health needs of the province. The objectives of the Department of Health in the Province of the KwaZulu–Natal are: contributing to the system for distributing healthcare services providing context for the development and application of regional health policy, norms, and values; to contribute to the success of the advanced understanding of the right to receive healthcare services by offering inclusive regional healthcare services that are simple to access using the province’s resources; create an environment that is conducive to both patients and staff understanding their civil rights and obligations; encourage the creation of a united regional healthcare system that will be run by suitable organizations in accordance with constitutional principles; provide for the advancement of improved management in the provision of public healthcare services; encourage community participation in the development of regional strategy, legislation, and health emergencies in the region; deliver for authorization certificates, licenses, and permissions for healthcare suppliers, the formation and monitoring of health formations; provide for the controls, responsibilities, and tasks of the monitoring health formations; create a space for the formation of a grievances and difference determination instrument; design an application tool; provide transparency and responsibility in the improvement and application of health policies and practices; and provide the materials linked therewith. (KZN Department of Health Annual Report 2020/2021)

From the above it can be realized that the Department of Health in the Province of the KwaZulu-Natal is assigned to fulfil the health needs of the province. To achieve this, the Department must set objectives that are responsive. The vision, mission, and core values of the Department of Health in the Province of KwaZulu–Natal as set out in its website read as follows:

**Goal:** To achieve perfect health for everyone in KwaZulu–Natal

**Objective:** To ensure that everyone has access to healthcare by developing and implementing a sustainable, coordinated, integrated, and comprehensive health system at all levels based on the Primary healthcare model.

**Core values:** Loyalty and compassion, continual learning, openness to change and innovation, transparency and consultation in communication, professionalism, accountability and commitment to excellence ([www.kznhealth.gov.za](http://www.kznhealth.gov.za)). The implementation of public health policies and practices are guided by the legislative mandate, which is divided into Constitutional and legal orders. The following sections and schedules; which are included in the 2018/2019–2020/2021 Service Delivery Improvement Plan; serve as a guide for the KZN Department of Health in accordance with the Constitution of the Republic of South Africa, Act No 108 of 1996 and other constitutional provisions.

#### **4.22 Constitutional mandate**

4.22.1 Everyone has the right to obtain healthcare services, including reproductive healthcare, according to Section 27(1) of the Constitution.

4.22.2 Section 27(2): The State must, within the limits of its resources, take reasonable legislative and other steps to ensure that each of these rights are gradually realized.

4.22.3 No one may be denied emergency medical treatment, according to Section 27(3).

4.22.4 Every child has the right to receive essential medical treatment, according to Section 28(1).

4.22.5 Health services are listed as a concurrent national and provincial legislative competency in schedule 4.

4.22.6 Section 195: The Constitution's enshrined democratic values and principles must guide public administration.

4.22.7 Section 195(b): Resources must be used in an efficient, economical, and effective manner.

4.22.8 Section 195(1d): Services must be rendered without bias, with impartiality, fairness, and equity.

4.22.9 Section 195(1h): To maximize human potential, good career development and human resources management techniques must be fostered.



#### **4.23 Legal mandates**

The Department is primarily controlled by the following Acts and Regulations governed by the national state and local laws. While some pieces of legislation directly or specifically affect the Department, others only have a minor effect.

4.23.1 Basic Conditions of Employment Act 9 Act No. 75 of 1997: Establishes the minimal standards of employment that employers are required to uphold in the workplace.

4.23.2 Child Care Act, 74 of 1983: Addresses incidental issues as well as the protection, care and treatment of specific children.

4.23.3 Choice of Termination of Pregnancy Act 9 Act No 92 of 1996: Establishes a legal framework for informed pregnancy terminations (under specified conditions).

4.23.4 Chiropractors, Homeopaths, and allied Health Service Professions Act, 63 of 1982: Provides for the regulation of the practice of the professions of chiropractic, homeopathy and allied health as well as subjects related thereto.

4.23.5 Dental Technicians Act, 19 of 1979: Consolidates and amends laws pertaining to the occupation of dental technicians and address issues associated therewith.

4.23.6 Because revenue collected may be distributed, the Division of Revenue Act (Act 7 of 2003) makes provisions for this.

4.23.7 Health Professions Act (Act No 56 of 1974): Regulates the health professions; including community service by medical practitioners, dentists, psychologists and other associated health professions.

4.23.8 Human Tissue Act (Act No. 65 of 1983): Establishes procedures for the management of issues involving human tissue.

4.23.9 KwaZulu–Natal Health Act (Act No. 1 of 2009) and Regulations: This legislation calls for the transformation of the provincial health system within the parameters of the National Health Act of 2003.

4.23.10 Labour Relations Act (Act No 66 of 1995): establishes the rules for labour relations and related issues.

4.23.11 Medicines and Related Substances Act (Act No. 101 of 1965, as modified): Ensures the safety, efficacy, and registration of medicines and other medicinal items. It also promotes transparency in the price of medications.

4.23.12 Mental Healthcare Act of 2002 (Act No. 17 of 2002): Establishes a legislative framework for mental health, including the admission and discharge of patients to mental health facilities.

4.23.13 National Health Act (Act No 61 of 2003) and Amendments: Ensures that the entire Republic has access to a modernized national health system.

4.23.14 statutory entity that offers laboratory services to the public health sector is established by the national Health Laboratories Services Act (Act no 37 of 2000).

4.23.15 Nursing Act (Act 33 of 2005): Establishes rules for the nursing industry.

4.23.16 Occupational Health and Safety Act (Act No 85 of 1993): establishes the rules that employees must follow in order to ensure a safe working environment.

4.23.17 Public Finance Management Act (Act No 1 of 1999 as amended) and Treasury Regulations: Covers the duties of functionaries who manage state finances as well as other related issues.

4.23.18 Preferential Purchase Policy Framework Act (Act No 5 of 2020): Lays out the procedures for implementing the preferential procurement policy for historically underrepresented business owners.

4.23.19 Public Service Act (Act No 103 of 1994) and Public Service Regulations Service: These laws establish rules for the management of the public service on a national and provincial level as well as the hiring and firing authority of ministers.

4.23.20 Pharmacy Act (Act No 53 of 1974, as modified): Regulates the pharmacy profession and pharmacists' involvement in charitable work.

4.23.21 Skills Development Act (Act No 97 of 1998) outlines the steps that companies must follow to raise the skill levels of their workforce.

4.23.22 Traditional Health Practitioners Act (Act No 35 of 2004): Governs the behaviour of traditional health practitioners.

4.23.23 Support for the Freedom of Information Act.

4.23.24 the Administrative Justice Promotion Act.

#### **4.24 Policy requirements**

4.24.1 Clinical rules and regulations: To enhance management and clinical outcomes, the Department is putting into practice and overseeing a large variety of clinical health policies.

4.24.2 The basis for efficient administration of health information at all levels of reporting is provided by national and provincial data management policies.

4.24.3 Financial Management Policies: In accordance with statutory requirements and Treasury Regulations, the Department develops financial management policies.

4.24.4 Provincial Health Research Policy and Guidelines: Offers a framework for policy and recommendations for doing health research.

4.24.5 Human Resource Policies: To guarantee compliance with human resource requirements, the Department produces and contributes to a number of provincial human resource policies.

4.24.6 National Health Insurance Policy: Calls for system improvements to guarantee everyone has access to medical care.

4.24.7 Hospital Management Policy: This policy outlines the requirements for managing public health hospitals.

4.24.8 Hospital Classification Regulations: Contains the policy foundation for classifying public hospitals.

4.24.9 Rules pertaining to forensic pathology services, emergency medical services and District Health Services.

4.24.10 Realization and maintenance of the ideal clinic.

4.24.11 Common core state standards.

#### **4.25 District Health System**

de Haan (2005:22) argues that the legal and policy framework for the rendering of primary healthcare services through a district health system (DHS) at the level of local government is in place. The DHS, in simple terms, is the vehicle to deliver primary health care. van Rensburg and Pelser (2004:132) concur with de Haan that “the new policies and legislation in the health and related spheres gave effect to a far-reaching re-organization of healthcare.” In this regard, two dominant strategies stand out as the linchpins of the new healthcare dispensation.

The advent of DHS and the clear shift toward PHC are the two examples. What is now referred to as a district-based PHC system combines these two. Decentralization was adopted by the South African government as a model for both management and governance. The powers and responsibilities of the three domains of government serve as the personification of decentralized governance in the Constitution. In general, the idea suggests that authority, power, and functions are moving away from the centre. It is viewed as a method of attaining greater justice and efficiency, increased community involvement and responsiveness, a smaller bureaucracy from the areas being serviced, and improved coordination between social sectors. Deconcentrating, delegation and privatization are some common examples of the various manners of decentralization, according to Bossert (1996).

#### **4.26 UMzinyathi district**

The district of uMzinyathi includes Greytown. The district is bounded by the following six districts: Amajuba to the north, Zululand to the northeast, King Cetshwayo to the east, iLembe to the south east, uMgungundlovu to the south west and uThukela to the west. It is located in the north-central part of KZN. There are 571,650 individuals living in the district, of whom 93% (531,634) lack insurance and mainly rely on public healthcare. UMzinyathi is an underdeveloped rural area with a low population density and limited economic progress. The district has a lot of difficulties. It is one of the poorest districts in the nation and is categorized as Socio-Economic Quintile 1. Its distinctive hilly landscape, deep valleys, and rough terrain affect access to services, access to clean water and sanitation, high rates of uninsured people (93%) and unemployment (36.6%), and significant levels of poverty (43.7%). Nearly a third of the district's residents are dependent on social assistance and the illiteracy rate is 21.1%. The most common illness in the area are hypertension, respiratory illnesses, gastroenteritis, and HIV and AIDS.

The Pomeroy Community Health Centre (CHC), which is located in the Msinga Sub Area and offers a comprehensive PHC package of services as well as certain district hospital services as a short-stay facility, is one of 53 clinics in the district that provide a Primary Healthcare package of services. Through the Municipal Ward-Based Outreach Team, the CHC also provides outreach initiatives. Health services are provided door to door. The Dundee, Charles Johnson Memorial, Church of Scotland and Greytown hospitals are among the region's four district hospitals. In Greytown, a sub-district of the district, there is a specialized TB hospital.

#### **4.27 Primary Healthcare**

The South African government follows the Primary Healthcare (PHC) approach to the delivery of health services. PHC was defined in the Declaration of Alma Ata as:

The essential healthcare based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (King 2001: 1).

PHC refers to “essential healthcare” that is based on technological and methodological advancements that are both ethically sound and accepted by society. Everyone in a community can now get universal healthcare thanks to this. PHC programs allow for complete community participation in decision-making and execution. This is the first level of healthcare and includes the Community Health Worker Programme, which was started in 1994 with the help of the then-KZN Health Minister, Dr Zweli Mkhize, in order to encourage community involvement.

The local communities that receive assistance from the Department of Health choose a select group of people who are taught and given the responsibility of educating the community about health issues, in an effort to avoid illness and hence improve health. Initiating and supporting community-based development projects, coordinating between the community and the Department of Health, community mobilization against diseases and ill health through awareness campaigns, health promotional materials, word of mouth, role modelling, counselling, support, passionate caring, stress relief, directly supervised treatment support, and home visits are all components of the core duties of community health workers.

#### **4.28 Provincial clinics**

Provincial clinics are locations where a variety of primary healthcare services are offered. Depending on the needs of the population they serve, they are typically open eight or more hours a day. The KZN Department of Health reports that there are 590 provincial clinics spread across all of the KZN health districts. Mostly, an ideal clinic provides the following treatments: minor ailments, chronic care, HIV, sexually-transmitted infections, tuberculosis (TB), mental health, maternal health, child health, sexual reproductive health, male medical circumcision (MMC), oral health, rehabilitation services and youth services.

#### **4.29 Community Health Centres**

Although it can also be used for first-contact care, a Community Health Centre (CHC) is the second stage in the delivery of healthcare. With the addition of a short-stay ward, emergency care, and casualty, and a 24-hour maternity service, a CHC provides services comparable to those of a provincial clinic. When necessary, the CHC refers a patient to a district hospital.

There are 22 CHCs in KZN: Amajuba and Danhausser, eThekwini, Cato Minor, Hlengisizwe, Inanda, KwaDabeka, KwaMashu, Newton A, Phoenix and Tongaat, iLembe, Ndwedwe and Sundumbili, Harry Gwala, Pholela, King Cetshwayo Ugu, Gamalakhe and Turton, uMgungundlovu, Bruntville, East Boom Street and Imbalenhle, uMkhanyakude, Othobothini, uMzinyathi, Pomeroy, uThukela–St Chards, Zululand, and eDumbe.

#### **4.30 District Hospitals<sup>6</sup>**

A district hospital is a facility that accepts referrals from community health centres and clinics, and offers generalist assistance to community health centres and clinics, where primary care nurses or general practitioners provide medical care. The district hospital plays a pivotal role in supporting primary healthcare on the one hand and being a gateway to more specialist care on the other. In the uMzinyathi Health District, Greytown is a district hospital. It provides services to the people of uMvoti Municipality. The hospital mostly serves people who live in rural and semi-urban areas. The hospital in Greytown provides the following services: a 24-hour accident and emergency department, a 24-hour crisis centre, a 24-hour x-ray and laboratory, and ARV, VCT and PMTCT.

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<sup>6</sup> [www.kznhealth.gov.za/definitions.htm](http://www.kznhealth.gov.za/definitions.htm)

Eleven (11) permanent clinics in the Umvoti sub-district are supported by Greytown Hospital as well.

#### **4.31 Umvoti AIDS Centre**

Umvoti AIDS Centre (UAC) is a registered non-profit organization that supports community health programs in Greytown and its surrounding rural areas. UAC has been in existence since 2001, with its main office based in Greytown. It provides comprehensive and dynamic programmes and mobilises the community to fulfil its own vision of a brighter tomorrow. According to the UAC annual 2020 report, UAC is experienced and has been recognized for delivering high-quality home-based care and prevention programmes as well as giving support to orphans and vulnerable children. More recently, the organisation has invested a great deal of time and energy in establishing community development initiatives that train, build capacity, and foster sustainable livelihoods. It now manages a large portfolio of programmes that use a more holistic approach to meeting the needs of the population of Umvoti, uMsinga and uMshwathi Municipalities.

#### **4.32 Conclusion**

This chapter has provided an overview of ARHAP's vision, objectives, and historical background. It has also given the definitions of terms as used by the ARHAP project, such as health, religion, assets, and agency. It has also highlighted the ARHAP conceptual framework of the theory matrix illustrating Religious Health Assets (RHA), tangible and intangible religious health assets and their relationship to the health outcome.

## **CHAPTER FIVE: METHODOLOGY**

### **5.0 Introduction**

This chapter will cover research methodology. The researcher will employ an auto ethnographic approach, because of his involvement of the researcher in the congregation under study. The discussion covers the study's context, time frame, design, source population, sample size and strategy, data collection and analysis, and steps taken to assure the study's credibility. Additionally, the study's ethical considerations are highlighted.

### **5.1 Auto ethnographic**

Dethloff (2005) maintains that in conventional research, it is anticipated that the researcher keeps their voice independent of the information and context they are examining. This study will get richer in its descriptions of major events, individual, artefacts and observed cultural norms as researchers hone their first-person narrative voices. The inner workings of the social setting being explored will intrigue readers of auto ethnographic fiction, making them feel as though they are a part of the narrative. This shared experience makes it possible for this kind of qualitative methodology to strengthen both the author's and the reader's understanding and familiarity with the culture under study.

The process, according to Pattern (2004), is a joint one between the author and the reader. In an effort to deepen their understanding of the culture at the centre of their research, these highly individualized stories draw on the experiences of the author/researcher (Sparkes, 2000). As researchers develop their first-person narrative voices, the study will become richer in its descriptions of significant events, characters, objects, and observable cultural norms. Readers of ethnographic literature will be fascinated by the social dynamics being investigated and will feel as though they are a part of the story. This type of qualitative methodology can help both author and reader have a deeper understanding and familiarity with the culture being studied because of this shared experience.

This form of research, which is outside the purview of proper scientific inquiry, has questioned conventional wisdom regarding silent authorship and author-evaluated texts (Sparks, 2000:22). According to Charmaz and Mitchell (1997), authors should keep quiet and keep their opinions out of their reports when conducting legitimate research.



Personal narrative writers act as the impetus for the query “What is happening here?” by incorporating themselves into their own works. Researchers participate in the process and you cannot avoid being part of it. Long ago, empirical investigations discredited a subjective methodology. The writing-down of a personal experience aids in the formation of meaning, and gives the author a clearer grasp of the social context. This happens for both the author and the readers who are taking part. According to Richardson (1994:517), writing is an investigative technique that may be used to learn more about a subject and oneself. Additionally, Richardson argues that writing is a form of knowing a method of discovery and analysis. We learn new things about our subject and how we relate to it by writing in various styles. According to Ellis and Bochner (2000), auto ethnographic reports are often in the first person and include contextual information, conversation and self-consciousness, as well as stories that are influenced by history, social structure, and culture. This makes judging it to be credible research difficult in many ways. According to Phillips (1987), self-study research critics contend that while specific research techniques may be persuasive in this context, they do not always represent the truth of what has been stated. The reality, however, has numerous facets. Self-study reveals a crucial truth component that is all too frequently overlooked. Readers can use the author’s experience to help them better comprehend a particular culture through auto ethnography. Such intense introspection might also become troublesome. Self-narratives are often perceived as being egotistical, although proponents argue that you cannot ignore the role of the researcher and their own biases when conducting research. Patten (2004) iterates that readers of auto ethnographies develop a variety of interpretations and what draws them in it is the first-person account that is published in the style of narrative. Auto ethnographic studies have the advantage of allowing respondents to actively participate in the narrative and connect with it on moral, emotional, aesthetic, and intellectual level.

## **5.2 History of Auto ethnography**

According to Raudenbush (1994), there are two essential parts to the word “”. The auto part of the name refers to the autobiographical or personal narrative component, while the foundation is ethnographic (or anthropological). Prior to the work in Europe in the field of human science research is where the use of lived experience as a research basis began. The driving forces behind human science research include description, interpretation and critical analysis.

Beginning in the middle of the 19<sup>th</sup> century, anthropologists struck out into the world to study and write about unusual or original cultures. They pioneered the practice of ethnography – observing, writing about, and systematically analysing people and their cultural practices - in the hope of constructing a systematic account or interpretation of cultures that deepens understanding of the subject's life and world. According to Van Maanen (1995), early ethnographers provided naturalistic realist tales that placed an emphasis on objectivity. These early writers acknowledged the problem and struggled to provide literary narratives that would give precise, rich descriptions of other people's cultural activities. Early ethnographies frequently took the perspective of an outsider looking in on the action as they observed happenings. But it soon became apparent that the locals were aware of - and adjusting to – the presence of these outsiders, therefore the goal of becoming a fly on the wall was doomed to failure. Gradually, as serious concerns about the feasibility and legitimacy of providing purely objective accounts of cultural practices, traditions, symbols, meanings, premises, rituals, rules and other social engagements emerged, the idea of writing about the researcher's experience in situation emerged. Qualitative researchers were assumed to be neutral or unbiased "scientific" observers, despite the fact that they are human actors who are inevitably impacted and influenced by their responses to unfolding events as well as their cultural and historical beliefs, rules and histories.

According to Van Maanen (1995), a native who reveals his or her own group conducts this kind of research. Van Manen (1990: 4) states that "the fundamental model of this approach is textual reflection on the lived experiences and practical actions of everyday life with the intent to increase one's thoughtfulness and practical resourcefulness or tact". Self-study and lived experience research are written with the researcher's personal experience in mind as well as that of the researchers in mind. According to Pinar (1988), a personal narrative would deliver deeper-than-ordinary reporting and provide a rich excavation of intention, purpose, and vision. Van Manen (1990) concurs; "Although phenomenology does not develop an explanation theory, it does provide the potential for insight that illuminates experience". The researcher has a better chance of discovering the encounter's fundamental meaning when they look at every facet of a customised experience. The nature and method of interpretation are known as hermeneutics. It is the study of meaning interpretation. What exactly does this experience mean, according to hermeneutics inquiry?

Auto ethnography is positioned within this vein of study. In an auto ethnography, the author examines himself or herself inside a subculture and makes an effort to interpret all of their experience there. Lastly, according to Walcott (1994), telling stories is a necessary skill for qualitative researchers and it should be one of their defining characteristics. Raudenbush, (1994) asserts that we have the ability to interact between personal lived experience and theoretical viewpoints through autobiography (an effective method for doing a self-reflexive analysis of the leadership and administration is auto ethnography).

### **5.3 Effective account**

Why a good story is considered scholarly? Determine whether a personal account is believable, reliable and trustworthy - all essential components of qualitative research – by asking this question. Auto ethnography's techniques and its status as a scientific study are hotly contested topics. In this sense, using one's self as the only data source can be problematic. According to Ellis (1995), a story qualifies a scholarly if it inspires the reader to think the experience is real, plausible, and convincing. Ellis and Bochner (2000) articulate that the intended purpose of auto ethnography is to provide the opportunity for the reader and author to become co-participants in the recorded experience. There are also multiple warning signs, skills, and difficulties that are experienced or needed in writing ethnography. Researchers must be adept at identifying pertinent details, introspection, descriptive and compelling writing, and controlling things about themselves that may be less than flattering. Also, the researcher must handle the vulnerability of revealing oneself to a greater audience. The use of self as the source of data can be restrictive, yet offers a powerful aspect of unpacking the many layers involved in the study of a particular culture or social context. According to Tierney (1998), the goal of auto ethnography is to challenge prevailing systems of representation and power in an effort to recover neglected representational spaces. Producing vivid writing that is categorized as research might be challenging in a society where empirical science still dominates.

### **5.4 Personal reflection of the author's positionality**

The researcher came became the Minister of Word and sacraments in Greytown congregation from 2019. He relocated from Richardsbay where he was an active member of the Richardsbay Uniting Reformed Church in Southern Africa and stay in a mission house in Nhlalakahle Location (one of the branches of Greytown congregation).

He was born and raised by a very religious family. His father was a minister before he passed on in the then Dutch Reformed Church in Africa, which later became Uniting Reformed Church in Southern Africa after the new democratically elected government in 1994. He grew up in a religious and church environment. He was baptised when he was three months old, started Sunday school class when he was three years old, attended catechism class when he was fourteen years, confirmed to faith when he was sixteen years old and that year he became a member of the then MBB which was a youth organisation. At the age of 21 years old, he became a member of the church council representing youth. At the age of 30 years old he became an elder representing his branch in the Ladysmith congregation. Then in 2008 he relocated to Empangeni and became an Empangeni URCSA member. In 2010 he became a church council member representing Nzalabantu branch. In 2012, he started studying to become an ordained URCSA minister of Word and Sacraments. Through his studies, God has helped him to recognise the challenges faced by the church. These are both opportunities and challenges. Since he has joined the Greytown URCSA he has seen many successes and downfalls that this congregation has encountered.

### **5.5 The implications of doing research as a minister in one's own congregation.**

This study make a very significant contribution to the local congregation on how to handle the paradoxes that continue to emerge in the congregation between reformed theology and public health. This study will also empower the people of the local congregation regarding the role of the church and the state.

Last by unpacking public health policies and practices that are good and do not clash with Reformed theology will boost the understanding of public health initiatives, and will also remove any confusion between being religion and state.

### **5.6 The limitations of doing an ethnographic study**

The study will only critique public health policies and practices through reformed theology doctrines and the public. It will also be limited to Kwazulu Natal province. The purpose of the study is for academic fulfilment.

## **5.7 Steps that were taken to reduce this biasness**

5.7.1. Throughout this, the researcher listened to participant's responses when answering interview questions, therefore he found a narrative approach to be the most appropriate approach for this particular study. He used personal interviews as a method of listening to his research participants' answers. Participants told their experiences on the topic under study.

5.7.2 Participants were not treated as objects, but as people. They were treated with dignity.

5.7.3 The researcher selected participants through their knowledge and experience of the subject of the study as per the requirements for the ethical clearance of the University of Kwazulu - Natal.

5.7.4 Participants were involved in the process of analysing the data. The researcher also saved all research data in his computer under an encrypted folder and at the end of his study, will hand it over to the Supervisor and it will be stored for a period of ten years, after that he will discard it. The results of the study will be made available in the form of a thesis.

## **5.8 Research Design**

This study employed the qualitative research methodology. The qualitative approach enables the researcher to obtain complex and authentic information from the primary sources. Semi-structured interviewing questions were utilised to collect data. Rebecca Malinga (2015) notes that semi-structured interviews take the form of a conversation that allows participants more freedom to respond in a way they deem appropriate for the question, without having to observe strict response options. Participants can thus include more information than is asked for by the researcher. In this way, the researcher secures "rich data." Everyone who took part favoured using IsiZulu to share their ideas and thoughts. Interviews were recorded by the researcher and then translated into English. The average interview session lasted between one and a half and two hours. This demonstrates that the interview had enough time, allowing for significant contributions to the study. The researcher decided to reserve extra time for respondents who needed more time to share their experience and express their ideas and opinions, because some respondents indicated that they could only afford a very limited amount of time for the interview.

Interview audio was recorded, with the respondent's permission. Interviews were transcribed later. Individual interviews were arranged on dates and times that were convenient to the respondents. Because of the COVID-19 pandemic, five interviews were done through electronic means such as WhatsApp, email and Zoom. Four physical interviews between researcher and the respondents were done and the researcher ensured that all COVID-19 protocols were followed when gathering data by: keeping social distance between himself and respondents (two metres apart), covering their mouth and nose with a mask, advising the respondents to wear a mask during the interview, and washing hands with soap or using hand sanitizer. Given the nature of the study, the researcher used the purposive sampling method that focused on collecting specific data from specific individuals to enable him to have information on public health policies and practices in KwaZulu-Natal (KZN).

