

THE ROLE OF CHRISTIAN FAITH-BASED ORGANIZATIONS IN HIV AND AIDS INTERVENTION

**A REVIEW OF ESSA CHRISTIAN AIDS PROGRAMME IN PIETERMARITZBURG,
SOUTH AFRICA (1999-2005)**


By

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of Master of Theology (History of Christianity) with special focus in HIV/AIDS, to
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DECLARATION

I, Charles Bester Manda a candidate of Master of Theology (History of Christianity with special focus in HIV and AIDS), in the School of Religion and Theology, University of KwaZulu-Natal, Pietermaritzburg, hereby declare that except for the quotations specifically indicated in this research paper, and such help as I have acknowledged, this is wholly my original work and that it has not been submitted at any institute for the fulfillment of another degree.

Student.......... Date: 30 November 2006.....

I acknowledge that this research paper is ready for examination.

Supervisor..... Date.....

DEDICATION

This thesis is dedicated to my family: Delie, Shalom and Tikva

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ACRONYMS AND ABBREVIATIONS

ABC.....	Abstain, Be faithful, Condomise
AE.....	African Enterprise
AIDS.....	Acquired Immunodeficiency Syndrome
ARVs.....	Antiretrovirals
ATTIC.....	AIDS Training Information and Counselling Centre
CBOs.....	Community Based Organizations
CBO.....	Community Based Organization
CCP.....	Community Care Project
EBSemSA.....	Evangelical Bible Seminary of Southern Africa
ECAP.....	ESSA Christian AIDS Programme
ESSA.....	Evangelical Seminary of Southern Africa.
FBO.....	Faith-Based Organization
GDP.....	Gross Domestic Product
HIV.....	Human Immunodeficiency Virus
ICVA.....	International Council of Voluntary Agencies
KABP.....	Knowledge, Attitudes, Beliefs and Practices
LWF.....	Lutheran World Federation
MIS.....	Masters in Information Studies
NACOSA.....	National AIDS Convention of South Africa
NGO.....	Non Governmental Organization
PACSA.....	Pietermaritzburg Agency for Christian Social Awareness
PCC.....	Pregnancy Crisis Centre
PWA.....	Person Living with AIDS
SAHECO	South Africa Health Care Organization
SIM.....	Serving in Mission
STD.....	Sexually Transmitted Disease
STDS.....	Sexually Transmitted Diseases
STI.....	Sexually Transmitted Infection
TAC.....	Treatment Action Campaign
TB.....	Tuberculosis
TFT.....	Training for Transformation

UMCP..... Urban Mission Community Development Programme
UNAIDS.....United Nations AIDS
UNICEF.....United Nations Children’s Fund
UNHCR.....United Nations High Commission for Refugees
USAID.....U.S. Agency for International Development
WCC..... World Council of Churches
WHO..... World Health Organization

ABSTRACT

As the burden of HIV and AIDS increases in different communities of the world today, new organizations are being formed to help mitigate its impact. The current study assessed whether Christian faith-based organizations (FBOs) were making any contribution to mitigate the impact of HIV and AIDS in Pietermaritzburg area using a case study of the ESSA Christian AIDS Programme (ECAP). ECAP has been involved in training churches in HIV and AIDS awareness, home-based and orphan care, assisting churches to initiate church-related projects, and facilitating the Church and AIDS course to the theology students at the Evangelical Seminary of Southern Africa (ESSA).

The population of this study comprised twenty (20) ESSA graduates who took the HIV and AIDS course between 1999 and 2000. The self-administered questionnaire was sent to all twenty to assess whether they experienced any change in their thinking, attitude and behaviour towards people with AIDS as a result of taking the Church and AIDS course, and what HIV and AIDS-related activities they were involved in. An interview schedule, with two phases, was used to collect data. The first phase elicited data from six (6) ECAP stakeholders to establish a brief historical background of ECAP. The second phase elicited data from ten (10) church ministers in whose churches ECAP conducted its training to assess whether the ECAP's training programmes made any difference in their attitude and behaviour towards people with AIDS, and what HIV and AIDS projects they started as a result of getting being trained.

Although the study could not generalize the results because of the case study methodology, the results showed that ECAP was making significant contribution to the fight against AIDS epidemic not only in the communities of Pietermaritzburg but also in other countries where the ESSA graduates were working. However, lack of enough human and financial resources is affecting ECAP's efficiency. Based on the findings in this study, recommendations have been made to ECAP's method of recruiting churches for training, venues for training and its approach to HIV prevention methods.

CHAPTER 1: SCOPE OF STUDY

1.1. Introduction

This chapter introduces the study that has taken place in Pietermaritzburg, the capital city of KwaZulu-Natal province, South Africa. The study assessed whether Christian faith-based organizations (FBOs) were making any contribution to mitigate the impact of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) in the Pietermaritzburg area using a case study of the Evangelical Seminary of Southern Africa (ESSA) Christian AIDS Programme. ESSA Christian AIDS Programme (ECAP), as a Christian FBO, has been involved in HIV intervention programmes in Pietermaritzburg since 1999 when it was officially started. However, its foundations began as early as 1997. The study sought to assess its work in the period between 1999 and 2005. As a Malawian student, I chose to conduct this research in South Africa and not in Malawi for the following reasons:

First, Pietermaritzburg was chosen because it falls under KwaZulu-Natal province which has the highest HIV prevalence rate in South Africa; it has been called, “the epicentre of HIV/AIDS in South Africa.”¹ According to the HIV and AIDS epidemic update compiled by United Nations AIDS (UNAIDS)/(World Health Organization (WHO) in 2005, KwaZulu-Natal still ranked the highest among the provinces in South Africa.

In the country’s worst-affected province, KwaZulu-Natal, prevalence has reached 40%, while it has remained exceptionally high at between 27% and 31% in the Eastern Cape, Free State, Gauteng, Mpumalanga and North West provinces.²

Therefore this study sought to establish whether Christian FBOs were contributing to the fight against HIV and AIDS in the province of KwaZulu-Natal.

Second, Liebowitz makes the case that FBOs possess significant advantages in delivering certain kinds of interventions, and he supports his argument by drawing on the case of

¹ Varga, C.A. "Sexual Decision-Making and Negotiation in the Midst of Aids: Youth in Kwazulu-Natal, South Africa." *Health Transition Review* 7, no. Supp 3 (1997):45-67.

² UNAIDS/WHO. *Uniting the world against AIDS: UNAIDS/WHO AIDS Epidemic Update: December 2005*. <http://www.unaids.org/epi/2005/doc/report_pdf.asp> accessed 10/05/06.

FBOs in Uganda, which have been relatively successful in reducing HIV prevalence rates and mitigating the worst impact of the AIDS epidemic.³ Therefore, I wanted to assess whether Liebowitz's argument could be true of the Christian FBOs in the severely affected province of KwaZulu-Natal.

Third, my academic experience with ECAP motivated me to undertake this research. I had a field placement with ECAP in 2003 when I took the Church and AIDS course at the School of Theology, the University of Natal. During the fifteen hours I spent with ECAP, I accompanied an ECAP staff member to different churches in some townships and rural areas of Pietermaritzburg where I observed the staff member facilitate some of the training programmes listed in Chapter 3 of this thesis. I was so motivated by the training sessions that I decided to study ECAP's work further so that the lessons learnt could be applied by other FBOs engaged in HIV and AIDS intervention in my country, Malawi, which is one of the countries in sub-Saharan Africa that have been hardest hit by HIV and AIDS pandemic.

1.2. The context of the study

This study took place in Pietermaritzburg, the capital city of the province of KwaZulu-Natal, South Africa. South Africa has the highest infection rate in the world of approximately 2000 infections per day. KwaZulu-Natal is the leading province with an estimated 40% prevalence rate of women attending antenatal clinics being HIV positive in 2004.⁴ Up to 60% of hospital patients in the province are screened HIV positive.⁵ Statistics show that 20 % of the 15-49 year old population in South Africa is infected with AIDS, and in parts of the country more than 35% of women of childbearing age are infected.⁶ Overall, 11-12% of the population is infected. About 1,700 new infections occur each day, and approximately 40% of deaths are believed to be AIDS-related. There

³ Liebowitz, Jeremy. 2002. The impact of faith-based organizations on HIV/aids prevention and mitigation in Africa: For the Health Economics and HIV/AIDS Research Division (HEARD), University of Natal with the support of the Department for International Development Knowledge Programme. October 2002. p.1

⁴ Source: National HIV and Syphilis Sero-Prevalence Survey of Women Attending Public Antenatal Clinics in South Africa, 2004)

⁵ SIM Hope for Africa. (<http://www.hopeforaids.org/prevention.asp>) accessed 21/10/06

⁶ "Background Note: South Africa"- <<http://www.state.gov/r/pa/ei/bgn/2898.htm>> accessed 31/07/06

are approximately 660,000 children who have lost one or both parents, and by 2008, 1.6 million children will have been orphaned by AIDS.⁷ Without effective prevention and treatment 5-7 million cumulative AIDS deaths are anticipated by 2010 (with 1.5 million deaths in 2010 alone), and there will be over five million sick with AIDS. The epidemic could cost South Africa as much as 17% in GDP growth by 2010. The extraction industries, education, and health are among the sectors that will be severely affected.⁸

1.2.1. AIDS cases in the 1980s

According to the Department of National Health and Population Development, the first AIDS case in South Africa was diagnosed in 1982. Whiteside and Sunter say that “the first two cases of AIDS were identified in South Africa in 1982.”⁹ Since then the prevalence recorded by the National Antenatal Seroprevalence Survey has risen steeply from less than one per cent in 1990 to nearly 25 per cent, ten years later. Zwi and Cabral attribute this steep rise to several factors: “impoverishment and disenfranchisement, rapid urbanization, the anonymity of urban life, labour migration, widespread population movements and displacements, social disruption, wars, especially counter-insurgency wars”¹⁰ and on any scale of these high-risk situations South Africa in the 1980s ranked near the top.

In 1983 the Department of Health reassured South Africans that AIDS was not a threat to society except for the homosexual group. Although initially HIV infections seemed mainly to be occurring amongst gay men, by 1985 it was clear that other sectors of society were also affected.¹¹ One of the sectors hardest hit was the mining sector. The art exhibition at the AIDS in South Africa Conference in 2002 showed that the rate of HIV/AIDS infections was high among South African miners as a result of the migrant labour system and the prevalence of unsafe prostitution. Miners from rural areas and

⁷ Background Note: South Africa”- <<http://www.state.gov/r/pa/ei/bgn/2898.htm>> accessed 31/07/06

⁸ Ibid

⁹ Whiteside A. and Sunter C. 2000. *AIDS the challenge for South Africa*. Tafelberg: Human & Rousseau. p. 47.

¹⁰ Dorrington R. and Johnson L 2002. Epidemiological and Demographic. In eds. Gow J., and Desmond C., *Impacts and interventions: The HIV/AIDS epidemic and the children of South Africa*. Pietermaritzburg: University of Natal Press. p.13-14

¹¹ AVERT (2006) <http://www.avert.org/aidssouthafrica.htm> accessed 16 July 2006

neighbouring countries, being away from their families, form new relationships in urban areas for most of their adult working life.¹² In 1987, the Chamber of Mines identified 130 miners with HIV and AIDS. Alarmed by the potential threat posed by foreign miners, the South African government passed regulations to bar non South African citizens with HIV/AIDS to be denied entry in South Africa or to be deported to their various countries.¹³ In 1988 promiscuity posed great danger and the then Minister of Health and Population Development and PFP spokesman on Health Dr Marius Barnard asked that HIV/AIDS carriers be isolated. In reinforcing this decision of isolation, the foreign mineworkers from countries surrounding South Africa were not allowed to renew their contracts. During this time, the government launched a campaign, spending R4 million to promote the department of Information. In 1989, as the epidemic continued to rage, Dr Reben Sher warned that HIV/AIDS could become a “biological holocaust”¹⁴ “People working on AIDS in the 1980s felt that it was inevitable that HIV would spread into the broader community.”¹⁵

For the first eight years, the epidemic was primarily located among white homosexuals. By this time a myth that “AIDS is a disease of gay white men in South Africa” dominated.¹⁶ However, as the number of cases increased, the disease began to spread among other groups so much so that the reality in July 1991 was that the number of heterosexually transmitted cases equaled the number of homosexual cases. From this time on “the homosexual epidemic has been completely overshadowed by the heterosexual epidemic.”¹⁷ Towards the end of the decade, as the abolition of Apartheid began, an increasing amount of attention was paid to the AIDS crisis.¹⁸

Another myth that shrouded the epidemic in the 1980s was that “AIDS is a disease of black people in South Africa.”¹⁹ But the reality as put by Whiteside and Sunter was that

¹² Art Exhibition displayed by Sam Nhlengethwa at a conference titled: “Aids in South Africa: The Social Expression of a Pandemic” held in South Africa on April 19 and 20, 2002 organized by Wellesley College.

¹³ *Times of AIDS in South Africa*. Natal Witness.. Pietermaritzburg. 1 Dcemeber 2004.

¹⁴ Ibid

¹⁵ Whiteside A. and Sunter C. 2000. *AIDS the challenge for South Africa*. p. 48

¹⁶ Ibid p. 47.

¹⁷ Ibid p. 47.

¹⁸ AVERT (2006) <http://www.avert.org/aidssouthafrica.htm> accessed 16 July 2006

¹⁹ Whiteside A. and Sunter C. 2000. *AIDS the challenge for South Africa*. p. 48

although there were many more black people infected in terms of absolute numbers than other race groups, the truth was that AIDS was spreading through all groups in South Africa and was breaching class barriers.²⁰

1.2.2. AIDS cases in the 1990s

The most common method of assessing HIV prevalence within a country is by conducting a survey of women attending antenatal clinics. In South Africa, such surveys have been conducted by the National Department of Health since 1990 at a sample of public antenatal clinics. These surveys are based on anonymous and unlinked samples accompanied by basic demographic data and are a low-cost tool for regularly monitoring key aspects of the HIV epidemic. The survey were compiled into a single study titled National HIV and Syphilis Sero-Prevalence of Women Attending Public Antenatal Clinics in South Africa.²¹ The results of these surveys have been broken down into provincial statistics. Surveys conducted from 1990 to 1999 annually among antenatal women in clinics throughout the provinces revealed an increase in the rate of infection. HIV and AIDS hit provinces at different rates and at different times. Some provinces scored higher than others. According to Whiteside and Sunter, KwaZulu-Natal has consistently had the highest level of HIV infection.²² Table 1 shows statistics of HIV prevalence in all the provinces of South Africa from 1994 to 2004.

Table 1: Provincial HIV prevalence: Antenatal Clinic attendees (ANCs), South Africa 1994-2004

²⁰ Whiteside A. and Sunter C. 2000. *AIDS the challenge for South Africa*. p.48.

²¹ Copied from HIV/AIDS Statistics. WEB20%stats.pdf

²² Whiteside A. and Sunter C. 2000. *AIDS the challenge for South Africa*. p. 50

Province	Estimated HIV- positive										
	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04
KwaZulu-Natal	14.4	18.2	19.9	26.8	32.5	32.5	36.2	33.5	36.5	37.5	40.7
Mpumalanga	12.1	18.3	15.8	22.6	30.0	27.3	29.7	29.2	28.6	32.6	30.8
Gauteng	6.4	12.0	15.5	17.1	22.5	23.9	29.4	29.8	31.6	29.6	33.1
Free State	9.2	11.0	17.5	19.6	22.8	27.9	27.9	30.1	28.8	30.1	29.5
North West	6.7	8.3	25.1	18.1	21.3	23.0	22.9	25.2	26.2	29.9	26.7
Eastern Cape	4.5	6.0	8.1	12.6	15.9	18.0	20.2	21.7	23.6	23.6	28.0
Limpopo	3.0	4.9	7.9	8.2	11.5	11.4	13.2	14.5	15.6	17.5	19.3
Northern Cape	1.83	5.3	6.6	8.6	9.9	10.1	11.2	15.9	15.1	16.7	17.6
Western Cape	1.2	1.7	3.09	6.3	5.2	7.1	8.7	8.6	12.4	13.1	15.4

(Source: National HIV and Syphilis Sero-Prevalence Survey of Women Attending Public Antenatal Clinics in South Africa, 2004)

Of the nine provinces of South Africa, the survey conducted in 2004 revealed that estimated prevalence of HIV was the highest in KwaZulu-Natal (KZN) and this is a trend that has been sustained since the first ANC HIV prevalence survey in 1990.

In 1990 the first antenatal survey was conducted across all communities of South Africa and these studies revealed that 0.8 % of women attending the state clinics were HIV positive representing a range of 74 000 and 120 000 HIV-infected people in South Africa. It must be mentioned that this survey did not include women in homeland areas at that time.²³ From 1990 onwards the antenatal surveys have been conducted annually and after 1994, the surveys have covered the entire country.²⁴ In 1991 the number of diagnosed

²³ Whiteside A. and Sunter C. 2000. *AIDS the challenge for South Africa*. P.49

²⁴ Ibid. p. 49

heterosexually transmitted HIV infections equalled the number transmitted through sex between men. Since this point, heterosexually acquired infections have dominated the epidemic. Several AIDS information, training and counselling centres were established during that year.²⁵ In 1992 the Government's first significant response to AIDS came when Nelson Mandela addressed the newly-formed National AIDS Convention of South Africa (NACOSA), although there was little action from the Government in the following few years. The purpose of NACOSA was to begin developing a national strategy to cope with AIDS. The free National AIDS Helpline was founded.²⁶ The National Health Department reported in 1993 that the number of recorded HIV infections had increased by 60% in the previous two years and the number was expected to double in 1993. The HIV prevalence rate among pregnant women was 4.3%.²⁷ By 1994 the Minister for Health accepted the basis of the NACOSA strategy as the foundation of the Government's AIDS plan. There was criticism that the plan, however well intended, was poorly thought-out and disorganized. The South African organization Soul City was formed, with the aim of developing media productions to educate people about health issues, including HIV/AIDS.²⁸ In 1995 the International Conference for People Living with HIV and AIDS was held in South Africa, the first time that the annual conference had been held in Africa. The then Deputy President, Thabo Mbeki, acknowledged the seriousness of the epidemic, and the South African Ministry of Health announced that some 850,000 people - 2.1% of the total population - were believed to be HIV positive.²⁹ In 1996 the HIV prevalence rate among pregnant women was 12.2% and in 1997 the rate among pregnant women had increased to 17.0%. In 1998 a survey showed that Mpumalanga ranked the second highest province in the country with women infected by HIV and AIDS representing 30%. On 10 December 1998 the pressure group Treatment Action Campaign (TAC) was founded, to advocate for the rights of people living with HIV/AIDS and to demand a national treatment plan for those who were infected.³⁰ In the

²⁵ AVERT (2006) <http://www.avert.org/aidssouthafrica.htm> accessed 16 July 2006

²⁶ Ibid

²⁷ Ibid

²⁸ Ibid

²⁹ Ibid

³⁰ Civil Society and Public Policy PDS 804. : Seminar five: Civil Society in Agenda Setting and Policy Formulation. Class notes, Policy and Development Studies. Pietermaritzburg: University of KwaZulu-Natal, 2005. *TAC: Treatment Action Campaign: An Overview*. p.4

same year, the then Deputy President Thabo Mbeki launched the Partnership Against AIDS, admitting that 1,500 HIV infections were occurring every day.³¹ However, the rate dropped in 1999 from 30 % to 27.3 % putting Mpumalanga in the third place behind the Free State.³² 1999 data revealed the rate increase in six provinces- Free State, Gauteng, North –West, Eastern Cape, Northern Cape and Western Cape. The rate in KwaZulu-Natal remained the same as in 1998.³³ The survey in 1999 revealed that the HIV prevalence rate among pregnant women was 22.4%.³⁴

1.2.3. AIDS cases in the 2000s

In the year 2000 the Department of Health outlined a five-year plan to combat AIDS, HIV and sexually transmitted infections (STIs).⁵ A National AIDS Council was set up to oversee these developments. At the International AIDS Conference in Durban, the new South African President Thabo Mbeki made a speech that avoided reference to HIV and instead focused on the problem of poverty, fuelling suspicions that he saw poverty, rather than HIV, as the main cause of AIDS. President Mbeki consulted a number of ‘dissident’ scientists who rejected the link between HIV and AIDS. The HIV prevalence rate among pregnant women was 24.8% in 2001. In 2002 South Africa's High Court ordered the Government to make the drug nevirapine available to pregnant women to help prevent the transmission of HIV to their babies. Despite international drug companies offering free or cheap antiretroviral drugs,⁶ the Health Ministry remained hesitant about providing treatment for people living with HIV. In 2003 the HIV prevalence rate among pregnant women had risen to 27.9%. In November, the Government finally approved a plan to make antiretroviral treatment publicly available. This national operational plan provided the structure for a comprehensive response to HIV and AIDS, including a national rollout of antiretroviral therapy.³⁵ In 2004 the rollout of antiretroviral drugs began in Gauteng in March, followed shortly afterwards by other provinces. However, the prevalence of AIDS in South Africa is now taking a devastating toll in human lives. According to data

³¹ Ibid p. 4

³² Whiteside A. and Sunter C. 2000. *AIDS the challenge for South Africa*. p. 50.