### **5.8.1 Descriptive research**

According to Akhtar (2016:75), descriptive research is used to identify and obtain information on characteristics of a particular issue like community, group or people. In agreement, Boru (2018:1) concurs that the purpose of a descriptive study is to provide a picture of a situation, person, or event or show how things are related to each other and as it naturally occurs. For this particular study, descriptive approach is more concerned about the views or attitudes of the reformed theology towards public health policies and practises in KZN. A descriptive research design was used to gain knowledge based on the current situation of the Greytown URCSA congregants regarding public health policies and practises.

### **5.8.2 Explorative research**

According to Akhtar (2016:73), exploratory research is the primary stage of research, and the purpose of this research is to achieve new insights into a phenomenon. In addition, Boru (2018: 2) avers that exploratory research is conducted when enough is not known about a phenomenon and a problem that has not been clearly defined. It does not aim to provide the final and conclusive answers to the research questions but merely explores the research topic with varying levels of depth. The author further posits that the exploratory research looks for causes and reasons and provides evidence to support or refute an explanation or prediction. The study explored religion values related to public health policies and practices in Greytown URCSA.

## **5.9 The Setting of the Study**

Four physical interviews between researcher and the respondents were done and the researcher ensured that all COVID-19 protocols were followed when gathering data by: keeping social distance between himself and respondents (two metres apart), covering their mouth and nose with a mask, advising the respondents to wear a mask during the interview, and washing hands with soap or using hand sanitizer. Given the nature of the study, the researcher used the purposive sampling method that focused on collecting specific data from specific individuals to enable him to have information on public health policies and practices in KwaZulu-Natal (KZN).

## **5.10 Population**

According to Noori (2018:38), the population is the target group under investigation; it is the entire set under consideration. The target population for this study was the congregants that are under Greytown URCSA and are familiar with public health policies and practices. All the participants were involved in both reformed theology and public health.

### **5.10.1 Sample Size**

The researcher identified nine respondents from the seven wards of the Greytown URCSA congregation, who are also involved in public health policies and practices. The researcher chose the following participants:

- (i) Primary Healthcare Nurse - because of her extensive education and training, which allowed her to do more primary healthcare duties in the areas of health promotion, disease and injury prevention, treatment, rehabilitation, and other services.
- (ii) An Elder, who is a church council member and a community health clinic member, because of his knowledge of church order, health policies, and practices.
- (iii) Four females and three males randomly chosen from each ward of the seven wards of Greytown URCSA congregation. They are aware of the basic tenets of providing services, including consultation standards, health access, consideration and courtesy, information, openness and transparency, redress, and value for money. According to congregational boundaries, each participant from each ward represented that ward.

The respondents were above the age of 21 years old, because the topic is very sensitive and needed mature people who did not need consent from their parents and it needed people who are informed on Reformed theology and public health.

The data gathered from the interviews was arranged according to the ARHAP classification of tangible and intangible assets. Thematic analysis was adopted in this study. Using this technique, themes uncovered in a data set can be found, analysed, organized, described and reported (Braun and Clarke, 2006).

### **5.10.2 Sampling Method**

A purposive sampling method was used to select participants for the study. According to Bums and Grove, (1997:309), purposive sampling includes the selection of subjects with particular characteristics in order to increase theoretical understanding of some facet of the phenomenon being studied (Bums & Grove, 1997:309). Purposive sampling means that representative units of the population are selected by the investigator. Babbie and Mouton (2001:166) maintain that “sometimes it is appropriate for an individual to select his/her sample based on the knowledge of the population, its element, and the nature of your research aims”.

The researcher decided to choose the subjects that are typical of the population in question or particularly knowledgeable about the issues under study. This method can be used to advantage certain instances like newly developed instruments and can be effectively pre-tested and evaluated with the use of a purposive sample (Polit and Hungler, 2001: 239).

### **5.10.3 Inclusion criteria**

Whitehead and Whitehead (2016:114) define inclusion criteria as specific characteristics that the person, population, or elements must possess, such as a certain age range or gender. The inclusion criteria were as follows:

- The participants included both males and females.
- Were above 18 years of age;
- Able to sign an informed consent;
- All participants were members of the Greytown URCSA residing in Bizana and familiar with public health policies and practices.
- Be willing to participate in the research study and Zulu speaking.



#### **5.10.4 Exclusion criteria**

Whitehead and Whitehead (2016:114) postulate that exclusion criteria identify characteristics that deem a participant inappropriate for inclusion in a study. The authors maintain that the use of exclusion criteria such as any person who is cognitively impaired, or where the language of the study is the participant's second language should be employed with caution so as not to marginalise the entire sector of society. In this study, all persons under the age of 18 years and those who are not familiar with public health policies and practices were excluded.

#### **5.10.5 Data Collection**

The University's Research Office was contacted in order to obtain ethical approval for the project before any data was collected. Regarding research ethics, participants were required to sign an informed permission form before taking part and interviews were videotaped. They were also informed of their choice to voluntarily participate in the study and their freedom to withdraw at any time without any negative consequences. Their anonymity was guaranteed by not recording their names. Hence, they (participants) were assigned numbers (P1 – P9). In this way, confidentiality was maintained. The significance of the validity and dependability of research findings is emphasized by Mouton (1996) and Silverman (2002). This study used qualitative research techniques to gather the necessary data, allowing for the production of legitimate and trustworthy results. Individual interviews were used for the qualitative component. Data was collected through individual in-depth interviews and document analysis. The researcher identified respondents and arranged appointments for interviews in writing. Confirmation of appointments was made telephonically, well in advance.

#### **5.10.6 Data Analysis**

The researcher immersed himself in the data by listening to the voice-recorded interviews repeatedly, reading and re-reading the verbatim transcription and getting a feel of the totality. Utilizing content analysis, information acquired from the interviews and documents was examined. The basis for the content analysis was supplied by Graeheim and Lundman (2004: 105-107). Each interview and piece of documentation served as an analytical unit. The raw information was reduced to meaning units that were similar to text. Words, phrases and paragraphs served as the building blocks of meaning units, since they had elements that were related to one another.

For this investigation, all data analysis was carried out manually. First, the transcribed data from the interviews was carefully read in this study as part of the data analysis process. Coding the data from the transcription was the next step. Codes were used to flag ideas that were discovered in the transcript. The ideas were subsequently grouped into categories or key themes.

A purposive approach to the theme identification was initially implemented, guided by the objectives of the study. An inductive approach was used to identify further themes. All data pertaining to one theme was grouped into a theme file. The data in each theme file was further read and re-read to identify sub-themes through further inductive analysis. The third and fourth steps included displaying and subsequently reducing and summarising the data. Data will be analysed manually using an analytical editing style, where the researcher acted as an interpreter. The researcher read through the data in search for meaningful segments (Polit and Hungler, 2001:383). Segments were identified and reviewed from the data, read and sorted several times using the following steps:

**a) Organization of data**

The raw data was audio-taped, transcribed from IsiZulu into English and transferred into clearly readable form for data analysis. Field notes were typed and photocopied. The original copies were kept aside for reference and photocopied data was used for analysis (Polit & Hungler, 2001:382).

**b) Coding the data**

The data was coded by assigning numbers, according to the type of data and source, and it was indicated where the data was taken from. Each data was labelled on the blank side with additional information that indicates importance as analysis proceeded such as age, occupation, and marital status of the interviewee (Mykut and Morehose, 1999:128).

**c) Credibility**

The researcher tried to establish a relationship of trust before conducting in-depth interviews. Two aspects as suggested by Lincoln and Guba (1985) as described in Polit and Hungler, (2001:313) which are prolonged engagement and persistent observations.

#### **d) Prolonged engagement**

The researcher spent two-three months in the field collecting data. An in-depth interview was conducted and sufficient time was invested. A minimum of 30-40 minutes was spent with each respondent in order to have an in-depth understanding of the language or view of the topic under study, and to test misinformation. The data was planned to be collected from nine respondents.

Prolonged engagement is also essential for building trust and rapport with informants (Polit & Hungler, 2001:313).

#### **e) Persistent Observation**

The researcher observed the emotional condition of the respondent, which included facial expressions, their mood, non-verbal communication, and the manner in which they responded to questions (Polit & Hungler, 2001:313).

#### **5.10.7 Clarifications about participants**

Participants were selected according to their knowledge and involvement in KZN's public health policies and practices of reformed theology and Greytown URCSA.

<b>Respondent's number</b>	<b>Ward</b>	<b>Relation to study</b>	<b>Remarks concerning Participants</b>
P- 1	Nhlalakahle	Primary Heath care Nurse	35-year-old female because of her extensive education and training, which allowed her to do more primary healthcare duties in the areas of health promotion, disease and injury prevention, treatment, rehabilitation and other services.
P-2	Nhlalakahle	An Elder	63-year-old male (retired teacher) - church council member and a community health clinic member, because of his knowledge of church order, health policies and practices.

			The elder articulated his knowledge about the topic under study.
P-3	Ngome	Church member	29-year-old female – Community Care Giver
P-4	Mbulwane	Church member	49-year-old female – Enrolled Nurse
P-5	Matimatolo	Church member	66-year-old female - Retired Nurse
P-6	Ntembisweni	Church member	54-year-old female – Childminder
P-7	Shane	Church member	30-year-old male – Clinic Committee Member
P-8	Mbuba	Church member	40-year-old male – Teacher
P-9	Nhlalakahle	Church member	66-year-old male – Retired Reverend

#### **5.10.7 The interview process**

Physical interviews were conducted at each branch's church office on different days at a suitable time for the respondents. The researcher made sure he got to the location for interviews early enough to have enough of time to check out and prepare the space, set up, and test tape recorders. The researcher began each interview session with a formal introduction. The researcher promised the participants that the information they would supply would stay with the researcher and went on to describe the aim of the study and why participants were chosen to be a part of it. Written and verbal consent was obtained from the respondents to participate in the interview process by asking them to sign an informed consent form (Appendix C). Respondents received assurances from the researcher that their personal information and the data they shared would be kept private. A tape recorder would be used to record the interview session; therefore respondents were warned in advance to remain silent and not make any extraneous noises.

Prior to the interview, respondents were made aware that they could stop and start again should they feel unable to continue talking due to physical discomfort, nausea, or needing to use the restroom. Depending on the cause, the interview may be postponed to a more convenient time.

Five individuals were interviewed electronically via WhatsApp calls, while four were physically interviewed. Permission to conduct interviews in the congregation was granted by the URCSA KZN Regional Synod Chief Executive Administrator, Rev Eric Ngema. In the interviews, respondents were asked to describe their understanding of public health policies and practices in KZN, public health policies are relevant to Reformed Theology, the opportunities and challenges of public health and reformed theology, model can be implemented that can shapes activities, formations and consequences to strengthen collaboration between public health and reformed theology and the state and the church collaborate to improve the public health system (Appendix D).

## **5.11. DATA PRESENTATION**

### **P-1**

**Question 1: Can you please explain to me your understanding of public health policies and practices in KZN?**

*The public health policies are there to set and provide standardize practices in the public health sector within the province as well as other provinces within the country. There are national policies like COVID-19 policies and guidelines on how to deal with the pandemic in a standardized manner, and provincial policies which are derived from the national policies and practices. They are, however, not different from national policies but have some additions that are specific to the health issues of the specific to the province. These policies are setting standards of how things are done in the health sector in KZN. e.g.*

- *How to deal with the COVID-19 pandemic, including targets and time frame.*
- *How to deal with HIV/AIDS infections within the province, including TB as well. Those guidelines and policies must be in line with national policies to ensure a standardized approach. This enables patients to receive the same care even if they relocate to another province.*

**Question 2: Can you please explain to me the public health policies that are relevant to Reformed theology?**

*The Department of Health initiated a program called ABC; which stands for “Abstinence, Be faithful and Condomize”; which is relevant to Reformed Theology as Reformed Theology encourages people to be responsible.*

*Family planning policies are designed to control unwanted pregnancies, teenage pregnancies, STIs and HIV transmission. All clients who visit health facilities must be screened for TB, HIV, and STIs, and treated if found to be infected. Condoms must be issued more, especially to those that are deemed to be sexually active and the ones that are at childbearing age. Family planning education is not given to married couples only, but all clients, and it is not gender-directed. Male condoms are given to female partners to give to their partners. Also, female condoms are given to male partners. Also, same-sex education and condoms are given to prevent infections.*

**Question 3: Can you please explain to me the opportunities and challenges of public health and Reformed theology?**

*There seem to be uniformity with regards to a healthy lifestyle approach whereby all the health-related aspects are addressed and taken care for. Talking about health aspects, we mean the physical aspect, psychological aspect, social aspect, and spiritual aspect. Some churches have healthcare workers who always contribute a lot by giving necessary health education. The church also plays an important role in dealing with self-destructive behaviours; such alcohol abuse, crime, smoking, and gender-based violence. By preaching love, self-care, and care for others, healthy eating, exercises, and recreation, people avoid self-destructive behaviours and disharmony in their communities. Some even provide bursaries, as mentioned above, invite business personnel to teach about business-related issues and healthcare workers to educate and screen members for chronic illnesses. The initiatives by the Reformed church do not only help individual members, but go to as far bringing harmony to the families and the entire community.*

**Question 4: Can you recommend the model can be implemented that can shapes activities, formations and consequences to strengthen collaboration between public health and Reformed theology?**

*First, there must be forums that will bring the two together and offer platforms to exchange ideas and educate each other. Collective community outreach whereby all the above entities are participants and are working together to bring about change.*

*Those outreaches indeed have to include other stakeholders such as social development, police, municipality/councillors, and education and home affairs so that everyone gets an opportunity to take their responsibility in helping community in the presence of others, which I believe can avoid incomplete work and poor commitment.*

**Question 5: In your opinion, how can the state and the Church collaborate to improve the public health system?**

*According to the Church, the body is the temple of the Lord, and the spirit of God does not like a dirty environment. According to health diseases, like dirty environment. Both these worldviews are against impurity and an unhealthy environment and unhealthy behaviours. They both comprehend each other, however there is contradiction.*

*The Church put more emphasis on spiritual healing which sometimes confuses members and ends in neglecting their treatment. Not that spiritual healing is a myth or does not exist, but if that can be collaborated in helping our communities, because the same medication is from God's nature (the trees and other plants). The mind behind the public health systems is from God. So, the two can work best if they be used together without anyone looking down upon the other.*

*Other issues have been touched on earlier, family planning. According to the Church a family is couple that is united by someone approved to carry out that duty, like the Pastor and Reverend. So, giving contraceptives and condoms to schoolchildren is ungodly as it promotes sex before marriage, but is sex before marriage not happening? Are there any measures in the Church to support and guide young couples within the church to avoid sex before marriage, unwanted pregnancy, back-street abortion, etc. The Church must work hand-in-hand with its members and the public health sector to create a platform that is friendly and usable.*

**P- 2**

**Question 1: Can you please explain to me your understanding of public health policies and practices in KZN?**

*The public health policies and practices are the decisions, the plans, and actions of the government to achieve healthcare goals within the society. The government aims to increase the life expectancy of its population. Its policies will enable it to prioritise and strategize accordingly. The government of KZN has adopted a District Health System, which emphasizes primary healthcare, where healthcare is provided to the families at the community level. The poverty-stricken rural communities have been affected by maternal and child mortality, which the government is trying to reduce by health education. There are programmes dealing with HIV prevention.*

**Question 2: Can you please explain to me the public health policies that are relevant to Reformed theology?**

*There is no public health policy that is relevant to Reformed theology that I know.*

**Question 3: Can you please explain to me what are the opportunities and challenges of public health and Reformed theology?**

**Opportunities of Public Health**

*Many people are employed in community programmes like the Community Health Worker Program (CHWP) and expanded Public Works Programme. The role of religion and religious entities that they play in contributing to health in communities?*

**Challenges of Public Health**

*Shortage of resources from government, like adequate clean water and proper sanitation which lead to many diseases.*

**Opportunities of Reformed Theology**

*People are given hope when having health challenges through preaching, counselling, and prayer.*



## **Challenges of Reformed Theology**

*Most proponents of this tradition are not trained enough in both of these worldviews.*

**Question 4: Can you recommend the model can be implemented that can shape activities, formations and consequences to strengthen collaboration between public health and Reformed theology?**

*In Public Health programmes, like public participation, health and safety, health promotion and HIV and AIDS, should be planned and implemented, and in Reformed theology training in ethics and morality standard living and appropriate Bible interpretation should be implemented.*

**Question 5: In your opinion, how can the state and the Church collaborate to improve the public health system?**

- *The state and the Church aim to promote the welfare of the population. The Church is committed to maintain the health of its members and the community she exists in.*
- *Most of the time the Church must cope with the illnesses among its members.*
- *Most of the elderly are found in the Church community. It is therefore mandatory that the state and the Church enter with partnership.*
- *This working relationship can take various shapes: the churches be trained on public health matters, especially on health promotion and disease prevention. This will assist the government to achieve their goal. There is problem of overcrowding in hospitals. The solution is prevention, which will lessen the strain on healthcare facilities. This collaboration can be on various levels, such as religious organisations at both provincial- and district-level.*

## **P-3**

**Question 1: Can you please explain to me your understanding of public health policies and practices in KZN?**

*Public health policies and practices give directions on how to provide health services to clients, how health workers should behave, and give directions to the scope of practices within the KZN Department of Health.*

**Question 2: Can you please explain to me the public health policies that are relevant to Reformed theology?**

- *Batho–Pele principles, which are about: Client’s rights, right to refuse treatment, identification of health workers (name tag), transparency (which include procedures during treatment), client must give all the relevant information to health workers and redress (client must be told when there is a problem regarding his/her treatment).*
- *Health and Safety, which is about: cleaning staff must put warning signs when cleaning, medico-legal hazards must be avoided, there must be no electric plugs exposed, containers must be labelled, staff must ensure proper disposal of waste, there must be reliable security for staff and clients, and there must be a safety drill every three months in case there is fire conducted by health and safety reps.*
- *Infection control, which is about: hand-washing policy, adequate PPE for both staff and clients, and waste disposal (red for medical waste, transparent for general waste, buckets for sharp objects, yellow containers for isolation of person’s waste).*

**Question 3: Can you please explain to me what are the opportunities and challenges of Public Health and Reformed theology?**

- *The Church is not doing enough. The Church must have health education in their Sunday school syllabus.*
- *The Church does not have a stable policy on public health and, from my observation, our church tradition (Reformed) is very irrelevant when it comes to public health policies and practices.*
- *Most of the church leadership is ignorant on health-related matters.*
- *Congregants in the church don’t know about public policies.*
- *The church knows nothing about health and safety, as currently we don’t even have fire extinguishers in case there is fire.*

**Question 4: Can you recommend the model can be implemented that can shape activities, formations and consequences to strengthen collaboration between public health and Reformed theology?**

- *By conducting health education and information-sharing from KZN Department of Health.*
- *There is no collaboration, because chaplains are irrelevant. They focus on preaching and memorial services for deceased staff members instead of becoming a link between the departments.*

**Question 5: In your opinion, how can the state and the Church collaborate to improve the public health system?**

- a) That theology and public health collaborate, and both these institutions work together as equal partners.*
- b) Health education must be mandatory for all religious institutions.*
- c) The job of health chaplains in the hospitals must be reviewed and focus on linking the Department of Health and the churches.*
- d) Churches must be encouraged to consider a health national health calendar when doing their yearly plans.*

**P-4**

**Question 1: Can you please explain to me your understanding of public health policies and practices in KZN?**

- *They are the vehicle by which quality health service is rendered.*
- *They protect staff and the KZN Department of Health from litigations.*
- *They are for the protection for workers, clients, and KZN Department of Health.*

**Question 2: Can you please explain to me the public health policies that are relevant to Reformed theology?**

*Patients' rights charter, Batho–Pele Principles, ideal hospital, national core standards, clinical guidance, levels of healthcare, ideal clinic, National Health Insurance, and Norms and Standards (pipeline).*

**Question 3: Can you please explain to me what are the opportunities and challenges of public health and Reformed theology?**

- *Religion - It brings love and helps people to have morals and values. Unfortunately, religious leaders don't understand their roles and responsibilities when it comes to health issues e.g., hospital chaplains focus on preaching when they are expected to render spiritual care and counselling to staff members and clients.*
- *Religious entities - They play a very important role in providing support for KZN Department of Health programmes.*

**Question 4: Can you recommend a model that can be implemented that can shape activities, formations, and consequences to strengthen collaboration between public health and Reformed theology?**

- *Preachers and religious leaders have a multidisciplinary task to perform.*
- *Government must provide training to religious leaders to enable partnership between health and religion.*
- *The Church must be involved in disseminating health information.*

**Question 5: In your opinion, how can the state and the Church collaborate to improve the public health system?**

- a) The Church and state must work together as equal partners in rendering quality service to the community.*
- b) The Church must avoid opposing the KZN Department of Health messages that create confusion to people because of little knowledge that the religious leaders have of health issues.*

- c) *Health and religion must work together.*
- d) *Religion must be one of the KZN Department of Health stakeholders.*
- e) *Chaplains to be more involved in spiritual counselling rather than preaching.*

**P-5**

**Question 1: Can you please explain to me your understanding of public health policies and practices in KZN?**

- *Public health policies and practices assist in spreading correct information to clients from the KZN Department of Health.*
- *They help to give guidance to the youth about STIs and family planning and how to be treated by health workers.*
- *They also give guidance to the KZN Department of Health about how to care for physically disabled people and equipment and resources needed for them.*

**Question 2: Can you please explain to me the public health policies that are relevant to Reformed theology?**

*Batho–Pele principles.*

**Question 3: Can you please explain to me what are the opportunities and challenges of public health and Reformed theology?**

*Churches under the Reformed tradition subscribe to the South African Council of Churches, which is the body that represents it to government. My understanding is that they are consulted when the state is taking decisions about its policies and practices.*

**Question 4: Can you recommend the model can be implemented that can shape activities, formations and consequences to strengthen collaboration between public health and Reformed theology?**

- *The Department of Health must involve religious leaders.*

- *Religious leaders must be relevant and focus on pastoral counselling rather than preaching and praying. Preaching and prayer is very important, but doesn't fill the gap for pastoral counselling where a person speaks to someone about his/her challenges and fears.*
- *Both these worldviews must speak one language and message so that they don't confuse people.*

**Question 5: In your opinion, how can the state and the Church collaborate to improve the public health system?**

*The state must educate religious leaders about diseases and campaigns.*

**P-6**

**Question 1: Can you please explain to me your understanding of public health policies and practices in KZN?**

- *Public health policies are related to or influence health and illness in KZN.*
- *Public health practices are the collection and analysis of identifiable data by public health authority.*

**Question 2: Can you please explain to me the public health policies that are relevant to Reformed theology?**

- *Food and safety policy.*
- *Public health practice – practices for healthy living, e.g. daily breakfast.*

**Question 3: Can you please explain to me what are the opportunities and challenges of public health and Reformed theology?**

- *To provide spiritual support.*
- *To provide pastoral counselling.*
- *To promote self-esteem.*

**Question 4: Can you recommend the model can be implemented that can shape activities, formations, and consequences to strengthen collaboration between public health and Reformed theology?**

*That both religion and health work together for the advancement of educating and treating people to avoid terminal illnesses.*

**Question 5: In your opinion, how can the state and the Church collaborate to improve the public health system?**

*Both these worldviews must work together to lessen the incidence of many diseases.*

**P-7**

**Question 1: Can you please explain to me your understanding of public health policies and practices in KZN?**

- *Public health policies and practices helps the community to understand government service especially at the primary healthcare level.*
- *They outline the guidelines of treating people with dignity.*
- *They are more focused on care and safety of clients.*
- *They help with the accreditation of professionals and facilities or institutions.*

**Question 2: Can you please explain to me the public health policies that are relevant to Reformed theology?**

- *Customer care policy - patients should be treated with high quality of care.*
- *Readiness policy – for clients complain when treated unfairly (office compliance).*
- *Transparency policy – clients must know the health worker who is treating them, their sickness, the process of treatment and the medication they will be receiving.*
- *Ethics policy – ethical behaviours of healthcare workers.*
- *Professionalism – health workers must dress, speak, and act professionally.*

**Question 3: Can you please explain to me what are the opportunities and challenges of public health and Reformed theology?**

- *The Reformed church complies with certain public health policies, like family planning and HIV and AIDS standard guidelines but reject other policies and practices like termination of pregnancy and homosexuality.*
- *In our congregation we have a health committee, but it is not functional.*

**Question 4: Can you recommend the model can be implemented that can shape activities, formations and consequences to strengthen collaboration between public health and Reformed theology?**

- a) They should interact with one another according to their levels, starting from national, provincial and district structures.*
- b) Reformed theology must create accessible programmes for spiritual support, especially during the times of the Covid-19 pandemic.*
- c) Thorough training must be given to religious leaders, because if not done they can be a great hazard to the community and state.*
- d) Religion must be regulated, considering many misunderstandings that have occurred that are related to the misinterpretation of the Scripture and doctrines.*

**Question 5: In your opinion, how can the state and the Church collaborate to improve the public health system?**

- *KZN government should interact more with churches to disseminate information.*
- *KZN DoH must empower religious leaders.*
- *The churches have a great role in moral regeneration programmes.*
- *Do you think these two worldviews (Reformed theology and public health) comprehend one another or are they in contradiction?*



- *They do cooperate because they have got the same objectives of community empowerment and development.*
- *The Church and state should work together to create sustainable projects that will eradicate poverty in the community.*

## **P-8**

### **Question 1: Can you please explain to me your understanding of public health policies and practices in KZN?**

- *Public health policies and practices are strategies that are put in place by government under the KZN Public Health System.*
- *They promote quality healthcare in KZN that is to be implemented.*
- *To realise the vision, plan, mission, and to improve its services to the public and create a safe and healthy working environment for the public servants under the health department.*

### **Question 2: Can you please explain to me the public health policies that are relevant to Reformed theology?**

- *Policy on National Health Insurance (NHI).*

*Informed by the problems that are faced by both private and public health systems, this policy proposes a total transformation of the healthcare system at all levels of government to provide and promote quality and efficient services and service delivery.*