³³ Civil Society and Public Policy PDS 804

³⁴ AVERT (2006) <http://www.avert.org/aidssouthafrica.htm> accessed 16 July 2006

³⁵ “Background Note: South Africa”- accessed online 31/07/06

presented by Statistics South Africa in 2005, a recent study of death registration data showed that deaths among people 15 years of age and older increased by 62% in 1997–2002, with deaths among people aged 25–44 years more than doubling. Based on information from nearly 2.9 million death notification certificates, the study revealed that more than one third of all deaths were among people in that age group.³⁶ Today, South Africa is currently experiencing one of the most severe HIV epidemics in the world. By the end of 2005, there were five and a half million (5.5 million) people living with HIV in South Africa, and almost 1,000 AIDS deaths occurring every day, according to United Nations AIDS (UNAIDS) estimates.³⁷

According to the South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005, HIV prevalence by province showed that KwaZulu-Natal, Mpumalanga and Free State had the highest HIV prevalence in South Africa in 2005. The lowest HIV prevalence levels were recorded in the Western Cape and Northern Cape. In rating the HIV prevalence in population aged two years and above, by province, Mpumalanga had the highest prevalence in this age group, 23.0%, followed by KwaZulu-Natal at 21.9%. Western Cape had the lowest prevalence, 3.2%. HIV prevalence among adults aged 15–49 years by province, revealed that Mpumalanga had the highest HIV prevalence in 2005, followed by KwaZulu-Natal and Free State. These three provinces have HIV prevalence rates that are not significantly different. Demographically, people living with HIV/AIDS were found in every race group in South Africa, although the observed prevalence differed. HIV prevalence in Africans was substantially greater than in any other racial group – 13.3% compared to less than 2% of other races. Because of a poor response rate among Whites and Indians, their HIV prevalence estimates should be treated with caution.³⁸

³⁶UNAIDS/WHO. Uniting the world against AIDS: UNAIDS/WHO AIDS Epidemic Update: December 2005. <http://www.unaids.org/epi/2005/doc/report_pdf.asp> accessed 10/05/06.

³⁷AVERT (2006) <http://www.avert.org/aidssouthafrica.htm> accessed 16 July 2006

³⁸South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005. Fact Sheet 2 Date: 30 November 2005.

1.3. Research objectives

ECAP has mainly two objectives in discharging its programmes to its beneficiaries. The first objective is to equip the churches in the Pietermaritzburg area to intervene in the HIV and AIDS situation. The second objective is to equip the students, who are undergoing training at the Evangelical Seminary of Southern Africa, with the knowledge and skills for ministering to people affected and infected with HIV and AIDS. This study took consideration of both groups of its beneficiaries. Therefore, the *first* objective of my study was to give a brief history of ECAP and its work in Pietermaritzburg from the time it started up to December 2005. The *second* objective was to assess both the programmes which ECAP has been running in HIV and AIDS intervention between the period 1999 and 2005 in Pietermaritzburg by interviewing church ministers and ESSA graduates who received ECAP's training. The *third* objective was to find out how ECAP recruits churches for training. And the *fourth* objective was to explore what changes have taken place in churches and the lives of trainees as a result of being equipped by ECAP in HIV and AIDS intervention.

1.4. Research questions

The main research question in this study was to assess whether Christian FBOs were making any contribution to the fight against HIV and AIDS to mitigate its impact in Pietermaritzburg, KwaZulu-Natal province. To answer this question, the following key questions guided the research: How does ECAP recruit churches for training? What strategies and methods does ECAP use to deliver its service to its beneficiaries? How has the knowledge and skills gained in HIV and AIDS training affected the trainees' attitude, thinking, and behaviour towards people living with HIV and AIDS? What HIV and AIDS related activities are you doing in your church as a result of receiving training from ECAP?

1.5. Research hypothesis

Faith-based organizations make a significant contribution in HIV and AIDS intervention. This assumption is based on Krakauer's theory that Africa's faith community—which in many countries already provides most of the care and comfort for the sick and dying as

well as the orphans and vulnerable children—has a significant role to play in “the social and cultural antecedents of AIDS.”³⁹ According to Krakauer the church’s versatility as a social actor allows it to play, at least in principle, an important role in changing the social processes of gender inequality, migrant labour networks, poor health care and education. He adds that, “in its already recognized role as a service provider, the church can economically empower communities and women in particular, through skills training and income-generating projects.”⁴⁰ He further argues that,

As a communicator of social messages, it can emphasize gender equality and safe sexual practices, and in the process, decrease stigmatization. The church has the institutional advantages of an established, loyal following; an existing infrastructure to reach people; a centralized structure to coordinate a consistent response; access to resources beyond the local church; and volunteerism/altruism as a core value. With respect to AIDS in particular, religion deals with the causes of disease (especially in African religions), sexual morality, and how to cope with illness and death.⁴¹

The application of this theory to this study was useful for providing answers the researcher was looking for since his case study was an African faith community, ECAP, which was working with churches and religious leaders in Pietermaritzburg in addressing the impact of AIDS, a disease as yet without a cure.

1.6. Research methodology

This section discusses the methods used to investigate the role of Christian faith-based organizations in HIV and AIDS intervention using a case study of the ESSA Christian AIDS Programme. The research adopted both a quantitative and qualitative approach.

1.6.1 Research method

A descriptive survey was employed in this study. This type of survey describes the characteristics of the population that is under study, estimates proportions in the

³⁹ Krakauer. M. *Churches’ Responses to AIDS in two Communities in KwaZulu-Natal, South Africa*. Thesis submitted in partial fulfilment of the requirements for the Degree of Master of Philosophy in Development Studies. International Development Centre Queen Elizabeth House St. Antony’s College Oxford University April 2004. p. 10

⁴⁰ Ibid p. 9-10

⁴¹ Ibid p. 10

population, makes specific predictions and tests associated relationships.⁴² According to Weisberg, Krosnick and Bowen⁴³ survey research is used to address the following questions:

- The prevalence of attitudes, beliefs and behaviour;
- Changes in them over time;
- Differences between groups of people in their attitudes, beliefs and behaviour; and
- Causal propositions about these attitudes, beliefs and behaviour.

This study investigated whether the students' attitude, thinking and behaviour towards people living with HIV and AIDS changed as a result of attending the Church and AIDS course at the Evangelical Seminary of Southern Africa, facilitated by ECAP staff. Survey research was most appropriate to establish the students' behaviour towards people living with AIDS. Another reason why the survey method was chosen in the present study was to establish what activities ESSA graduates were involved in their various communities as a result of the training they received at from ECAP.

Survey research is used to gather contemporary data (Powell 1997: 58). It was projected that the findings of the study would portray the role of ESSA Christian AIDS Programme in HIV and AIDS intervention.

1.6.2. Population

A study population is defined as the aggregation of elements from which a sample is actually selected.⁴⁴ The population in this study comprised of two categories. The first category was ESSA graduates, who attended the Church and AIDS course at ESSA facilitated by ECAP. The second category was church ministers in Pietermaritzburg area where ECAP conducted its trainings in HIV and AIDS awareness, prevention and home-based care.

⁴² Powell, Ronald R. 1997. *Basic research methods for librarians*. 3rd ed. Greenwich, Conn.: Ablex.p. 61.

⁴³ Weisberg, Krosnick and Bowen 1996 *An introduction to survey research, polling and data analysis*. 3rd ed. Thousand Oaks: Sage Publications. p. 15

⁴⁴ Babbie and Mouton 2001 p.174.

1.6.3. Size of population

The population of this study comprised 20 graduates from ESSA, 10 church ministers from Pietermaritzburg area, and six members associated with the founding and management of ECAP from its inception to 2005. Former and current members associated with ECAP were interviewed to establish the history of ECAP, its progress and challenges it has met. Sampling in survey research allows the researcher to generalize findings across the population from which the sample was taken.

In the present study, the population of ESSA graduates was 141. All of them did the actual course because it was compulsory for every student to take it. Out of these 141, 20 respondents were sampled. There were 78 churches whose members were trained between 1999 and 2005 and 10 ministers were sampled for interviews. In both samples the population was obtained using purposive sampling. Babbie defines purposive sampling as “a type of non-probability sampling in which you select the units to be observed on the basis of your own judgement about which ones will be the most useful or representative”. He adds that “in studying all or a sample of the most visible leaders, you may collect data sufficient for your purposes.”⁴⁵ These samples were chosen because it was assumed that the population would be knowledgeable about the research questions. The population, therefore, consisted of individuals who were similar in that all of them went through HIV and AIDS training with ECAP. The rationale was that by virtue of their high-ranking positions, these respondents would be able to offer the necessary insights regarding the effectiveness of ECAP’s programme. A list of key informants was obtained from the coordinator in ECAP’s office.

1.6.4. Known characteristics of the population

In this section, known characteristics of the population are discussed. These include ESSA graduates, their gender, race, nationality, church ministers and ECAP staff.

⁴⁵ Babbie 2004 p. 183

1.6.4.1. ESSA graduates

20 respondents were students who studied the Church and AIDS course at ESSA at different times between 1999 and 2005. They all graduated and are involved in one way or another in the communities where they are situated.

1.6.4.2. Gender

Of the twenty respondents that received questionnaires nine were male and eleven were female graduates. The population list was obtained from the academic registrar of the Evangelical Seminary of Southern Africa.

1.6.4.3. Race

There were three white, seventeen black and one Indian ESSA graduates. The majority of students at ESSA come from African countries.

1.6.4.4. Nationality

ESSA graduates who took part in this study came from eight different countries of which 7 are African countries and 1 is European. These countries are: South Africa, Rwanda, Zimbabwe, Mozambique, Malawi, Switzerland, Zambia, and Ghana.

1.6.4.5. Church ministers

10 church ministers were sampled for face-to-face interviews. ECAP conducted training in the churches led by these ministers in the period between 1999 and 2005.

1.6.4.6. The ECAP staff

The ECAP staff were responsible for furnishing me with the historical background of ECAP and data concerning the number of churches that were trained in HIV and AIDS prevention and home-based care of people living with AIDS; and the history of ECAP.

1.6.5. Instrumentation

Most surveys utilize a simple data collection technique. Nevertheless, combinations are sometimes used.⁴⁶ Two methods were used in collecting data in the present study. These were a self-administered questionnaire for ESSA graduates and a structured interview schedule, which was used to collect data from the staff of ECAP and the church ministers.

A self-administered questionnaire was used because it allows respondents to complete the instrument themselves.⁴⁷ Bourque and Fielder argue that self-administered questionnaires must be closed-ended ones. Respondents of self-administered questionnaire dominated by open-ended questions are not always highly motivated to answer the questions. As a result the researcher finds out that returned questionnaires “will frequently have substantial amounts of missing or irrelevant data.”⁴⁸ To minimise this problem, the self-administered questionnaire used in the present study included more close-ended questions and fewer open-ended questions.

Access to the graduates was difficult because of their busy schedules and because most of them come from different countries. Some questionnaires were emailed to the respondents while others were submitted to the respondents who were within my reach. The self-administered questionnaire was deemed appropriate, to allow the graduates to complete it at their own convenience. A self-administered questionnaire also guarantees anonymity. Due to the limited time at my disposal, the self-administered questionnaire was chosen because it allows one to collect large amounts of data within a short period of time.⁴⁹

⁴⁶ Fowler F.J.1993. *Survey research methods*. 2nd ed. Newbury Park, Ca. Sage Publications. p. 54.

⁴⁷ Bourque and Fielder 1995. *How to conduct self-administered and mail surveys*. London: Sage Publications. p. 2

⁴⁸ Ibid p. 17

⁴⁹ Busha and Harter 1980 *Research methods in librarianship: techniques and interpretation*. New York: Academic Press. p. 62.

Apart from producing a better response rate, face-to-face interviews provide a greater capacity for the correction of misunderstandings by respondents.⁵⁰ They also allow the interviewer to probe further for elaboration or clarity on respondents' answers. Busha and Harter point out that verbal responses often provide valuable original data.⁵¹ The interview with the staff of ECAP and church ministers provided some background information that could not have been elicited from the graduate students.

1.6.5.1. The questionnaire

The questionnaire was 2 pages long and consisted of 11 questions or items. The questionnaire was semi-structured, that is both open-ended and close-ended questions were included in the questionnaire. In close-ended or structured questions, respondents are provided with fixed responses from which they are supposed to choose. A series of alternative responses are given, from which respondents are allowed to choose⁵² These types of questions are less demanding for the respondent and much easier to code and analyze, as opposed to open-ended questions.

Powell states that close-ended questions are “standardisable”, easy to administer and more easily understood by respondents, in terms of the dimensions along which the answers are sought.⁵³ For example, the questionnaire used in this study included questions that forced respondents to choose between fixed responses like “yes” and “no”. The shortcoming of such kind of responses is that they sometimes force a statement of opinion on an issue about which the respondent has no opinion. Respondents may also be forced to choose inaccurate answers.⁵⁴ Attitudinal questions were included in the questionnaire to obtain data of a subjective nature.⁵⁵ The questionnaire was designed to assess the effectiveness of the Church and AIDS course that the graduates took at the Evangelical Seminary of Southern Africa.

⁵⁰ Powell 1997 p.112.

⁵¹ Busha and Harter 1980 p. 78

⁵² Busha and Harter 1980 p. 70

⁵³ Powell 1997 p. 94

⁵⁴ Ibid p. 95

⁵⁵ Pather 2004. *A comparative study of the costs and benefits of journal ownership versus full-text electronic access in the Faculty of Science at the University of Natal, Durban Libraries*. MIS thesis. Pietermaritzburg: University of KwaZulu-Natal. p. 85

1.6.5.2. Categories of information

The questionnaire⁵⁶ was divided into three sections. These were:

- Section A: Background information
- Section B: Assessing the effect of the course on the attitude, thinking and behaviour of graduates towards people living with AIDS.
- Section C: Use of the knowledge and skills obtained on the course.

Questions one to four solicited background information in which respondents were asked about their name, title, gender, race, nationality and year graduated from ESSA. Section B comprised four questions which sought to establish whether the graduate took the Church and AIDS course or not. Respondents who indicated that they took Church and AIDS course were directed to respond to questions six to eight which sought to establish whether they found the course helpful or not, and how the course influenced their attitude, thinking and behaviour towards people living with AIDS. Those that indicated that they found the course useful and that it impacted their attitude, thinking and behaviour were further directed to respond to questions nine to eleven that sought to establish how they were using the knowledge and skills they got from the Church and AIDS course in their daily life and ministry to people.

1.6.5.3. The interview schedule

The interview schedule was divided into two phases. The first phase was intended to solicit data from respondents who were involved in the founding and running of ECAP from 1997 to 2005. The second schedule sought to gather data from church ministers in whose churches ECAP conducted training in HIV and AIDS. The schedule had four key guiding questions.⁵⁷

⁵⁶ Please note Appendix..... for a questionnaire that was used to solicit data from ESSA graduates.

⁵⁷ Note the appendix 3 for the interview schedule with ECAP staff and other members associated with the founding and running of ECAP.

1.6.5.4. Pre-testing the questionnaire

A pre-test allows the researcher to “learn how well their questions or instructions are understood and how comprehensive the response categories are.”⁵⁸ A pre-test also allows the researcher to identify questionnaire items that tend to be misunderstood by the respondents and hence fail to yield the information that is needed.⁵⁹

1.6.5.5. Population for the pre-test

The population for the pre-tests were five graduate students from the University of KwaZulu-Natal. Two were Masters students in Information Studies (MIS) while the remaining three were Masters students doing Theology with an HIV and AIDS focus in the School of Religion and Theology, at the University of KwaZulu-Natal. The respondents were asked to fill in the questionnaire and comment on the structure, wording, clarity and relevance of the questions. Babbie and Mouton mention that it is proper to pre-test the questionnaire on people to whom it is at least relevant.⁶⁰ In the present study Masters students were chosen because they were accessible through e-mail and had consented beforehand to participate in the pre-test. Also they were at the same level of studies as the researcher and were within same faculty of Humanities, Development and Social Sciences.

1.6.5. 6. Administering the pre-test

Bourque and Fielder argue that the pre-test should always be conducted prior to the actual data collection and the results should be carefully evaluated and used in making changes to the questionnaire.⁶¹ The questionnaire was sent in August through e-mail to five students because they could not be reached. The respondents were given one week to complete the questionnaire and e-mail or send it back to the researcher, together with their comments. Of the five questionnaires sent, four were returned.

⁵⁸ Bourque and Fielder 1995 p. 89 as cited by Mawindo D. p. 45

⁵⁹ Powell 1997 p.105.

⁶⁰ Babbie and Mouton 2001 p. 245

⁶¹ Bourque and Fielder 1995 p. 89

1.6.5.7. Changes resulting from the pre-test

Very few changes were made to the questionnaire. Some spelling mistakes in the questionnaire were corrected and the structure of some questions was revised.