*It also aims to eradicate things such as: staff attitude, drug stock-outs, and long waiting hours and improve safety and security of both staff members and patients. It will bring access to quality healthcare to bridge the gap between private and public health sectors by developing on integrated systems. This will see in improvement in technology, equipment, and staffing (human resources). The department will be moving to a paperless filing as an attempt to improve record-keeping, among other things.*

**Question 3: Can you please explain to me what are the opportunities and challenges of public health and Reformed theology?**

- *There should be a set of principles to guide to the legislative process. This can be effective in the creation of policies and practices that are capable of being implemented and are adequate.*
- *The manner that the current laws are drafted is not meeting the needs of the society it's created for. This will place a duty on the government to promote health and well-being of the population, legislature should create a standard to measure health authorities' performance.*
- *Further, to give power to public health authorities to regulate individuals and business to achieve the communal benefits of health and security (the health and well-being of the community).*
- *Create boundaries to avoid government overreacting in the name of public health, therefore decisions on policies should be fair and just and be for the good of the community.*
- *The prior consultation with stakeholders, workers, and the community before legislation is created will enable the health sector to be effective and efficient, save its community and allow for proper implementation thereof. Therefore, Reformed theology doctrines must be in line with the health policies and practices to improve the health and well-being of the society, the church, and the health sector itself.*

**Question 4: Can you recommend the model can be implemented that can shapes activities, formations, and consequences to strengthen collaboration between public health and Reformed theology?**

*Both these two worldviews must have a common meeting point to draft the policies for the people on the ground level. This will be a best way to allow these two worldviews to work hand-in-hand.*

**Question 5: In your opinion, how can the state and the Church collaborate to improve the public health system?**

*Both the state and the Church must hold meetings with members of both parties to lay rules and policies to accommodate everyone in a common way. We cannot be allowed to hide our beliefs and procedures when attending to health facilities.*

**P-9**

**Question 1: Can you please explain to me your understanding of public health policies and practices in KZN?**

*They are rules and regulations that govern the way the KZN public health system is to operate at all levels of government. Further, these help government to meet the needs of the public and to improve the manner that public servants implement them, to ensure that this department fulfils the purpose for which it was created.*

**Question 2: Can you please explain to me the public health policies that are relevant to Reformed theology?**

*The policy framework on skill development and training in the KwaZulu-Natal Department of Health. The aim of this policy is to promote quality and efficient service delivery of the Department of Health through the development of its employees. This is done by the creation of initiatives and activities aimed at improving their work performance, also to ensure that employee's skills are in line with the framework of the department's operational policies and improves the implementation of this framework. According to the policy, an employee's work performance is rated annually and every second quarter of the year. This takes the form of checks and balances performed by the employer to evaluate an employee. It looks at whether the employee's performance is up to standard, and an appraisal bonus is given to an employee that has performed well. Further, here an employee can point out to an employer if they would like to be trained in a specific area, to improve their key performance areas. All this is done at the discretion of the employer (supervisor).*

**Question 3: Can you please explain to me what are the opportunities and challenges of public health and Reformed theology?**

*The Reformed perspective believes that things should be done for the greater good or common well, therefore should be universally acceptable and applied. Some public health policies are outdated, inconsistent, and poorly drafted, and those are difficult to implement. The major problem is that these policies and practices are one-sided. This could be the result of a lack of consultation with the end user, who the implementers themselves cannot relate to.*

*The legislators who draft these policies and practices are not well invested with the health sector, which has a negative impact and negates the purpose of the health sector, which is to serve its people. Thus, we find that the implementer finds themselves thrown in the deep end and must apply these policies or practices while having no understanding in why they were created or how it assists them in fulfilling the purpose of the health sector. Their relevancy and importance is also not clear to them. Therefore, there is a call for the transformation of the policies and practices to be an essential tool for creating policies and practices that promote end-user condition, well-being and health.*

**Question 4: Can you recommend the model can be implemented that can shape activities, formations and consequences to strengthen collaboration between public health and Reformed theology?**

*I would recommend that instead of each pushing for their own agenda, they should try and create a goal that they both want to achieve.*

*They should both ensure that they try to learn more from one another, and in so doing they create a space for learning and teaching by creating a balance.*

**Question 5: In your opinion, how can the state and the Church collaborate to improve the public health system?**

*The Church can collaborate with the health system in KZN. Firstly, by helping the Department of Health to remove the barrier of access to quality healthcare, thus allowing for the poorest people to access to good quality and compassionate healthcare. Secondly, by providing support and strengthening the health sector as its ever-evolving network bears a risk of having certain individuals falling between the cracks. Thirdly, by helping to promote best practices that will impact positively on strengthening health systems, e.g. churches can be used as a collection point for medications, which lessens the crowding at clinics or hospitals, and thus there is less pressure in these institutions. Lastly, by helping the health sector realise the goals and values that they set by creating a culture of helping each other, participating in board meetings, including as stakeholders in the community, and helping in the implementation of the vision and mission of health in KZN.*

**5.12 DATA INTERPRETATION**

**5.10.1 Understanding of public health policies and practices**

Four of the participants are of the conviction that public health policies and practices are the decisions, the plans, and actions of the government towards achieving healthcare goals within society. Daniel Callahan (2006:4) argues that the goal of healthcare is that of health. The fundamental moral objective of pursuing healthcare is for socio-economic change, providing curative medicine, the preservation and improvement of health, which are an integral part of any broad scheme of healthcare. A society's planned methods for promoting the health of its citizens are referred to as healthcare, and they typically combine the fields of public infrastructure and medicine. The connection of particular strategies into a comprehensive economic and distributive structure designed to adhere to the overarching objectives of healthcare and, ultimately, of health constitutes a society's health policy. The most accurate and straightforward way to define health is a person's sense of well-being and physical and mental integrity. There are convincing justifications for placing a larger priority on health, according to Anna Cloote (2004:05). Not merely effective health services, but also a healthy people, are necessary for a just society and strong economy. In preserving and enhancing health, health services have a significant but constrained role.

Over the past ten years, health disparities between socio-economic classes have gotten worse. In order to close these gaps, it is imperative to address the social, economic, and environmental factors that contribute to poor health. According to Lungile P. Luthuli and Trywell Kalusopa (2017), concerns about public service delivery in South Africa are protected by *Batho-Pele* ideals, which were adopted in 1997 to develop public service delivery to emphasize openness and accountability. Considering that community health services have historically focused on chronic disease prevention, early intervention, and health education, and are significant providers of primary healthcare in many countries, Kathleen M. McElwane (2013) argues that they represent an important scientific background for the delivery of preventive care. These services may involve frequent interactions with healthcare professionals for the provision of specialized, non-acute care.

Two of the participants are of the view that public health policies are there to set and provide standardized practices in the public health sector within the province, as well as other provinces within the country.

There are national policies like COVID-19 policies and guidelines on how to deal with the pandemic in a standardized manner and provincial policies which are derived from the national policies and practices. These policies are, however, not different from the national policies, but some additions that are specific to the health issues of the specific province. These policies set standards of how things are done in the health sector in the province of KwaZulu-Natal. For example, they address the same issues of how to deal with COVID-19 pandemic including targets and timeframe, and how to deal with HIV and AIDS infections within the province, including TB. Those guidelines and policies must be in line with national policies to ensure a standardized approach. This enables patients to receive the same care even if they relocate to another province. Two of the participants are of the conviction that public health policies and practices assist in spreading correct information to clients from the KwaZulu-Natal Department of Health, give guidance to the youth on STIs and family planning, on how to be treated by health workers, and how to care for physically disabled people and equipment and resources needed for them.

Jannie Hugo and Lucie Allan (2008:11) argue that the fundamental premise of the South African Constitution is that everyone is equal. Therefore, everyone is equally entitled to the rights, privileges, and benefits of citizenship, including the right to have access to healthcare. This is attested to by article 25 of the Universal Declaration of Human Rights which states that: “Everyone has the right to a standard of living adequate for the health and well-being of himself/herself and of his/her family, including food, clothing, housing and medical care and necessary social services”.

One of the participants is of the conviction that public health policies are related to health in the province of KwaZulu-Natal and are also the collection and analysis of identifiable data by public health authority. Hodge et al (2007:239-240) assert that public health functions involve the collection, use, and analysis of health data from healthcare providers, insurers, laboratories, government agencies, and individuals. These include activities such as surveillance, for example, reporting requirements, disease registries, sentinel networks, epidemiologic investigations, for example, disease outbreak investigations, and evaluation and monitoring activities comprising public health programme development and analysis and oversight functions.

Keeping tabs on illness and injury rates in the population and offering prevention services that are specially targeted are important steps in lowering risks to the public health and boosting community health. It may be necessary to gather and use personally identifiable health information for each of these actions. The practice of public health depends on this data. Data is used to track the incidence, patterns, and trends of disease and injury in the population after being compiled by the public health authority.

### 5.10.2 What are the opportunities and challenges of public health and Reformed theology?

Most of the participants are of the conviction that both these worldviews are against impurity, an unhealthy environment, and unhealthy behaviours. It is notable though that the mutual comprehension between these worldviews notwithstanding, there is, however, a contradiction. The Church puts more emphasis on spiritual healing, which sometimes confuses the members, and this results in them neglecting their treatment. This does not mean that spiritual healing is a myth or does not exist, but if that can be worked into helping our communities, because the same medication is from God's nature (the trees and other plants), the mind behind the public health systems is from God. So, the two can work best if they collaborate without either looking down upon the other. Other issues have been touched upon earlier; family planning, in which according to the Church, a family is couple that is united by someone approved to carry out that duty like the pastor or minister. So, giving contraceptives and condoms to school children is ungodly, as it promotes sex before marriage, but is sex before marriage not happening? Are there any measures in the Church to support and guide young couples within the church to avoid sex before marriage, unwanted pregnancy, back-street abortions, etc.? The Church must work hand in hand with its members and the public health sector to create a platform that is friendly and usable. According to de Gruchy (2015:243), what accounts for the fact we are uncertain about what it means to be Church in a time of AIDS in South Africa today is that we have not reckoned with the fact that public theology; or social theology; in South Africa is heir to a divided ecclesiological legacy, symbolised by the contrast between the *Kairos Document's*<sup>7</sup> demeaning of "church theology", and the *Belhar Confession's* concern for the integrity of the Church. It may be argued that two distinct theological developments – the Kairos and the Belhar - that were essentially travelling in the same direction helped to form the Christian struggle against Apartheid and the national security state in South Africa. de Gruchy (2015:87) is of the view that to be a Christian means to participate in the *missio Dei*, God's work in the world. In order to bring our communities, society, and world closer to God's goal of shalom, we must offer witness to the work of God in collaboration with others – both inside and outside the Christian Church.

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<sup>7</sup> Kairos Theologians" Kairos Document"( Braamfontein: Kairos Theologians, 1985)



Shalom, the “abundant life” Jesus refers to in John 10:10, is the state of being in harmony with God, one’s neighbours and other people, as well as the natural world.

In addition to being a more general social vision of peace and justice in which those who are excluded and marginalized are significant guests at the feast, it finds expression in homes and neighbourhoods. Two of the respondents are of the view that these worldviews complement and sometimes contradict one another. Complement, because the fundamental moral obligation of both worldviews has to do with catering for the health needs of the people. Contradict refers to when different messages are sent. According to de Gruchy (2015:262), religion’s symbolic mission is to convert the world to a better place. Public health is dedicated to fostering the circumstances that will make this possible. It may be argued that it is time to develop a shared solidarity in the fight for survival and the circumstances that allow this to happen.

One of the participants is of the conviction that the founders of Reformed theology supported public health. Therefore for many churches, evangelism and health promotion may be part of the overall goal of saving souls. West (1988:180) asserts that Reformed tradition stresses life within the Christian community and the body of Christ as a means of health. In the Church we meet Christ, the Word, witnessed to by the Holy Spirit in the Scriptures and in preaching. In the Church we receive the benefits of the sacraments of Baptism and the Lord’s Supper. In the Church we learn discipleship and how to bear one another’s burdens. Notably, in Geneva Calvin honoured those who studied medicine and dispensed physical treatment, which is why he encouraged the upgrading of medical care in hospitals. These were supported at city expense so that even the poor might receive treatment. Pastors visited the sick and drew lots for the chaplaincy of those with contagious diseases. Deacons assisted by women took over the service of the sick which had been interrupted when the religious orders were dissolved.

The KwaZulu-Natal government should interact more with the churches to disseminate information that empowers religious leaders. The churches have a great role to play in moral regeneration programmes.

### **5.10.3 What is the role of Reformed theology in public health?**

All participants agree that Reformed theology supports some health policies like public participation, health and safety, health promotion, HIV and AIDS, and rejects some like the termination of pregnancy. According to de Gruchy (2015:242), the WHO has urged for an unparalleled humanitarian effort to stop the pandemic's spread and lessen the suffering of millions by ensuring that everyone has access to HIV and AIDS treatment, care, and prevention services by the year 2010. Faith-based groups, which now control between 30 and 70 percent of the medical infrastructure in sub-Saharan Africa and are thought to possess even more religious resources that support good health, will be a significant partner in this endeavour. According to Brownson et al (1999), public health professionals should always include scientific evidence when making management choices, creating policies, and putting initiatives into place. The development of policies and initiatives, however, typically centres on anecdotal information and these judgements are frequently based on short-term demands rather than extensive research.

In resolving these difficulties, a number of factors, including improved individual skills, greater use of data and analytical tools, and a more favourable organizational atmosphere, may contribute to a more evidence-based approach to decision-making. One of the participants believes that the Church isn't doing enough, because Sunday school curricula don't include health education and there isn't a consistent public health policy. Based on this observation, the Reformed tradition is irrelevant when it comes to public health policies and practices, because the majority of the church leadership is uninformed about health-related issues. Another participant is of the conviction that some public health policies are outdated, inconsistent, and poorly drafted. Therefore, there is a call for the transformation of the policies and practices to be an essential tool for creating policies and practices that promote personal condition, well-being, and health. de Gruchy (2015: 262) asserts that numerous individuals have attempted to bridge the religious and public health sectors in the past. The early generation of medical missionaries, who made significant contributions to the establishment of primary healthcare, community health workers, and tropical medicine, serve as the best example of this.

### **5.13. Conclusion**

Data has been given, examined and interpreted in this chapter. All participants' right to confidentiality has been honoured and respected. Every interview question was written so that any responses would, to the greatest extent feasible, address the central study question. The information gathered from the interviews clearly shows the diversity of experience and understanding of health, well-being, and religion.

It is clear from the responses that the relationship that exists between religion and health-seeking is deeply placed at the centre of health-seeking, particularly among those who profess faith in God. Another aspect noted from the responses is that there is little understanding of Reformed theology from Reformed church members. The last thing observed is that the KZN Department of Health does not share information with the religious leaders and members, because hospital chaplains only focus on preaching and praying and thus do not share KZN health policies with the churches.

## **CHAPTER SIX**

### **TOWARDS AN EFFECTIVE SOUTH AFRICAN PUBLIC HEALTH POLICIES AND PRACTICES**

#### **6.0 Introduction**

This chapter discusses the components that will enable effective public health policies and practices. It focuses on how policies and practices can be used to enhance the delivery of healthcare; enhancing and utilizing methods based on their avowed usefulness is a significant objective for enhancing South African's health status. Additionally, it shows that more work is being done to enhance our capacity to prevent, recognize, and remediate common, pricey or profoundly condense health or intentional size problems. The following topics will be covered: major national health challenges, innovation to build the evidence base for action, citizen participation and community empowerment, partnerships between stakeholders, communication between stakeholders, policymaking, setting and situational analysis, procedural package, managing performance, and the Constitutional and organizational context of the South African health system, and organizational context of the South African health system

#### **6.1 Constitutional and organisational context of the South African Health System**

##### **6.1.1 The right to have access to healthcare**

The right to health, which is essential to everyone's physical and mental wellness, is a prerequisite for the pursuit of a sufficient quality of living and other human rights, such as the right to physical and mental health. The right to receive health services is protected by three provisions of the South African Constitution. The Constitution of the Republic of South Africa, Act 108 of 1996, Sections 27 (1)(a), (b) and (c), Section 28 (1)(c) and Section 35(2)( e) guarantee the right to access medical care, including reproductive health and emergency services, basic healthcare for children and medical care for people in detention and prisoners. Section 27(1)(a), which states that everyone has a right to free healthcare, makes universal access possible.

The State may adopt reasonable legislative and other steps to attain the advanced awareness of the right, as provided for in Section 27(1), in line with the resources at its disposal.

According to the Limburg Principles, unbiased comprehension does not entail that the State can perpetually uphold the right in its totality. State parties, on the other hand, are required to take immediate action to grant the basic minimum of privileges and to move as soon as they can toward a full understanding of the right. Section 27 states that no one may be denied access to emergency medical care (3). Basic healthcare services are provided for children under Section 28(1) (c), while prisoners and criminal defendants are given “adequate medical treatment” at the nation’s expense under Section 35(2) (e).

### **6.1.2 Policies, programmes and projects**

In addition to outlining how they respect, preserve, promote and realize the right to healthcare, government institutions were requested to list and describe the policies, programmes and initiatives implemented during the reporting period, which ran from 2000 to 2002. The National Department of Health (NDH) and provincial agencies’ answers are summarized here. Data from independent research has been used to provide a more complete view of recently deployed procedures. According to Scheibe et al (2020:), South Africa made the transition to democracy in 1994 after more than 50 years of Apartheid rule and hundreds of years of colonialism, both of which attempted to take advantage of the possibilities and empower the nation’s white minority citizens. The Constitution includes broad protections for people as well as universal human rights and respect for one’s own dignity, which is in contrast to the previous administration. It emphasizes that everyone has the right to live with equality, dignity, and access to healthcare without being subjected to any form of discrimination based on their “race, gender, sex, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language, or birth, among others” (South African Government, 1996). In an environment of extreme poverty, a failing economy, and infrastructure (particularly the health system) built for a minority of the population, governmental organizations and ministries were tasked with improving the lives of the historically disadvantaged population. The administration sought more funding and infrastructure.

### **6.1.2.1 National Strategic Plan on HIV and AIDS Policy of 2017-2022**

The goal of the HIV New Strategic Plan (NSP) is to reduce new HIV infections and how they affect people, families, and communities. Prevention, treatment, care, human rights, monitoring, and assessment are the key areas of concern (National Strategic Plan on HIV, TB, and STIs 2017-2022:14). The NSP created the following initiatives to stop the spread of AIDS: management of sexuality transmitted diseases, reducing mother-to-child transmission, voluntary testing, and counselling and post-exposure prophylaxis. Scheibe et al (2020:278) estimate that South Africa has the highest number of HIV-positive residents at 7.9 million, with most new infections occurring in young black women between the ages of 15 and 25 (Council for Human Sciences Research, 2018). With 301,000 active cases in 2018, it also has one of the highest TB incidence rates in the world (WHO, 2019). Non-communicable illnesses are the primary cause of death in half of all cases (260 000 annually). One-third of South Africans will have a mental illness during their lifetime. There are 33 homicides for every 100,000 people, 25 percent of women have experienced sexual assault, and 40 percent of children have either observed or experienced violence. In 2018, South Africa's performance for universal healthcare was 66 percent, compared to the global average of 65 (with a range of 22 – 86 out of a possible 100).

According to Edwin Wouters, South Africa's path toward freedom has been significantly embedded (2009). The first democratic elections were held in 1994 and 7.6 % of pregnant moms visited prenatal clinics had HIV testing results that were positive. This percentage was nearly four times greater in 2007 at 28.0% (Department of Health, 2008). Each South African is affected, whether directly or indirectly. Strong socio-political, economic, and developmental factors are present in the area. Despite the most recent data on occurrences indicates that the rate of HIV infection may be levelling off, the government's response to the epidemic has continually come under fire on a number of fronts, both locally and internationally. The HIV & AIDS and STI Strategic Plan for South Africa 2007- 2011 is the most recent attempt to tackle these diseases in South Africa. In practice, these nearly perfect AIDS methods frequently proved to be essentially worthless due to improper or inadequate execution. Karsany et al (2020:131) assert, however, that national representative population-based household surveys in South Africa demonstrate the widespread of HIV infection there (Human Research Council, 2018).

With a countrywide HIV prevalence of 20.6% among those aged 15 to 49, the region's prevalence is regarded as generally overactive and broad. At the provincial level, KwaZulu–Natal had the highest prevalence of HIV cases (27.0%) while the Western Cape had the lowest (12.6%).

#### **6.1.2.2 Sexually Transmitted Diseases Management**

Programmes and projects may be built around one or more policies with related goals. Interventions are divided into numerous types. One of the strategies is the syndromic care of HIV and AIDS, STIs, and TB, an opportunistic infection frequently found in AIDS patients. (People Living with HIV and AIDS). The goal is to prepare medical professionals to correctly diagnose and handle a particular set of symptoms. Additionally, health professionals speak with sexual partners and offer counselling instruction. Sexually-transmitted diseases (STIs) are a class of infections that are communicated through sexual contact, according to Abdul-Aziz Seidu's study from 2020. *Trichomonas*, syphilis, chlamydia, and gonorrhoea are notable infections. The implications of these STIs on health and well-being cannot be understated, even though the majority of them are curable. In addition to an increased chance of contracting HIV, severe STIs can cause blindness, infertility, heart conditions, and sterility. STI occurrences continue to be significant despite obvious prevention measures and relatively inexpensive and straightforward treatments.

According to WHO reports, there were 637 million new cases of curable STIs in 2012. Asia, Latin America and Sub-Saharan Africa (SSA) all have high rates of these illnesses. SSA alone is responsible for 93 million STI cases each year. Sexually-transmitted infections (STIs) are among the most prevalent infectious disorders in the world, according to Adams *et al* (2020). They are spread around the globe and are linked to serious sickness and fatalities. By enabling quick identification and early treatment of infections, point-of-care testing has the potential to revolutionize the prevention and management of STIs by halting transmission and stopping the cycle of untreated infections.

### **6.1.2.3 Reducing Mother-to-Child Transmission**

The Mother-to-Child Transmission (MTCT) of HIV and AIDS trial initiative aims to reduce the risk of HIV transmission to unborn children by giving anti-retroviral medications (ARVs) and formula milk to HIV-positive pregnant women working in the public sector. There are two trial locations in each province. Geddes et al (2011) estimate that in 2009, 370 000 new paediatric HIV infections occurred worldwide, with an estimated 2.5 million of those infections occurring in Sub-Saharan Africa due to mother-to-child transmission (MTCT). Without treatment, the MTCT of HIV ranges from 25 to 45 percent. In high-income nations, MTCT has been all but eradicated thanks to efficient testing and counselling, accessibility to antiretroviral therapy, and safe delivery and baby-feeding procedures.

In South Africa in 2009, 29% of women between the ages of 15 and 49 receiving prenatal treatment at public health facilities were HIV-positive. While child mortality rates are declining globally, they are increasing in South Africa, where HIV is the primary cause of death for children under the age of five, killing 40% of children. The implementation and advancement of PMTCT services, which were started in South Africa approximately ten years ago, have been slow. PMTCT programmes present a singular chance for health services to interact with women living with HIV, their infants, and their partners to give comprehensive treatment and care, and to build relationships that can increase their long-term survival.

Prior to the introduction of dual therapy (zidovudine during pregnancy and nevirapine after birth) in early 2008, PMTCT services in South Africa's public sector, like those in many other resource-constrained nations, only offered a single dosage of nevirapine to the mother and her child upon delivery. Despite a continually high prenatal HIV prevalence of over 30%, Wessels (2019) note that South Africa has taken numerous initiatives to reduce the vertical transmission of HIV in the first two months of life from 23 percent (2003) to 0.7 percent (2019). This accomplishment has been greatly aided by expanding access to antiretroviral medication during prenatal care, but it has also increased the proportion of vertical transmission caused by breastfeeding in the first six months after delivery. However, given the hazards of not breastfeeding as well as the short- and long-term benefits of nursing, women must be encouraged to breastfeed their children for as long as they are able to, while also maintaining virological suppression to lower the chance of vertical transmission.



Three key measures for programme improvement are outlined in the new South African National Guideline for the Prevention of Mother to Child Transmission of communicable Infections (2019):

- 1). Preventing primary HIV infection and unintended pregnancy in women who are capable of having children.
- 2). Increasing the rates of maternal viral suppression at birth and in the postpartum period using effective, well-tolerated antiretroviral regimens, strategic use of maternal viral load monitoring, connecting mothers to postpartum HIV care and integrating mother–infant healthcare, and
- 3). during the breastfeeding periods, women with HIV viral loads should receive better prevention, while every attempt is made to restore their viral suppression.

Implementing this recommendation strictly may help South Africa get closer to its objectives of lowering mother-to-child transmission and ensuring an HIV–free generation.

#### **6.1.2.4 Voluntary Testing and Counselling**

To determine a person’s HIV status, the VTC program offers private testing and counselling in public health facilities. After receiving counselling, the service will allow individuals to learn their HIV status and make informed decisions. Rapid AIDS testing is required by the initiative, which also needs qualified staff and financing. It also needs a distinct area that will guarantee secrecy and respect for the patient’s right to privacy. According to Ziningi Jaya et al (2017), the primary goal of rapid tests is to give medical staff quick diagnostic results so that treatment may start right away and improve health outcomes more quickly. Because they enable a prompt start to antiretroviral therapy (ART), and make connection to care easier, fast HIV testing has been an effective technique for enhancing healthcare access and health outcomes in Sub-Saharan Africa. Innovative rapid HIV diagnostic tests that can be used in a variety of settings, including places where access to high-quality laboratory testing is restricted, are encouraged by the UNAIDS 90:90:90 strategy and the Consolidated Antiretroviral Drugs Guidelines for Testing and Preventing HIV from WHO.