1.6.6. Administering the research instruments

In this section, the procedures that were followed in administering the research instruments are discussed. The research instruments used in this study were the questionnaire and the interview schedule.

1.6.6.1. Administering the questionnaire

The questionnaire was finalized and sent out, together with a covering letter, to ESSA graduates. A list of the names of the students was obtained from the Academic Registrar. The questionnaires were sent on different dates in July and August 2006. The covering letter explained the aim of the study and assured the respondents of confidentiality and anonymity. The first page of the questionnaire included instructions on how to complete the questionnaire. Respondents were asked to return the questionnaire to the researcher either by hand or by email. Several reminders were sent to students to return the questionnaires. The response rate was so low that it necessitated the extension of the deadline for completing the questionnaire. The number of questionnaires eventually received totalled fourteen out of twenty, a response rate of 70%.

1.6.6.2. Administering the interview schedule

Appointments were booked with the ministers of the churches sampled prior to the interviews. The interviews took place in different venues and at different times as agreed by the ministers.

1.7. Data analysis

Once data is collected it should be checked for completeness, comprehensibility, consistency and reliability. This process is referred to as data cleaning. It involves “everything from simply reading the results, looking for surprising responses and

unexpected patterns, to verifying or checking the coding of the data.”⁶² Data cleaning is done both after data collection and after data entry into the computer. According to Ngulube “data analysis may aid a researcher to arrive at a better understanding of the operation of the social processes”.⁶³ Data analysis involves categorizing, ordering, manipulating and summarizing data to find answers to the research questions.⁶⁴

Since the questionnaire included both open- and close-ended questions, coding was done after the data was collected. Coding is “the conversion of raw data or responses to numerical codes so that they can be tabulated or tallied.”⁶⁵ Responses to open-ended questions were first content-analyzed before they were coded. Busha and Harter define content analysis as: “... the procedure designed to facilitate the objective analysis of the appearance of words, phrases, concepts, themes, characters, or even sentences and paragraphs contained in printed or audiovisual materials.”⁶⁶

Data was entered into a computer and analyzed. The presentation of data included the use of frequency tables. The results are presented in chapter four. Data analysis of the interviews with the ministers was done qualitatively, because the data could not be quantified and comparisons made with other respondents in the population under study.

1.8. Evaluation of the research method

Evaluation of a research method is necessary to find out if it measured what it intended to. Evaluation requires assessing the reliability and validity of the research method, as well as the instrumentation. Reliability is defined as “the degree to which a test consistently measures what it sets out to measure, while at the same time yielding the same results.”⁶⁷ Validity refers to “the degree to which a test measures what it is

⁶² Powell 1997: p. 63

⁶³ Ngulube cited in Mawindo D. *Evaluation of students' use of print and electronic resources at the University of Malawi College Of Medicine*. Masters thesis submitted to the School of Information Studies, The University of KwaZulu-Natal. p. 48

⁶⁴ Kerlinger 1986 in Ngulube 2005. p. 138.

⁶⁵ Powell 1997 p. 182.

⁶⁶ Busha and Harter 1980 cited in Mawindo D. 49

⁶⁷ Ngulube in. Mawindo D. 2005 p.49

supposed to measure.”⁶⁸ In other words, a valid research method measures the concepts it is intended to measure.⁶⁹ All surveys have certain methodological limitations in common. Additional limitations are imposed by constraints in time and money and by other factors unique to a particular object.⁷⁰ It is not good for researchers to give readers the impression that their research was perfect. Errors and limitations need to be acknowledged.

1.9. Overview of the thesis

The study comprises seven chapters. Chapter *one* introduces the study rationale, the context, objectives, research methodology, and the limitations to the study. Chapter *two* presents existing literature on the role of Christian faith-based organizations in HIV/AIDS intervention in KwaZulu-Natal. This chapter seeks to define the gap left by other research which this study intends to cover. Chapter *three* gives the background of ECAP, a brief overview of its history from the time it was started to 2005 and finally it gives an overview of ECAP’s programmes in Pietermaritzburg. Chapter *four* presents the results and analysis of the research that was conducted in Pietermaritzburg. It answers the research questions that were posed in chapter one to guide the research. Chapter *five* gives a summary of the results of the dissertation, and suggests recommendations for further research.

1.10. Summary of the chapter

This chapter has mainly looked at the motivation of the study and the research objectives. Several reasons underpin the choice of the topic and site of research. As said earlier, Pietermaritzburg was chosen as it is located in KwaZulu-Natal, an ‘epicenter of HIV and AIDS’ in South Africa. The main aim of the study was to assess whether Christian faith-based organizations were making any contribution to the fight against HIV and AIDS in the province using a case study of ECAP, a Pietermaritzburg based Christian FBO. To get

⁶⁸ Gay 1996 in Mawindo D. p. 49

⁶⁹ Weisberg, Krosnick and Bowen in Mawindo D. p. 49

⁷⁰ Doyle, James K. 2001. Handbook of IQP advisors and students.

<<http://www.wpi.edu/Academics/Depts/IGSD/IQPHbook/ch10.html#10>> 23 March 2004.

the relevant data, quantitative and qualitative methods were used. Descriptions of the population under study, instruments, their form and categories of questions have been discussed. Data collection procedures and the evaluation of the research method have also been discussed in this chapter.

CHAPTER 2: THE ROLE OF CHRISTIAN FBOs IN HIV/AIDS INTERVENTION.

2.1. Introduction

This chapter deals with existing body of knowledge in the field of faith-based organizations and HIV and AIDS. It covers a review of the literature that is related to the research study. It intends to indicate where the present study fits into the broader debates, thereby justifying the significance of the study.⁷¹ I then review the literature on how faith-based organizations have responded to the HIV and AIDS pandemic in KwaZulu-Natal Province, in particular in the Pietermaritzburg area where the study was carried out, in order to provide a context for the issues surrounding my research topic and to place my research within this body of work.

The literature review “discusses published information in a particular subject area, and sometimes information in a particular subject area within a certain time period.”⁷² The present study was relevant in determining the role of faith-based organizations in HIV and AIDS prevention and mitigation which would assist many faith communities to provide relevant assistance to people infected and affected with HIV and AIDS in their communities. A number of studies have been done on the role of faith-based organizations in HIV and AIDS intervention. Some of them focused entirely on faith communities in general, others focused on leaders of churches while others focused on the activities faith communities are engaged in. Not all studies covered the roles played by specific faith-based organizations or churches.

The studies reviewed here concerned Christian FBOs although others included FBOs of other faiths.⁷³ A few studies have looked at the issue of churches and AIDS from a

⁷¹ Pather, Roshini. 2004. *A comparative study of the costs and benefits of journal ownership versus full-text electronic access in the Faculty of Science at the University of Natal, Durban Libraries*. MIS thesis. Pietermaritzburg: University of KwaZulu-Natal. P.72

⁷² Mawindo Diana 2005. *Evaluation of students' use of print and electronic resources at the University of Malawi College Of Medicine*. Masters thesis submitted to the School of Information Studies, The University of KwaZulu-Natal.

⁷³ Liebowitz Jeremy 2004. *Faith-based organizations and HIV/AIDS in Uganda and KwaZulu-Natal Final report*. Liebowitz was a researcher for the Health Economics and HIV/AIDS Research Division (HEARD),

sociomedical perspective. These quantitative studies do not start with religion as their focus, but rather some specific outcome, such as sexual behaviour. They test for variables, including religion, that display differences in the outcome across the population⁷⁴ Takyi's study is an exception in that she does start with religion as her focus. She explores how AIDS knowledge and sexual behaviour differ across religions, using a large, pre-existing dataset (4593 women) from a national survey in Ghana.⁷⁵

Therefore, I felt that a community-based study would be a positive contribution to the field. This approach provides an analysis of what is happening on the ground, which is especially valuable for a topic that seems swamped at times with large-scale statistics and high-level policy debate.⁷⁶ Casley and Lury argue that this case-study approach is useful for detailed, micro -level research, because it allows for a variety of data collection methods.⁷⁷ However, the study cannot generalize the results because of the case study research design. This study examined the role of faith-based organizations, particularly Christian organizations, in HIV and AIDS prevention and mitigation within the broader context of the NGO world using a case study methodology. It is a continuation of the studies that were conducted by Liebowitz, Krakauer, Garner and Xaba in KwaZulu-Natal.

University of Natal with the support of the Department for International Development Knowledge Programme. He researched on "The impact of faith-based organizations on HIV/AIDS prevention and mitigation in Africa" by comparing FBOs in Uganda and Kwazulu-Natal, South Africa.

⁷⁴ Adegbola, O., and O. Babatola. "Premarital and Extramarital Sex in Lagos, Nigeria". *The Continuing African HIV/AIDS Epidemic*, edited by J.C. Caldwell, I.O. Orubuloye and J.P.M. Ntozi. Canberra: Australian National University, 1999 As cited by Krakauer 2004

⁷⁵ Takyi, Baffour K. "Religion and Women's Health in Ghana: Insights into HIV/AIDS Preventive and protective Behaviour." *Social Science and Medicine* 56 (2003): 1221-34.

⁷⁶ Mark Krakauer 2004. Churches' Responses to AIDS in two Communities in KwaZulu-Natal, South Africa: Thesis submitted in partial fulfillment of the requirements for the Degree of Master of Philosophy in Development Studies. International Development Centre Queen Elizabeth House St. Antony's College Oxford University. p. 114.

⁷⁷ Casley, D. J., and D. A. Lury. *Data Collection in Developing Countries*. 2nd ed. Oxford: Clarendon Press, 1987.p.64

My main sources in this study were Krakauer,⁷⁸ Liebowitz⁷⁹, and Garner⁸⁰ who studied churches' response to HIV and AIDS; the impact of faith-based organizations in the prevention and mitigation of HIV and AIDS and the knowledge ministers had about HIV and AIDS. While Krakauer's study focused on three denominations in the two communities of Durban, KwaZulu-Natal and used both quantitative and qualitative methodologies, my study focused on ten (10) churches belonging to a variety of denominations in eight (8) different communities of Pietermaritzburg. Data was collected using qualitative and quantitative methods.

2.2. Definition of faith-based organization

Faith-based organization, as defined by U.S. Agency for International Development (USAID), "are groups of individuals who have come together voluntarily around a stated spiritual or belief system that informs and guides their work together. They range from small, grassroots organizations with simple structure and limited personnel to large, global institutions with highly sophisticated bureaucracies, wide networks, substantial financial resources, and significant human resources."⁸¹ Yekholo sees FBOs as religious and religious-based organizations, places of religious worship or congregations, specialized religious institutions, and registered and unregistered non-profit institutions that have religious character or mission.⁸² Ferris says that "faith-based and secular humanitarian organizations have a long history of responding to people in need and today are important players in the international community's response to emergencies."⁸³ For example, Smillie and Minear point out that

Government officials are now aware that the world's largest NGOs actually provide more aid than do some donor governments. NGOs are active in more countries than many governments, and they

⁷⁸ Mark Krakauer 2004. *Churches' Responses to AIDS in two Communities in KwaZulu-Natal, South Africa*.

⁷⁹ Jeremy Liebowitz 2002. "The impact of faith-based organizations on HIV/AIDS prevention and mitigation in Africa." October 2002

⁸⁰ Garner, Robert C. "Safe Sects? Dynamic Religion and Aids in South Africa." *Journal of Modern African Studies* 38, no. 1 (2000): 41-69.

⁸¹ Green E.C. 2003. *Faith-Based Organizations: Contributions to HIV Prevention*. Harvard Center for Population and Development Studies. U.S. Agency for International Development. p.3

⁸² Imisebenzi Yekholo. Defining 'Faith-based Organization' p.28. Available online www.globalhealth.org/images/pdf/faith_in_action/defining/pdf accessed 29 October 2006.

⁸³ Elizabeth Ferris. "Faith-based and secular humanitarian organizations". *International review of the Red Cross*. Volume 87 Number 858 June 2005. p 317. Available online [www.icrc.org/Web/eng/siteeng0.nsf/htmlall/review-858-p311/\\$File/irrc_858_Ferris.pdf](http://www.icrc.org/Web/eng/siteeng0.nsf/htmlall/review-858-p311/$File/irrc_858_Ferris.pdf) -

carry more credibility with taxpayers than do government aid agencies. Indeed, some individual NGOs have country programmes with larger budgets than the government ministries to which they relate.⁸⁴

Although FBOs share many characteristics with other NGOs that are not religious by definition like being influenced by the same political, social and economic contexts, faith-based humanitarian organizations are distinct from most secular humanitarian organizations. Ferris argues that FBOs are motivated by their faith and they have a constituency which is broader than humanitarian concerns. She adds,

For believers, to be a Jew or a Muslim or a Christian implies a duty to respond to the needs of the poor and the marginalized. The expression of this faith takes different forms in different religious traditions but is a powerful motivation for humanitarian action.⁸⁵

For example, mission societies which flourished in Europe and North America in the eighteenth and nineteenth centuries sought to evangelize in distant continents, but provided humanitarian assistance too. They also raised awareness in their home countries of humanitarian needs elsewhere, and individual congregations therefore often sponsored missionaries, sending money and relief items in response to the needs they reported.⁸⁶

The long Christian missionary tradition, although often faulted today for its complicity in colonialism, left a legacy of church involvement in social services in all regions, particularly in the areas of education and health.⁸⁷ Headley of Catholic Relief Services asserts, “The principal agents of human development in the world have been or continue to be faith-based organizations.”⁸⁸ For example, in the United States of America, the Catholic Church is the largest non-public provider of human services to poor families. One-third of all AIDS patients in the world are served through the auspices of the Catholic Church.⁸⁹ Ferris continues to argue that Christian NGOs are active in virtually every country in the world. She states that, while Jewish and Islamic NGOs primarily serve members of their own religious communities, Christian organizations tend to have a

⁸⁴ Ian Smillie and Larry Minear 2004, *The Charity of Nations*. Kumarian Press, Inc, Bloomfield, USA.

⁸⁵ Elizabeth Ferris 2005. p 317.

⁸⁶ Ibid p 314

⁸⁷ Ibid p 316.

⁸⁸ William Headley “International faith-based initiatives: Can they work?” as cited by Elizabeth Ferris. In “Faith-based and secular humanitarian organizations”..... p 316.

⁸⁹ Elizabeth Ferris. 2005. p 316

more global outreach: to assist those in need regardless of their religious affiliation. Although within the world of Christian organizations, there are sharp differences between them, their humanitarian work is an integral part of their missionary activities.⁹⁰

Historically, faith-based organizations have been very active in alleviating human ills and promoting the welfare of the people. In the immediate post-World War II period, there was a dramatic increase in the number of secular and Christian organizations that were created to respond to humanitarian need. Care International, Christian Aid and Church World Service all had their roots in the interwar period but grew rapidly in the years following World War II. The World Council of Churches (WCC) was formed in 1948 as a fellowship of churches, but much of its programmatic work in its early years was concerned with responding to humanitarian need, particularly the needs of Europe's displaced millions. Similarly, the Lutheran World Federation (LWF) was founded in 1947 and focused much of its early work on responding to the needs of Lutherans displaced by the war.⁹¹ During the 1950s and 1960s, NGOs, particularly faith-based organizations, continued to provide substantial relief and were essential to the functioning of the refugee-serving community. One 1953 analysis found that fully 90% of post-war relief was provided by religious agencies.⁹² But NGOs also took the lead in lobbying for resettlement opportunities and in providing the resources needed for resettlement of the hundreds of thousands of Hungarian refugees fleeing Soviet intervention in 1956. Over the years, Northern church-based organizations channeled millions of dollars to churches and related organizations in the South through what was known as "inter-church aid" in support of local church work with the poor and with victims of wars and other disasters. In 1962, the International Council of Voluntary Agencies (ICVA) was formed, largely as a result of the initiative of faith-based organizations, and by 1965, as many as 65 agencies had become members of ICVA. The ICVA played, and continues to play, a unique role as a coalition of both Southern and Northern NGOs active in the fields of development and

⁹⁰ Ibid p. 316

⁹¹ Elizabeth Ferris 2005. p. 314-315.

⁹² Nichols, J. B., *The Uneasy Alliance: Refugee Work and US Foreign Policy*. Oxford University Press, New York, 1998, pp. 32-33

humanitarian relief.⁹³ From the early 1960s to the early 1980s NGOs grew in size and range of activities, but their expansion did not keep pace with the growth in intergovernmental organizations, particularly that of the United Nations High Commission for Refugees (UNHCR). The steady expansion of the UNHCR's mandate, especially with the adoption of the 1967 Protocol relating to the Status of Refugees which removed the geographical restrictions, meant that UNHCR became active in situations from which it had previously been excluded.⁹⁴ By the 1980s the proliferation of NGOs, the growth of indigenous NGOs in developing countries and changing understandings of development meant that secular and faith-based international organizations came under increasing pressure to decrease their direct involvement in provision of services abroad and instead to support the development of local institutions. Institution-building and empowerment replaced concepts of community organizing which had largely been carried out by expatriate staff in the 1960s and 1970s.⁹⁵ The United States Agency for International Development has played a leading role since the early 1990s in working with faith-based organizations to support HIV and AIDS prevention and care interventions. Several of these USAID-funded interventions have been recognized as best practices by the United Nations AIDS (UNAIDS) Programme. These include the work in Uganda with Imams on HIV prevention, the collaboration with religious leaders on policy and HIV prevention in Senegal, and the work by MAP International in Kenya to bring different faiths together to address policy, prevention and care issues. These are only a few of the many examples of the leadership of faith-based institutions and communities since the 1980s in HIV and AIDS prevention and care.⁹⁶

Mark Krakauer studied 'Churches' Responses to AIDS in two communities in KwaZulu-Natal, South Africa'. In his research Krakauer compared how three denominations responded to AIDS in two communities of Magwaveni and Mlandeni in the Durban

⁹³ Elizabeth Ferris 2005. p 315.

⁹⁴ Ibid p.316

⁹⁵ Elizabeth Ferris 2005. p 316.