The UNAIDS 90:90:90 strategy is to make sure that, by 2020, 90% of all HIV-positive individuals are aware of their status, 90% of those with HIV infection are receiving sustained antiretroviral treatment, and 90% of those receiving treatment have viral suppression. Since the implementation of this approach, the value of HIV fast tests in assisting with diagnosis and facilitating treatment linkage in a variety of contexts cannot be understated. Rapid HIV testing has been linked to improved access to antiretroviral therapy, care for HIV-infected women and a reduction in mother-to-child HIV transmission. Wall (2020) claims that thanks to international preventive initiatives, the number of incident HIV infections in sub-Saharan Africa has decreased by 13% in recent years. While this decrease in new infections is slow, there are still gaps in the expansion of treatment and prevention services and flattening funding levels make it unlikely that the 2030 Sustainable Development Goals will be met. In order to better allocate scarce resources, it is more important than ever to make the most of the financing that is available. To do this, HIV prevention and treatment initiatives must be assessed for their cost effectiveness. Pre-exposure prophylaxis (PrEP), voluntary medical male circumcision (VMMC), and prevention of mother-to-child transmission are just a few of the methods that have been evaluated using the HIV prevention flow, which evaluates areas of intervention inspiration for use, admittance, and effectiveness between significant individuals.

#### **6.1.2.5 Post-Exposure Prophylaxis**

The PEP program is designed to provide ARVs to healthcare professionals who unknowingly contract HIV at work. All rape victims are now covered by this programme and are eligible to receive free ARVs at government facilities. In her study, Ndlovu (2005) noted that all rape survivors would be eligible to use PEP without charge as part of the South African government's broad policy to assist those who have experienced sexual violence as part of the prevention and eradication of violence against women and children, which was unveiled in April 2002 (Sexual Assault Policy and Procedure, 2002:01). According to the National Health Policy no. G4712002, dated 25/09/2002, which was released in April 2003, women and girls between the ages of 14 and 49 who have experienced sexual abuse may visit a medical facility and obtain post-exposure prophylactic care (Sexual Assault Policy and Procedure, 2002:01).

The Sexual Assault Policy and Procedure's principal objective was to provide specific free healthcare services that were available around the clock for the total management of sexually abused individuals.

Instead of being a part of primary healthcare services, the service for managing rape survivors should be offered by specialists who have undergone the necessary training (Sexual Assault Policy and Procedure, 2002:13). This service should include screening, filling out records for clinical and forensic evidence, treating co-existing injuries, preventing pregnancy, providing a secure and comforting environment for counselling, collecting comprehensive data on STIs, including HIV, and making referrals to appropriate services. Even within a province, there are variations in the ways these things are done. Long before the National Department of Health made its decision, the Western Cape oversaw PEP activities. In Gauteng, PEP program execution started in April 2002, and by October 2002, 16 out of 26 locations had completed it.

A procedure was carried out in the Free State in July 2002, and as of this writing, 28 institutions are listed as managing PEP. At the end of September 2002, KwaZulu–Natal declared that PEP will be available at all crisis centres, hospitals, and community health centres. While Bekker (2020) asserts that pre-exposure prophylaxis is a useful form of HIV prevention for any sexually active person who may come into contact with HIV through contact with bodily fluids, persons of any sex, gender, or sexual orientation may use pre-exposure prophylaxis in areas where the prevalence of HIV is 3%. In areas where the prevalence of HIV is 3% or higher, the WHO advises scaling up PEP. In Southern Africa, the danger is unevenly distributed across subpopulations and geographical areas, but a very large proportion of those who engage in sexual activity are exposed to this level of risk. While various PEP initiatives have focused on particular “high-risk” or primary population groups, PEP may be advantageous for any client who indicates that he or she is at risk of infection. PEP education and intervention should be given in these institutions. Contrarily, the use of a danger-counting tool is mandatory, and clients must be asked the right questions about their sexual history in order to discover sexual behaviours that support the development of better or more effective HIV-prevention strategies.

This is because no single risk score has been validated for widespread usage, risk ratings fail when risk is poorly assessed and individual risk levels are high. People seeking PEP should be encouraged to start PEP if they are sexually active and there is a reasonable risk that they might be exposed to HIV, given the high rates of HIV transmission that continue to exist in South Africa, the low current demand for PEP, and the lack of saturation in both the private and public sectors.

#### **6.1.2.6 Home- and Community-Based Care**

The administration and care of PLWA, AIDS orphans, and persons with physical or mental disabilities is another intervention. According to Donela Besada et al (2019), community health workers (CHWs) are being promoted as a promising solution to acute human resource shortages and enhance health coverage as part of continuing procedures of health system reforms aimed at enhancing access to primary healthcare. In a variety of low- and middle-income and underserved settings where persistent shortages of nurses and doctors and significant travel times to healthcare facilities have resulted in limited access to essential services for exposed people, CHWs have been demonstrated to be an imperative and cost-effective preference. This medical care has been utilized in South Africa for at least 50 years. In order to rectify the unequal distribution of healthcare services brought by the Apartheid era, NGOs developed CHW programmes in the 1970s. However, after 1994, a primary healthcare emphasis on facility-based treatments led to the demise of numerous CHW programmes across the nation. Following that, a new trend of NGO-supported CHWs with a disease-specific focus emerged, with a primary focus on HIV- and TB-related treatment and support. Although this strategy met a pressing need, it led to the underutilization of this unit, which could have had a greater social and health impact had other programmes been included in the CHWs scope of practice. The health system is under a lot of pressure to provide comprehensive services because of the evolving disease problem in South Africa over the past 20 years, the decreased death rate brought on by the prolonged rollout of antiretroviral therapy (ART), the aging population, and associated lifestyle diseases. Currently, CHW responsibilities have increased to include supporting the delivery of significant interventions related to maternal and child health, HIV & AIDS, tuberculosis (TB) and chronic diseases. Although they have contributed significantly to the success of many of these programmes throughout the years, there have been considerable differences in how CHW programmes are managed and run throughout South Africa. The fact that the role of CHWs has never been properly specified in national or provincial health policies is one of the major issues with CHW programmes.

Due to the lack of a formalized CHW policy, there has been no guidance on the training, employment, and scope of practice requirements for CHWs. Programmes provide palliative care through home-based care in the home or in the community.

The programmes' enhanced training requirements for health workers who visit patients in their homes and provide proper care will reduce the number of hospital beds occupied by chronic care patients for prolonged periods of time, which will reduce hospital spending.

#### **6.1.2.7 Life Skills Programme**

This preventative initiative involves providing free condoms and information to the target populations most at risk of developing AIDS. The Life Skills Programme, which was included to the outcomes-based curricula in schools, instructs students on how to handle challenges related to AIDS. Youth participation is one of the fundamental tenets of effective HIV and AIDS prevention, according to Raniga (2006). Community involvement is crucial to the success of development projects, just like it is for other social development initiatives. Greater acceptance and appropriate behaviour result from young people's involvement in the identification of needs as well as the design and development of HIV and AIDS programmes. "Through meaningful participation, young people become a potential resource in fighting the worldwide epidemic," the UNAIDS Global Report (2004:42) stated. High levels of "social capital", which includes community trust, reciprocal help and support, a positive sense of place, and high levels of civic involvement, have also been linked to young people's health and well-being. HIV and AIDS prevention programs will be meaningful and effective when young people feel that their needs and opinions are recognized and valued and when they have access to channels to participate in decision-making.

The United Nations Conventions on the Rights of the Child serve as one of the main justifications for young people's participation and active involvement in HIV and AIDS programmes. This agreement grants children and young people the freedom to openly express their ideas and have them taken into account in connection to a variety of spheres of life. Any comprehensive HIV and AIDS social and health strategy should be built upon both this and the South African Constitution (1996). Young people frequently feel alienated from larger social decision-making, according to Morrow (1999), and they are sceptical of their token representation on learner representative councils at schools and other community organizations. Therefore, creating HIV and AIDS programmes and policy frameworks that are pertinent to young people's needs and valued by young people is a challenge. As a result, students must be considered as a significant stakeholder in the planning of HIV and AIDS programmes in the setting of schools.

According to Jaballah Sandra & Wallin Anna (2020), South Africa is the HIV pandemic's epicentre and the country's women are disproportionately impacted by the illness. The adoption of life skills education in all primary and secondary schools is a crucial method to stop and slow the speed of HIV infection. By providing young people with education, care, and support, the goal is to develop their understanding of and competency in sexual and reproductive health. The South African government, in partnership with a number of stakeholders, created the five-year HIV & AIDS and STI National Strategic Plan for South Africa 2000–2005 (NSP 2005) in 1999 in response to the increasing HIV infection rates (Government of South Africa, 2000:5-6). Four priority areas are listed in the South African NSP 2005: Prevention, treatment, care, and support, legal and human rights, monitoring, research, and evaluation (Government of South Africa, 2000:5-6).

The main goals of life skills and HIV education in the curriculum are to increase gender equality and decrease sexual violence, according to the National Coordinating Committee for Life Skills and HIV & AIDS. However, as each of the nine provinces was in charge of the structure and execution of their own, it was determined that the subject's implementation was insufficient and inconsistent. As a result, the South African government recognized the need for a life skills program that had national reach. Consequently, the 2005 LSE programme was established. By redefining the topic as “the systematic teaching of prerequisite skills for surviving living with others and achieving in a complex society”, the 2005 LSE programme broadens the scope of life skills education.

Additionally, the 2005 LSE programme explicitly emphasizes the significance of targeting youth in accordance with the United Nations General Assembly Session (UNGASS) on HIV and AIDS, because behavioural change is easier to achieve at younger ages and today's youth are essential for the future of society, particularly in terms of the economy (Government of South Africa, 2000:25; Government of South Africa, 2006; 36). The 2005 LSE programme emphasizes how crucial it is to modify young people's sexual behaviours while also raising their degree of life skills knowledge (LSK).

It is emphasized that if student's sexual risk behaviours (SRB) do not diminish as a result of greater awareness brought on by life skills education, HIV will continue to exist. To ensure an equitable allocation of the resources allotted to the implementation of the 2005 LSE programme, decision-makers from the national, provincial, and local district levels worked together (Government of South Africa, 2000:29). With the use of these materials, teachers were to receive the proper instruction aimed at improving their subject-matter-teaching abilities. According to the Curriculum 2005, students in grades 1 through 3 are required to learn about their Constitutional rights as well as how to act morally and responsibly towards their health and the environment. Additionally, students are expected to learn the fundamentals of diseases like HIV and AIDS through general health information on how to maintain a healthy body (Department of Basic Education, 2011a). By incorporating more instruction on HIV transmission, self-protection and how to deal with stigma around HIV and AIDS by dispelling prevalent beliefs, grade 4 through 6 raises the bar for LSE. Additionally, it covers topics like safe and unsafe relationships as well as physical integrity. In addition to prior knowledge about HIV and AIDS, sexual behaviour education is taught in secondary school (grades 7-12). Each school level gradually raises the level of LSE being taught and the amount of LSK required, with the more advanced information being taught beginning in grade 4 and upwards (Department of Education, 2002:18; Department of Basic Education, 2011b).

Students exposed to the 2005 LSE curriculum are specifically expected to: 1). Exhibit an accurate and thorough comprehension of sex, sexuality, gender, and STIs. 2). Critically evaluate the possible and unlikely methods of HIV and STI transmission. 3). Determine and assess the efficiency of HIV and STI prevention strategies. 4). Locate, use, and organize community-based resources for aid. 4). Analyse the justifications for postponing sexual activity or abstinence. 5). React forcefully to requests for unprotected sex and sexual contact. 6). Analyse critically the justifications for and techniques of protected sex when/if sexually active. 7). Accept, manage, and live a positive life despite having HIV. 8). Show empathy and support for those living with HIV and AIDS and others who are impacted. 9). Offer basic care to family members and neighbours who are HIV- and AIDS-positive, and 10). Recognize loss and the grieving process and learn to deal with it (May *et al*, 2004:8; Magnani *et al*, 2004:290).

The rate of new HIV infections decreased over the course of the implementation period from 2000 to 2005. The prevalence rate was still extremely high though. Although life skills education has been mandated in all schools since 2005, the issue persists, since altering behaviours is a difficult task. Therefore, there is still room for development.

#### **6.1.2.8 Rehabilitation of the mentally ill through psychosocial rehabilitation**

The programme's objective is to help mentally disabled people with their psychosocial rehabilitation by supporting the above-discussed community- and home-based treatment while deinstitutionalizing patients from psychiatric hospitals. The mental health paradigm, which has its origin in the community mental health movement, is founded on the express purpose to avoid mental illness and the associated disturbance of daily routine, according to Seedat et al (1988). In order to avoid mental illness, it aims to build, conserve, and develop human resources. This strategy aims to reduce the escalating demand on mental hospitals by expanding the reach and effect of services and the potential for more people to get care sooner. This is a departure from the traditional psychotherapy approach. The focus of preventative actions shifts from the exclusive treatment of a patient to a variety of ecological levels that encompass whole populations, small groups, and organizations within them. The efforts involve both people who are healthy and those who are mentally ill, who may or may not seek treatment. It is intended to reduce hazardous environment circumstances, prevent unnecessary psychological suffering, and increase communities' resilience to inevitably traumatic events in the future. It emphasizes the growth of abilities and coping mechanisms rather than only correcting pathology and deficit.

Planning and implementing prevention strategies can help decrease the following: 1). prevalence of mental disorders of all kinds in the community (primary prevention). 2). length of time that many of those problems last (secondary prevention). 3). damage that these disorders may cause. The population-wide strategy, the milestones model, and the high-risk group method are the three primary intervention approaches. In order to shorten the duration and severity of an illness, secondary prevention tries to "detect and treat at the earliest possible opportunity". It encourages growth-enhancing initiatives designed to lessen issues before they become serious through early detection. It is truly a treatment-based strategy that aims to increase the community's access to services. This process needs to be accompanied with a rise in the community's use of services in order to pick up steam.



#### **6.1.2.9 National Quality of Care Policy**

A thorough set of rules has been created by the National Department of Health (NDH) to standardize the quality of basic healthcare delivery across all provinces. According to Whitaker et al (2000), a fragmented health system that primarily provides first-world healthcare to some of its people and third-world healthcare to the rest of the population is one of the unfortunate by-products of Apartheid. The fact that South Africa has 11 official languages and is a melting pot of many deeply ingrained cultures adds another layer of complexity, making the problem unique and necessitating a unique solution. The reforms envisioned for the South African health system were thought to be made possible by an impartial, powerful accreditation procedure that also allowed for unbiased review. The Constitution's stated goal is to "ensure that a health system is built that is capable of efficiently creating quality healthcare for all citizens in a conducive and caring manner". A certification scheme for healthcare services is emerging in this environment of economic and social diversity. The sole organization in South Africa that oversees the accreditation of medical facilities is the Council for Health Service Accreditation of Southern Africa (COHSASA).

#### **6.1.2.10 Cervical Cancer Screening (CS)**

This initiative aims to lower the number of female cervical cancer fatalities. One of the main causes of death for women is cervical cancer, which, if detected early, can be treated. Regular screening allows for early detection, which allows for treatment. According to Arbyn et al (2019), 10 years ago, cervical cancer was the third most frequent malignancy in women overall. However, it was the most prevalent type of cancer in women in 42 low-resource nations. New avenues for primary and secondary prevention have been made possible by the realization that the main cause causing the onset of cervical cancer is infection with carcinogenic types of human papillomavirus (HPV).

The development of cervical cancer and death from it can be significantly reduced with the application of both preventative strategies. The licensed bivalent and quadrivalent HPV vaccinations with HPV-16 and HPV-18 antigens appear to provide highly effective protection against infection and precancerous cervical lesions linked to these kinds when people are not yet exposed. Together, the two types are responsible for 40–60% of cervical cancer precursors and 70–75% of all cases of cervical cancer.

A non-lethal vaccination that guards against seven carcinogenic HPV strains, which collectively account for over 90% of cervical malignancies, has also recently received approval. The paradigm of secondary prevention of cervical cancer for fifty years has been the treatment of pre-cancerous lesions found by microscopic examination of cells scraped from the cervix. Although there is no doubt that cytological screening has significantly reduced the burden of cervical cancer in a number of resource-rich nations, the approach may have reached its limits. This is because reports from a number of nations with long-standing, high-quality pap smear- based programmes show that trends have either stabilized or started to rise. HPV testing protects against future cervical precancerous lesions and invasive cancers better than cytology screening, according to meta-analyses and pooled analyses of randomised trials. As a result, virological screening programmes are becoming more and more advised.

Given the accessibility of these new preventative technologies, public health professionals are faced with the problem of defining fully integrated plans that include cervical cancer screening and HPV vaccinations and match the target populations while being cost-effective. The WHO Director General made an ambitious appeal to all countries in the globe in 2018 amid a drastically shifting preventive environment to mobilize resource in order to put an end to cervical cancer. More than ever, access to reliable statistics is necessary for successful cervical cancer-control strategy. One of the essential phases in the WHO's action plan for non-communicable disease is establishing a top-notch surveillance and monitoring system that gives, at a minimum level, trustworthy population-based statistics data on the major non-communicable illnesses. Using the 2018 estimates of the global cancer burden compiled by the International Agency for Research on Cancer (IARC), based on available cancer registry and vital statistics data, we describe the current patterns of cervical cancer incidence and mortality rate along with HPV prevalence data in this study, allowing a thorough baseline assessment of the global cervical cancer burden.

#### **6.1.2.11 Maternal Death Notification (MDN)**

The latter is intended to document all maternal deaths due to all causes in order to lower the mortality rate and, for statistical reasons, enhance monitoring. All fatalities in South Africa must be reported to the Department of Home Affairs via the death certification process, according to Barron et al (2019). Statistics South Africa analyses death certificates and compiles them into official annual mortality reports that list the causes of death, age ranges, and provinces where people died. In South Africa, a doctor must complete a death notification form and submit it to the Department of Home Affairs within 72 hours of the death. The form can be filled out by traditional leaders in the absence of a medical professional. The age, sex, district, and Identification Classification of diseases and related health problems (ICD – 10) code are all listed on each death notice form.

#### **6.1.2.12 Health Research Policy in South Africa**

This strategy outlines the creation of a national health research system that will support the advancement of equitable health and innovation in service provision. By developing a national framework for research that would enhance the quality, impact, effectiveness, and efficiency of the research, the goal is to advance knowledge that supports the provision of high-quality healthcare.

### **6.2 Legislative measures**

#### **6.2.1 The National Health Bill (2001)**

The National Health Bill establishes greater cooperation between the three branches of government in order to provide healthcare on a national level. By increasing the capacity of health workers, it aims to increase access to healthcare facilities and care quality. The proposed law is said to be in accordance with section 27(1) of the Constitution, which guarantees everyone access to healthcare services, including the right to an abortion, in the preamble. The national framework legislation's goals are to create a national health system that includes public, private, and non-governmental providers of all health services, offer the Republic of South Africa's population the best healthcare possible within the means of available resources, and define the rights and obligations of both healthcare providers and users.

According to Section 7 of the Bill, if a private or public health facility is open and equipped to offer such services, the minister or the appropriate MEC responsible for health may order that no one needing emergency medical treatment be turned away. Emergency treatment is defined in the bill as therapy needed to treat a life-threatening but reversible deterioration in person's health status. It continues to be considered emergency treatment until the person's condition has stabilized or has been reversed to a particular level.

### **6.2.2 The Mental Healthcare Act 17 of 2002**

Coordination, integration, and regulation of non-discriminatory access to mental healthcare, treatment and rehabilitation services are the main objectives of the Act. It also recommends integrating mental health into routine medical care. Another area of focus is the creation of community-support services to aid in the deinstitutionalization of patients from psychiatric hospitals as well as community, district, and regional mental health services (group homes, day programmes, rehabilitation groups and home-based care). Users of mental health services are entitled by the Act to legal representation and information about their rights. Additionally, it states that a prisoner who is deemed mentally unfit following a prison investigation may be moved to a mental health facility on the advice of medical professional. Upon completion of the sentence, he or she may be released. According to Naidoo (2012)'s further explanation, the estimated population of South Africa is 54 956 900. Most of these individuals use public hospitals and clinics that are run by the government. The health sector is made up of the commercial sector and the public-sector run by the government. The public health services are divided into primary, secondary, and tertiary levels through medical institutes that are under the supervision of the provincial ministries of health.

The national Ministry of Health is in charge of developing and coordinating policy, while the provincial departments are the actual providers of the health workforce. The Constitution of South Africa gives every citizen access to medical treatment (Section 27 of the Bill of Rights). Public and private healthcare, however, are available to everyone, with access to private health services based on a person's financial situation. Private hospitals, which typically operate in urban areas, or individual physicians, who own private practices, provide healthcare services. About 8.8% of the nation's gross domestic product was spent on the healthcare system in 2012. The public-sector district health system, which is the preferred mechanism for health supply within a primary healthcare approach, is how the majority of individuals get medical services.

16% of the population is served by the private sector, while 84% is served by the public sector. According to the population distribution of the nation, around 64.7% of people live in the provinces, which are primary rural. Despite the fact that the majority of people live in rural areas, some of these provinces do have sizable cities.

### **6.3 Major Health Challenges**

There are numerous health-related issues that the South African government, national Department of Health, and KZN Department of Health must overcome. The complicated relationship between wealth and health, according to Bongani Mayosi & Solomon Benatar (2014), should be taken into account when looking at health in a broader perspective. When extreme poverty affects a large portion of the population, as it does in South Africa, health is primarily impacted by a lack of access to the necessities of life, such as clean water, nutritious food, effective sanitation, decent housing, access to immunizations, quality education, and the nurturing of children and adolescents, who, along with the availability of jobs, set the stage for improved health and longevity. Better access to primary and later advanced healthcare increases the likelihood of living longer and healthier lives in areas of less extreme poverty. Both extreme and relative poverty are significant. Disparities in health and well-being are less pronounced in societies with lower relative levels of poverty.

The origins and manifestations of both absolute and relative poverty in South Africa are similar to those of poverty worldwide. Beyond the abolition of statutory racial policies, South Africa has made progress over the past 20 years through significant economic growth, the emergence of the black African middle class, and a sharp increase in the monetary amount of social subsidies provided to the most vulnerable and unemployed. Improvements in population health are incompatible with the continuation of such inequalities. After a peaceful end to Apartheid and the establishment of a constitutional democracy in South Africa, significant social progress has been accomplished in the direction of ending the discriminatory practices that were prevalent in many facets of life before 1994. However, a relentless burden of infectious and non-communicable diseases, enduring social disparities, and lack of human resources to adequately care for a growing population with a rising tide of refugees and economic migrants continue to negatively impact the health and well-being of the majority of South Africans (Whiteside 2014, 652:166).

The socio-economic determinants of health (which are outside the health system) should be addressed as a national priority. The healthcare system should be strengthened and universal health coverage should be made easier. The prospects can be seen by considering several significant health issues as well as current trends in wealth, health, and medical staff. It is recognized that, notwithstanding South Africa's particular concerns, the world's population health challenges can be seen as a macrocosm of local problems (Benatar, 2002:347). The lack of resources, conspiracy theories, contempt for human dignity, the prevalence of HIV and AIDS, and the shortage of all health professionals, are some of the primary health concerns.

### **6.3.1 Lack of resources**

South Africans must devise a comprehensive plan to address social and economic inequality, end poverty, cut down on waste, boost efficiency, and encourage more community and individual control over all facets of life. This will require a full overhaul of the country's system for delivering healthcare as well as all pertinent institutions. According to De Beer et al (2011), there are currently 47.9 million people living in SA. Only 20% of the population has private medical insurance and is taken care of by it. This profit-driven industry uses 60% of the nation's healthcare budget and employs 70% of its medical professionals. Contrary, the state-run healthcare system provides care for 80% of the population, 50% of whom are unemployed. This industry is supported by tax money, accounts for 40% of South Africa's care spending, and employs 30% of the medical specialists. A significant attempt has been made to shift funding to primary healthcare in order to assist the majority of the population in light of historical healthcare disparities. Resources for high-tech medicine, especially intensive care, are very scarce. Additionally, South Africa has opened its borders to its neighbors since the democratic elections in 1994, which has led to an inflow of immigrants looking for, among other things, better health facilities. This only adds pressure to a system that is already struggling to care for its indigenous population. In South Africa, intensive care is also being severely impacted by the HIV and AIDS pandemic. Five million of the 40 million HIV-positive people in the world - or 12.5% of the population live in South Africa. These patients frequently necessitate lengthy hospitalizations in ICUs, adding to the burden on the system and straining already scarce resources. In addition to this issue, a nationwide survey of 222 healthcare facilities found that 16% of healthcare professionals are themselves HIV-positive.

Even though South Africa has a sophisticated health system in certain respects, the disease profile is more similar to a less developed nation.

### **6.3.2 Conspiracy theories**

An adequate constellation of services, good knowledge, education, and interpersonal relationships are all considered to be components of high-quality healthcare. According to Richards Stein *et al* (2021), people are frequently lured to complex conspiracy ideas rather than the plain facts. Conspiracy theories and false information have increased in response to the COVID-19 pandemic. Even though there is little empirical support for the antimalarial medicine hydroxychloroquine's effectiveness and safety in the management of SAR-CoV-2, the then-President of the United States of America, Donald Trump, praised it as a “game changer”. Others in the administration have promoted the unfounded theory that the SARS-CoV-2 virus started in a Chinese laboratory, despite the scientific community's consensus that the virus is likely started in an animal source before spreading zoonotically and the lack of evidence that the virus emerged as a result of purposeful laboratory manipulation of a related virus.

Early in May, conspiracy theorists made the widely circulated allegation that Dr Anthony Fauci, the director of the National Institute of Allergy and Infectious Diseases, and Bill Gates, the head of a philanthropic organization and founder of Microsoft, had conspired to use the pandemic to make money and seize political power. Some conspiracy theories are harmless and amusing, such as the notion that the Earth is flat or that the moon landing was a government hoax. Others are highly harmful and may create a disease outbreak, such as the idea that vaccines are a part of a plan to damage a large number of people. For example, the Earth is in danger because one-third of Americans think that climate change is a hoax created by the scientific community.

### **6.3.3 Disregard for human dignity**

Health professionals must respect everyone's right to be treated with dignity and respect. Every person has the right to achieve perfect health, and it is the state's duty to make these conditions available. According to Kateb (2011:06), all people are equal and only humans are equal to other species.

The idea of human dignity is comprised of these two fundamental tenets. When comparing species from an outside, unchanging perspective, the notion that humanity is unique enters the picture. Conceptually, human grandeur comes before individual position; human equality comes before human glory. According to Arthur Chakalson (2009:24), the theme of the year-long celebration of the Universal Declaration of Human Right's 60<sup>th</sup> anniversary is "Dignity and Justice for all". The preamble to the Declaration states that the advent of a world in which people will enjoy the freedom of speech and belief, as well as freedom from fear and want, has been proclaimed as the highest aspiration of the common people. This is because disregard and contempt for human rights have led to barbarous acts that have outraged the conscience of humankind.

#### **6.3.4 HIV and AIDS as an epidemic**

According to Gao *et al.* (1999), the idea that zoonotic transfer (the transfer from animals to humans), as is generally accepted in the scientific and biomedical sphere, was the initiator of the HIV epidemic is the basis for the claim that the origins of HIV are frequently linked to Africa. Questions like when, where, and how HIV first appeared, however, remain unanswered. nevertheless, all theories presuppose and elaborate on the idea of a zoonosis, regardless of whether they consider the so-called hunter theory (in which local people eat and hunt chimpanzees), the colonialism theory (in which local people's working and living conditions were severely affected and made worse by colonial forces, resulting in poor health susceptible to further weakened immunity), or the conspiracy theory (in which HIV was man-made and intended to control African politics and economics).

In South Africa, the costs associated with HIV infection and tuberculosis (TB) are significant. South Africa was given the most ambitious HIV target in the world by the WHO "3 by 5" initiative; to have 1 million individuals receiving antiretroviral medication (ART) by 2005 due to its comparatively well-developed public health system and access to cutting-edge technologies. Estimates for the middle of 2006 however, indicate that the WHO target is still unmet. Only 230,000 of the estimated 1 million HIV-positive South Africans who needed ART were actually receiving it. The incidence of TB/HIV coinfection adds to the complexity of the HIV epidemic.



The employment of community health workers (CHWs) in Lima, Peru, for instance, has significantly reduced the transmission of the illness. South Africa's TB rate, which necessitates even more complex treatment regimens, such as MDR-TB, is extremely high. Both TB treatment and ARTs have been employed via directly monitored treatment to assure adherence. Thus, a good CHW programme could have huge potential to help to stop the spread of both epidemics, despite the high proportion of TB and HIV coinfection in KwaZulu-Natal. The purpose of the current paper is to suggest strategies to enhance the current CHW programme in order to more effectively battle the spread of HIV and TB by examining the viewpoints of CHWs through an analysis of questionnaire responses, focused group discussions and individual interviews.

### **6.3.5 Shortage of all health professionals**

All categories of healthcare workers are in short supply, including nurses, physiotherapists, occupational therapists, pharmacists, doctors of medicine, speech and language therapists, and audiologists, all of whom are crucial members of the healthcare team (WHO, 2013; Kuehn, 2007). According to Frantz (2007), in 2000, there was a ratio of around 1:1 400 physiotherapists per 100,000 people in industrialized countries, compared to 1:550 000 in poor nations. According to Mars (2011), there were 2.5 physiotherapists and 2 occupational therapists for every 100,000 people in South Africa's public healthcare system. Physiotherapists in Australia are reportedly getting older, with 41% of those in practice in 2001 expected to retire by 2026, similar to the nursing, medical, and dental professions (Schofield & Fletcher, 2007). The capacity of many nations to meet the healthcare demands of their people is expected to be significantly reduced as a result of this pattern of aging healthcare personnel, which is a global problem.

Pharmacists are the third-largest group of healthcare professionals in the world and their unequal distribution between developed and developing countries has major effects on how many millions of people receive healthcare (Rennie & Anderson, 2013; Hawthorne & Anderson, 2009). According to Zweli Mkhize, who served as the National Minister of Health from May 2019 until August 2021, 90% of hospitals in rural areas in South Africa lack competent pharmacists? (Rothmann & Malan, 2011) (SABC News, 03 May 2020).

According to Manana (2013), there are only about 1 200 pharmacy graduates in South Africa each year, in part due to the university system's capacity having room for only so many new students. In order to secure a rise in graduates, the South African Minister of Higher Education and Training, Dr Blade Nzimande, made an appeal to all stakeholders (Nzimande, 2020). Additionally, there is a scarcity of nurses in South Africa's healthcare system. The lack of nursing experts is a global issue (Department of Health, 2013), not just in this country (Oulton, 2006, Brodie, Andrews, Thomas, Wong & Rixon, 2004). This shortfall is made worse in many nations by an aging nursing workforce and lower nursing recruitment (International Council of Nurses & Florence Nightingale International Foundation, 2013, Littlejohn, Campbell, Collins – McNeil & Khanyile, 2012). 43.7% of registered professional nurses in South Africa are over 50, and 30 000 will retire each year for the next 10 to 15 years (Department of Health, 2013). Despite the fact that 2 966 registered nurses completed the four-year professional nurse programme in 2011, it is stated that 40% of those graduates choose not to become nurses (Department of Health, 2013). Despite being the largest single group of healthcare workers in the health system and essential to the successful and efficient provision of healthcare, the Minister of Health was only moved to call for a nursing summit during a crisis, which took place in April 2011 (Department of Health, 2013).

The summit's subject, "Reconstructing and Revitalising the Nursing Profession for a Long and Healthy Life for all South Africans," (Department of Health, 2013,p.15) aimed to draw attention to nurses' worries about the future of their industry in relation to supplying South Africa's healthcare needs.

#### **6.4 Using innovation to build the case for action**

Innovation, in the opinion of Frieden (2014:17), is essential to the development of public health strategies and programmes as well as to laying the groundwork for designing and enhancing the technical elements of successful programme execution. Operational innovations can aid in improving the user experience of programmes. Innovations in programme assessment can help to build the evidence base for interventions by more accurately identifying treatments that are effective as intended, and those that are efficient and ready for scaling up. Programme management can be enhanced through the application of innovation in order to scale up, disseminate, and sustain high-impact interventions.

A new diagnostic technique, drug, or vaccine may have made it possible to achieve a goal that was previously unattainable. Thanks to new bacterial genome sequencing and bioinformatics tools, we may be able to discover outbreaks that we are presently unable to find, which may also help us better prevent and slow the spread of infectious diseases. Not all innovations are in the scientific or medical domains. Innovations in information technology, data collection, communication strategies, and issue-framing are necessary for progress and can increase political commitment. Though the persistent introduction and use of innovations such as new organizational techniques, methods for locating smallpox cases, tactics for determining which populations to target for vaccination, new types of needles, and methods for immunizing various populations, smallpox was eradicated. Innovative communication strategies, such as making the most of social media and other media developments and making a compelling argument for a certain course of action, can strengthen partnerships and draw in new collaborators. It is not required to create unique techniques from nothing everywhere, rather innovations that are begun and meticulously examined in other jurisdictions contribute to the corpus of information regarding effective public health efforts, enabling for their extension and wider implementation. Because many innovations are built on the foundation of currently accepted information or practices, many will advance research and public health practice.

## **6.5 Community participation and empowerment**

According to Frik de Beer and Hennie Swanepoel, community is often defined in terms of geographic vicinity, similar interests and needs, or in terms of deprivation and disadvantage (1998:17-23). Either the picture of the traditional African village, or the urban slum or squatter settlement, is implicit in the use of the concept (Migglet, 1986:24-25). Participation refers to the efforts taken by communities, groups, or people to advance, enhance, or alter a current condition. There are extremely few examples of participatory experiences from independent grassroots organizations and participation efforts are frequently top-down in nature (Burbidge, 1988:188). “Empowerment” is a learning process and a group action in which individuals acting on behalf of a common interest, sentiment, or concern. Outside support is also necessary for empowerment in the form of “skills and organizational training, loans, income-generating schemes, proper technology, education and access to essential services” (Racelis 1986:178).

According to Davis Zakus et al (1998:02), community or public participation in health can be defined as the process by which members of the community, either individually or collectively, with varying levels of commitment: (a) develop the capacity to assume greater responsibility for assessing their health needs and problems; (b) plan and then act to implement their solutions; and (c) create and maintain organizations in support of the community. Therefore, community involvement is a tactic that gives individuals the impression that they can address their problems via thorough consideration and teamwork. There are numerous individual elements that help to increase community involvement in health. According to conventional knowledge, one of the main benefits of community involvement is that it gives people a way to engage in activities that could improve their health. By educating patients, involving them in decision-making and empowering patients to take care of themselves, community involvement and the adoption of the *Batho Pele* principles are essential to empowering service users to take charge of their healthcare and that of their families. Communities as a whole need to be encouraged to participate in healthcare, not just individuals. The fight against AIDS has already shown the value of community involvement.

## **6.6 Partnerships between stakeholders**

In order to preserve and improve people's health, public- and private-sector partners have important duties, and public health is a field that is getting more and more complex. According to Frieden (2014:17), collaboration is frequently necessary for advancement. Getting multiple organizations to cooperate can be difficult and time-consuming, but it is frequently necessary to build the support required to execute new or enhanced programmes and provide for financial, legislative, or regulatory reform. When non-governmental organizations back government initiatives, they have an increased likelihood of success and sustainability. Partners can help and carry out important tasks, as well as improve the financial or human resources that are already accessible. By supporting disparate groups in reaching consensus and taking action to actualize a shared agenda, one can create powerful long-lasting coalitions that extend beyond a single topic.

A wide range of socioeconomic sectors, including education, business, law enforcement, transportation, agriculture, and labour can gain from public health initiatives, policies, and objectives. It can be difficult to forge and keep strong partnerships between organizations operating at different levels of government.

The allocation of responsibilities and funds, for instance, between the state and municipal health departments can be challenging and politically charged. The research on the sustainability of community health partnerships suggests accepting collective responsibility and mutual accountability, articulating a shared mission and vision to achieve common goals and maintaining focus in order to keep governmental and non-governmental partners coordinated and prevent turf wars and resource competition among partners. There might be ethical issues while forming public partnerships for public health.

### **6.7 Communication between stakeholders**

By involving various segments of civil society and influencing the public's view of an issue, good communication can affect behaviour but, more crucially, it can boost political commitment and programme efficiency. The internet, social media, and other communication technologies have increased the amount of information available from more sources than ever. However, some of it may be false or even harmful, according to Frieden (2014:17). New communication techniques and technologies enable interactive dialogues between public health professionals and people of impacted communities and other stakeholders. Public health messages may be drowned out by the abundance of communication channels and voices if timely, well-defined, well-executed, and sustained communication tactics are not used to achieve specific goals.

The backdrop for public health action can be changed by effective communication, which can also persuade significant individuals to endorse or lead a project. Effective communication has the power to modify behaviour across the board and affect societal norms. With more knowledge, people and communities may make wiser choices regarding their health and public health programmes. Different audiences must be presented with different types of facts in different ways in order to get the desired result. Healthcare professionals need up-to-date information, which can be provided through traditional channels like publications and medical association advice, as well as through electronic outreach, measuring systems, and other more contemporary communication channels that can aid in navigating a clinical and healthcare delivery environment that is frequently changing. In order to make informed decisions, decision-makers need accurate, timely, and succinct information about the financial and medical effects of various policy options.

A successful programme must effectively communicate both its successes and advantages as well as the dangers to health and health equity, using stories and case studies to support these notions. Giving abstract data a human face can help decision-makers understand that people's health and lives are on the line. The business community needs information proving the business case. The introduction, justification, mobilization of support and facilitation of the execution of public health policies and programmes are frequently dependant on media framing and news coverage. by providing accurate, timely, and convincing information that includes data on outcomes. Public health organizations can increase their credibility with prospective stakeholders such as decision-makers, healthcare providers, the general public and private programme funders. Communication is also crucial for saving lives in an emergency. In a situation where things are changing quickly, it may be necessary to communicate instantly and clearly with the public, first responders, and other organizations. Even when a public health emergency develops more gradually, it may still be necessary to transmit new information as it becomes available in order to carry out specific actions and reduce uncertainty and mistrust.

## **6.8 Policymaking**

According to Oliver (2006), research can pinpoint answers to urgent public health issues, but only politics can make the majority of those solutions a reality. He asserted that there are numerous factors that make population health a political concern. First, both individual and institutional actions frequently have unfavourable repercussions. Making political judgements regarding when and how to impose limitations is necessary to compensate for these impacts. Second, governments have a responsibility to recognize and meet a range of social and physical demands from society. Third, safeguarding public health includes moral judgements and values that are more a function of political structure than of scientific knowledge. These ideals can encourage the political agenda to include some public health measures. Fourth, social stability and economic progress depend on a healthy populace and labour force. Humphrey's et al (2012) contend that because science also has limitations on how health policy decisions are made, scientific evidence alone is insufficient as a foundation for health policy. As a result, it's crucial to take into account society and governmental values. Social health disparities and the many initiatives taken to close them can be prioritized in this perspective (depending on the government and social values).

Furthermore, because they are primarily focused on targeted treatments, city policymakers rarely understand the underlying causes of health inequality and health policy documents from cities occasionally fail to address these issues. Implementing policies at the neighbourhood level that direct more resources to areas with the greatest needs is one method of tackling inequality. It is important to note that the persistent structural inequalities caused by political decision-making, the availability of neighbourhood amenities, neighbourhood economic development, and resident democratic traits are what cause health inequalities in neighbourhoods. Health inequalities will be a priority for governments that prioritize social justice and they will allocate a particular budget to address them.

## **6.9 Procedural package**

According to Frieden (2014:17), the most effective public health programs are based on a set of practice standards that are backed by data. A well-designed group of related interventions that, when taken together, will significantly and sporadically improve the outcome of a particular disease or risk factor. A procedural bundle of proven interventions clarifies and concentrates what could otherwise be vague promises to activity by committing to the implementation of certain actions that are shown to be beneficial. Additionally, it avoids a disjointed approach of using a variety of therapies, many of which have insignificant results. Simplicity is the key to success. A procedural package ensures that the best, most useful, and longest-lasting interventions are selected and can occasionally foster synergy between various intervention elements. The creation of a procedural package may be challenging due to pressure to include all methods. It is unlikely that a procedural package with inclusivity of approaches as a goal can succeed. The secret is to find components that can be sustained over a long length of time and are both extremely effective and able to reach populations of different sizes, demographic compositions or geographic locations. Due to their small size, inability to be sustained, inability to be scaled for population impact or other factors, certain interventions with a track record of effectiveness may not be included. A crucial and perhaps contentious idea is feasibility. How quickly and widely public health programmes can expand their reach is realistic, with independent but linked constraints on financial and human resources, institutional capacity, quality of the healthcare system, behaviour change and politics.

Making an effective intervention package requires a thorough understanding of the whole range of available evidence-based techniques, the size and makeup of the population to be targeted, the expected impacts of each intervention and estimated costs. With rising expense or complexity, each intervention's potential to significantly affect a broad population will decline. A technical package with more strategies will produce more expensive, cumbersome programmes with a lesser chance of success. Though a study that quantifies the burden each risk factor generates, it is possible to identify the risk factors that have the greatest impacts on population health and, if effectively addressed, can result in the greatest benefits in health. Occasionally, organizations, doctors, or advocates might demand individualized treatment plans. Although it is theoretically conceivable for patients to benefit from individualized care and treatment plans, doing so may make it difficult or impossible to develop a workable set of procedures that encourages universal acceptance of at least a minimal standard of care. The management of HIV, drug-susceptible tuberculosis, and malaria, as well as standardization of immunization protocols, have reduced the cost of medications, made programme implementation and supervision easier, and improved the ability of nurses and other trained health workers to initiate and monitor treatment. All of these are elements that are essential for a successful scale-up. According to a policy on Quality HealthCare for South Africa, there are four main intervention goals: health professionals, patients, the community, and the health service delivery system.

### **6.9.1 Interventions aimed at health professionals<sup>8</sup>**

The speed of change and innovation in medical procedures is one of the biggest problems facing health practitioners. The interventions that can be used to screen for diseases, stop diseases from emerging, diagnose, treat ailments, and track the progression of diseases advance every year. The task of keeping up with these developments is onerous. Additionally, there is a tremendous amount of information available to health professionals and managing this information overload is a significant difficulty. A health professional's erroneous, out-of-date or outright lack of knowledge or abilities is one factor that contributes to issues with quality of care. Continual professional development is the standard strategy for keeping health professionals current.

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<sup>8</sup> A policy on quality in healthcare for South Africa, 2007



### **6.9.2 Interventions aimed at patients<sup>9</sup>**

Partnerships between the patient and the practitioner are becoming increasingly important in healthcare. Health outcomes are positively impacted by better patient-provider communication and by giving patients clear information about their conditions and available treatments. Single initiatives, such as user-education strategies, are frequently ineffective on their own, much like changing practitioners' behaviour to improve quality. Instead, a number of strategies are needed.

### **6.9.3 Interventions aimed at the community<sup>10</sup>**

The active involvement of entire communities is just as crucial to enhancing quality as individual patient participation. This has been amply illustrated by the crucial role that communities have played in the battle against HIV and AIDS. To mobilize community action and advocacy around health issues, partnerships with community structures like non-governmental organizations (NGOs) and community-based organizations (CBOs) are crucial. Domestic violence, road safety, environmental awareness (such as preventing the pollution of rivers and groundwater, waste management, and sanitation), and efforts to raise awareness of common illnesses and ailments like HIV and AIDS, diabetes, hypertension, and obesity are a few examples. In addition, NGOs and CBOs are essential to the provision of services including home-based care and community health workers. The participation of the local community in local decision-making on health issues that are important to the community is facilitated through representative structures like clinic committees and hospital boards.

### **6.9.4 Interventions aimed at systems<sup>11</sup>**

The greater attention being paid to systematic issues has perhaps been the most significant innovation in quality improvement. Systems can be changed to eliminate errors and raise the standard of healthcare delivery by recognizing systematic flaws that lead to errors in procedures or results. It is possible to track, assess, and make future adjustments based on the outcomes of system changes.

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<sup>9</sup> A policy on quality in healthcare for South Africa, 2007

<sup>10</sup> A policy on quality in healthcare for South Africa, 2007

<sup>11</sup> A policy on quality in healthcare for South Africa, 2007

As part of ongoing process of assessment, redesign, monitoring, and evaluation, it is made sure that systems are continuously assessed and, where appropriate modernized, to increase quality.

### **6.10 Managing performance**

Many public health project implementations are essentially a managerial concern. Even if there is political support, financing, and a technical package, effective management may still be impossible. Frieden (2014:17) argues that managing public health activities is particularly difficult because there is frequently no automatic, accurate, or cost-effective way to track programme performance in real time. This is in contrast to the private sector, where metrics like product sales provide quick feedback on performance. Evaluation of performance is made more challenging by the fact that the efficacy of public health efforts may take months or even years to become apparent. For the implementation of public health programmes and the surveillance of diseases or risk factors, reliable, timely information systems are required. To provide a transparent, truthful service, any efficient technological package includes surveillance and information systems that can be maintained and provide timely and critical information on programme execution and impacts over the long term. Monitoring and evaluation must be meticulous and incorporate safeguards against data bias and overconfidence in programme effectiveness, if progress and sustainability are to be achieved. Honest and open evaluation of progress, or its absence, even when doing so is momentarily uncomfortable or unpleasant due to a lack of resources, such as meeting spaces and buildings with kitchens. Churches may also give access to organizations that already meet regularly for services on a weekly basis and ongoing events like Sunday school and Bible study. In addition to frequently establishing health committees and taking part in community outreach initiatives like soup kitchens, many religious organizations consider health as part of their purpose or ministry. Given that they usually have members who attend regularly over many years and are generally solid institutions, churches can offer an appealing platform for recruiting and keeping participation. Due to recent economic changes and globalization, other institutions such as workplaces have become less stable, making it more challenging to hire new employees and keep track of their overtime. Therefore, it is more important than ever for health researchers conducting community-based intervention research in organizational settings to find alternatives, like churches.

Recent legislation has enhanced access to resources for churches and other faith-based organizations to conduct health programmes by granting government money for initiatives like substance misuse counselling. On both sides, though, questions have been raised regarding the separation of Church and state. Numerous initiatives, in particular, have targeted Black churches as a setting to lessen inequality between African groups. For many Africans, the Reformed churches have served as the epicentre of their social, religious, and political lives for a very long time. In the past, the Reformed churches' missions have gone well beyond the usual roles of worship and spiritual development. Numerous Reformed churches also support the social, economic, and political well-being of their members and the neighbourhood as a whole. Reformed churches participate in outreach initiatives to provide the community with health information and to meet their health needs.

Pastors give congregations leadership for social action and community outreach in addition to spiritual problems. The Church is frequently one of the most well-known, well-regarded, and reliable institutions in the neighbourhood and as a result, the credibility of public health organizations that collaborate with Reformed churches may be significantly increased. Programmes for health promotion run by churches have been implemented in rural areas and have the ability to lessen gaps between various ethnic groups. In certain populations and societies, religion may play a significant role. However, the communities may differ significantly in a number of ways, including the population's demographics and health issues, how health fits into the congregation's and its leadership's objectives and priorities, and the kinds of programmes and messages that are thought suitable and practicable. As a result, it cannot be presumed that programmes that have been successful in one community or religious institution will function similarly in another. One of the most significant changes in the Church today, according to Bosch (1995:467), is the transition from seeing ministry as the sole province of ordained men to seeing it as the duty of all God's people, including ordained and non-ordained.

## **6.11 Political commitment**

Political commitments are formed and supported by the aforementioned factors, all of which are crucial for giving the government a strong foundation on which to operate. According to Thomas R. Frieden (2014:17), effective political engagement yields the resources and support necessary to develop, implement, and sustain public health interventions, including policy reform where appropriate. Organizations that carry out public health programmes normally managed by departments of public health or other governmental institutions might not have as much influence over budget and policy decisions as other branches of the government or members of civil society. Change is often unpleasant. Interventions have an impact on many parts of society, some of which may be passionately opposed to public health concepts. Even when a public health initiative provides huge social advantages overall, its opponents may be vocal, well-funded, and well-organized and their opposition may have a sizeable political influence. Many public health policies such as those to reduce tobacco use, benefit tens of millions of people (smokers and those exposed to second-hand smoke in this example), yet they frequently conflict with the interests of a very tiny but powerful organization, in this case the tobacco industry.

Political commitment must be successful in overcoming opposition to public health programmes by special interest groups like the tobacco industry. This requires an understanding of industry tactics, effective communication with stakeholders, the people who receive benefits from particular public health programmes may not be aware of the health and other advantages they have received or may not know that these programmes fall under the purview of public health. They may also be only moderately vocal in their support for programmes and services, and in some cases, may even be politically marginalized. Public health programs benefits being better known can improve advocacy and lead to higher levels of political commitment. Because the “prevention paradox”, which states that “a preventative intervention that gives substantial benefits to the community offers little to each participating individual”, public health programs are occasionally not embraced. Instead of making big changes for fewer people, huge improvements in population health frequently result from minor adjustments for many people.

## **6.12 Conclusion**

This chapter has explained effective public health policies and practices and the improvement of healthcare treatment through policies and practices as a basic philosophy that seeks to improve the ability to prevent, diagnose, and treat conditions that are common, costly, or significantly reduce health or functional capacity. Topics that were covered are in line with the core values of the KZN Department of Health and Christianity that uphold that humans made in the image of God and thus have the ability to change their circumstances of public health. A national commitment to measuring, improving and maintaining high-quality healthcare for all of its residents is necessary to achieve the goal of a quality healthcare system. This entails assessing the discrepancy between expected behaviour and actual practice, and devising solutions to narrow it.

## **CHAPTER SEVEN**

### **DISCUSSION OF THE FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS**

#### **7.0 Introduction**

This chapter provides a summary of findings, conclusions, and recommendations from the findings drawn from the study. It is important again to consider the aims and objective of this study in order to establish if they have been achieved. The purpose of the study as stated was: a Reformed critique of public health policies in KZN. The objectives of the study were to: Critically examine KZN's public health policies and practices considering Reformed theology doctrines, recognize the public health policies that are relevant to Reformed theology, identify opportunities and challenges that emerge from public health and Reformed theology, create a reasoning model that shapes activities, formations, and consequences to strengthen collaboration between public health and Reformed theology and to create a self-assessment procedure on how dialogue may be initiated between the state and the Church.

Nine individuals, members of the Greytown Uniting Reformed Church in Southern Africa, were invited to participate in this study. A purposive sampling method was used to select participants with strong experience engaging or working in the Church, or with the KZN Department of Health respectively. The findings from this study provided a greater understanding of the strengths of, weaknesses of, and barriers to current collective efforts based on the perspectives of the respondents. However, these views are not necessarily reflective of all churches in KZN. The results from the study supported the literature in demonstrating that there is openness and benefits to relationships, and that trust, personal relationships, and unified priorities strengthen the effectiveness of the relationship.

The primary results from the study established that Reformed theology and public health from KZN desire to work together with each other. Hindering the current relationship is a lack of understanding from each other about the actual needs of these two worldviews. When respondents were asked about the alignment of Reformed theology and public health, the most common response was both these worldviews must be aligned.

The literature suggests that common barriers to the relationship between Reformed theology and public health include practical barriers, such as lack of communication and personal relationships, as well as fears based on religious programmes or moral judgment. Examples of effective collaborative models in Greytown Uniting Reformed Church suggested that relationship was desired for both worldviews, but restricted until mutual trust and a common agenda were established. The researcher considered that the study findings in the Greytown URCSA congregation would likely resemble barriers in other regions of Kwazulu-Natal and hoped that sharing perspectives from both sides would lead to new combined strategies being identified and practised. The researcher was able to establish through in-depth interviews public health policies and practices considering Reformed theology doctrines, Public Health policies that are relevant to Reformed theology, opportunities and challenges that emerge from public health and Reformed theology, a reasoning model that shapes activities, formations and consequences to strengthen collaboration between public health and Reformed theology and a self-assessment procedure on how dialogue may be initiated between the state and the Church.