⁹⁶ HIV/AIDS prevention, care and support across faith-based communities: an annotated bibliography of resources. This document has been funded by USAID/REDSO through FHI's Implementing AIDS Prevention and Care (IMPACT) project, cooperative agreement HRN-A-00-97-00017-00.

area, KwaZulu-Natal.⁹⁷ Magwaveni is an informal settlement in Tongaat, a small city 70 km north of Durban and falls under eThekweni (Durban) Municipality. Mlandeni, falls under the rural municipality of Ndwedwe. He collected data using a variety of methods, from various social actors, in a process of triangulation. Several dozen community leaders, eleven households who held some leadership role in their local church, and 26 sick families were interviewed. He also used a resource questionnaire with each family he interviewed. He was thus able to see the issue of what the community was doing about AIDS from a variety of perspectives, and to corroborate what informants were telling him.⁹⁸ Krakauer found that while none of the churches that he studied were involved in overt prevention campaigns; they did communicate messages about sexual behaviour as part of routine church discourse. Not surprisingly, their sexual behaviour messages took a moral-religious, rather than medical, approach. The Catholic Church was the only one involved in AIDS care in these two communities.⁹⁹ A similar study was done in the Pietermaritzburg area focusing on sexual behaviour was done by Garner.¹⁰⁰ Garner studied the relationship between behaviour and religious affiliation in Pietermaritzburg using quantitative and qualitative methodologies to produce a more meaningful conclusion. He interviewed 78 people belonging to five religious categories. The respondents were not randomly selected; he does not compute the statistical significance of his results; and his results do not allow or check for intervening variables. The consequence of an unsophisticated approach is questionable result validity, but he substantiates his conclusions with qualitative data—semi-structured interviews and focus groups.¹⁰¹ He found that mainline, Zionist, and Apostolic church members and those with no church affiliation all reported similar levels of extra- and pre-marital sexual activity. Pentecostal church members were unique in reporting lower levels of extra- and premarital sexual activity. From interviews and investigations into church teachings and practice, he explained his results by noting what made the Pentecostal churches different from the other churches. He hypothesizes that Pentecostal church members had lower levels of

⁹⁷ Mark Krakauer 2004. p. 118-119

⁹⁸ Mark Krakauer 2004. p.118-119

⁹⁹ Mark Krakauer 2004. p. 104

¹⁰⁰ Garner, Robert C. "Safe Sects? Dynamic Religion and Aids in South Africa." *Journal of Modern African Studies* 38, no. 1 (2000): 41-69.

¹⁰¹ Krakauer 2004

extra- and pre-marital sexual activity because the Pentecostal denomination has a higher level of ideological power over members than the other denominations. He defines ideological power as being composed of indoctrination, exclusion, socialization, and religious experience. Thus Garner's study presents an observed pattern, as well as a mechanism to explain the pattern.¹⁰² Thandeka Xaba¹⁰³ studied the impact of ECAP in training women in home-based and orphan care. She interviewed six of the eleven women that received ECAP's training in home-based and orphan care in Ekuthuleni Zionist Church in Imbali, Pietermaritzburg. Her research aimed at analyzing the impact of ECAP in empowering women with skills in home-based and orphan care. All the six women reported that they received the relevant knowledge about HIV and AIDS and skills to take care of the orphans and the dying AIDS patients, which they began to do after their training. However, Xaba's study focused on a group of women in Ekuthuleni Zionist Church in one community of Imbali, and did not include the assessment of the training of clergy and ESSA students by the same ECAP in Pietermaritzburg, which this study seeks to address.

Churches play an integral part in the combat against HIV and AIDS. For example, studies conducted in Uganda have revealed that the involvement of churches in AIDS in Uganda, which has received the most scholarly attention due to its being regarded as a success story, have been viewed as an integral part of the country's success in decreasing prevalence rates. Surveys of pregnant women show a decrease in prevalence from a peak of 15% in 1991 to 5% in 2001.¹⁰⁴ Parkhurst¹⁰⁵ notes that Uganda's success is primarily attributed to the early steps the government took to publicize the disease. Uganda's President Museveni went beyond encouraging action by the government; he used a multi-

¹⁰² Ibid.

¹⁰³ Xaba, Thandeka. *Community Involvement in the fight against HIV/AIDS: a critical analysis of ESSA Christian AIDS Programme in Pietermaritzburg*. Unpublished Honours research project. Pietermaritzburg: The School of Religion and Theology, University of KwaZulu-Natal. October 2005.

¹⁰⁴ Green, Edward C., V. Nantulya, R. Stonburner, and J. Stover. "What Happened in Uganda?: Declining HIV Prevalence, Behaviour Change, and the National Response." edited by J. Hogle, 1-13: *Synergy Project*, USAID, 2002.p. 2

¹⁰⁵ Parkhurst, J. (2001): "The Crisis of Aids and the Politics of Response: The Case of Uganda." *International Relations* 15 P.69-87.

sectoral approach that coordinated and mobilized other social institutions—industry, NGOs, religious bodies, student groups, etc. For their part, religious leaders in Uganda stressed the prevention slogans of Abstinence, Be faithful (monogamy), and Condoms—the ABCs of AIDS prevention.¹⁰⁶ Parkhurst¹⁰⁷ adds that Uganda’s multi-sectoral approach to AIDS was embodied in its prevention campaign, where different organizations promoted different methods of prevention. “The government of Uganda did not push for condoms very strongly, instead pursuing a ‘quiet promotion of condoms’, and inviting religious leaders to take part in discussions of condoms as a state policy.” While different sectors promoted different modes of prevention, they did not snipe at each other, and thus presented a united front in AIDS education.¹⁰⁸ Since FBOs made a significant contribution to Uganda’s success story in preventing and mitigating the impact of HIV and AIDS some researchers like Liebowitz chose to make a comparative study between FBOs in Uganda (which have reported low rate of infection) and KwaZulu-Natal Province which has the highest HIV prevalence rate in South Africa. Liebowitz¹⁰⁹ studied the impact of faith-based organizations on HIV/AIDS prevention and mitigation in Africa. He sampled a cross-section of faiths. In Uganda, this included the following faiths and denominations: Catholic; Anglican (Church of Uganda); Pentecostal; Baptist; Locally-based Evangelical; Islamic (including both *tabliq* groups and mainline Sunni Islamic groups); Hindus; and Traditional Religious Practitioners. In South Africa, this cross-section included the following faiths and denominations: Catholic; Methodist; Pentecostal; Apostolic; Zionist; Shembe; Muslims; and Hindus. This cross-section captured the diversity of faiths and denominations across two religiously diverse countries. Liebowitz say that “these two countries also contain many common faiths and allowed us to examine how faiths work differently across different countries.”¹¹⁰

¹⁰⁶ Liebowitz. October 2002. p.26.

¹⁰⁷ Ibid p.69-87.

¹⁰⁸ Liebowitz cited in Krakauer 2004.

¹⁰⁹ Ibid p.5

¹¹⁰ Ibid p.5

To begin his study, Liebowitz interviewed religious leaders and officials to determine what messages they were delivering and what activities they were carrying out. Second, members of faith communities at the local level were interviewed to determine: how they perceived the activities being carried out and the messages being delivered; what activities they are carrying out at the community level; and in what they think their faith communities should become more involved. An introductory workshop was held at the beginning of the research in KwaZulu-Natal, while a concluding workshop was held in Luuka. Feedback from these workshops was integrated into the final report.

In KwaZulu-Natal, Liebowitz's research focused on Durban (a major city), Ntuzuma (a township of Durban), and Newcastle, a rural area in KwaZulu-Natal. In all these areas a wide variety of denominations and faiths exist. They also represent widely varying socioeconomic, organizational, and political contexts. This choice of sites accommodated potentially significant variation in the activities of FBOs across these divides. The research also sampled a cross-section of faiths which included the following faiths: Catholic; Methodist; Pentecostal; Apostolic; Zionist; Shembe; Muslims; and Hindus in KwaZulu-Natal. This cross-section captured the diversity of faiths and in KwaZulu-Natal.¹¹¹ Religious leaders and officials were interviewed to determine what messages they were delivering and what activities they were carrying out. Second, members of faith communities at the local level were interviewed to determine: how they perceive the activities being carried out and the messages being delivered; what activities they were carrying out at the community level; and in what they thought their faith communities should become more involved. The study found that these FBOs were involved in significant and positive activities in AIDS prevention, care and support at the community level. Almost all FBOs were carrying out some form of activity in one of these categories. The most common activities being carried out were, in order of most common to least common: 1) Awareness/education; 2) Counselling and supporting testing; 3) Home care; 4) Food or material support; 5) Support for orphans; 6) Providing treatment or medication of some kind; 7) Income generating activities and 8) Condom supply. In some cases there was significant overlap across these activities, so in some cases different

¹¹¹ Liebowitz 2004. p. 6.

activities may be part of integrated services.¹¹² However, Liebowitz¹¹³ comments that in some areas FBOs have done very little due to certain constraints. Few FBOs have provided treatment and medication due to cost, lack of medical expertise, and administrative weaknesses. He adds that FBOs have also done little to refer patients to appropriate services and provide information on those services. Finally, FBOs have not yet done much to develop support groups for those infected/affected or to develop peer education programs that involve individuals as trainers for their peers.¹¹⁴ Activities such as counselling and home care were often difficult for FBOs to implement because of the labour-intensiveness of these strategies and the reliance of FBOs on voluntary workers from their community.¹¹⁵

This current study sought to complement the work of Liebowitz, Krakauer, and Garner by studying a sample of a Christian FBOs. While Liebowitz studied a cross section of FBOs whether they were of Christian, Muslim or Hindu faith; Ntsimane studied two ministers and Krakauer studied three denominations in two communities of KwaZulu-Natal, this study enlarged the sample size by studying ten (10) churches in eight (8) communities of Pietermaritzburg which received training from ESSA Christian AIDS Programme. These communities comprised urban, semi-rural and rural communities. While Liebowitz studied a cross section of FBOs in KwaZulu-Natal this study focused on one FBO, ECAP to assess whether it was making any contribution to the fight against HIV and AIDS pandemic in Pietermaritzburg.

2.3. An overview of FBOs and their activities in KwaZulu- Natal

Liebowitz makes the case that FBOs possess significant advantages in delivering certain kinds of interventions, which have been relatively successful in reducing HIV prevalence rates and mitigating the worst impact of the AIDS epidemic¹¹⁶. In his research in 2002, Liebowitz discovered that, in many cases, members of FBOs demonstrated more commitment to their FBOs compared to other political, social and economic institutions.

¹¹² Ibid p. 7

¹¹⁴ Ibid p.3

¹¹⁵ Liebowitz p. 3

¹¹⁶ Ibid p.1

FBOs often have a direct impact on social institutions, such as schools, which socialize people and change values over time. In addition, their jurisdiction often includes a number of areas closely connected to HIV and AIDS, such as morality, beliefs about the spiritual basis of disease, and rules of family life and sexual activity. Other institutions such as public health organizations, political leadership, and international NGOs have frequently excluded such areas from their activities. For all these reasons, therefore, FBOs are in a unique position to contribute to the campaign against the AIDS epidemic in Africa.¹¹⁷ FBOs can also be engaged in providing treatment and medication to people living with AIDS. Liebowitz says that “Despite the high cost of ARVs [Antiretrovirals] and the limited medical capabilities of many FBOs, a fair number are providing some kinds of treatment or medication for their members and communities.”¹¹⁸ For example, mission hospitals like McCord in Durban and St Mary’s in Mariannhill, are among the large Christian hospitals in KwaZulu-Natal which are involved in treating AIDS patients in KwaZulu-Natal. Although only a few FBOs are currently providing ARVs, many are offering other kinds of medication that can help those infected to resist related and opportunistic infections. For example, the Methodist Church in Ntuzuma provides medication against a form of flu that can be particularly devastating for those with AIDS.¹¹⁹ In cooperation with donors and government health providers some FBOs have been able to provide various kind of useful treatments. However, most of the treatments remain out of the reach of FBOs that do not have the financial or medical resources within their organizations, which is the case for vast majority of FBOs. Research has shown that when FBOs act in cooperation with other donors and government health units, they may be extremely effective in providing access to medicine among those who lack it for reasons of limited resources, geographical constraints, or lack of information.¹²⁰

FBOs have a role to play in advocacy and communication. According to a report by the United Nations Children's Fund (UNICEF) (2003), “The majority of FBOs involved in HIV work place a strong emphasis on advocacy, communication and training. For

¹¹⁷ Liebowitz 2004:7

¹¹⁸ Ibid p. 11

¹¹⁹ Ibid p. 11

¹²⁰ Ibid p.11

example, the Pietermaritzburg Agency for Christian Social Awareness (PACSA), a Pietermaritzburg based FBO, has been involved in advocacy against gender-based violence in South Africa. Haddad says that “gender violence is all pervasive in South African Society”. She adds,

....domestic violence is not presently classified as a crime and therefore there are no accurate police statistics. Given the shockingly high incidence of domestic violence and rape in South Africa, the magnitude of women’s vulnerability to infection is overwhelming.¹²¹

Thus the South African society is facing an enormous crisis regarding the prevalence of sexual violence....and each crisis relates to human sexuality and to unequal power relations between men and women.¹²² Therefore, Christian FBOs must engage in advocacy against gender imbalances in KwaZulu-Natal that catalyze the spread of HIV and AIDS.

In terms of sexual behaviour, Garner¹²³ conducted a research in the Pietermaritzburg area in which he compared the relationship between behaviour and religious affiliation.

2.4. Activities of some Christian FBOs in Pietermaritzburg

2.4.1. Awareness and education

Ntsimane¹²⁴ conducted interviews with two ministers in a rural area of KwaZulu- Natal to compare their knowledge of AIDS. He spoke to a Zionist minister and a Nazareth Baptist (Shembe) minister. Both ministers knew that AIDS was a deadly sexually transmitted disease. Neither knew anybody in their congregations with AIDS and neither spoke to their congregations about AIDS. The Shembe minister believed that the leader of his church could cure all diseases, including AIDS. The results from Ntsimane’s study show

¹²¹ Haddad B. 2002. Gender violence and HIV/AIDS: A deadly silence in the Church. *Journal of Theology for Southern Africa* 114 (November 2002) p.150

¹²² Haddad B. 2002. Gender violence and HIV/AIDS: A deadly silence in the Church. *Journal of Theology for Southern Africa* 114 (November 2002) p.150

¹²³ Garner, Robert C. "Safe Sects? Dynamic Religion and Aids in South Africa." *Journal of Modern African Studies* 38, no. 1 (2000): 41-69.

¹²⁴ Ntsimane, Radikobo. "The Challenge of Aids in the Rural Aics [African Initiated Churches or African Independent Churches]." *Bulletin for Contextual Theology* 7, no. 1 (2000): 22-25.

that there are still some people, even religious leaders, who are not well informed about HIV and AIDS. This underscores the need for FBOs to get involved in activities to increase knowledge about HIV and AIDS within their congregations and the community.

Nicolson suggests that

Ministry on the AIDS problem will involve education, attempts at social reconstruction, provision of support for those who are HIV positive, those with AIDS, and their friends, partners and families, the provision of direct practical care and basic nursing, and care for AIDS widows and orphans.

Education about AIDS is vital, but the truth is that probably millions of people have the virus already, and even if our educational programme was successful, there will still be all of those already infected who will soon need our care.”¹²⁵

During his research, Liebowitz found that FBOs were involved in activities that ranged from communication during sermons to workshops to crusades to peer education.¹²⁶ He adds, “They are described under various labels, usually as awareness, education, or providing information in KwaZulu-Natal and as sensitization or education in Uganda.”¹²⁷

As part of its HIV and AIDS awareness and education, PACSA on 17 October, 2000 facilitated a workshop with ministers in training at the Evangelical Seminary of Southern Africa to explore the “ten myths” that shrouded HIV and AIDS. They also grappled with the issue of use of condoms by young people and abstinence as the cure for AIDS. This is an example of an FBO is engaging the community in HIV and AIDS awareness and education.

Liebowitz is right in saying that “In most cases congregation members and other targets of educational messages are eager to know more about HIV and AIDS and respond with many further questions.” I remember joining ECAP during my HIV and AIDS field placement in 2003 in the Ethiopian church, in Sobantu. ECAP was conducting an HIV and AIDS awareness programme through interactive drama. The ECAP official and a volunteer engaged in a conversation about HIV and AIDS and myths. After the drama, some members of the congregation asked many questions. This is an indication that

¹²⁵ Nicolson R. 1995. AIDS: A Christian response. Pietermaritzburg: Cluster Publications. p.72

¹²⁶ Liebowitz 2004: 8-9.

¹²⁷ Ibid p. 8-9.

FBOs are an asset within communities to deliver messages on a regular basis and can be very effective in HIV and AIDS intervention.

Project Gateway is running the “No Apologies” Programme where it engages students in some high schools of Pietermaritzburg in HIV and AIDS education, awareness and empowers the young people to make informed decisions about every action they take. However, the main constraints that FBOs face in their attempts to provide education and awareness about AIDS are a lack of knowledge and technical expertise among those members of FBOs carrying out the educational activities.¹²⁸ In KwaZulu-Natal, the higher level of stigma also seems to be a barrier for some groups as they are reluctant to discuss HIV and AIDS or reluctant to allow their children to discuss the subject publicly.

2.4.2. Early childhood education

Some FBOs go beyond HIV and AIDS awareness and education; they are involved in educating the children in formal schools. For example, Kenosis is a Christian FBO which is situated in Bishopstowe, a farming community near Pietermaritzburg, where there is no schooling facility available for pre school-going children. Many of these children are therefore left to their own devices while their parents go to work on the farms during the day. Poverty, unemployment and AIDS are very evident. Kenosis has intervened in this situation by establishing a pre-school to give education to vulnerable and helpless children in Bishopstowe. It aims to encourage the educational development of underprivileged children; to offer children a safe environment while their parents are at work; and to assist the wider community by offering an educational facility.¹²⁹ The children come from three main areas: first and foremost, Kenosis offers space to children of farm labourers in the area, as the need for them seems the greatest and it was their initiative that led to the establishment of the school. A number of children come from an informal settlement, Thamboville, about 5 kilometers away from Kenosis. Lastly some children come from Glenwood, a township or suburb of Pietermaritzburg. The crèche facility is also available to the children from Kenosis’s foster homes and the children of

¹²⁸ Liebowitz 2004. p. 8-9.

¹²⁹ Kenosis <http://www.kenosis.org.za/sisters.html> accessed 20/09/06

staff working at Kenosis. Another Christian FBO involved in formal education is Project Gateway. It runs Gateway Christian School which aims to provide good quality education, at affordable fees, in a Christian setting. Many of the children that attend this school come from deprived backgrounds and depend on sponsorship to cover their school fees. Some of these children are orphans who have lost their parents or relatives to AIDS-related illnesses.¹³⁰

2.4.3. Home- based care, food and material support

Liebowitz found that home-based care and visitation were the common activities of many FBOs in KwaZulu-Natal. During such visits, those involved provide care, moral, emotional, and support, food, and treatment. In some cases congregation members initiated such programs and often are entirely responsible for carrying them out. For example, Rivelife Community Centre is a Christian FBO based in Eastwood, a suburb in Pietermaritzburg, a project of River of Life Ministries. It is actively involved in home-based care and support of people and families infected and affected with HIV and AIDS. During my interview with the project manager, I gathered that the project works in Cinderella Park in Ward 34. It has volunteers that were trained and now work in the nine communities in Ward 34 to help people. Every day a volunteer is assigned to one or two patients or to a family that has a person living with AIDS to help with delivering food parcels, to encourage the patient to take medication and prepare meals. After this work is done volunteers go back to RiveLife Community Centre to report on their visit. If one reports, for example, that he or she found a sick child who needs treatment, RiveLife sends that child to a doctor and pays for the medical bills. If the child is school-going, RiveLife reports to the school and pleads with the school to keep the child's place while the child gets hospital treatment. In cases where a patient has died, volunteers come to report to RiveLife, then proceed to report to the Ward counselor, who then goes to the nearest hospital to sign a document to obtain a 'pauper's burial' (it is a burial where the family can't afford to pay for burial so the hospital pays for burial).¹³¹

¹³⁰ Project Gateway brochure accessed 8 September 2006.

¹³¹ Mrs M. Naidoo, Interview by the researcher on 18 September 2006 at Rivelife Community Centre in EastWood, Pietermaritzburg.

Another FBO involved in home-based care is the Community Care Project, which is part of the many programmes that Project Gateway houses. The project focuses on caring for, assisting and equipping care-givers and children, paying particular attention to widows and orphans. Community Care Project gives food parcels and toiletries to people living with AIDS through caregivers. However, this activity has proved unsustainable due to a lack of funds from Project Gateway and as such the giving of parcels is limited to people who are in great need. Home visiting and care programs allow FBOs to provide support to those who might otherwise not get access to it due to stigma, poverty or the inability to reach services.

2.4.4. Providing medication

Some FBOs are involved in providing medical facilities to people in their communities. One such FBO is Kenosis which runs Bishopstowe Family and Health Care Clinic. The Clinic provides the broader Bishopstowe Community with comprehensive health care. It is serviced once a month by Pietermaritzburg City Health on the second Tuesday of each month. Besides providing comprehensive health care, it educates people about HIV and AIDS; and provides support to those infected and affected by HIV and AIDS. It offers the following service: Basic health care; HIV and AIDS counselling and testing; family planning; well baby clinic and care of minor ailments.¹³²

It also runs an outreach amongst farm labourers in the community of Bishopstowe with the aim to educate labourers (mostly cane cutters) about HIV and AIDS and related issues; to encourage people to go for testing; to encourage positive healthy living; and to encourage people to make use of the local clinic.

2.4.5. Counselling and supporting testing;

Many FBOs also regularly undertake counselling and provide advice and encouragement to those infected and others in need of advice and support.¹³³ In his research in KwaZulu-Natal, Liebowitz discovered that topics of counselling varied but included areas such as encouraging testing, living positively, and knowing where to go to get support and access

¹³² Kenosis <http://www.kenosis.org.za/sisters.html> accessed 20/10/2006

¹³³ Liebowitz 2004 p.9

services. FBO leaders and workers identified counselling as an area of high demand and a service appreciated by those who received it. He also noted some challenges to this service in that FBO leaders and workers also identified significant obstacles to FBOs carrying out effective counselling. The *first* obstacle was that “unwillingness of those infected to identify themselves publicly (due to stigma) made them reluctant to come and seek counselling.”¹³⁴ The *second* obstacle was the lack of training and experience in counselling among some FBOs. This means that most counselling activities by FBOs have targeted small numbers or have been limited in what they could achieve due to resources.¹³⁵

Grace Pregnancy Crisis Centre (PCC), under the auspices of Project Gateway, does not do HIV and AIDS testing but has negotiated with another organization in Pietermaritzburg where it sends its clients for HIV and AIDS testing. Their focus is rather on pregnancy testing. Those women that are found pregnant get continuous counselling. Even abortion and post abortion counselling is available for any woman who feels trapped by the issues of pregnancies. During an interview with an official at this centre,¹³⁶ I gathered that 40- 50% of women who pass through the Pregnancy Crisis Centre are HIV-positive, and that counselling is an integral part of PCC. However, every Christian Faith-Based Organization has some limitations, particularly financial limitations. Thus PCC can accommodate only eight women per period of three months.

2.4.6. Support for orphans.

Another ministry of FBOs is supporting orphans. According to the findings in Liebowitz’s study of FBOs’ involvement in HIV and AIDS mitigation in KwaZulu-Natal, FBOs provide support for orphans through direct material support, food, paying school fees, and providing care and treatment. For example, one such church project is KwaCare in Pinetown under the auspices of His Church (His Church is a Pentecostal Church in Pinetown). This project has “adopted” Kwadabeka Township in outer Pinetown area to

¹³⁴ Liebowitz p.9

¹³⁵ Ibid p.9

¹³⁶ Interview with stakeholder of Grace Pregnancy Crisis Centre 14/07/06. The name has been withheld because the stakeholder was not authorised to give the information.

care for the orphans and vulnerable children living there. During my year three in my ministerial studies in 1999, we students used to go to an orphanage in Kwadabeka to help with caring for orphaned and abandoned children. KwaCare used to collect clothes, food parcels, household utensils and money to be distributed in this poverty stricken township. Some items were sold and money collected to support families. Besides giving KwaCare money and items, some members of the congregation used to adopt families and children so they would provide monthly financial support to send children to school and support them with food, clothing and good shelter. Other FBOs in Pietermaritzburg area that are involved in orphan care are: Project Gateway, Umngeni AIDS, and God's Golden Acre. Project Gateway runs orphan care and support in a Duduza home. This home provides a short-term place of comfort to fourteen children at a time, where each child is cared for by a special foster mother. This includes all vulnerable children and those infected and affected by HIV and AIDS up to the age of five years. This project is sponsored by New Covenant Fellowship in Pietermaritzburg but is housed by Project Gateway.¹³⁷

Umngeni AIDS is an Anglican FBO that undertakes orphan care among other HIV-related activities. God's Golden Acre Khayalihle is another FBO that is involved in a community outreach project that supports orphans in extended families in rural areas, residential care in cluster foster homes, home schooling and a pediatric hospice in Cato Ridge.¹³⁸ While the list of those FBOs involved in orphan care is fairly long, it is important to note that the number of FBOs with the resources to undertake this activity on a sustained basis remains few. Although many do so informally through congregational initiatives for support, or through family networks, formal programs remain limited in number. In line with the findings of another study, most orphan support programs at the congregational level are small-scale and support a few orphans, often less than 100 per congregation.¹³⁹ In some cases, such activities may be handled through other NGOs that specialize in support.

¹³⁷ Project Gateway brochure for 2005

¹³⁸ God's Golden Acre <http://www.godsgoldenacre.nl/uk/index.html> accessed 08/10/06

¹³⁹ Muhangi 2004

HOPE for AIDS is a project of Serving in Mission (SIM) and is most active in Kwa-Zulu Natal. The sheer number of AIDS orphans makes it impossible for all of them to be cared for in foster homes or by their extended families. Therefore, HOPE for AIDS runs three orphanages, two of them in combination with a foster care program. It also runs home-based care programs which seek to help and encourage those who are dying, and also to provide education and prevention awareness for the families, along with spiritual care and counselling for all.¹⁴⁰ In addition it is involved in translation.

We are translating AIDS-related training materials into Zulu.¹⁴¹

A SIM-related Bible School offers a comprehensive course on dealing with AIDS, not only for its students but also for nearby pastors and community leaders. The AIDS crisis has been a catalyst for successful cooperation between Asian-Indian churches and black-African churches in outreach and care.¹⁴²

2.4.7. Empowerment through income generating activities

Liebowitz sees another role of FBOs as initiating income generating activities which can be used to support their congregations under increasing strain due to the financial burden of AIDS. According to the findings from this research, several FBOs are involved in generating income.¹⁴³ For example, the Project Gateway is involved in training people in communities around Pietermaritzburg in income generating activities like business development, and rural home industries. Included in rural industries is community vegetable growing. With the pressing need for people living with AIDS to supplement their vitamins to boost immunity, Project Gateway trains people in the rural areas of Pietermaritzburg to grow vegetables. These community vegetable gardens are managed by the community and proceeds sold to community members to generate income. Other activities are sewing and dress making, knitting and fabric painting. Project Gateway thus trains disadvantaged women to make or market garments and household goods, which they can be proud to use or sell.¹⁴⁴ During my interview with the trainer, she told me that the public donate fabric and cotton which the trainees practice on. I saw a woman at

¹⁴⁰ SIM Hope for Africa. <http://www.hopeforaids.org/country.asp?ID=15> accessed 21/10/06

¹⁴¹ SIM Hope for Africa. <http://www.hopeforaids.org/country.asp?ID=15> accessed 21/10/06

¹⁴² Ibid

¹⁴³ Liebowitz 2004: 12

¹⁴⁴ Project Gateway brochure

Project Gateway who had sewn a very beautiful duvet of many colours and told me that would sell it for R600.

The second FBO is the Pregnancy Crisis Centre (PCC), which trains pregnant women in skills of vegetable growing, making soap, and different types of candles at the centre which helps them to sell their items. During my interview with the manager of this centre, he stated that “this is the way to empower these women so that they feel confident as they release their creativity.”

The third FBO involved in income generating activities is God’s Golden Acre, which runs the Agricultural Project as part of the Rural Outreach Programme (Gcinosopho). The aim of this programme is to support orphaned and abandoned children in impoverished families, affected and infected by HIV and AIDS, by facilitating the family's capacity to cope and eventually to become as self sustainable as possible.¹⁴⁵ The project is involved in both animal and crop production. Families which take care of orphans in their homes are given a chicken coop with five hens and one rooster. After ten months they are expected to have bred and the people keeping these chickens are required to give eight chickens back to the program. The chickens that have been given back to the program are then redistributed to families which have not received any chickens yet. In terms of crop production, families plant fruit trees and seeds in a small piece of ground next to their dwellings. These are first planted by an agricultural professional and then the families are given advice on how to nurture and grow these seeds and trees so that one day they can be fruitful.¹⁴⁶

2.4.8. Promoting arts and sports

Some Christian FBOs are involved in promoting arts and sports. For example, God’s Golden Acre¹⁴⁷ is an FBO involved in promoting sports among the young people who are orphaned or destitute. “In the poverty-stricken rural areas of KwaZulu-Natal the HIV and AIDS pandemic has caused a serious breakdown in the traditional family, and community

¹⁴⁵ God’s Golden Acre <http://www.godsgoldenacre.nl/uk/index.html> accessed 08/10/06

¹⁴⁶ God’s Golden Acre <http://www.godsgoldenacre.nl/uk/index.html> accessed 08/10/06

¹⁴⁷ Ibid

structures. The youth who live here face a very bleak future.”¹⁴⁸ In response to this situation, God’s Golden Acre started empowering children through sports and arts and crafts. The FBO believes that “sport has a very positive influence on the self-image, gives relaxation, confidence and discipline to the individuals taking part. As a result, the children gain real sense of belonging and purpose.”¹⁴⁹ God's Golden Acre has started a football league in which about one hundred teams are currently participating with the ethos that the active participation of these children in an organized soccer league would empower them and provide a social venue whilst drawing them away from the grip of drugs, alcohol and violence. It also believes that the soccer league can promote a sense of group identity; act as a form of reintegration into the community and give youths an alternative to joining gangs in order to gain that sense of belonging. Sport also helps them to boost self-esteem by taking part in team sport and promotes a culture of health and fitness and hence decreases the appeal of drugs and alcohol. Through these sporting activities, God’s Golden Acre identifies talented individuals from disadvantaged communities and empowers them through the game of football to create career opportunities.¹⁵⁰

The second programme is the arts and crafts educational training programme. This programme is aimed at supporting “orphaned and abandoned children in impoverished families, affected and infected by HIV and AIDS. This helps the family's capacity to cope and eventually to become as self-sustainable as possible.”¹⁵¹ In the Arts and Crafts Programme the young adults receive professional training in arts and craft skills. The training focuses on craft products such as sewing and beadwork, and mosaic.¹⁵² Included in arts is the Song and Dance educational training programme. It is a professional training project in music, song and dance. God’s Golden Acre has a partnership with Dancelink, a professional dance company, from which the youth receive professional training. The FBO believes that the youth’s involvement in song and dance training assists them in building their self-confidence and developing their natural talents. The organization takes

¹⁴⁸ Ibid

¹⁴⁹ Ibid

¹⁵⁰ God’s Golden Acre <http://www.godsgoldenacre.nl/uk/index.html> accessed 08/10/06

¹⁵¹ Ibid

¹⁵² Ibid

pride in what it has achieved so far. For example, several of its youth that had been supported achieved very well, and from among them a well-trained choir and dance group has been formed. The highlight of this arts programme was the performance of some of its dance groups for ex-president Nelson Mandela several times, as well as at the opening of the World Child Abuse Conference at the International Conference Centre in Durban. “For these children the project is a real lifeline, giving them a purpose and direction in life.”¹⁵³

2.5. Can FBOs be hindrances to HIV and AIDS intervention?

Liebowitz argues that some analysts designate FBOs as an obstacle or a hindrance to preventing and mitigating HIV/AIDS. They highlight the resistance of religious leaders to condom use, the stigmatization of AIDS as an immoral disease, and the way in which religion limits open discussion on sexuality, gender relations, and intergenerational relations.¹⁵⁴ For example, he cites Amuyunzu-Nyamongo as claiming that “religious barriers that oppose the promotion of condoms can lead to ineffective prevention strategies.”¹⁵⁵

2.6. Summary of the chapter

The literature review in this chapter focussed mainly on three authors- Liebowitz, Krakauer and Garner- who researched the role that the FBOs or Christian faith communities are playing in KwaZulu-Natal to combat the HIV and AIDS pandemic. From the literature studied above it appears that HIV and AIDS has taken a heavy toll on people’s lives and health and that government agencies are struggling to cope with the pandemic. In this situation, FBOs have emerged as auxiliary partners of the governments in preventing and mitigating the impact of the pandemic. While some FBOs may struggle financially to run their programmes, others are making a contribution to the reduction of HIV and AIDS.

¹⁵³ God’s Golden Acre <http://www.godsgoldenacre.nl/uk/index.html> accessed 08/10/06

¹⁵⁴ Liebowitz 2002:5.

¹⁵⁵ Amuyunzu-Nyamongo, et. al., “Barriers to behaviour change as a response to STDs including HIV/AIDS: The East African Experience,” pp. 1, 7-9. In. Liebowitz 2002 p.60

Although there are many FBOs in KwaZulu-Natal and Pietermaritzburg area in particular, which are involved in HIV and AIDS-related activities, this literature review surveyed a total of thirteen FBOs. Many of these FBOs are involved in various activities including: awareness and education; counselling and supporting testing; home care; food or material support; support for orphans; providing treatment or medication of some kind; income generating activities; and condom supply. However, other FBOs have done very little due to certain such as: inadequate funds, lack of medical expertise, and administrative weaknesses.

CHAPTER 3: THE BACKGROUND OF ESSA CHRISTIAN PROGRAMME

3.1. Introduction

ESSA Christian AIDS Programme (ECAP) is a project of the Evangelical Seminary of Southern Africa (ESSA), which was designed to respond to the HIV and AIDS pandemic around the city of Pietermaritzburg. The programme began with a notion of educating not just its own theological students but also local church congregations, pastors and their wives on the realities of the HIV and AIDS pandemic. The programme encourages and equips participants to develop a caring response in their own ministry contexts.¹⁵⁶ It has been in operation for over seven years. The work of ECAP is mainly concentrated in the black townships in the Pietermaritzburg area where HIV and AIDS is most prevalent. With the respect and confidence that pastors have within the black communities, the focus is on local congregations for HIV and AIDS education, training in care giving and empowerment, and networking with other local groups so that they will eventually initiate their own HIV and AIDS projects in their communities.¹⁵⁷ By the end of 2005, 78 churches had already been trained some of which have established HIV and AIDS projects in their churches or communities and have begun HIV and AIDS ministry.¹⁵⁸ This chapter presents a brief history of ECAP and its activities since the time it was initiated.

3.2. Historical Background

3.2.1. Early developments of ECAP (1997-1999)

ECAP started in 1997 as the Church and AIDS course run by Rev. Jim Johnston.¹⁵⁹ At the time, Johnston was a chaplain and lecturer in counselling and practical subjects like pastoral theology and preaching at the Evangelical Bible Seminary of Southern Africa (EBSemSA). EBSemSA later became what is known as the Evangelical Seminary of

¹⁵⁶ SIM Hope for Africa. (<http://www.hopeforaids.org/prevention.asp>) accessed 21/10/06

¹⁵⁷ Ibid

¹⁵⁸ Data retrieved from ECAP's list of churches that have been trained since 1999 to 2005.

¹⁵⁹ Rev Jim Johnston was a chaplain and lecturer in counselling and practical subjects like pastoral theology and preaching at the Evangelical Bible Seminary of Southern Africa (EBSemSA). He is the one who started teaching the Church and AIDS course at ESSA which later evolved into ECAP. Meanwhile he manages Beth Shalom House in Hilton.

Southern Africa (ESSA) in the year 2000. During my interview with Houston¹⁶⁰, I wanted to establish what motivated him as the principal of ESSA to establish ECAP. In his response he said,

ESSA had wanted to be seen connected to the community and not just an 'ivory tower'. As such ESSA ran a course called Urban Mission Community Development Programme (UMCP) for some ten years also.¹⁶¹

This course, the Urban Mission Community Development Programme, was started as a response to the catastrophe caused by the seven-day war between the Inkatha Movement and the non-Inkatha controlled areas in Edendale and Imbali townships in Pietermaritzburg area.. Aitchison said according to witnesses, Inkatha members were behind most of attacks on members of the United Democratic Front (UDF) between March 25 and March 31.¹⁶² The UDF was formed in 1983 as a front organisation for the then banned African National Congress.¹⁶³ These attacks devastated Pietermaritzburg community.¹⁶⁴ According to South African Press Association,

At least 80 people were killed and 20,000 left homeless in the so-called seven-day war which began in Msunduzi valley in the KwaZulu-Natal Midlands on March 25, 1990.¹⁶⁵

Therefore, in its attempt to contribute to the rebuilding of the devastated communities, ESSA started UMCP course, , which offered skills like sewing, carpentry and secretarial training. This course encountered three problems: *first*, training was very good but not many people who went through it were getting jobs. *Second*, Project Gateway began

¹⁶⁰ Bill Houston was the vice principal for EBSeMSA from 1993 to 2002 when he was appointed the principal for ESSA. During his time as the vice principal, (between 1997 and 1999) he played a major role in establishing the foundations of ECAP. He was part of the AIDS committee that held meetings every now and then about ECAP and he drew strategic plans for ECAP. He stopped working with ESSA in 2005 and now works for OCI [Overseas?] as the regional director for Africa responsible for consultancy in 30 theological colleges in Africa.

¹⁶¹ Bill Houston, interview by Charles Manda on 2 November 2006 at ESSA, Pietermaritzburg.

¹⁶² South African Press Association, 1996 "Kwazulu-Natal's Seven-Day War Claimed At Least 80 Lives." South African Press Association, Pietermaritzburg Nov 18, 1996 available online

< <http://www.doj.gov.za/trc/media/1996/9611/s961118b.htm>>

¹⁶³ Ibid

¹⁶⁴ Aitchison, J.J.W. 1999. The seven days war (25 March to 31 March 1990): background, course and questions. In. Levine, L. (Ed) *Faith in turmoil. The seven days war*. Pietermaritzburg: Pietermaritzburg Agency for Christian Social Awareness, pp 109-135.