### **7.1 Findings of the study**

The findings show that health is thought of as something holistic in nature. The understanding of public health policies goes far beyond the constricted human life. From the holistic concept, health includes everything that makes humans exist for the rest of life. Looking at the responses from the participants on the understanding of public health policies and practices and Reformed theology, the research clearly shows that a holistic understanding and meaning of both worldviews has a direct implication in community at large. Health is known as the completeness of an individual, which includes the physical, emotional, mental, and spiritual. It also involves having a sound relationship with anything that contributes to the health of an individual, such as the environment and healthy relationships with other people. A review of the research suggests that churches wanting to facilitate stronger relationships to effectively serve people need a greater understanding of the health sector and knowledge of key players within the department. Public health policies were identified as a positive and tangible way to bridge the lack of personal relationships with health workers as well as deepen understanding of the complexities of the health sector, identify tangible needs churches can meet, and create greater empathy. Further research needs to be conducted on the effectiveness of public health policies with a focus on determining how best to implement them.

### **7.1.1 KZN's public health policies and practices**

Public health practices and policies were developed in KZN to increase access to and the calibre of healthcare for all residents and vulnerable populations like children, expectant women, and people with disabilities. According to Daniel Simbeye (2013), several research projects have demonstrated increasing use of medical services after the adoption of public health policies and practices. The study has revealed the limited knowledge among respondents of the foundation of public health policies and practices; varied understanding about the content of the policies, including the purpose of the policies and the eligibility criteria to access healthcare; and inadequate knowledge on the specific roles of implementers. The study respondents reported unpredictable implementation of public health policies and practices in KwaZulu-Natal.

Some participants presented barriers to their understanding of the policies and practices, content, providers involved, and their responsibilities as well as barriers to effective implementation of public health policies and practices. Some of the barriers highlighted by respondents to understanding of the policies include: lack of awareness of the existence of policies by some health service personnel; lack of consultation during the developmental process of the policies by the implementers; inadequate information about the policies to health service personnel; lack of translation of the policies, as they are usually written in English despite the fact that they are Zulu speakers. This study revealed a general lack of understanding of the policies by some respondents due to poor communication strategies. Lack of communication strategies may result in poor understanding of the rationale for the policies and practices, the content of the policies and practices, and the responsibility of the communities.

Good communication regarding elements of policies would allow for relevant stakeholders and beneficiaries of the policies to understand, own, and actively participate in their implementation. Respondents of this study recommended the creation of awareness of the implementation of public health policies. Creation of awareness would include: the development of pamphlets and posters about the policies; translation of the policies and practices, as well as pamphlets and posters, into local languages such as isiZulu. Use of national and community radio stations, putting up posters and pamphlets at health facilities, as well as distribution of pamphlets at community events, such as *Izimbizo*, would facilitate awareness of public health policies and practices.



Furthermore, a communication strategy for implementation of public health policies and practices may include: conducting road shows, and workshops with all relevant stakeholders such as religious leaders, traditional leaders, and NGO's.

### **7.1.2 Public Health policies that are relevant to Reformed Theology.**

All participants are in agreement that Reformed theology and public health should be aligned. There must be forums that bring the two together and offer platforms for the exchange of ideas and thus a way to educate each other. There must be collective community outreach, which both of the above entities are part of and work together to bring about change. Those outreaches must include other stakeholders, such as social development, the police, and municipality via its councillors, educators, and home affairs officials, so that everyone can get the opportunity to take responsibility in helping the community in the presence of others. According to Marci Kramish Campbell et al (2006), it is becoming more typical for health advancement programmes and studies to be carried out in churches and other faith-based organisation (FBO) groups. Since most people frequent churches or other structured religious institutions, this venue is ideal for reaching and recruiting potential participants in public health programmes.

Across all religions and populations, belonging to a religion and going to church boost physical and mental health. There are several possible explanations for this connection, such as the beneficial effects of social networks and the social support offered by peers, as well as the significance of prayer, religious practices, and beliefs for psychological well-being. Following the tenets of numerous religions such as Judaism, Islam, Mormonism, and others, which forbid the intake of foods and substances like pork, alcohol and cigarettes, may have positive health effects. Certain religious groups – such as Seventh-Day Adventists – practice vegetarianism, which may result in reduced intake of saturated fat and higher intake of fibre, fruits, and vegetables when compared to other populations. Numerous dietary studies have focused on Adventists in particular and have shown important nutrition–health relationships, such as the advantages of maintaining a lean body weight over the course of one's life and the prevention of coronary artery disease by certain dietary habits, such as eating a lot of nuts.

Typically, churches have the facilities; like buildings with kitchens and meeting rooms; needed to promote health. The following public health policies and practices which are health-promoting behaviours were highlighted during the data collection and interviews with participants: Choice Termination of Pregnancy policy, 909090 Policy, Family Planning policies, Supply Chain Management system (SCM), Batho-Pele principles, Health and Safety, Infection Control, Patients' Rights, National Core Standards, Ideal clinic, National Health Insurance, Food and Safety Policy, and Practices for Healthy Living. In order to create congregation-healing communities, Peter Okaalet (2006:677) suggests that health committees be established at the local level in each congregation. These committees should concentrate on increasing awareness and promoting prevention, providing in-home care and support for individuals who have been infected or impacted, looking after orphans and advocating for change at all societal levels. The Church can play a significant role in the fight against HIV/AIDS and other diseases due to a variety of circumstances. These include its proclamation, persuasion and long history of presence, as well as its sophisticated architect. The Church is also self-supporting, has a faithful following that gathers each week, reliable leadership, transcends borders of geography, ethnicity, nation, gender, and others, has grassroots support and speaks the local language. More than this, it possesses the Bible, a holy book that has been tried and shown to be successful at altering behaviour and values, and it can provide hope that endures after death.

It must be noted that in this study the state is represented by the Department of Health and religion is represented by the Church. An important finding on the collaboration between state and religion to improve the public health system in KZN showed that religion plays a very important role in impacting the agency of health seekers and health providers. An answer to the question on the state and religion collaboration is very clear: religion is perceived and treated as a positive agency that contributes to the health and well-being of people. It is interesting to observe from the response given, the respondents mention the role which religion plays or serves as a motivation for health-seeking and for the health providers to locate the place of religion in their health provision. The observation from the responses shows that religion is not just perceived as playing a very important role, but is consciously treated as an essential entity in health matters.

Note, for example, a response from one respondent when she said that faith or belief in the highest being is a dominant aspect of health-seeking, because health and religion are both gifts from God. These two are closely connected, so when one is sick, there is an inner belief of receiving healing from the giver of health: God, so prayer and hope are subsequent results of this belief in the highest being. The Judaeo-Christian tradition describes God from a variety of relationship perspectives.

The prehistoric relationality of creation as it is described in the Genesis texts comes first (GN1:1-3:24). Israel's sense of election into a covenantal relationship with the God who is Lord of all is the source of this creation story. The opening of Genesis depicts humans as having been made in God's likeness (Gn 1:26). Humans realize their purpose by taking part in the divine creation. As human agents live out the fundamental relationship at the centre of their existence, human action is a product of God's creative power. In their heavenly beginnings, individuals assume a mutual form. The most important aspect of how humans relate to God, who decided to have a relationship with them, is the foundation of that connection. It is a historical fact that the Christian vision and its principles have significantly influenced ethical thought and action as healthcare delivery models evolved.

Additionally, theologians like Richard Osmar, Jim McManus, and Stephen James Heinrich Hendricks have recently gained a reputation as highly regarded experts in medical ethics. Scientifically-based models of health have been formed and supported by a range of Christian perspectives. Christian theorists were not content to only provide a theoretical or inspirational contribution to difficult medical problems. Instead, they engaged with specific cases while fully aware of the lack of a straightforward "religious answer" in the face of such difficulty. These theologians do, however, share the idea that religions perspectives offer a framework within which ethical consideration and decision-making in the field of health might be more critical and effective. Therefore, it is appropriate to investigate the type of religious outlook or theological framework in question further. In contrast to the past, modern and African medicine provides the sick and the suffering a variety of frequently astounding alternatives. The findings show that religion is something that cannot be ignored in health-seeking and provision. Mokgethi Motlhabi (2001<sup>10</sup>) articulates that following the Reformation, however, there has been greater consensus that the powers of the state and the Church should be separated – on the basis that one wields spiritual power and other earthly power.

Many centuries ago, Augustine had distinguished between the City of God and the earthly city and described their different qualities and roles. Following in his footsteps, Luther and Calvin much later were to specify the roles of the “Two Kingdoms”. While seen as separate in their spheres, the Church was allowed to maintain the prophetic role of admonishing the State against godliness and injustice. Though Reformed theology is not immediately recognised in health arrangements, this study has shown that its presence adds an exceptional value to the well-being and health of people. Some of the important findings on the value added to health services by the religious health establishments are, first that religious entities offer voluntary and free services to the community and have ready personnel willing to offer services of compassion and care, which is not the practice among the public health system.

The findings highlight the following intangible assets which contribute to health: prayers and personalised counselling stand out as a common asset - the presence of a spiritual leader such as a pastor or psychosocial Christian counsellors to give prayers and Biblical and specialised counsel. The nature of assets given is intangible and yet rich in the results. The prayers and the specialised counselling provides to the patient or client the resilience, hope, information on health-seeking behaviour, motivation to trust and hope for healing, and a sense of belonging and acceptance which ultimately creates a positive attitude in health outcomes and the people's well-being. It is worth noting that love and acceptance are virtues that are richly present in religion, especially in the context of HIV and AIDS, to which Reformed theology contributes. According to Vuyani Vellem (2010:101-119), there is little doubt that the confessions of our Reformed religion and other writings that date back to the 16<sup>th</sup> century, including Calvin's teachings, include the origins of public theology (Ferguson 2004:107). The Belhar Confession is a fantastic example of how confessions in this tradition for our South African culture are made public. The Reformed tradition has always extended beyond the walls of the Church in its endeavours to build a civic government based on the word of God. The myth of Calvin's theocracy has been a problem for the Reformed faith, because John Calvin's teachings included almost every aspect of society and the need for continual reformation of the entire community, according to Bieler.

### **7.1.3 Opportunities and challenges that emerge from public health and Reformed theology**

Participants implied that religion, as a system of meaning, demonstrates the possibility of beneficial community development at all levels. Prevention and healing are the two main ways that a person's personal well-being can be enhanced. In addition to providing protective elements like a value for life, religious coping mechanisms, and social and spiritual support systems, which frequently serve to increase resilience in the face of significant life stressors, religion also contributes to prevention through individual and communal preparations and prohibitions regarding lifestyle choices, healthy behaviours, and purposeful understanding and goals, all of which directly improve health and well-being (cf. Pargament, Maton, & Hess, 1992; Winett et al., 1999).

According to Kenneth I Matonet et al (2005), religion also contributes to health-giving through a variety of means, including spiritual support from pastoral counsellors, other believers, and spiritually-based self-help groups, as well as personal spirituality, self-value and self-acceptance, and concurrent special interactions, among other things. There are potential detrimental repercussions of religion as a sensory system in addition to the good effects of religion for the individual. Numerous aspects of religion have the potential to have a negative impact on people's motivations, emotions, beliefs, and behaviours. When viewed from a group perspective, religion's meaning system has the potential to significantly uplift the morale and enable a variety of social groups, perhaps most notably those who experience oppression and discrimination as well as those who have few financial and political resources. As a result, at local, state, and national levels of government, social and political activism in support of ethnic minorities and lower-income groups has been organized using religion as an important structure.

The affiliation and significance of religion can also be perceived as a barrier to group empowerment. For instance, some theological ideologies may encourage social groups to isolate themselves from the greater community or to place more emphasis on personal salvation than on reforming repressive social norms and laws. Furthermore, historically, social groups like women, gays and lesbians, and ethnic minorities have been oppressed rather than empowered by particular religious doctrines and systems.

Faith-based organizations have frequently supported such initiatives by continuously mobilizing volunteers and financial resources, by offering social assistance programmes, and by gaining access to underserve and difficult-to-reach ethnic minorities. For instance, congregations frequently play a key role in the development of mentoring and volunteer programmes for schools and troubled youth, the formation of coalitions to address issues facing the entire community, and the generation of sizeable financial contributions that are directed to a variety of social programmes.

Religious organizations frequently are one of the few enduring community structures existing in our most difficult urban and lower-income communities. The potential benefits of religion aside, religious organizations and activities can also play a significant role in societal ills. For instance, rather than enhancing community capacity, religious differences can foster prejudice, distrust, and intergroup conflict. When religious inequalities are linked to social status discrepancies and, in turn, to unequal access to political and economic power, such issues may become even more serious. Churches may also give access to organizations that already meet regularly for services on a weekly basis and ongoing events like Sunday school and Bible study. In addition to frequently establishing health committees and taking part in community outreach initiatives like soup kitchens, many religious organizations consider health as part of their purpose or ministry. Given that they usually have members who attend regularly over many years and are generally solid institutions, churches can offer an appealing platform for recruiting and keeping participation. Due to recent economic changes and globalization, other institutions such as workplaces have become less stable, making it more challenging to hire new employees and keep track of them over time. Therefore, it is more important than ever for health researches conducting community-based intervention research in organizational settings to find alternatives, like churches. The availability of resources for churches and other faith-based organizations to conduct health programmes has risen as a result of recent legislation, which provides government support for initiatives like substance misuse counselling. On both sides, though, questions have been raised regarding the separation of Church and state. Numerous initiatives, in particular, have targeted black churches as a setting to lessen inequality between African groups.

For many Africans, Reformed churches have served as the epicentre of their social, religious and political lives for a very long time. In the past, the Reformed churches' missions have gone well beyond the usual roles of worship and spiritual development. Numerous Reformed churches also support the social, economic and political well-being of their members and the neighbourhood as a whole. Reformed churches participate in outreach initiatives to provide community members with health information and to meet their health needs. Pastors give congregational leadership for social action and community outreach in addition to spiritual problems.

The Church is frequently one of the most well-known, well-regarded, and reliable institutions in the neighbourhood, and as a result, the credibility of public health organizations that collaborate with Reformed churches may be significantly increased. Programmes for health promotion run by churches have been implemented in rural areas and have the ability to lessen gaps amongst various ethnic groups. In certain populations and societies, religion may play a significant role. However, the communities may differ significantly in a number of ways, including the population's demographics and health issues, how health fits into the congregation's and its leadership's objectives and priorities, and the kinds of programmes and messages that are thought suitable and practical. As a result, it cannot be presumed that programmes that have been successful in one community or religious institution will function similarly in another. One of the most significant changes in the Church today, according to Bosch (1995:467), is the transition from seeing ministry as the sole area of ordained men to seeing it as the duty of all God's people, including ordained and non-ordained. The institutionalization of church offices is one of the characteristics of the Constantine special treatment, according to Boerwinkil (1974:54-64), and the present "forfeit" of the Church indicates the end of Constantinianism. Christian theology will no longer be limited to being a theology for priests and pastors, but will also include a theology for the laity in their mission in the world, according to Moltmann (1975:11), who has stated six viewpoints on the task of the Church and theology in our day.

Last but not least, at the societal level, religious standards can, at their best, test an excessive cultural focus on greediness, egoism, and national interests focus on developing those who lack status and power in society, and promoting a sense of common cause, which exceeds group-focused and society-focused margins. On the contrary, in terms of culture and society.

According to Steve De Gruchy (2015: 270), at its inaugural meeting in Geneva in 1952, the WHO defined health as:

The art and science of preventing disease, endorsing health and efficiency through synchronized community determination for conservational cleanliness, infectious contamination control and personal cleanliness education, the organization of health and treatment facilities for early identification and preventative management of disease, and improvement of societal equipment to confirm that every individual has a standard of living adequate for the preservation of health.

This definition gives expression to the most important hypothesis of public health; namely that while individual health requires individual intervention, the health of citizens as a collective is dependent upon public intervention and public agencies. Hence the WHO suggests that community efforts, control, education, organisation, and social machinery are required to ensure a standard of living adequate for health. The partnerships for policy implementation should be established to increase the ability of communication between churches, Non-Governmental Organisations (NGOs) and the KZN Department of Health.

Churches and Non-Governmental Organizations (NGOs) have a long history of individually and jointly organizing health promotion initiatives in fields like health education, dietary counselling, and mental healthcare. About these programmes' effectiveness, though, little is known. Such programmes may be delivering anticipated – but unmeasured – benefits to community health if they consistently give people access to particular types of care. The aim of both churches and health is to create and put into place a workable, coordinated, unified, and whole health system at all levels. Both rural and urban communities are a part of KZN.

In order to provide healthcare services to rural communities without access to clinics, community health centres, or hospitals, the then-KZN Health Minister, Dr Zweli Mkhize, introduced the Community Health Programme in 1994. This locally based education and treatment programme is typically available to people who are living in poverty and/or those who do not have health insurance coverage. The Community Health Worker Programme (CHWP) is a programme that is supported by the National Department of Health and KZN Health Department that addresses barriers in access related to service delivery. The community-based health programme is found in communities where the services are needed the most, and the services are tailored to the populations of residents.



The Department of Health can benefit from the rich heritage of Western missionaries. This history provides a variety of instances and role models that could help motivate healthcare professionals and the general public. The new relationships that emerged in the communities through partnerships reflected the core character of the early Christians. Notably, these relationships included the acceptance of one another as brothers and sisters from Jews and Romans, Greeks and barbarians, free and enslaved people, the rich and the destitute, and men and women (Bosch, 2008:48).

Bosch essentially lists this as one of the five pinnacles of the early Christian mission that Christ Himself played a part in.

- House visits were primarily the responsibility of missionaries. This feature turned out to be a really helpful tool for members to grow spiritually. Additionally, it was a good chance to share the Gospel with the “unchurched”, creating a welcoming atmosphere for enlisting new members.
- It will help to reinstate it if the elders are taught that it is their responsibility to do the house visiting duty.

The issue that also comes up often in the KZN Department of Health is that there are two forms of community participation. One is “active” participation and the other is “passive” participation. So, politicians, e.g. ward councillors, will always refer to their communities as being active in decision-making e.g. in the war room concept that Hon Minister Dr Zweli Mkhize started when he was premier, versus the passive participation where communities will tell you that they are taken for granted and are only consulted at election time whereas the rest of the time they never see some of their ward councillors.

Swanepoel & Frik (2016:107) articulate the importance of community participation as follows:

- Effective problem-solving will result from people and groups taking an active role in the promotion of their well-being through community action.

- Encouraging ongoing participation in the planning and monitoring of existing services, facilities and projects as well as the extension or alteration of successful projects entails improving community's capacity to make informed decisions and prioritize needs. It also promotes the legitimacy of any institutional structures established within the community.

The last level of participation aims to actively mobilize community resources and assets (both natural and human) for the advancement of project goals. The KZN Department of Health must involve religious leaders so that they will focus on pastoral counselling instead of focusing only on preaching and praying. Preaching and prayer are very important, but do not fill the gap for pastoral counselling where a person speaks to someone about his/her challenges and fears. Both these worldviews must speak one language and message so that they do not confuse people.

Counselling, according to Nicholas Owino Onyachi (1988), is essentially a partnership in which one person supports another in understanding and resolving their difficulties. It thus has a purpose as a supportive connection. Pastoral counselling would then refer to a supportive relationship as God has made it known to us. Counselling also improves self-worth and produces outcomes because it is a two-way conversation between the counselled and counsellor. This two-way communication, for instance, has a depth component. The client develops a much deeper knowledge. This leads to sounder and longer-lasting solutions. Delivering health services effectively depends heavily on the collaboration between public health and Reformed theology.

Delivering health services effectively depends heavily on the collaboration between public health and Reformed theology. According to Katherine Marshal and Marisa van Saanen (2007:14), partners should clearly state what they expect from the relationship over the long term, including whether they have an "exit strategy", will still be interested in the project, or prefer a more open-ended arrangement with regular review and adjustment. Uncertain expectations can lead to serious misunderstandings and can ruin even successful endeavours. The long-term character of development work is frequently acknowledged verbally far more than it is in practice. If partners are aware that an engagement's lifespan is limited, they must be upfront about it.

According to Joel S Meister (1996:04), community mobilization models frequently place an emphasis on high rates of participation from community members, broad presentation of local interests and “stakeholders”, community members determining needs, goals, and objectives rather than outside professionals and the development of large-scale projects that include economic and political initiatives, as well as specific health components as well as grassroots control programmes. This is indeed an ambitious vision which reflects the complexity and systematic nature of health problems along the border and which holds promise as a guide for us. Both the Church and the state work together as the state assists the Church with training and updates regarding health matters and the Church formulates policies that will be in line with the policies of the KwaZulu-Natal Department of Health. de Gruchy (2015:242-243) states that the church in post-Apartheid South Africa, unlike during the Apartheid era, does not know how to respond constructively. A great deal of caring and compassion for the sick, dying, and bereaved on an individual and domestic level have clearly been evidenced, albeit by and large we have been wilfully silent,, intolerant, arrogant, dismissive, and hard-of-hearing in the face of a massive social, political, and public disaster.

#### **7.1.4 Reasoning model that shapes activities, formations and consequences to strengthen collaboration between public health and Reformed theology.**

It is true, according to Patrick McArdle (2006:70), that the development of Western models of healthcare was greatly affected by the Christian vision and its principles. Additionally, theologians like James Gustafson, Paul Ramsay, Stanley Hauerwas, and Richard McCormick have recently gained a reputation as highly regarded experts in medical ethics. Different Christian worldviews have contributed to the development and endorsement of methodically based healthcare models. Christian philosophers were not content to merely theorize or provide inspiration for complex medical problems. Instead, they dealt with specific circumstances while well cognizant that there was no easy “religious solution” to such complexity. However, these theologians agree that religious ideas offer a potential framework within which ethical consideration and decision-making in healthcare may be more serious and effective. It is therefore appropriate to take a closer look at the specific type of religious perspective or theological programme in question.

In comparison to earlier treatment, there is no doubt that modern medicine provides the sick and afflicted with a choice of frequently unexpected options. Diseases that were once commonplace in humans have been significantly lessened. But all of this has also brought with it a feeling of powerlessness, confusion, and loss of control over our lives. Such an option is no longer merely subjective or the results of thorough observation.

The importance of spirituality and faith in fostering human development and keeping wellness is becoming more widely acknowledged in today's culture. The phrase "health, sacredness, and completeness" has semantic ties that indicate a desired interdisciplinary approach to healthcare. When one distinguishes between faith – regarded as a specific religious behaviour – and spirituality, with its more expansive connotation of typically necessary life-enhancing qualities, there is a risk of misinterpretation. According to Samuel Ngewa (2006:1457), the Church is both an organization and an organism. No matter where each member is located, it is unified around the atoning act of Christ and the presence of the Holy Spirit, making it an organism. It is an organization in that it unites under a shared mission and guiding principles and recognizes specific officers as leaders. Although the organization aspect is less crucial than the organism one, it is nonetheless required for the Church to carry out the Great Commission. But when Jesus stated, "I will construct my Church, and the gates of Hades shall not overthrow it", the organism was the main point of emphasis (Matt 16:18). Those who are part of the Church have a purpose for being here on Earth. Jesus used the phrases "salt and light" to describe his purpose (Matt 5:13-16). Just like salt prevents food from going bad, believers are obligated to stop moral degradation in the world. The genuine light (John 1:9), who transforms lives by bringing love where there is anger, reconciliation where there is animosity, and hope where there is desperation, is the one whom believers are supposed to guide all people to. The Church is mandated to carry out this mission both in Africa and beyond.

Churches were founded by Western missionaries with the goal of enhancing people's physical, intellectual, and spiritual well-being. They established hospitals and schools as examples of their good works. The missionaries used the Church's organizations for men, women, and the youth to safeguard the longevity of these institutions. They provided training to the members of these organizations so they could work in hospitals and schools to enable them to perform a variety of tasks.

The investigation uncovered religious resources that contribute to people's health and well-being. David Bosch's works effectively express the Church's mission, according to Luwaile (2015). Bosch notes in his scholastic work that God's plan is for humanity to be saved through the efforts of the Church. In similar vein, Clifford Madondo (2009:71) contends that participating in ecumenical church life increases the Church's visibility in society. It is available to those seeking health, since it obeys God's mission. The Church takes upon itself the obligation to imitate its master by providing health services, drawing from the mission of Jesus. The Church, on the other hand, is a component of the community, thus members of the community should make use of it because of its accessibility as a way of learning and disseminating religious health assets by both those seeking healthcare and those providing it. As a result, joining the neighbourhood and church community fosters strong sense of belonging. It is clear from the responses given by respondents that intangible and tangible religious assets completely influence the health and well-being of people. It is worth noting that the value contributed by religious intangible assets is hard to measure, however, the study shows that their influence and results cannot be overlooked.

Religious assets, specifically the intangible ones which are invisible to the human eye, make it difficult to appreciate. However, the study shows the influence of religious assets on health, an example from the responses to the question, "What value does religion add to health and well-being"? A range of positive responses to health results was credited to religious assets. The principal ones had to do with the encouragement religious assets bring in the area of resilience, the moral formation of character, which consequently impacts health, trust, communication, personal relationships, and prayers offered for recovery.

#### **7.1.5 Self-assessment procedure on how dialogue may be initiated between the state and the Church.**

This study shows that the strength of religious health establishments depends on the productivity and diversity of religious assets they offer to health results, through such assets as praying for the sick, specialised counselling, complement, leadership, friendship, sharing of love through care and support groups. This aspect of health-giving, supported by religious health establishments, brings with it effects that are essential to the general health systems.