<http://www.pacsa.org.za/publications.html>

¹⁶⁵ South African Press Association, 1996 Kwazulu-Natal's Seven-Day War Nov 18, 1996

offering training in skills as well like bricklaying, sewing, carpentry, business course to mention a few. *Third*, ESSA could not find a good board to manage it. Then ESSA leadership decided to stop offering the UMCP course and started another course called Training for Transformation (TFT) having reasoned that duplicating activities was a waste of resources.

We tried to start the Training for Transformation (TFT) idea. It aimed at training members of local churches to be involved in development issues. The idea was to use our final year students and get connected with local churches and train members of local churches to go into community development.¹⁶⁶

ESSA got a small grant from the PEW Foundation that assisted it to start TFT. This course ran for two years but then it stopped because there was not enough time for teaching it. As an alternative, ESSA leadership asked Johnston to design and teach a course on HIV and AIDS to ESSA students. Johnston attended a meeting at African Enterprise (AE) together with a medical person who was working internationally with AIDS. The meeting was about HIV and AIDS in the church. Johnston said, “She was horrified that so many Christians were just saying it is God’s judgment and they had nothing to do with this.”¹⁶⁷ By this time Johnston was already working to get the course going and he was asked by the seminarians to network with them to bring about a course in HIV and AIDS.

So we worked pretty close together and had biblical subjects looking at some of the issues – judgment issues for instance, looking at the healing ministry of the church together with issues of HIV and AIDS. Then we needed to work at the knowledge of what happened on the medical side of the disease and then how the church could minister in this.¹⁶⁸

Johnston and his team of seminarians continued putting together material for the course by drawing together a team of experts to speak on the subject among whom were Professor H. Philpot, the then dean of Medical School in Durban and Anna Voce who helped design curriculum.

¹⁶⁶ Bill Houston, interview by Charles Manda on 2/11/06, at ESSA, Pietermaritzburg.

¹⁶⁷ Jim Johnston interview by Charles Manda on 18/09/06 at Hilton, Pietermaritzburg.

¹⁶⁸ Ibid

The committee continued to develop and outsource materials to use for the AIDS course at EBESemSA and for outreach to the community.¹⁶⁹

In his letter written on 1st October 1998 to Mr. David Cunningham of AID for AIDS- part of Scripture Union in Bulawayo, Zimbabwe, Pastor Paulos Nkonyane requested some training material for use at EBESemSA. He wrote, “Now the seminary is developing itself in terms of collecting material for the benefit of the students and the outside Christian community”.¹⁷⁰ The team also visited some of the units where testing for AIDS was being done. They also went to hospital and spoke to people who were doing counselling. Thus the Church and AIDS course developed along those lines. By this time EBESemSA was already teaching the Church and AIDS course to students using material from the AIDS Training Information and Counselling Centre (ATTIC), an organization that was dealing with the HIV and AIDS patients in Pietermaritzburg City. The course was offered in the second semester and became a compulsory course for every student. It was facilitated by qualified staff members of ATTIC and the seminary lecturers.¹⁷¹ So by 1997 and 1998 Church and AIDS course was taught to students at EBESemSA. I asked Johnston what motivated him to start teaching the Church and AIDS course and this is what he told me,

It was in the mid 1990s when papers were being written about HIV and AIDS and it was appearing in news papers and journals about how catastrophic this pandemic would be but the Christian world seemed not to be interested. In fact they were also wringing their hands that this is God’s judgment and the disease was labelled a disease for homosexuals and this was a punishment for homosexuals. But already in Africa it was very clear that it was not just a homosexual thing it was heterosexual and it was spreading rapidly.¹⁷²

So Johnston was determined to do something about the new disease and the first thing that came to him was a vision to start teaching a course on HIV and AIDS at EBESemSA with the hope that students could get involved in the intervention strategies.

¹⁶⁹ Minutes of the AIDS Committee of 21 May 1998 held at EBESemSA. The minutes are kept at the ECAP’s office, 10 Long Market Street, Pietermaritzburg.

¹⁷⁰ Letter written on 1st October 1998 by Pastor Paulos Nkonyane to Mr. David Cunningham of AID for AIDS- Scripture Union, Bulawayo, Zimbabwe. It is preserved in ECAP’s file of Minutes, in ECAP’s Office.

¹⁷¹ Minutes of the AIDS Committee of 21 May 1998 held at EBESemSA held at ECAP’s office.

¹⁷² Jim Johnston interview by Charles Manda on 18/09/06 at Hilton, Pietermaritzburg.

3.2.2. Launching the HIV and AIDS course into the community

When the issue of HIV and AIDS training came up the AIDS committee¹⁷³ saw it as an opportunity to get involved because at that time TFT was closing down. Therefore they used the resources they had in TFT and the links with the churches to do HIV and AIDS work. The need to extend their efforts in HIV and AIDS awareness went beyond the classroom into the communities surrounding Pietermaritzburg after the situational analysis which was conducted by Okyere-Manu¹⁷⁴ and Nkonyane¹⁷⁵ in the communities of Sobantu and Imbali. The analysis revealed that many pastors in the churches around Pietermaritzburg did not know anything about HIV.

They had no clue about HIV/AIDS and people were stigmatized; I mean HIV was associated with evil. People who are involved in prostitution and all that were the ones who were seen having the disease so there was a lot of silence about the disease.¹⁷⁶

The study also revealed that some people were being victimized after being diagnosed HIV positive.

There was even violence around the disease if one should say I am HIV positive. People would want to get you out of the community and things like that.¹⁷⁷

There was a myth circulating that if an HIV positive man has sex with a virgin, it will cure AIDS. This caused the rape of children and virgins in Sobantu. In response to this situation the AIDS committee came up with the strategy of negotiating with pastors and if they agreed then the team would enter into their churches and begin training.

We used to go to a church and speak to the minister; If he or she allowed us to speak to the congregation about AIDS then we spoke. They realized that ESSA is part of the Cluster and the

¹⁷³ AIDS Committee was a group of staff and students at EBSemSA who were steering the Church and AIDS course.

¹⁷⁴ Benson Okyere-Manu was a member of the AIDS committee from 1997 to 1999 and a lecturer in Training for Transformation. He initiated the development course at ESSA while he was pursuing further studies at the University of Natal. He also worked together with Professor Philippe Denis at the School of Theology in teaching Church and AIDS course. He became the first manager of ECAP and served from 1999 to 2004 when he resigned from office. He now works as the manager for Community Care Project at Project Gateway.

¹⁷⁵ Paulos Nkonyane was a member of the AIDS committee, who together Okyere-Manu conducted a situational analysis in Sobantu and Imbali townships to assess the impact of HIV and AIDS and what the churches were doing about it. Nkonyane was the first employee of ECAP as a fieldworker in April 1999. He now works as a chaplain in Pretoria, South Africa.

¹⁷⁶ Okyere-Manu, interview by Charles Manda on 20/09/06, at Project Gateway, Pietermaritzburg.

¹⁷⁷ Ibid

distinctive thing about the Cluster¹⁷⁸ is contextualization- Christianity in context...So the idea of ECAP was to have a ministry from the seminary where students could be involved. In fact, the early committee comprised of some of those students who had done the Church and AIDS course and were particularly burdened by what was happening around them.¹⁷⁹

Thus the AIDS committee put together a course similar to the one being taught at EBSemSA using the TFT methodology to instruct people in the churches and that is how ECAP came about. Thus

ECAP was never officially launched, there was a period of developing ideas- what shall we teach, how shall we teach, role play, [and assimilate] the testimony of persons living with AIDS.¹⁸⁰

To begin training churches, ECAP staff met with pastors individually to talk to them, to gain access into their churches and then minister to the entire church. Once permission was granted by the minister, then ECAP would start running workshops and seminars for them to bring awareness of issues pertaining to HIV and AIDS at a broader scale. There was a time when ECAP invited the then deputy mayor of Pietermaritzburg to come and give input because she was very outspoken in the area of HIV and AIDS.

So we brought her in and she too ministered. A number of other people from the university and all that, we invited them to come and give input.¹⁸¹

ECAP staff used to have monthly training for pastors and churches so the two were going concurrently- the training of pastors and their committees, and the training of churches. ECAP was not only effective at ESSA and in the churches; it also had a link with the School of Theology, at the University of Natal. During my interview with Okyere-Manu, he told me that,

Actually I worked with Professor Philippe Denis for nearly three years doing HIV and AIDS work, the course on Church and AIDS and normally we would invite some of the people living with the disease that we were working with at ECAP to come and work with us. They would give their testimonies to encourage other people so that they can be open about HIV.¹⁸²

¹⁷⁸ Cluster is a group of theological institutions around Pietermaritzburg which share common resources especially literature. These institutions include the School of Religion and Theology, the Evangelical Seminary of Southern Africa, Maphumulo Seminary now closed, and St. Joseph Catholic Seminary at Cedara, Howick.

¹⁷⁹ Jim Johnston interview by Charles Manda on 18/09/06 at Hilton, Pietermaritzburg

¹⁸⁰ Ibid

¹⁸¹ Okyere-Manu, interview by Charles Manda on 20/9/06 at Project Gateway, Pietermaritzburg.

¹⁸² Ibid

ECAP also worked with the university to access the input into the HIV research that was going on there.

3.2.3. Strategic planning

The AIDS committee invited Professor Philpot again to help them do strategic planning. The knowledge and skills obtained assisted them to draw up the strategic plan which was submitted to the Australian Government and through that they received some funding from Serving in Mission (SIM) Christian mission organization. However, the first grant of R40000 came from the Department of Health after submitting a proposal which the ECAP committee drew up with the help of Professor Philpot.¹⁸³

3.2.4. Implementing HIV and AIDS course in the churches

The meetings that led to the founding of ECAP started as early as 1998. In one meeting which was held at EBSemSA on 21 May 1998, the AIDS Committee members (the committee of the few students, who had completed HIV and AIDS and the Church's Response to AIDS, as a first year course) discussed many issues of concern. ECAP faced two challenges to carrying out its strategic plan. The first one was the attitude of people that reinforced discrimination and stigma against people living with AIDS. The churches' response to AIDS was the attitude that AIDS was punishment from God.

Our challenge is to change the attitudes of the Evangelical and Independent churches reluctance to accept AIDS as any other disease; our major obstacle is to change our viewing of AIDS as an effect of the judgment of God.¹⁸⁴

On 4th March 1999, Houston, the then vice principal of the EBSemSA drew up a business plan for the EBSemSA Christian AIDS Programme. The objectives of this programme would be to provide training for local churches in the community with respect to HIV and AIDS awareness, counselling and home-based care; to establish a network of church leaders and other para-church organizations such as RAP, Project Gateway, the Cathedral, and many others; and to devise strategies for community-based care

¹⁸³ Minutes of the AIDS Committee of 21 May 1998 held at EBSemSA. Documents are kept at ECAP office.

¹⁸⁴ Minutes of the AIDS Committee of 21 May 1998 held at EBSemSA. Minutes kept at ECAP office.

education.¹⁸⁵ In this network, ECAP's role would be to provide training for those programmes; and to provide training in the seminary for EBSemSA's final year ministerial students.¹⁸⁶ At this time ECAP's main focus would be in educating ministers, and church workers on HIV and AIDS.

The second challenge was that of raising funds to meet the running costs of ECAP. To this end the AIDS Committee members encouraged each other to pray for the project. They drew examples from Zimbabwe where a similar AIDS project worked was being run through the church and those who were working there were volunteers. Thus Christian volunteers were recruited while the AIDS committee members wrote a proposal to submit at a meeting of physicians in Durban asking for funding.¹⁸⁷ Different volunteers were assigned tasks to carry out in the communities and they reported success. For example, one volunteer ran workshops on AIDS awareness. The project manager facilitated workshops on positive living for people with AIDS which were held at ATTIC. Some staff members attended workshops on adolescent health and income-generating activities. ECAP did not only concentrate on HIV awareness campaigns but also on training communities to establish community-based projects, with the help of volunteers, to generate their own income which could be used to support people living with AIDS. For example, one volunteer reported, "The work on sewing is still continuing well from the sewing groups."¹⁸⁸

On 11 November 1998 a regional meeting was organized by the Department of Health KwaZulu-Natal HIV and AIDS and STDS [Sexually Transmitted Diseases] Programme and EBSemSA was invited to attend. The objectives of this meeting were to define the roles and functions of the regional coordinator for NGOs and CBOs [Community Based Organizations]; to integrate HIV and AIDS and STDs and TB [Tuberculosis] into district health systems; and to eliminate duplication of functions. The results of this interaction with the Department of Health was that the EBSemSA Christian AIDS Programme

¹⁸⁵ ECAP's annual quarterly report 1999. Report accessed from ECAP office.

¹⁸⁶ Minutes of All Staff Meeting held on 12 March 1999 at 11.35 am in the Tearoom. Minutes kept at ECAP office.

¹⁸⁷ Minutes of the AIDS Committee of 21 May 1998 held at EBSemSA located at ECAP's office.

¹⁸⁸ ECAP's annual quarterly report 1999 preserved at ECAP's office.

received a donation of forty thousand Rands.¹⁸⁹ During the All Staff Meeting on 12 March 1999, the vice principal of EBSemSA announced that ECAP had received this donation from the Department of Health.¹⁹⁰ It was agreed in the same meeting that a fieldworker would be appointed by 31 March 1999 on contract until the end of 1999. This fieldworker would be a theologically and pastorally trained Zulu speaking person who would design an effective training or educational programme together with the helpful teaching aids for use in local congregations. The hope was that by 1 April 1999, ECAP would be up and running. On 14 April EBSemSA appointed Mr. Paulos Nkonyane to the position of EBSemSA Christian AIDS Programme (ECAP) fieldworker on contract which would expire on 31 December 1999.¹⁹¹ And so the project was called ECAP.

3.2.5. ECAP between 2000 and 2003

After carefully designing the curriculum, ECAP started conducting seminars with pastors and church leaders. The purpose of training pastors by way of seminars was to equip them with more knowledge around HIV and AIDS than their church members. Also the training of pastors was done at the outset because they resisted HIV and AIDS training because of theological issues. For example, some pastors associated AIDS with sin, and therefore AIDS was seen as a punishment from God. After some time such barriers were removed because pastors were burying dead church members and this reality brought them face-to-face with the reality of the impact of AIDS on their communities.

During the seminars pastors were given the opportunity to interact with each other and discuss current challenges in HIV and AIDS that they were facing in their communities. When it was convenient for pastors in their congregations during the course of the year, ECAP would be invited to go and facilitate training in the church. In this phase of its development ECAP also encouraged the networking of those church projects with other projects in the area that were doing the same work. Pastors' seminars were held quarterly up until 2003 when ECAP changed the strategy of training pastors apart from their

¹⁸⁹ Minutes of All Staff Meeting held on 12 March 1999 at 11.35 am in the Tearoom located at ECAP.

¹⁹⁰ Okyere-Manu, interview by Charles Manda on 20/9/06 at Project Gateway, Pietermaritzburg

¹⁹¹ From a copy of a letter of appointment written to Mr Paulos Nkonyane on 14 March 1999. The letter is available at ECAP office.

congregations. The strategy changed because pastors were not able to implement what they learnt apart from their congregations. Thus ECAP started training pastors together with their congregants.

From the time ECAP was started, the training used to take place in churches in the community. The ECAP trainers would visit churches and conduct all the seven stages of training called ECAP Training 1-7. This covered everything from awareness to introduction to home-based and orphan care. After these stages, the churches were asked to select volunteers and send them to Community Care Project, at the Bethany House¹⁹² where they would undergo a five-day training in the theory and practice of home-based and orphan care. Upon finishing this phase of training the expectation was that these volunteers would go back to their communities and start home-based care projects where they would visit the sick people. They were also expected to engage members of their congregation in the awareness campaign and in home visits for people living with AIDS. This went on from 2000 to 2003.

During this period ECAP's presence was felt beyond the South African borders. For example, in 2002, Okyere-Manu, went to present what ECAP was doing at the Micah Conference that was held in Thailand.

They wanted us to present what we were doing in ECAP because they saw it as the best practice, so thus how I had to go to Thailand in 2002 to present what theological institutions would be able to do in terms of HIV and AIDS. And that was quite successful, out of that a number of theological institutions began looking at the whole issue of HIV and AIDS.¹⁹³

ESSA was the first evangelical institution in Africa to set up an FBO that was engaged in HIV and AIDS work.¹⁹⁴

3.2.6. ECAP between 2004 and 2005

In 2004 ECAP stopped training people in their local churches. Instead those people who were recruited for training were required to attend the training at ECAP's office. This

¹⁹² Bethany House is where Community Care Project has its offices. It is near the Old Pietermaritzburg Prison which is being used by Project Gateway .

¹⁹³ Okyere-Manu, interview by Charles Manda on 20/9/06 at Project Gateway, Pietermaritzburg

¹⁹⁴ Ibid

change came about for two main reasons. First, it was difficult for the ECAP staff to finish training in each congregation because of the postponements of sessions. From 2000 to 2003, training used to take place on Sundays. Sometimes when an appointment was made with a congregation, it would be cancelled because the congregation had a funeral or some other programme to attend to.

So you could start Training 1 then stop and time lapsed. When you come back for Training 2 you find new members who were asking questions which were covered in the past seminar.¹⁹⁵

Second, some of the people who attended the training were not members of that particular congregation and problems would arise when it came to recruiting volunteers for further training in home-based and orphan care. It could happen that may be only two people were available in this particular congregation who attended the training; the rest went back to their churches or elsewhere. So there was no way to get the number of volunteers they needed for further training. As a result, ECAP changed its strategy in 2004 from training the whole congregation to training only eight members of a particular congregation at the ECAP's office. To recruit these eight members, a congregation that has shown interest in having caregivers, selects eight members and sends them to ECAP for training. One of the requirements for a caregiver is that she or he is not employed so that she or he would remain in the church and community to implement the home-based and orphan care projects. This strategy is more effective for ECAP to meet its target of churches to be trained per given period since the training only lasts three days. However, the level of awareness that the congregation used to receive is now limited to eight persons. These eight may not even be able to teach their own churches all that the ECAP experts taught them in three days given the fact that churches in Pietermaritzburg generally still remain patriarchal as evidenced from the list of churches that ECAP has trained since 1999 to 2005 (of the seventy-eight churches ECAP trained, only two were led by women ministers). This means that women do not have much voice in the church despite the majority of members being women. In a group of eight caregivers women tend also to outnumber men. Also since volunteers are not employed, the church may not be able to implement or initiate home based care projects should the volunteers find

¹⁹⁵ Sibongile Goba, interview by Charles Manda on 29/03/06, at ECAP's office.

employment or decide to go and look for work elsewhere. This may dash the hopes of establishing projects. For example, during my interview, Ndaba¹⁹⁶ expressed his longing for ECAP to go back to his congregation and train some more caregivers since those who received training in 2003 left the church. When I asked him if they are doing any AIDS-related projects, he said,

.....there is nothing. After training in 2003 some of the people who were with us are not there today and we have new members.¹⁹⁷

Another change in ECAP's training programme concerns the partnership. From 2000 to 2003 ECAP used to send its volunteers to Community Care Project for home-based care training but this partnership stopped in 2004. So ECAP has forged another partnership with the South African Health Care Organization (SAHECO) which trains ECAP's volunteers for five days also in home-based and orphan care.

The distribution of food parcels is yet another change that has come about as a result of severing relationship with Community Care Project. At first volunteers, upon finishing their home-based care training, were given food parcels to distribute to people living with AIDS in their communities together with a kit for bathing and dressing the patients. But this was terminated when the partnership ended. During an interview with the current manager of Community Care Project, I gathered that by 2004 this organization had also changed its strategy of training caregivers from running training sessions at Bethany House to running the sessions in families which have members living with AIDS. And also funding has dwindled as compared to the early days when more people were contributing food, finances and other items to Bethany House which then would be distributed to people with AIDS in form of food parcels and kits.¹⁹⁸

By 2005, ECAP had progressed a lot in terms of its structure. It started as the Church and AIDS course at ESSA but over a period of nine years also it has evolved tremendously.

¹⁹⁶ Ndaba, interview by Charles Manda on 18/10/06 at Imbali 18 Pietermaritzburg. .Mr. Ndaba is a church leader in the Assemblies of God in Willowfontein.

¹⁹⁷ Ibid.

¹⁹⁸ Okyere-Manu, interview by Charles Manda on 20/09/06 at Project Gateway.

During my interview with Rev. Albert Chetty¹⁹⁹, I gathered that ECAP is gaining autonomy slowly.

I was challenged to make ECAP become an autonomous project from ESSA as everything was under the control of ESSA though it had NGO status and no public accountability.²⁰⁰ Lots of donors were distancing themselves because ECAP seemed like it was sustaining ESSA.²⁰¹

Since March 2005 there have been more changes in ECAP. For example, ECAP has its own constitution drafted, accepted and signed by all role players. On 14 September 2006, ECAP opened its own bank account.

Yesterday I opened the bank account for ECAP and we are now in the process of registering ECAP as an NGO with government.²⁰²

However, ECAP will still remain ESSA's project, but it is now autonomous. Future plans are that ECAP will have its own website, board, and registering NGO status. ECAP will have its own fundraising number. It is currently in the process of embarking on self-sustaining programmes because donors are tightening up.²⁰³

3.3. How ECAP recruits churches for training

One of the objectives in this study was to find out the criteria that ECAP uses to recruit churches for training. I wanted to know these criteria because there are many churches in the Pietermaritzburg area which have not received training from ECAP yet. To answer this question, I had an interview with Israel Ndlovu²⁰⁴ who told me that ECAP only trains churches which approach it and ask to be trained.²⁰⁵ ECAP advertises itself in different ways. First, ECAP staff attend ministers' fraternals in Pietermaritzburg and share with ministers what ECAP does on a one to one basis. If the minister is interested, he or she invites ECAP to come and do a presentation in his or her church.

Once agreed we ask the minister to identify eight volunteers in the church who will be committed, who can go for training.²⁰⁶

¹⁹⁹ Rev Albert Chetty, interview byu Charles Manda on 15/09/06 at ECAP office. He is the current manager of ECAP.

²⁰⁰ Ibid

²⁰¹ Ibid.

²⁰² Ibid

²⁰³ Rev Albert Chetty, interview byu Charles Manda on 15/09/06 at ECAP office.

²⁰⁴ Israel Ndlovu, interview by Charles Manda on 01/06/06 at ECAP. He is the current training coordinator for ECAP.

²⁰⁵ Ibid

²⁰⁶ Ibid

Second, ECAP used to advertise its services through the radio when there was a radio station in Pietermaritzburg. Its services could also be made known through word of mouth.

Trained people in the communities refer people to us who want training.²⁰⁷

Third, ECAP utilizes the network it has with other organizations. For example, its staff attend government programmes which are similar to what ECAP is doing. Thus, the office of the premier invited ECAP and HIV and AIDS organizations in the province to consult with stakeholders and secretarial representatives from the district in the development of a comprehensive, integrated HIV and AIDS strategy for KwaZulu-Natal. ECAP staff seize this opportunity to talk to other people about what ECAP is doing, after which interested people will contact ECAP.

May be somebody heard about our training and comes to ask for training. We tell him or her to consult his or her church minister, then the minister contacts us or we contact him or her when we access his or her telephone number.²⁰⁸

My next question was: Do you have any preference of churches you recruit for training? Ndlovu's answer was that they train any church that approaches them.

We use government funding to train people and the government does not set boundaries as to which church we must train. We train any church that needs training regardless of their theology.²⁰⁹

However, ECAP has not yet trained any Shembe church and Zionist church because they have never approached ECAP for training.

3.4. Description of ECAP's training programmes

ECAP runs several workshops or programmes, which include: training, church initiated community projects; facilitating the Church and AIDS course at ESSA; and the pastors/leaders seminar. The workshop is run for three days and comprises seven sessions called *ECAP Training 1-7*.

3.4.1. ECAP Training 1: Interactive drama²¹⁰

²⁰⁷ Ibid

²⁰⁸ Israel Ndlovu, interview by Charles Manda on 01/06/06 at ECAP.

²⁰⁹ Ibid

²¹⁰ ESSA Christian AIDS Programme (ECAP). (n.d.) Three Day HIV/AIDS Training Manual.

HIV and AIDS awareness training is done in form of the interactive drama where an ECAP member and one trained volunteer perform. Either the ECAP staff or volunteer will play the role of Mr. AIDS and the other Mrs. AIDS. It is a question and answer type of drama, which is based on HIV and AIDS transmission, gender and the role of the church in this AIDS pandemic. This drama dispels a lot of myths surrounding HIV and AIDS. This drama gives the participants knowledge of the origins of HIV and AIDS, the difference between HIV and AIDS, the content or overview of ECAP's training, and an understanding of how HIV and AIDS is transmitted and what one can do to prevent being infected.

3.4.2. ECAP Training 2: Testimony by a Person living With HIV and AIDS (PWA)²¹¹

Here the PWA gives his or her story of how she or he contracted HIV and AIDS to create awareness about the reality of the pandemic and also what is expected of the church in this situation. This training aims at helping the course participants to understand that HIV and AIDS is real, through interaction with a person living with the disease. The testimony, which is given by either a man or woman living with HIV, demonstrates to the group that HIV and AIDS affects both male and female, and that Christians are also infected by HIV and AIDS just like anybody else.

3.4.3. ECAP Training 3: Theological/ or Biblical Reflection on HIV and AIDS²¹²

This training session engages the participants in a theological debate about HIV and AIDS and challenges them to respond to the pandemic. The session examines the most commonly asked questions around the HIV and AIDS pandemic and how God sees it. Questions such as the following are asked: Where is God in this pandemic? Is AIDS a curse, the punishment from God or not? If God is all-powerful, why does He not stop the pandemic from destroying people and causing a lot of suffering? What would Jesus do in a situation like this one?

²¹¹ ESSA Christian AIDS Programme (ECAP). (n.d.) Three Day HIV/AIDS Training Manual. p.18

²¹² Ibid

3.4.4. ECAP Training 4: Gender issues in relation to HIV and AIDS²¹³

This training seeks to define gender. According to ECAP, gender “...refers to socially constructed differences between men and women and the unequal power relationships that result.....what is acceptable behaviour to this society for men is not what is necessarily acceptable for men in another society.”²¹⁴

The participants discuss gender issues such as sex, behaviour, care, inheritance, marriage, parenting, gender imbalances, why women and children are more vulnerable to HIV/AIDS infection, what the church’s response should be to these issues, and what the church should do to protect women and children. Finally they discuss the challenges facing the church in creating healthy families, healthy relations between men and women; and how to protect women against vulnerability to HIV infection. This training ends with encouraging churches to start support groups where women and men can dialogue and empower each other to play their roles according to the word of God.²¹⁵

3.4.5. ECAP Training 5: Life Skills

This mainly targets the youth who are more vulnerable to this pandemic. The aim is to help them with skills of communication. Youth find problems in making informed decisions and how to resist peer pressure. Participants discuss the definition of life skills, different kinds of relationships; how they can communicate their feelings; and demonstrate knowledge of dealing with peer pressure in this era of HIV and AIDS. They thus discuss themes such as life skills; self esteem; relationships; expectations; responsibilities; communicating feelings; making choices; and peer pressure.²¹⁶

3.4.6. ECAP Training 6: Pre and Post HIV/AIDS Test Counselling

This training is aimed at helping the participants to understand the importance of obtaining informed consent for HIV testing. Counselling may have components of listening, giving feedback/ reflecting what one hears, and giving input to possible

²¹³ Ibid

²¹⁴ Ibid

²¹⁵ ESSA Christian AIDS Programme. n.d. Three Day HIV/AIDS Training Manual.p. 22

²¹⁶ Ibid p. 24-27

solutions. It may provide input on physical care, nutritional support and spiritual care; and personal experience.²¹⁷ The participants should demonstrate an understanding of pre-test counselling; identify counseling issues that arise in different counselling situations; and practice pre-test counselling.²¹⁸ The participants are trained in basic counselling skills for them to be able to help people who decide to go for HIV test. Basic skills in post- test counselling are also offered. Included in this session are the characteristics of a counsellor, different kinds of tests and what pre and post counseling covers. This session does not equip them to be counselors; however, it gives them basic knowledge about counselling.²¹⁹

3.4.7. ECAP Training 7: Motivation for home based care and orphan care

The objectives of this training include: assisting participants to understand the importance of the church caring for the sick, orphans and widows; understand what kind of a person a volunteer needs to be; and list advantages and disadvantages of being a volunteer. The churches are motivated to start their own home-based care and opportunities are offered to selected congregations to be trained in the practical care of a patient. This is encouraged because in many countries in Africa, medical facilities like hospitals and clinics are not coping with the enormous number of patients. Thus training promotes care of the sufferers while at home.²²⁰

3.5. The Church and AIDS course

Another main component of ECAP's work is facilitating the Church and AIDS course at ESSA where students from different countries, many of them from sub-Saharan Africa, undergo the three-year training in theology. ECAP's goal here is to equip students with knowledge and skills about HIV and AIDS so that they go back to their communities equipped to impact those communities in the area of HIV/AIDS. Since it is an established course at ESSA, the expectation is that every minister who is trained at ESSA will go back to his/her community or country, or mission field and utilize the knowledge

²¹⁷ Ibid.p. 29

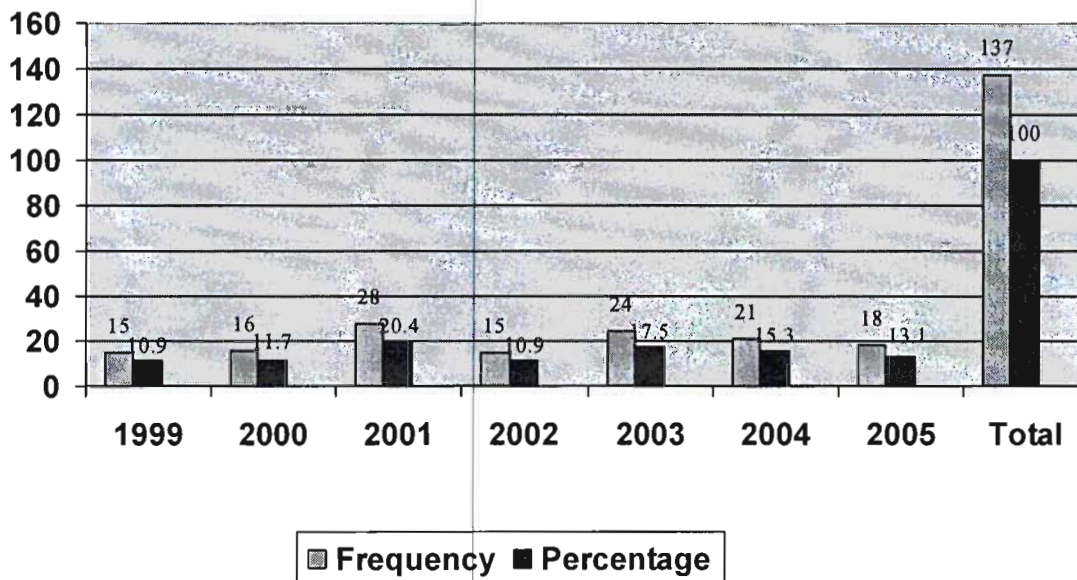
²¹⁸ Ibid.p. 28

²¹⁹ ESSA Christian AIDS Programme. brochure for 2006.

²²⁰ ESSA Christian AIDS Programme. n.d. Three Day HIV/AIDS Training Manual.p.37

and skills gained during training.²²¹ The chart 3.1 shows the total number of students who attended the Church and AIDS course at ESSA from 1999 to 2005.

Chart 3.1: Number of students who took the church and AIDS course (1999-2005)



3.6. Current challenges facing ECAP

Most of these activities which ECAP runs require extensive funding, technical expertise, medical equipment, and knowledge. All these areas represent opportunities for ECAP, but, its limitations of resources and capacity pose a big challenge. ECAP is a non-profit making organization and as such, it does not generate its own income to sustain its services. All the training ECAP runs in churches is done at its cost own and no church pays for the training. The first major challenge is that in the early days, around 2000 to 2003, ECAP, after training congregations would recruit fifteen volunteers to go for home-based care practical training at Community Care Project at the Project Gateway's Bethany house. Then the volunteers were receiving infection control kits which included disinfectants, gloves, soap for use in bathing and cleaning the patients. They were also given food parcels to give to people they visited during their home-based care. All these items came from Community Care Project. Thus ECAP's ultimate goal of seeing

²²¹ Ibid

churches initiate AIDS related projects was being accomplished through this partnership with Community Care Project which came to an end in 2004. Liebowitz is right that in some cases FBOs have been able to meet the challenges of funding, medical equipment, technical expertise through collaboration with NGOs, government, and other FBOs. For example, FBOs in Uganda have been more successful in building collaborative relationships with other groups to support their activities.²²² Thus true for ECAP which collaborated with Community Care Project (CCP). However, when the Community Care Project stopped giving the volunteers supplies, this affected the community based organizations (CBOs) which volunteers were establishing in their communities. During my interview with Benson, the current manager of Community Care Project, I wanted to know why his project stopped giving supplies to volunteers. He responded,

When we began doing the project of CCP going in the communities to clean people, people were sympathetic so they could give food and money, so one could easily get food parcels to give to the people in need. Now with time that type of funding dwindled, they started going down and HIV became more and more a professional type of work. You can't easily get things as it used to be. At that time I was also working more with CCP so we felt we needed to strategize to begin to equip the families rather than just giving food parcels all the time. So that is what brought about the stoppage, not that it stopped completely because even up to now food parcels are still given but only given to very needy people.²²³

The second challenge facing ECAP is that CCP has stopped receiving volunteers from ECAP for home-based care training. This has happened because CCP has changed its strategy for training volunteers.

These days CCP is not training the people as we used to do the training; so most of the training is done in the families because we need to equip the family rather than us going to do it because it is becoming a burden so there is that change. So if the church is trained we need to follow people who are infected and affected and then begin doing our training because our training has changed. There is training in wellness, training in ARVs to know how to give medication and take care of the people.²²⁴

²²² Liebowitz J.2004 *Faith-based organizations and HIV/aids in Uganda and Kwazulu-Natal final report*. Health Economics and HIV/AIDS Research Division, University of KwaZulu-Natal. p.23

²²³ Okyere-Manu, interview by Charles Manda on 20/09/06 at Project Gateway.

²²⁴ Ibid

The third challenge is that ECAP, after CCP stopped supplying volunteers with kits, forged a relationship with the clinics which were supplying them with the kits. However, clinics have started training their own caregivers and as such ECAP has to supply its own kits to its volunteers, which it does not have. Since it has helped initiate as many as thirty-five community projects around Pietermaritzburg, it can not meet the demand. However, it gets some assistance with regard to the kits from the Department of Health and CINDI, though not enough to meet the demand.

The fourth challenge is the shortage of staff. There are only three staff now at ECAP, the manager, training coordinator, and administrator. They used to be five workers but two found employment elsewhere so they left ECAP. During our interview the training coordinator said that he is doing the work of three people. All these challenges impact greatly on the output of ECAP among its beneficiaries.

3.7. Summary of the chapter

This chapter has looked, rather briefly, at the history of ECAP. It has attempted to explore the origins of ECAP which goes as far back as 1997. ECAP has gone through many changes and at no time has it been able to accomplish what it has desired fully mainly because, as a non-profit organization, it has to rely on funding from donors. Now the donor community is becoming overwhelmed as well with the increased burden of HIV and AIDS globally. This has thus affected ECAP's output and staff capacity. However, ECAP has not given up but continues to provide services that are within its reach.

CHAPTER 4: RESULTS AND ANALYSIS OF THE STUDY

4.1. Introduction

Chapter four presents the results of the study. The study set out to investigate whether Christian faith-based organizations were making any contribution in HIV and AIDS intervention by assessing the work of the ESSA Christian AIDS Programme (ECAP) in Pietermaritzburg, between the period 1999 to 2005. Of the twenty questionnaires sent to former graduates of ESSA, fourteen questionnaires were completed and returned, giving a response rate of 70%. Babbie and Mouton state that a response rate of 50% is fairly good, while those of 60% and 70% are good and very good, respectively.²²⁵ They stress, however, that these arguments have no statistical basis and are hence used as rough guides for researchers.²²⁶ Ten church ministers were sampled for face-to-face interviews and all of them were interviewed. Results for the questionnaire and interview schedule are presented. Themes emerged from these data using content analysis and each theme is discussed in this chapter. It should be noted here that ESSA used to have graduation ceremonies in November every year from 2000 to 2004 but in 2005 ESSA management decided to put graduation ceremony forward in April 2006. Therefore, since the study is concerned with the graduates who finished the course at ESSA up to December 2005, those who graduated in April 2006 were categorized as graduates from 2005 in this study.