The formal and structural relationship is needed to render quality health and spiritual package together. However, this can only happen effectively when there is a personal connection among role-players. The most effective partnerships occurred when a relationship existed. This may be because relationships facilitate greater trust and open communication. It was clear that when relationships and communication did not exist, there was a lack of understanding that delayed partnership. For example, some church leaders develop a negative impression of working with the KZN Department of Health because they fear that if they communicate openly and express their needs and opinions, they might jeopardise their position in the Church. Church leaders are also feeling frustrated because they do not know who to contact within the KZN Department of Health. There is a need for key players from churches and the KZN Department of Health to meet face-to-face and share their ideas, priorities, organisational structure, and contact information, especially through health chaplains. Health chaplains understand all the dynamics from both worldviews (religion and health). As the KZN Department of Health considers ways that churches can support the department, they must understand that lack of follow-up with churches can cause church leaders to abandon their activities. Additionally, when churches do not understand the decisions of the KZN Department of Health, it can negatively affect their view and trust.

When participants had the opportunity to ask questions during the interviews, the researcher realised that there is no understanding and trust in the health system, including the policies that administer it. Controversy occurs when personal communication does not occur. For example, regarding policies surrounding the state and the Church's relationship to improve the public health system in KZN. The researcher believes that if specific policies and decisions regarding the issues were explained more clearly to the church members, trust barriers may have been reduced. Additional findings show that both the health sector and Church are comprised of people who care deeply about people.

When church members had opportunities for relationships with health workers, they realised that health services are not just a governmental voice on the end of the phone, but people who have a difficult job and a similar goal of caring for people. The Church benefits by understanding that the health sector is reactive and not proactive, by design and need. Churches wanting to increase their engagement with the health sector need to understand and remember this when they approach health workers to team up on a project.

While health workers had concerns about churches pushing an evangelistic and moral agenda, the respondent (a church council member) explicitly stated that their goal for engaging with the health sector was to serve, and not convert people to Christianity. This is a valid concern by another respondent (health worker) and may pertain to some churches, however, the respondents interviewed in this study expressed an appropriate awareness of the role of religion in the health sector. As churches increase their engagement with the health sector, they may need to participate in training around sensitive issues and diversity to ease the KZN Department of Health's concerns. Although much information in the literature review matched the study's findings, lack of time was only mentioned as a barrier by some respondents. The researcher was surprised to find that the topic of time did not emerge more in the study, but acknowledged that it may have simply been expressed differently. For example, building trust and relationships were found to be a significant barrier and that process can be very time-consuming.

Lastly, the study's findings also indicated that the relationships among church leaders in KZN would be beneficial, but until recently, many have been primarily working independently of each other. Most respondents expressed the desire to have churches working in a circle with other churches to establish standards and build trust with the health sector. Similarly, one elder mentioned that she saw a lack of church relationships in her ward. They believe that relationships primarily amongst churches can increase the effectiveness of the efforts.

## **7.2 Recommendations**

Health and religion must work together and religion must be part of the KZN Department of Health stakeholders and chaplains to be more in spiritual counselling other than preaching. de Gruchy (2015:262) suggests establishing a shared unity between these two worldviews because the goal of this discourse is change rather than conversation. Religious leaders and medical professionals are allies in the fight for health in the face of global political and economic system that is determined on causing suffering, misery, poverty, illness, and death. They should interact with one another according to their levels, starting from the national, to the provincial and the district structures.

Reformed theology must create accessible programmes for spiritual support, especially during the times of the COVID-19 pandemic. Both of these two worldviews must have a common meeting to draft the policies for the people on the ground level. This will be a best way to attend to these two worldviews to work hand-in-hand. According to Luwaile (2015-35), the Church is the second-most important source of support for government-run medical facilities in terms of its ability to improve people's health. Therefore, discussing the subject of health outside Church is unavoidable. The Church has a duty to watch out for the well-being of its people. The Church is able to teach its members self-care skills and equip them to look out for one another. Luwaile adds that, according to Douglas and Merrill Tennet, the term "church" has Greek roots. They contend that the Greek word "*kuriako*", which means "belonging to the Lord", is the source of the English term "church". They also mention that the term congregation is derived from the Greek word "*ekklesia*", which is related to the word "church". In this study, the term "church" refers to both denominational and non-denominational local Christian believers gathering. Additionally, it is useful for groups with Christian roots and for Biblically minded individuals.

The word belonging in the description of the Church clearly translates the African idea of the community, which emphasizes a sense of belonging. The Christian vision and its principles have clearly had a significant impact on ethical thought and behaviour as Western patterns of healthcare development have evolved. Given the complexity of the medical challenges they dealt with, Christian intellectuals were not content to just provide an academic or inspirational contribution. They were aware that there was no straightforward "religious solution" to these issues. But despite differences in focus, these theologians have one thing in common: they believe that religious viewpoints set a boundary within which ethical consideration and decision-making in healthcare can be more rigorous and effective. Informed by a range of Christian perspectives, health issues today can present unexpected opportunities. Through these regulations, the suffering of humans from formerly common diseases has been significantly decreased. However, all of this has resulted in a feeling of helplessness, confusion, and lack of control over our life. Such a viewpoint goes beyond being untrustworthy or simply being a report of an observation.



Yusuf Turaki (2006:1397) asserts that the Bible sees the Church as serving four purposes:

- A priestly duty: the Church must pray for individuals in positions of authority as well as for the safety and well-being of the country (1 Tim 2:1-3). The Church has a pastoral duty to the rulers and the governed by teaching, counselling and directing them (Matt 28:19-29).
- As a result, the Church ought to inspire Christians to act as law-abiding citizens who pay their taxes (Rom 13:1, 7, 1 Peter 2: 13). However, as long as their activities do not conflict with God's word, this does not entail that the Church can dictate the specifics of what authorities must do or the actions citizens should take.
- A prophetic role: when the state rebels against God or commits injustice, the Church must confront it (2 Sam. 12:1-14; Dan. 4:20 – 27; 5: 17 – 28).
- Absolute obedience can be expensive when it comes to a conflict between Christians and government authorities. Archbishop Luwum was killed as a result of persecution against the Ugandan Church for opposing Idi Amin's oppressive government. There are many of such examples all around the continent.

The improvement of health outcomes is the main objective of public health policies and practices. Health recipients, such as patients, their families, and the community they live in, as well as behaviour of health staff often have a big impact on people feel about their health. Emotions, beliefs, perceptions, attitudes, and unrestrained behaviour are all examples of behaviour (Institute of Medicine, National Research Council, 2004). Health-related behaviour can either improve or harm one's health. Having a healthy diet and exercise are two examples of health-promoting behaviours that raise the likelihood of future health. Activities that have a high risk of injury, smoking, drinking, and careless driving are examples of behaviours that harm one's health.

Most people's health behaviours may be influenced by others in their family, their community, or themselves. These healthy behaviours, which are geared toward altering behaviour, are frequently viewed as alternatives to health and health policy. Laws requiring the use of seatbelts and regular attendance at school are two examples of policies that aim to change behaviour through legislation. Broadly speaking, preventative health can be defined as a set of actions taken to lessen actions that harm one's health.

### **7.3 Conclusion**

The researcher concludes that the issue of public health cannot be addressed by the government alone. Based on the findings of this study, there is great potential for church ministers to be strong community support for the health sector. Churches have already successfully engaged in public health and retention, supported the health sector, and helped to meet many of the tangible needs of people. Both churches and health services have an openness toward collaborating, and the KZN Department of Health has identified areas where increased church ministry support would be welcome, including further engagement in supporting disadvantaged communities and providing support for transitional-age youth. Though the relationship between Church and state requires a gentle balance, the findings of this study indicate that many barriers are resolvable. Open communication, developing personal relationships, and building trust between both groups are key to enhanced relationships in the future. Through this, a stronger sense of trust can be built bringing a clearer understanding of each other's role and function. This will aid in the development of unified goals with the best interests in mind for communities. Ultimately, both groups have positive intentions and desire quality service delivery for every helpless person.

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## **APPENDIX 1: PERMISSION TO CONDUCT INTERVIEWS**



**OFFICE OF THE REGIONAL ADMINISTRATOR**

**Ref: 28/2019**

**CONTACT NUMBER: 0834748968**

**EMAIL: [ngema@worldonline.co.za](mailto:ngema@worldonline.co.za)**

**Date: 28/ 02/2019**

Dear Rev N.L Mbatha

**YOUR REQUEST TO CONDUCT RESEARCH WITHIN THE GREYTOWN CONGREGATION  
TABLED BEFORE THE KZN REGIONAL SYNOD MODERAMEN THAT SAT ON MARCH 01,  
2019.**

This is to officially translate the resolution of the KZN Regional Synod held as stated supra, into a permission to conduct the desired research within the membership of the Church. The chairmen of the local branches have been requested to assist you wherever you require their assistance. They will inform the membership about your request and ask them to cooperate with you.

You will decide where you want to start your research and you will please need to advise the local chairman so that he can alert the members. It will be incumbent upon you to decide on the age groups of the people you would like to interview. The times and venues will be decided by you, and you will have to sort all that with the chairmen of the local branches. I take it that you know the confidentiality of research remains between you and your respondents.

Let me assure you of our support and assistance as you conduct your research.

Yours in Christ.

  
Reverend Eric Ngema

## Appendix 2: Letter to the Participants

40 Khomba Road

Greytown

3250

20 February 2020

Greeting: Sir / Madam

My name is **Nkosinathi Lawrence Mbatha (Student No. 219083143)** a Doctor of Philosophy, (PhD) student in the School of Religion, Philosophy, and Classics of the College of Humanities at the University of KwaZulu-Natal (Pietermaritzburg campus).

You are being invited to consider participating in a study that involves research: **A Reformed critique of public health policies and practices in KwaZulu-Natal: a case study of Greytown Uniting Reformed Church in Southern Africa.**

The aim and purpose of this research is to examine the relationship between religion and health in the Greytown Uniting Reformed Church in Southern Africa. The study is expected to enrol nine participants in eight wards of Greytown congregation and one church council member, one in each ward will be interviewed, in the congregation office. It will involve the following procedures; Participants will be required to participate in semi-structured interviews that are expected to last between 20 to 40 minutes at a time suitable to them. Follow-up interviews may be conducted if necessary. Each interview will be voice-recorded. The duration of participation if you choose to participate and remain in the study is expected to be 4-6 weeks.

This study will not involve any risks and/or discomfort for the church and participants. Also, the study will not provide direct benefits for the Church or participants.

In the event of any problems or concerns/questions you may contact me, my supervisor, or the UKZN Humanities & Social Sciences Research Ethics Committee. Contact details as follows:

### My contact information

Email: [nkosinathilmbatha@gmail.com](mailto:nkosinathilmbatha@gmail.com)





**Supervisor:**

Prof Simangaliso Kumalo

Email address: [kumalor@ukzn.ac.za](mailto:kumalor@ukzn.ac.za)

Telephone: [REDACTED]

In the event of any problems or concerns/questions you may contact the researcher at (provide contact details) or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

**HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION**

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 260 4557- Fax: 27 31 260 4609

Email: [HSSREC@ukzn.ac.za](mailto:HSSREC@ukzn.ac.za)

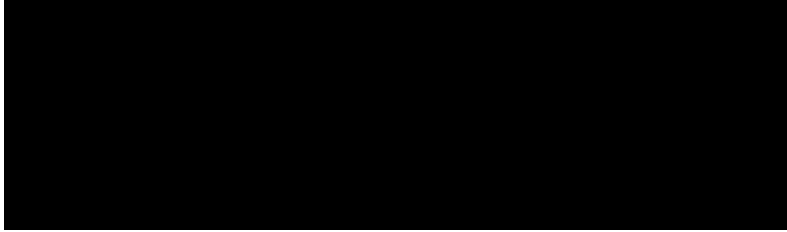
Participation in this research study is voluntary and participants may withdraw participation at any point. In the event of refusal/withdrawal of participation, the participants will not be penalized. There are no consequences for participants who withdraw from the study

No costs will be incurred by participants as a result of participation in the study and there are no incentives or reimbursements for participation in the study.

All names of wards and participants will be changed, and pseudonyms will be used so that wards and participants remain anonymous. Information provided by participants will remain confidential and will not be shared with anyone else. Data generated through semi-structured interviews will be stored in my supervisor's office, at the School of Religion, Philosophy and Classics College of Humanities, Pietermaritzburg campus, for five years, and thereafter be destroyed.

Thank you for your cooperation.

Yours faithfully



Nkosinathi Lawrence Mbatha

## **CONSENT**

I \_\_\_\_\_ have been informed about the study entitled (provide details) by (provide name of researcher/fieldworker).

I understand the purpose and procedures of the study (add these again if appropriate).

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

I have been informed about any available compensation or medical treatment if injury occurs to me as a result of study-related procedures.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at (provide details).

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 260 4557 - Fax: 27 31 260 4609

Email: [HSSREC@ukzn.ac.za](mailto:HSSREC@ukzn.ac.za)

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Signature of Participant

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Date

---

Signature of Witness

---

Date

---

Signature of Translator

---

Date

### Appendix 3: Interview questions

Participant code no: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Position: \_\_\_\_\_

#### P - 1

##### **1. Ngicela ungichazele okwaziyo ngenqubomgomo nemikhuba oyaziyo ngezempilo zomphakathi.**

Izinqubomgomo zezempilo zomphakathi zikhona ukubeka nokuhlinzeka ngezindlela eziwayelekile emkhakheni wezempilo womphakathi ngaphakathi esifundazweni kanjalo nakwezinye izifundazwe ngaphakathi ezweni. Kunezinqubomgomo zikazwelonke ezifana nezinqubomgomo nemihlahlandlela ye-COVID-19 mayelana nendlela yokubhekana nalolu bhubhane ngendlela eziwayelekile, kanye nezinqubomgomo zesifundazwe ezisuselwa kwizinqubomgomo nemikhuba kazwelonke. Kodwa-ke azihlukile kwimigomo kazwelonke kodwa zinezinye izengezo eziqondene nezindaba zezempilo eziqondene nesifundazwe. Le migomo ibeka amazinga endlela izinto ezenziwa ngayo emkhakheni wezempilo eKZN. isib.

- Indlela yokubhekana nobhubhane lwe-COVID-19, kufaka phakathi izinhloso nesikhathi esibekiwe.
- Indlela yokubhekana nokutheleleka nge-HIV/AIDS ngaphakathi esifundazweni, kuhlanganise ne-TB futhi.

Lezo ziqondiso nemigomo kumele zihambisane nemigomo kazwelonke ukuqinisekisa indlela eziwayelekile. Lokhu kwenza iziguli zithole ukunakekelwa okufanayo ngisho noma zifudukela kwesinye isifundazwe.

##### **2. Ngicela ungichazele ngenqubomgomo yezempilo zomphakathi eziphathelele nemfundiso yenkolo yesilungiso.**

UMnyango wezeMpilo waqala uhlelo olubizwa nge-ABC; okumele "Ukuzithiba, Thembeka futhi usebenzise i condom "; okufanele i-Reformed Theology njengoba i-Reformed Theology ikhuthaza abantu ukuba babe nesibopho.

Izinqubomgomo zokuhlela umndeni zenzelwe ukulawula ukukhulelwa okungafuneki, ukukhulelwa kwentsha, ama-STI kanye nokudluliselwa kwe-HIV. Wonke amaklayenti avakashela izikhungo zezempilo kumele ahlololwe i-TB, i-HIV, nama-STI, futhi alashwe uma kutholakala ukuthi anegciwane. Amakhondomu kumele akhishwe kakhulu, ikakhulukazi kulawo athathwa njengasebenza ngocansi nalawo aseminyakeni yokuzala izingane.

### **3. Ngicela ungichazele ngamathuba kanye nezinselelo eziphathelele nezempilo zomphakathi kanye nemfundiso yenkolo yesilungiso.**

Imfundo yokuhlela umndeni ayinikezwa imibhangqwana eshadile kuphela, kodwa wonke amaklayenti, futhi ayiqondiswa ubulili. Amakhondomu abesilisa anikezwa abalingani besifazane ukuba banikeze abalingani babo. Futhi, amakhondomu abesifazane anikezwa abalingani besilisa. Futhi, imfundo yobulili obufanayo kanye namakhondomu anikezwa ukuvimbela izifo.

Kubonakala sengathi kukhona ukufana mayelana nendlela yokuphila enempilo lapho zonke izici ezihlobene nempilo zibhekwa futhi zinakekelwa. Ukukhuluma ngezici zempilo, sisho isici somzimba, isici sengqondo, isici senhlalo, kanye nesici esingokomoya. Amanye amasonto anabasebenzi bezempilo abahlala benegalelo elikhulu ngokunikeza imfundo yezempilo edingekayo.

Isonto nalo lidlala indima ebalulekile ekubhekaneni nokuziphatha okuzibhubhisayo; ukusebenzisa kabi utshwala okunjalo, ubugebengu, ukubhema nodlame olubhekiswe ebulilini. Ngokushumayela uthando, ukuzinakekela nokunakekela abanye, ukudla okunempilo, ukuzivocavoca nokuzilibazisa, abantu bagwema ukuziphatha okuzibhubhisayo nokungahloniphi emiphakathini yabo.

Abanye baze banikeze ama-bursaries, njengoba kushiwo ngenhla, bamema abasebenzi bezamabhizinisi ukuba bafundise ngezindaba ezihlobene nebhizinisi kanye nabasebenzi bezempilo ukuze bafundise futhi bahlole amalungu ngezifo ezingamahlalakhona. Izinyathelo zesonto le-Reformed azisizi amalungu ngamanye kuphela, kodwa ziya kude nokuletha ukuzwana emindenini nasemphakathini wonke.

**4. Ungakwazi ukuncoma uhlelo olungabumba imisebenzi, ukwakheka kanye nemiphumela yokuqinisa ukusebenzisana phakathi kwezempilo zomphathathi kanye nemfundiso yenkolo yesilungiso.**

Okokuqala, kumele kube nezinkundla ezizohlanganisa laba ababili futhi zinikeze amapulatifomu okushintshanisa imibono nokufundisana. Ukufinyelela komphakathi ngokuhlanganyela lapho zonke izinhlangano ezingenhla ziyibahlanganyeli futhi zisebenza ndawonye ukuletha ushintsho.

Lezo zinto ezifinyelela ngempela kufanele zihlanganise abanye abathintekayo njengentuthuko yezenhlalakahle, amaphoyisa, umasipala/amakhansela, kanye nemfundo nezindaba zasekhaya ukuze wonke umuntu athole ithuba lokuthatha umthwalo wakhe ekusizeni umphakathi phambi kwabanye, engikholelwa ukuthi kungagwema umsebenzi ongaphelele nokuzinikela kabi.

**5. Ngokombono wakho, ibandla kanye nohulumeni bengasebenzisana kanjani ukuthuthukisa uhlelo lwezempilo yomphakathi?**

Ngokusho kweBandla, umzimba uyithempeli leNkosi, futhi umoya kaNkulunkulu awuthandi indawo engcolile. Ngokusho kwezifo zempilo, njengendawo engcolile. Yomibili le mibono yezwe iphikisana nokungcola kanye nendawo engenampilo nokuziphatha okungenampilo. Bobabili baqondana, nokho kukhona ukuphikisana.

ISonto lagcizelela kakhulu ukuphulukiswa ngokomoya ngezinye izikhathi okudida amalungu futhi kuphele ngokunganaki ukwelashwa kwawo. Hhayi ukuthi ukuphulukiswa ngokomoya kuyinkolelo-ze noma akukho, kodwa uma lokho kungabambisana ekusizeni imiphakathi yethu, ngoba umuthi ofanayo uvela emvelweni kaNkulunkulu (imithi nezinye izitshalo). Umqondo ngemuva kwezinhlelo zezempilo zomphakathi uvela kuNkulunkulu. Ngakho-ke, laba bobabili bangasebenza kangcono uma besetshenziswa ndawonye ngaphandle kokuthi umuntu abheke phansi omunye.

Ezinye izindaba zithintwe ngeledlule, ukuhlela umndeni. Ngokusho kweSonto umndeni ngumbhangqwana ohlangene ngumuntu ovunyelwe ukuqhuba lowo msebenzi, njengoMfundisi noMfundisi. Ngakho-ke, ukunikeza izingane zesikole izindlela zokuvimbela inzalo namakhondomu akuyona into engahloniphi uNkulunkulu njengoba kukhuthaza ucansi ngaphambi komshado, kodwa ingabe ucansi ngaphambi komshado alwenzekanga? Ingabe zikhona izinyathelo eBandleni zokusekela nokuqondisa imibhangqwana encane ngaphakathi esontweni ukugwema ucansi ngaphambi komshado, ukukhulelwa okungafuneki, ukukhipha isisu emuva emgwaqweni, isonto kumele lisebenzisane namalungu alo kanye nomkhakha wezempilo womphakathi ukwenza ipulatifomu enobungane futhi esebenzisekayo.

## **P – 2**

### **1. Ngicela ungichazele okwaziyo ngenqubomgomo nemikhuba oyaziyo ngezempilo zomphakathi.**

Izinqubomgomo nemikhuba yezempilo yomphakathi izinqumo, izinhlelo, nezenzo zikahulumeni zokufeza izinhloso zokunakekelwa kwezempilo ngaphakathi emphakathini. Uhulumeni uhlose ukwandisa isikhathi sokuphila kwabantu bako. Izinqubomgomo zayo zizokwenza ukuthi ikwazi ukubeka phambili futhi yenze amasu ngokufanele. Uhulumeni waseKZN wamukele uhlelo lwe-District Health System, olugcizelela ukunakekelwa kwezempilo okuyinhloko, lapho kunikezwa khona usizo lwezempilo emindenini ezingeni lomphakathi. Imiphakathi yasemaphandleni ehlaselwe ubuphofu ithintekile ngenxa yokufa kwabesimame nezingane, okuyinto uhulumeni azama ukuyinciphisa ngemfundo yezempilo. Kunezinhlelo ezibhekene nokuvimbela i-HIV.

### **2. Ngicela ungichazele ngenqubomgomo yezempilo zomphakathi eziphathelele nemfundiso yenkolo yesilungiso.**

Ayikho inqubomgomo yezempilo yomphakathi efanele i-Reformed theology engiyaziyo.

### **3. Ngicela ungichazele ngamathuba kanye nezinselelo eziphathelele nezempilo zomphakathi kanye nemfundiso yenkolo yesilungiso.**

## **Amathuba Empilo Yomphakathi**

Abantu abaningi baqashwe ezinhlelweni zomphakathi ezifana noHlelo Lwabasebenzi Bezempilo Yomphakathi (CHWP) kanye noHlelo Lwemisebenzi Yomphakathi olwandisiwe. Indima yenkolo nezinhlangano zenkolo ezizidlalayo ekufakeni isandla empilweni emiphakathini?

## **Izinselelo Zempilo Yomphakathi**

Ukushoda kwezinsiza ezivela kuhulumeni, njengamanzi ahlanzekile anele kanye nezindlu zangasese ezifanele eziholela ezifweni eziningi.

## **Amathuba e-Reformed Theology**

Abantu banikezwa ithemba lapho benezinselelo zempilo ngokushumayela, ukwelulekwa nomthandazo.

## **Izinselele ze-Reformed Theology**

Iningi labasekeli baleli siko abaqeqeshiwe ngokwanele kuyo yomibili le mibono yezwe.

- 4. Ungakwazi ukuncoma uhlelo olungabumba imisebenzi, ukwakheka kanye nemiphumela yokuqinisa ukusebenzisana phakathi kwezempilo zomphathathi kanye nemfundiso yenkolo yesilungiso.**

Ezinhlelweni zezeMpilo yoMphakathi, njengokubamba iqhaza komphakathi, ezempilo nokuphepha, ukukhuthaza ezempilo kanye ne-HIV ne-AIDS, kufanele kuhlelwe futhi kusetshenziswe, futhi ekuqeqesheni inkolo eguquliwe ekuziphatheni nasekuphileni okujwayelekile kokuziphatha kanye nokuhunyushwa kweBhayibheli okufanele kufanele kwenziwe.

- 5. Ngokombono wakho, ibandla kanye nohulumeni bengasebenzisana kanjani ukuthuthukisa uhlelo lwezempilo yomphakathi?**

- Umbuso neSonto bahlose ukukhuthaza inhlalakahle yabantu. ISonto lizibophezele ekugcineni impilo yamalungu alo nomphakathi akhona kuwo.
- Isikhathi esiningi iSonto kumele libhekane nezifo phakathi kwamalungu alo.



- Iningi labantu asebekhulile litholakala emphakathini weSonto. Ngakho-ke kuphoqelekele ukuthi umbuso neSonto bangene ngokubambisana.
- Lobu budlelwane bokusebenza bungathatha izimo ezahlukahlukeni: amasonto aqeqeshwe ezindabeni zempilo yomphakathi, ikakhulukazi ekukhuthazeni impilo nokuvimbela izifo. Lokhu kuzosiza uhulumeni ukuthi afeze umgomo wakhe. Kunenkinga yokugcwala ngokweqile ezibhedlela. Isixazululo ukuvimbela, okuzonciphisa ukucindezeleka ezikhungweni zokunakekelwa kwezempilo. Lokhu kusebenzisana kungaba emazingeni ahlukahlukene, njengezinhlango zenkolo ezingeni lesifundazwe nesifunda.

### **P – 3**

#### **1. Ngicela ungichazele okwaziyo ngenqubomgomo nemikhuba oyaziyo ngezempilo zomphakathi.**

Izinqubomgomo nemikhuba yezempilo yomphakathi inikeza iziqondiso zendlela yokuhlinzeka ngezinsizakalo zezempilo kumakhasimende, ukuthi abasebenzi bezempilo kufanele baziphathe kanjani, futhi banikeze iziqondiso ebubanzini bezindlela ngaphakathi koMnyango wezeMpilo eKZN.

#### **2. Ngicela ungichazele ngenqubomgomo yezempilo zomphakathi eziphathelele nemfundiso yenkolo yesilungiso.**

- Izimiso ze-Batho-Pele, ezimayelana: Amalungelo eklayenti, ilungelo lokwenqaba ukwelashwa, ukuhlonza abasebenzi bezempilo (ithegi yegama), ukubonakala obala (okubandakanya izinqubo ngesikhathi sokwelashwa), iklayenti kumele linikeze lonke ulwazi olufanele kubasebenzi bezempilo nokulungiswa (iklayenti kumele litshelwe lapho kunenkinga mayelana nokwelashwa kwakhe).
- Ezempilo Nokuphepha, okuyinto mayelana: abasebenzi bokuhlazwa kumele babeke izimpawu ezixwayisayo lapho kuhlanzwa, kumele kugwenywe izingozi ze-medico-legal, akumele kube khona amapulagi kagesi aveziwe, kumele kubhalwe izitsha, abasebenzi kumele baqinisekise ukulahlwa kwemfucuzo ngendlela efanele, kumele kube nokuvikeleka okuthembekile kwabasebenzi namakhasimende, futhi kumele kube khona ukuvivinya ukuphepha njalo ezinyangeni ezintathu uma kwenzeka kunomlilo owenziwa ngabaphindayo bezempilo nokuphepha.

- Ukulawulwa kwezifo, okuyinto mayelana: inqubomgomo yokugeza izandla, i-PPE eyanele kokubili abasebenzi namaklayenti, kanye nokulahlwa kwemfucuza (okubomvu kwemfucuza yezokwelapha, okusobala kwemfucuza ejwayelekile, amabhakede ezinto ezibukhali, izitsha eziphuze zokuhlukaniswa kwemfucuza yomuntu).

### **3. Ngicela ungichazele ngamathuba kanye nezinselelo eziphathelene nezempilo zomphakathi kanye nemfundiso yenkolo yesilungiso.**

- ISonto alenzi okwanele. ISonto kumele kube nemfundo yezempilo esilabhasini labo lesikole seSonto.
- ISonto alinayo inqubomgomo ezinzile ngempilo yomphakathi futhi, ngokubona kwami, isiko lethu lesonto (Reformed) alinamsebenzi kakhulu uma kuziwa kwizinqubomgomo nemikhuba yezempilo yomphakathi.
- Iningi lobuholi besonto a abanalwazi ngezindaba eziphathelene nempilo.
- Amabandla esontweni awazi ngemigomo yomphakathi.
- Ibandla alazi lutho ngempilo nokuphepha, njengoba okwamanje singenazo ngisho izicishamlilo uma kwenzeka kukhona umlilo.

### **4. Ungakwazi ukuncoma uhlelo olungabumba imisebenzi, ukwakheka kanye nemiphumela yokuqinisa ukusebenzisana phakathi kwezempilo zomphathathi kanye nemfundiso yenkolo yesilungiso.**

- Ngokuqhuba imfundo yezempilo nokwabelana ngolwazi eMnyangweni wezeMpilo eKZN.
- Akukho ukubambisana, ngoba abefundisi ababalulekile. Bagxile ekutshumayeleni nasezinkonzo zesikhumbuzo zabasebenzi abashonile esikhundleni sokuba ukuxhumana phakathi kweminyango.

### **5. Ngokombono wakho, ibandla kanye nohulumeni bengasebenzisana kanjani ukuthuthukisa uhlelo lwezempilo yomphakathi?**

- a) Leyo mfundiso yenkolo nempilo yomphakathi ibambisene, futhi zombili lezi zikhungo zisebenza ndawonye njengabalingani abalinganayo.
- b) Imfundo yezempilo kumele ibe yinto ephoqelekile kuzo zonke izikhungo zenkolo.

c) Umsebenzi wabefundisi bezempilo ezibhedlela kumele ubuyekwezwe futhi ugxile ekuxhumaniseni uMnyango wezeMpilo namasonto.

d) Amasonto kumele akhuthazwe ukuba acabangele ikhalenda yezempilo kazwelonke yezempilo lapho enza izinhlelo zawo zonyaka.

#### **P – 4**

### **1. Ngicela ungichazele okwaziyo ngenqubomgomo nemikhuba oyaziyo ngezempilo zomphakathi.**

- Ziyimoto lapho kunikezwa khona insizakalo yezempilo yekhwalthi.
- Bavikela abasebenzi noMnyango wezeMpilo eKZN ekumangalelweni.
- Zenzelwe ukuvikelwa kwabasebenzi, amaklayenti, noMnyango wezeMpilo eKZN.

### **2. Ngicela ungichazele ngenqubomgomo yezempilo zomphakathi eziphathelene nemfundiso yenkolo yesilungiso.**

I-charter yamalungelo eziguli, i-Batho-Pele Principles, isibhedlela esihle, izindinganiso eziyinhloko zikazwelonke, isiqondiso somtholampilo, amazanga okunakekelwa kwezempilo, umtholampilo ofanele, i-National Health Insurance, ne-Norms and Standards (ipayipi).

### **3. Ngicela ungichazele ngamathuba kanye nezinselelo eziphathelene nezempilo zomphakathi kanye nemfundiso yenkolo yesilungiso.**

- Inkolo - Kuletha uthando futhi kusiza abantu ukuba babe nokuziphatha namagugu. Ngeshwa, abaholi benkolo abaziqondi izindima nemithwalo yabo uma kuziwa ezindabeni zempilo isib., Abefundisi bezibhedlela bagxile ekutshumayeleni lapho kulindeleke ukuthi banikeze ukunakekelwa okungokomoya nokwelulekwa kumalungu abasebenzi kanye namaklayenti.
- Izinhlangano zenkolo - Zidlala indima ebaluleke kakhulu ekuhlinzekeni ukwesekwa kwezinhlelo zoMnyango wezeMpilo eKZN.

**4. Ungakwazi ukuncoma uhlelo olungabumba imisebenzi, ukwakheka kanye nemiphumela yokuqinisa ukusebenzisana phakathi kwezempilo zomphathathi kanye nemfundiso yenkolo yesilungiso.**

- Abashumayeli nabaholi benkolo banomsebenzi we-multidisciplinary okufanele bayenze.
- UHulumeni kumele anikeze ukuqeqeshwa kubaholi bezenkolo ukuze kube nokubambisana phakathi kwezempilo nenkolo.
- ISonto kumele libandakanyeke ekusakazeni ulwazi lwezempilo.

**5. Ngokombono wakho, ibandla kanye nohulumeni bengasebenzisana kanjani ukuthuthukisa uhlelo lwezempilo yomphakathi?**

- a) ISonto nombuso kumele basebenzisane njengabalingani abalinganayo ekunikezeni inkonzo yekhwalithi emphakathini.
- b) ISonto kumele ligweme ukuphikisana nemiyalezo yoMnyango wezeMpilo eKZN edala ukudideka kubantu ngenxa yolwazi oluncane abaholi benkolo abanalo ngezindaba zempilo.
- c) Impilo nenkolo kumele basebenzisane.
- d) Inkolo kumele ibe ngomunye wababambiqhaza boMnyango wezeMpilo eKZN.
- e) Abefundisi kufanele bazibandakanye kakhulu ekwelulekeni ngokomoya kunokushumayela.

**P -5**

**1. Ngicela ungichazele okwaziyo ngenqubomgomo nemikhuba oyaziyo ngezempilo zomphakathi.**

- Izinqubomgomo nemikhuba yezempilo yomphakathi isiza ekusakazeni ulwazi olulungile kumakhasimende avela eMnyangweni wezeMpilo eKZN.
- Basiza ukunikeza isiqondiso entsheni mayelana nama-STI nokuhlela umndenini nokuthi ingaphathwa kanjani ngabasebenzi bezempilo.
- Baphinde banikeze umhlahlandlela eMnyangweni wezeMpilo eKZN mayelana nendlela yokunakekela abantu abakhubazekile ngokomzimba kanye nemishini nezinsiza ezidingekayo kubo.

**2. Ngicela ungichazele ngenqubomgomo yezempilo zomphakathi eziphathelene nemfundiso yenkolo yesilungiso.**

Izimiso zeBatho–Pele.

**3. Ngicela ungichazele ngamathuba kanye nezinselelo eziphathelene nezempilo zomphakathi kanye nemfundiso yenkolo yesilungiso.**

Amasonto angaphansi kwesiko leNguquko abhalisela iSouth African Council of Churches, okuyinhlangano emele uhulumeni. Ukuqonda kwami ukuthi bayabonisana lapho umbuso uthatha izinqumo mayelana nemigomo nemikhuba yawo. Izimiso zeBatho–Pele.

**4. Ungakwazi ukuncoma uhlelo olungabumba imisebenzi, ukwakheka kanye nemiphumela yokuqinisa ukusebenzisana phakathi kwezempilo zomphathathi kanye nemfundiso yenkolo yesilungiso.**

- UMnyango wezeMpilo kumele ubandakanye abaholi benkolo.
- Abaholi benkolo kumele bafaneleke futhi bagxile ekwelulekeni ngabelusi kunokushumayela nokuthandaza. Ukushumayela nomthandazo kubaluleke kakhulu, kodwa akugcwalisi isikhala sokwelulekwa kwabelusi lapho umuntu ekhuluma nomuntu ngezinsalelo zakhe nokwesaba.
- Yomibili le mibono yezwe kumele ikhulume ulimi olulodwa nomyalezo ukuze ingamadidanisi abantu.

**5. Ngokombono wakho, ibandla kanye nohulumeni bengasebenzisana kanjani ukuthuthukisa uhlelo lwezempilo yomphakathi?**

Umbuso kumele ufundise abaholi benkolo ngezifo nemikhankaso.

**P – 6**

**1. Ngicela ungichazele okwaziyo ngenqubomgomo nemikhuba oyaziyo ngezempilo zomphakathi.**

- Izinqubomgomo zempilo yomphakathi zihlobene noma zithonya impilo nokugula eKZN.
- Imikhuba yezempilo yomphakathi ukuqoqwa nokuhlaziywa kwedatha ebonakalayo ngegunya lezempilo lomphakathi.

**2. Ngicela ungichazele ngenqubomgomo yezempilo zomphakathi eziphathelene nemfundiso yenkolo yesilungiso.**

- Inqubomgomo yokudla nokuphepha.
- Umkhuba wezempilo womphakathi - imikhuba yokuphila okunempilo, isib. ukudla kwasekuseni kwansuku zonke.

**3. Ngicela ungichazele ngamathuba kanye nezinselelo eziphathelene nezempilo zomphakathi kanye nemfundiso yenkolo yesilungiso.**

- Ukunikeza ukwesekwa ngokomoya.
- Ukunikeza ukwelulekwa kwaezikamoya.
- Ukukhuthaza ukuzihlonipha.

**4. Ungakwazi ukuncoma uhlelo olungabumba imisebenzi, ukwakheka kanye nemiphumela yokuqinisa ukusebenzisana phakathi kwezempilo zomphathathi kanye nemfundiso yenkolo yesilungiso.**

Ukuthi kokubili inkolo nempilo kusebenza ndawonye ukuze kuthuthukiswe ukufundisa nokwelapha abantu ukuze bagweme izifo ezibulalayo.

**5. Ngokombono wakho, ibandla kanye nohulumeni bengasebenzisana kanjani ukuthuthukisa uhlelo lwezempilo yomphakathi?**

Yomibili le mibono yezwe kumele isebenzisane ukunciphisa izigameko zezifo eziningi.

**P – 7**

**1. Ngicela ungichazele okwaziyo ngenqubomgomo nemikhuba oyaziyo ngezempilo zomphakathi.**

- Izinqubomgomo nemikhuba yezempilo yomphakathi isiza umphakathi ukuba uqonde inkonzo kahulumeni ikakhulukazi ezingeni lokunakekelwa kwezempilo lokuqala.
- Baveza imihlahlandlela yokuphatha abantu ngesithunzi.
- Bagxile kakhulu ekunakekelweni nasekuphepheni kwamaklayenti.
- Basiza ngokugunyazwa kwabachwepheshe kanye nezikhungo noma izikhungo.

**2. Ngicela ungichazele ngenqubomgomo yezempilo zomphakathi eziphathelene nemfundiso yenkolo yesilungiso.**

- Inqubomgomo yokunakekelwa kwamakhasimende - iziguli kufanele ziphathwe ngekhwalithi ephezulu yokunakekelwa.
- Inqubomgomo yokulungele - kumakhasimende akhononda lapho ephathwa ngokungafanele (ukuhambisana nehhovisi).
- Inqubomgomo ye-Transparency - amaklayenti kumele azi umsebenzi wezempilo olaphayo, ukugula kwabo, inqubo yokwelashwa kanye nemithi abazobe beyithola.
- Inqubomgomo yokuziphatha - ukuziphatha kokuziphatha kwabasebenzi bezempilo.
- Ubungcweti – abasebenzi bezempilo kumele bagqoke, bakhulume, futhi benze ngobuchwepheshe.

**3. Ngicela ungichazele ngamathuba kanye nezinselelo eziphathelene nezempilo zomphakathi kanye nemfundiso yenkolo yesilungiso.**

- Isonto le-Reformed lihambisana nemigomo ethile yezempilo yomphakathi, njengokuhlela umndeni kanye nemihlahlandlela ejwayelekile ye-HIV ne-AIDS kodwa lilahla eminye imigomo nemikhuba efana nokuqedwa kokukhulelwa nobufanasini.
- Ebandleni lethu sinekomidi lezempilo, kodwa alisebenzi.

**4. Ungakwazi ukuncoma uhlelo olungabumba imisebenzi, ukwakheka kanye nemiphumela yokuqinisa ukusebenzisana phakathi kwezempilo zomphathathi kanye nemfundiso yenkolo yesilungiso.**

- a) Kufanele basebenzisane ngokwamazinga abo, kusukela ezakhiweni zikazwelonke, zesifundazwe nezifunda.
- b) I-theology eguquliwe kumele idale izinhlelo ezifinyelelekayo zokwesekwa ngokomoya, ikakhulukazi ngezikhathi zobhubhane lweCovid-19.
- c) Ukuqeqeshwa okuphelele kumele kunikezwe abaholi benkolo, ngoba uma kungenziwanga kungaba yingozi enkulu emphakathini nasesifundazweni.

d) Inkolo kumele ilawulwe, uma kubhekwa ukungaqondi okuningi okwenzekile okuhlobene nokuchazwa kabi koMbhalo nezimfundiso.

**5. Ngokombono wakho, ibandla kanye nohulumeni bengasebenzisana kanjani ukuthuthukisa uhlelo lwezempilo yomphakathi?**

- Uhulumeni waseKZN kufanele asebenzisane kakhulu namasonto ukusabalalisa ulwazi.
- I-KZN DoH kumele inikeze amandla abaholi benkolo.
- Amasonto anendima enkulu ezinhlelweni zokuvuselela ukuziphatha.
- Ucabanga ukuthi le mibono emibili yezwe (i-Reformed theology kanye nempilo yomphakathi) yaqondana noma iyaphikisana?
- Benza ukubambisana ngoba bathole izinhloso ezifanayo zokunikezwa amandla komphakathi nentuthuko.
- ISonto nombuso kufanele basebenzisane ukudala amaprojekthi aqhubekayo azoqeda ubuphofu emphakathini.

**P – 8**

**1. Ngicela ungichazele okwaziyo ngenqubomgomo nemikhuba oyaziyo ngezempilo zomphakathi.**

- Izinqubomgomo nemikhuba yezempilo yomphakathi ngamasu abekwa nguhulumeni ngaphansi koHlelo Lwezempilo Lomphakathi lwaseKZN.
- Bagquguzela ukunakekelwa kwezempilo okusezingeni eKZN okuzosetshenziswa.
- Ukuqaphela umbono, ukuhlela, umsebenzi, nokuthuthukisa izinsizakalo zayo emphakathini nokudala indawo yokusebenza ephephile futhi enempilo yabasebenzi bakahulumeni ngaphansi komnyango wezempilo.



## **2. Ngicela ungichazele ngenqubomgomo yezempilo zomphakathi eziphathelele nemfundiso yenkolo yesilungiso.**

Inqubomgomo Yomshuwalense Wezempilo Kazwelonke (NHI). Ukwaziswa ngezinkinga ezibhekene nazo zombili izinhlelo zezempilo ezizimele nezomphakathi, le nqubomgomo iphakamisa ukuguqulwa ngokuphelele kohlelo lwezempilo kuwo wonke amazanga kahulumeni ukuhlinzeka nokukhuthaza izinsizakalo ezisezingeni futhi ezisebenza kahle kanye nokulethwa kwezinsiza.

Iphinde ihlose ukuqeda izinto ezifana: isimo sengqondo sabasebenzi, ukugcinwa kwezidakamizwa—ukuphuma, kanye namahora amade okulinda nokuthuthukisa ukuphepha nokuvikeleka kokubili amalungu abasebenzi neziguli. Kuzoletha ukufinyelela kwezempilo esezingeni ukuvala igebe phakathi kwemikhakha yezempilo yangasese neyomphakathi ngokuthuthukisa ezinhlelweni ezihlanganisiwe. Lokhu kuzobona ukuthuthukiswa kobuchwepheshe, imishini, kanye nabasebenzi (abasebenzi). Umnyango uzobe uthuthela ekugcwalisweni okungenamaphepha njengomzamo wokuthuthukisa ukugcinwa kwamarekhodi, phakathi kwezinye izinto.

## **3. Ngicela ungichazele ngamathuba kanye nezinselelo eziphathelele nezempilo zomphakathi kanye nemfundiso yenkolo yesilungiso.**

- Kufanele kube neqoqo lezimiso zokuqondisa inqubo yomthetho. Lokhu kungasebenza ekudalweni kwezinqubomgomo nemikhuba ekwazi ukusetshenziswa futhi eyanele.
- Indlela imithetho yamanje ebhalwe ngayo ayihlangabezani nezidingo zomphakathi eyenzelwe lona. Lokhu kuzobeka umsebenzi kuhulumeni wokugqugquzela impilo nenhlalakahle yabantu, isishayamthetho kufanele sidale izinga lokulinganisa ukusebenza kweziphathimandla zezempilo.
- Dala imingcele yokugwema ukusabela ngokweqile kukahulumeni egameni lempilo yomphakathi, ngakho-ke izinqumo ngezinqubomgomo kufanele zibe nobulungiswa nobulungiswa futhi zibe kuhle emphakathini.

- Ukubonisana kwangaphambili nababambiqhaza, abasebenzi, kanye nomphakathi ngaphambi kokudalwa komthetho kuzokwenza ukuthi umkhakha wezempilo uphumelele futhi usebenze kahle, usindise umphakathi wawo futhi uvumele ukuqaliswa kwawo ngendlela efanele. Ngakho-ke, izimfundiso zenkolo eziguquliwe kumele zihambisane nemigomo nemikhuba yezempilo ukuthuthukisa impilo nenhlalakahle yomphakathi, isonto, kanye nomkhakha wezempilo uqobo.

**4. Ungakwazi ukuncoma uhlelo olungabumba imisebenzi, ukwakheka kanye nemiphumela yokuqinisa ukusebenzisana phakathi kwezempilo zomphathathi kanye nemfundiso yenkolo yesilungiso.**

Yomibili le mibono emibili yezwe kumele ibe nephuzu lokuhlangana elifanayo lokuhlela imigomo yabantu abasezingeni lomhlaba. Lokhu kuzoba yindlela engcono kakhulu yokuvumela le mibono emibili yezwe ukuba isebenze ngesandla.

**5. Ngokombono wakho, ibandla kanye nohulumeni bengasebenzisana kanjani ukuthuthukisa uhlelo lwezempilo yomphakathi?**

Bobabili umbuso neSonto kumele babambe imihlangano namalungu womabili amaqembu ukubeka imithetho nemigomo yokuhlalisa wonke umuntu ngendlela efanayo. Asikwazi ukuvunyelwa ukufihla izinkolelo nezinqubo zethu lapho sinakekela izikhungo zezempilo.

**P -9**

**1. Ngicela ungichazele okwaziyo ngenqubomgomo nemikhuba oyaziyo ngezempilo zomphakathi.**

Yimithetho nemigomo elawula indlela uhlelo lwezempilo lomphakathi lwaseKZN oluzosebenza ngayo kuwo wonke amazanga kahulumeni. Ngaphezu kwalokho, lezi zisiza uhulumeni ukuba ahlangebezane nezidingo zomphakathi nokwenza ngcono indlela izisebenzi zikahulumeni ezizisebenzisa ngayo, ukuqinisekisa ukuthi lo mnyango ufeza inhloso owadalwa ngayo.

## **2. Ngicela ungichazele ngenqubomgomo yezempilo zomphakathi eziphathelele nemfundiso yenkolo yesilungiso.**

Uhlaka lwenqubomgomo mayelana nokuthuthukiswa kwamakhono nokuqeqeshwa eMnyangweni wezeMpilo KwaZulu-Natal. Inhloso yale nqubomgomo ukugqugquzela ukulethwa kwezinsizakalo ngekhwalithi nangendlela efanele yoMnyango wezeMpilo ngokuthuthukiswa kwabasebenzi bawo. Lokhu kwenziwa wukudalwa kwezinyathelo nemisebenzi okuhloswe ngayo ukuthuthukisa ukusebenza komsebenzi wabo, nokuqinisekisa ukuthi amakhono abasebenzi ahambisana nohlaka lwemigomo yokusebenza yomnyango nokuthuthukisa ukwenziwa kwalolu hlaka. Ngokomgomo, ukusebenza komsebenzi wesisebenzi kulinganiswa minyaka yonke futhi njalo ngekota yesibili yonyaka. Lokhu kuthatha isimo sokuhlola nokulinganisela okwenziwa ngumqashi ukuhlola isisebenzi. Ibheka ukuthi ukusebenza kwesisebenzi kuxhomeke ezingeni, futhi ibhonasi yokulinganisa inikezwa isisebenzi e senze kahle. Ngaphezu kwalokho, lapha isisebenzi singakhomba umqashi uma singathanda ukuqeqeshwa endaweni ethile, ukuthuthukisa izindawo zabo ezisemqoka zokusebenza. Konke lokhu kwenziwa ngokubona komqashi (umphathi).

## **3. Ngicela ungichazele ngamathuba kanye nezinsalelo eziphathelele nezempilo zomphakathi kanye nemfundiso yenkolo yesilungiso.**

Umbono weNguquko ukholelwa ukuthi izinto kufanele zenziwe ukuze kube kuhle okukhulu noma okujwayelekile, ngakho-ke kufanele zamukeleke emhlabeni wonke futhi zisetshenziswe. Ezinye izinqubomgomo zempilo yomphakathi ziphelelwe yisikhathi, azihambisani, futhi azibhalwanga kahle, futhi lezo kunzima ukuzisebenzisa. Inkinga enkulu ukuthi le migomo nemikhuba ihlangothini olulodwa. Lokhu kungaba umphumela wokuntuleka kokubonisana nomsebenzisi wokugcina, abahlaziyi ngokwabo abangakwazi ukuhlobana naye.

Izishayamthetho ezihlela le migomo nemikhuba azitshalwa kahle nomkhakha wezempilo, onomthelela omubi futhi u-negates inhloso yomkhakha wezempilo, okuwukukhonza abantu bawo. Ngakho, sithola ukuthi umqalisi uzithola ephonswe ekugcineni okujulile futhi kumele asebenzise le migomo noma imikhuba ngenkathi engenakuqonda ekutheni yadalwa noma ibasiza kanjani ekugcwaliseni inhloso yomkhakha wezempilo. Ukufaneleka nokubaluleka kwabo nakho akucaci kubo. Ngakho-ke, kunesimemezelo sokuthi ukuguqulwa kwezinqubomgomo nemikhuba kube yithuluzi elibalulekile lokudala izinqubomgomo nemikhuba ekhuthaza isimo somsebenzisi wokugcina, inhlalakahle kanye nempilo.

**4. Ungakwazi ukuncoma uhlelo olungabumba imisebenzi, ukwakheka kanye nemiphumela yokuqinisa ukusebenzisana phakathi kwezempilo zomphathathi kanye nemfundiso yenkolo yesilungiso.**

Ngingakuncoma ukuthi esikhundleni sokuthi ngamunye aphokophelele i-ajenda yakhe, kufanele bazame futhi benze umgomo abafuna ukuwufeza bobabili.

Kufanele bobabili baqinisekise ukuthi bazama ukufunda okuningi komunye nomunye, futhi ngokwenza kanjalo bakha isikhala sokufunda nokufundisa ngokudala ukulinganisela.

**5. Ngokombono wakho, ibandla kanye nohulumeni bengasebenzisana kanjani ukuthuthukisa uhlelo lwezempilo yomphakathi?**

ISonto lingasebenzisana nohlelo lwezempilo eKZN. Okokuqala, ngokusiza uMnyango wezeMpilo ukuba ususe umgoqo wokuthola usizo lwezempilo olusezingeni, ngaleyo ndlela uvumele abantu abampofu kakhulu ukuba bathole usizo lwezempilo oluhle nolunozwelo. Okwesibili, ngokunikeza ukwesekwa nokuqinisa umkhakha wezempilo njengoba inethiwekhi yawo eguquka njalo isengozini yokuba nabantu abathile abawela phakathi kwemifantu. Okwesithathu, ngokusiza ukukhuthaza imikhuba emihle ezoba nomthelela omuhle ekuqiniseni izinhlelo zezempilo, isib. amasonto angasetshenziswa njengendawo yokuqoqa imithi, okunciphisa ukuminyana emitholampilo noma ezibhedlela, futhi ngaleyo ndlela kunengcindezi encane kulezi zikhungo. Okokugcina, ngokusiza umkhakha wezempilo ukuba uqonde izinhloso namagugu abawabeka ngokudala isiko lokusizana, ukubamba iqhaza emihlanganweni yebhodi, kuhlanganise njengababambiqhaza emphakathini, nokusiza ekusetshenzisweni kombono nomsebenzi wezempilo eKZN.

# A REFORMED CRITIQUE OF PUBLIC HEALTH POLICIES AND PRACTICES IN KWAZULU-NATAL: A CASE STUDY OF GREYTOWN UNITING REFORMED CHURCH IN SOUTHERN AFRICA

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<b>6</b>	<b>Marci Kramish Campbell, Marlyn Allicock Hudson, Ken Resnicow, Natasha Blakeney, Amy Paxton, Monica Baskin. "Church-Based Health Promotion Interventions: Evidence and Lessons Learned", Annual Review of Public Health, 2007</b> Publication	<b>&lt;1</b> %