4.2. Description of the respondents

4.2.1. Gender of the respondents

It is now widely acknowledged that the gender dimension of the AIDS pandemic is critical both for the understanding of its impact and for the successful implementation of prevention and amelioration campaigns. Gender inequalities clearly fuel the pandemic, leaving young women particularly vulnerable to infection.²²⁷

²²⁵ Babbie and Mouton 2001 p. 261

²²⁶ Ibid p. 261

²²⁷ Epstein, D., Morrell, R., Moletsane, R., and Unterhalter, E. Gender and HIV/AIDS in Africa south of the Sahara: interventions, activism, identities. *Transformation* 54 (2004) Isss 0258-7696 p.1
Available online

<http://muse.jhu.edu/journals/transformation> accessed 16 November 2006

Marilyn Linton suggests that gender inequality and the low status of women are the principal drivers of HIV.²²⁸ She adds,

Two-thirds of young women in sub-Saharan Africa, where HIV has skyrocketed, do not know how HIV is transmitted. In many of these countries, women remain unequal partners in their marriages or sexual relationships (extramarital sex is ignored; women dare not insist their partners use condoms). Often they are married off as young virgins to older men who have sexual experience and who are infected with the virus.²²⁹

Makahye sees gender as a societal construct that encompasses widely shared expectations, norms, customs, beliefs and practices within a particular society. It is about roles and responsibilities as determined by different societies. Society puts different expectations on men and women to fulfill based on the prevalent beliefs, practices and norms of that society. These expectations are learnt in families, schools, the workplace and other institutions.²³⁰ There were two categories of respondents in this study: those who completed a questionnaire and those who were interviewed. Of the fourteen ESSA graduates who returned the questionnaire, seven (50%) respondents were male, while the other seven (50%) were female. Of the ten ministers who were interviewed, eight (80%) were male while two (20%) were female ministers. The respondents to the questionnaire represent gender equality where we have equal numbers of respondents from both male and female. This is partly because of the skill of the researcher in selecting his sample but also because ESSA is a theological institution influenced by the School of Religion and Theology of the University of KwaZulu-Natal whose value is gender equality in school and workplace and which is currently advocating equality of ordination of both male and female ministers. On the other hand, the interviews represent a different paradigm. These interviews were conducted in an area and time when patriarchy remains very strong in the churches where ECAP conducted its training. For example, of the seventy-eight ministers that ECAP has trained from 1999 to 2005 only two were women ministers.²³¹ During my

²²⁸ Marilyn Linton. 2006. *ABC of AIDs*
http://chealth.canoe.ca/columns.asp?columnistid=7&articleid=18280&relation_id=3224 accessed 19/10/06.

²²⁹ Ibid

²³⁰ Makahye 2005. In eds. Karim A. and Karim Q.A. *HIV/AIDS in South Africa*. Cambridge: Cambridge University Press. P. 313

²³¹ Data retrieved from an ECAP's list of churches that were trained in HIV and AIDS from 1999 to 2005.

interview with one of the church ministers, I gathered that patriarchy still reigns in the church.

Gender issues were difficult to change because it's a patriarchal society. They still believe men are superior to women...Some thought ECAP was taking advantage of them as men.²³²

This concurs with Haddad who says,

As a South African society we are faced with an enormous crisis regarding the prevalence of sexual violence. Each crisis relates to human sexuality and to unequal power relations between men and women.²³³

Perhaps ECAP needs to revise its strategy of recruiting churches for training so that it can accommodate more women ministers. The current strategy is to train those who approach ECAP, but this seems not to be the best practice for gender equality. The current statistics do not indicate that no women ministers are experiencing the ills of the AIDS pandemic, neither does it mean that there have been only two women ministers in the whole of Pietermaritzburg area for the past seven years.

4.2.2. Race category of the respondents

Question three was intended to establish which race category ECAP has impacted in large numbers with its facilitation of the Church and AIDS course at ESSA. Table 4.1 shows the frequency distribution of the respondents to this question.

Table 4.1: Race of respondents

Race category	Frequency (N= 14)	Percentage (%)
African	10	71.4
White	3	21.4
Indian	1	7.1
Coloured	-	-
Other	-	-
Total	14	100

²³² Rev Sibusiso Dladla, interview conducted by Charles Manda on 23 October 2006 in Pietermaritzburg.

²³³ Haddad B. 2002. Gender violence and HIV/AIDS: A deadly silence in the Church. *Journal of Theology for Southern Africa* 114 (November 2002) p. 96

Race of ministers interviewed

Of the ten church ministers I interviewed eight were black South Africans, one was an Indian South African, and one was Congolese. Although the sample is not representative of the whole population of ministers who received training, this shows that ECAP has done most of its work among black churches in Pietermaritzburg area. Thus of the seventy pastors that ECAP trained only six are Indian pastors the rest are black ministers. Although there are many churches in Pietermaritzburg which are led by White ministers, none of them has received training from ECAP since 1999 up to 2005. This sets a limitation on ECAP's work as HIV and AIDS is a problem in every church in Pietermaritzburg across the colour divides. The myth that "AIDS is a disease of black people in South Africa"²³⁴ is not true. The reality is that AIDS is spreading through all groups in South Africa and is breaching class barriers.²³⁵

4.2.3. Nationality

Two samples were selected for the purpose of this study. The first sample comprised of ESSA graduates and the second one comprised of church ministers. ESSA graduates represented eight different countries. Seven (87.5%) represented African countries and one (12.5%) European countries. Respondents from different countries were included in this study because the study sought to assess ECAP's work of which one of its programmes is training ESSA students whose population includes foreign students as well. Table 4.2 shows the countries where the respondents came from.

²³⁴ Whiteside A. and Sunter C. 2000. *AIDS the challenge for South Africa*. p. 48.

²³⁵ Ibid p. 48.

Table 4. 2: Nationality of respondents who completed questionnaire

Country	Frequency (N=14)
South Africa	5
Rwanda	3
Zimbabwe	1
Mozambique	1
Malawi	1
Switzerland	1
Zambia	1
Ghana	1
Total	14

Nationality of ministers who were interviewed

Of the ten church ministers who received training, nine (90%) were South Africans (eight blacks and one Indian) while one (10%) was a Congolese from the Democratic Republic of Congo (DRC).

4.2.4. When training took place

ECAP conducted training in HIV and AIDS at the Evangelical Seminary of Southern Africa as well as in the churches at different times in different years. Question 4 asked both respondents to the questionnaire and interviews when they attended ECAP's training. Different years were given but all fell within the period 1999-2005.

4.2.4.1. Training of ministers

Table 4.3 shows the year when each congregation received training.

Serial Number	Name of Congregation	Community	Year trained
1	St Marks Anglican Church	Imbali B	2002
2	Maranatha Christian Fellowship	Pietermaritzburg	2003
3	Assemblies of God	Willowfontein	2001-2002
4	Full Gospel Church of God	Imbali	2000
5	Apostolic Faith Mission	Sweetwaters	1999
6	Apostolic Faith Mission	Snathing	2003
7	Seventh Day Adventist of Jerusalem	France	2004
8	Independent Methodist Church of Southern Africa	Imbali	2003
9	Apostolic Faith Mission	Sobantu	1999-2000
10	Entabeni Community Church	Northdale	2002

Between 1999 and 2003 ECAP's training was done in churches where ECAP training 1-7 was conducted at different times. Sometimes training could start in one year and only finish in the following year. When I asked one ECAP staff member why it took ECAP so long to finish training, I gathered that training could begin but when trainers made an appointment to do further training, the churches would be busy with other engagements like funerals, meetings, and other unforeseen circumstances. So ECAP had to postpone the training sessions until an opportune time. Also ECAP used to conduct its training on Sundays and since funerals are conducted on these days, it was difficult to get members in for training. This accounted for the change of training strategy from training on Sundays to a three-day intensive training course for volunteers only at ECAP's office. This change has helped ECAP to complete all the seven training sessions in three days, which is normally done during the week days.

4.1.4.2. Training of ESSA graduates

Table 4.4 shows the frequencies and percentages of the years that respondents graduated from ESSA.

Table 4: Year respondents graduated from ESSA

Year of graduation	Frequency N=14	Percentage (%)
1999		
2000		
2001	1	7.1
2002	1	7.1
2003	1	7.1
2004	4	28.6
2005	7	50.0
Total	14	100

Different numbers of respondents are shown in this table. Equal numbers of respondents (1) indicated that they graduated in 2001, 2002, and 2003, indicating a response rate of 7.1 % for each year. Four respondents (28.6 %) graduated in 2004 while the highest number of respondents, seven, graduated in 2005, representing a response rate of 50 %. It should, however, be noted here that the sample included respondents who graduated in 1999 and 2000 but there was no response from them. Equally graduates from 2001, 2002, and 2003 were included in the sample but only one respondent returned the questionnaire from each year. The year 2005 scored the highest response rate.

4.2.5. Respondents' perceptions of the importance of the course

Question nine sought to establish whether graduates were using the training they got in the Church and AIDS course in their church/ community or in whatever ministry they were involved in. This question was asked only to those respondents who completed the questionnaire. The respondents indicated their answer by ticking either 'yes' or 'no'

where 'yes' meant they were doing something about it and 'no' meant nothing was happening. Table 4.5 shows the answers to this question.

Table 4.5: Showing whether graduates were using their training or not

Response	Frequency (N=14)	Percentage %
Yes	9	64.3
No	5	35.7
Total	14	100

Of the fourteen respondents five answered 'no' representing 35.7% while nine answered 'yes', representing 64.3%. Thus 64.3% were using ECAP's training in one way or another while 35.7% were not.

4.3. Results and analysis of the research

This section presents the results and the analysis of the study. It combines both the results from the questionnaire that was sent to ESSA graduates and the face-to-face interviews with ministers of the churches in Pietermaritzburg area.

4.3.1. Knowledge and skills obtained

Both the respondents to the questionnaire and those involved in the face-to-face interviews were asked whether they acquired any knowledge and skills from the training that was facilitated by ECAP at ESSA and in the churches. The respondents who completed the questionnaire were asked to indicate their response by either 'yes' or 'no'. Of the fourteen respondents thirteen (92.9%) answered 'yes' indicating that the course was helpful to them while one (7.1%) respondent answered 'no'. Of the ten ministers I interviewed, nine (90%) showed that they benefited from the training, while one (10%) minister said that it benefited the group of volunteers who were selected from his church to be trained by ECAP, but not him personally.

The next question was aimed at establishing what knowledge and skills they obtained from the training. There were varying answers as to the particular knowledge and skills

they obtained, but almost all of them indicated that they were made more aware about HIV and AIDS and its impact. Various answers were given but most of them showed that the course helped them in one way or another. For example, one respondent said,

Prior to the course, I did not have much knowledge about the disease and the course really helped me to understand and I also saw the need for my involvement.²³⁶

Another respondent added,

The Church and AIDS course at ESSA has exposed me to various levels of society and how HIV/AIDS has affected them. The problem is complex and there can be no simplistic solutions.²³⁷

And yet another said,

It was a practical course in that we had encounters with HIV/AIDS in terms of visits by people living with HIV/AIDS, hearing their testimonies and learning from them without judging them.²³⁸

ECAP uses two other tools besides teaching in its awareness campaign. These are video showing and testimony from an HIV positive person. The video is titled “Doctors for Life” and was compiled by doctors working with AIDS patients. This video was shown both in class to ESSA graduates and in churches to members of congregations. One respondent commented,

After watching the video of “Doctors for Life” I believed that AIDS is real not just a story. I was able to see that people suffer a lot right away from their private parts which is so sad.²³⁹

Another respondent found the testimony from an HIV positive person very educative.

Coming from a white middle class background where I was privileged to receive a good education my ‘knowledge’ of HIV/AIDS was good, but one thing I had never had the opportunity to do was to talk with someone who was HIV positive; this was something we had to do as part of the course requirement, find out how HIV had affected their lives. It was an eye opening experience.²⁴⁰

Like many students find some courses dull, one respondent found the Church and AIDS training dull at the time it was being facilitated in class by ECAP because he felt that it was not presented very well. However, he acknowledged that the course helped him in some way.

²³⁶ Respondent to questionnaire

²³⁷ Ibid

²³⁸ Ibid

²³⁹ Respondent to questionnaire

²⁴⁰ Ibid

Now that I look back, I actually did enjoy it and it has proved to be a rather fruitful course for me. I am teaching high school kids the subject of Life Orientation and a part of the syllabus is HIV and AIDS so the course is really coming in handy right now.²⁴¹

In terms of skills obtained from the training, one respondent commented,

We learnt counselling, life skills, gender and AIDS, and what the Bible says about AIDS. Then we proceeded to Bethany House for home-based care. They trained us to open a project and taught us the proper language to use when communicating with people about our project...we were taught to write down when we go to visit a person living with AIDS what we saw and did, the condition of the client. So every visit had to be recorded in the book.²⁴²

This shows that people did not only learn theoretical issues concerning HIV and AIDS but also skills and these skills did not only deal with how to care for person living with AIDS but included how to communicate effectively as project owners and how to keep records.

4.3.2. Attitude, thinking and behaviour of respondents after training

Webb argues that,

Community responses to AIDS can be investigated by examining attitudes towards people with AIDS. Underlying trends of stigma, fear, ignorance and compassion can be highlighted, and sections of the community with similar perceptions may be seen to form distinct groups.²⁴³

Stigma has been the main obstacle to dealing effectively with the issue of HIV and AIDS because of its association with myths and sin. Nicolson says,

Many people endure pain, or die while they are still young, from illness, accident or human crimes. Normally our theology takes that in its stride, especially when we are not personally involved. We are able to justify our continuing belief in God by saying that God's purposes are often too mysterious to understand, or by faith that in the end it will all work out for the best, or by suggesting that people's sufferings are caused by their own fault or, if not their fault directly, then by the consequence of some other human beings who, exercising free will against God's will, involve others in the consequences of their actions.²⁴⁴

While these other forms of pain and suffering may be accepted as God's will, it is difficult for people to accept AIDS as a normal disease not because of its incurability but

²⁴¹ Ibid

²⁴² Rev D. Msomi, interview conducted by Charles Manda on 19/10/06 in Pietermaritzburg.

²⁴³ Webb Douglas 1997. *HIV and AIDS in Africa*. Pietermaritzburg: University of Natal Press. P.165

²⁴⁴ Nicolson R. 1996. *God in AIDS? A theological Enquiry*. London. SCM Press Limited.p.24

because AIDS is associated with beliefs and myths which reinforce discrimination. During my interviews with church ministers, one minister said,

I asked the church members what they can do with a pastor who is HIV positive- They said we can chase him; God can't allow his servant, pastor to have such an embarrassing sickness.²⁴⁵

According to them the sickness was embarrassing because it is associated with sexual sin.

To investigate my respondents' perception of people living with AIDS, the following question was asked to both ESSA graduates and church ministers: How has the ECAP's training affected your thinking, attitude, and behaviour towards people living with HIV and AIDS? The respondents answered this question with various answers. Almost all respondents reported that the course conscientized them in one way or another.

In terms of thinking and attitude, three said:

It helped me to get rid of the stigma I had around people living with HIV and AIDS.²⁴⁶

It has reduced my fear, stigma, judgment toward people living with HIV and AIDS.²⁴⁷

I now have a positive attitude free from stigmatization because the course has enlightened me.²⁴⁸

Another respondent said,

My mind is completely changed. Instead of being judgmental I am looking at AIDS as one of the other diseases that we have in the society. People with AIDS need the same treatment and attention like others who are lying at home and in hospitals.²⁴⁹

One respondent expressed how his judgmental attitude towards people affected and infected with AIDS was impacted:

I used to think that HIV and AIDS is a remote disease that is out there, which only affects and infect the immoral people only, but now I have a different perspective which accommodates those that are both affected and infected.²⁵⁰

People come on the course with different perceptions about AIDS.

²⁴⁵ Rev S.Dladla, interview conducted by Charles Manda on 23 October 2006 in Pietermaritzburg.

²⁴⁶ Respondent to questionnaire

²⁴⁷ Ibid

²⁴⁸ Ibid

²⁴⁹ Ibid

²⁵⁰ Ibid

I used not only to judge people having the AIDS, but seeing them as unclean. , In addition I could not believe that someone can live with it for long time no matter what medicine the person is getting.²⁵¹

However, after attending this course, one respondent commented,

What changed my attitude is the conviction from the course itself and different people who came to expose their status. This made me think about people who are sick and therefore by witnessing that these people are normal as other human beings, they have the right to study, to work. I get to understand that the disease itself is not a big problem but the loneliness, poverty, rejection are the strong virus of AIDS and we need to give more love than bread and...²⁵²

In terms of behaviour, all respondents expressed a change in their behaviour towards people living with HIV and AIDS. Various comments were made, for example,

The course has made me to be friendlier and open to PWAs [people living with AIDS]. It helped me to have compassion toward people affected and infected with HIV and AIDS.²⁵³

Some church members are even involved in praying for people living with AIDS which during the early 1990s was taboo to them because AIDS sufferers were seen as deserving of suffering because of their promiscuous behaviour. The training showed some graduates how to behave or relate with people living with the HIV.

Shaping a theology that is free of stigma against people living with HIV and AIDS and free of prejudice has certainly influenced me positively, but what I believe has really made me sensitive, understanding and empathetic to people living with HIV was my personal contact, in fact, close friendship with some persons who are HIV positive.²⁵⁴

Stigma in the church has been perpetuated by the doctrine that AIDS is a punishment from God for the homosexuals or the sexually immoral people. One minister said,

Many people living with AIDS were separated from other people; many were feeling ashamed of themselves because AIDS was associated with sin.²⁵⁵

²⁵¹ Ibid

²⁵² Ibid

²⁵³ Ibid

²⁵⁴ Respondent to questionnaire.

²⁵⁵ Pastor Hadebe, interview conducted by Charles Manda on 21 October 2006 in Pietermaritzburg.

However, this kind of thinking has been challenged by ECAP during the training when it engaged its clients in a theological debate on HIV and AIDS. Almost 99 % respondents indicated a change of thinking.

My thinking and attitude was changed in a way that I knew people are not infected with HIV and AIDS because they are sinners or cursed by God. HIV and AIDS is a moral and gender issue.²⁵⁶

Other students felt confident to accompany and minister to people living with AIDS after the course.

I do have a heart to help them if they need help like counselling and not all of them are sick through sexual intercourse.²⁵⁷

One minister I interviewed indicated that the awareness that ECAP brought has brought change in his community.

There is a very big change because now people understand that if you sit, eat, and drink with people living with AIDS you are not going to get AIDS. Some people help people living with AIDS in their homes. In those days even if somebody is talking, you find that he is fighting somebody with the disease but now they have changed because they know this is a disease which can affect anyone.²⁵⁸

This is a major shift in the hearts of many people especially those who used to believe that AIDS is only transmitted through sex and therefore whoever is HIV positive is sinful.

The effectiveness of the training was also observed in the churches in that some people living with AIDS started to disclose their status, something they could not do at first for fear of discrimination. Balcomb suggests that

Denial happens at all levels of the history of the disease from denying that the virus is the cause of the disease in the first instance, to the denial that it was the cause of death in the final instance, with all the stages of denial in between.²⁵⁹

Frequently, what makes people hide their status is the fear of a negative response from the community. For example, Webb says, "the desire to see a PWA killed is perhaps extreme but has been a universal response to the epidemic."²⁶⁰ He gives the example of Britain in the mid 1980s, when overt homophobia often culminated in hysterical press

²⁵⁶ Respondent to questionnaire

²⁵⁷ Ibid

²⁵⁸ Pastor Hadebe, interview conducted by Charles Manda on 21 October 2006 in Pietermaritzburg.

²⁵⁹ Balcomb T. "Sex, sorcery, and stigma- Probing some no-go areas of the denial syndrome in the AIDS debate." In. *Journal of Theology for Southern Africa* 125 July 2006 p.104

²⁶⁰ Webb Douglas 1997. *HIV and AIDS in Africa*. Pietermaritzburg: University of Natal Press. P.167

reports advocating the killing of PWAs and the isolation of homosexuals.²⁶¹ In Zimbabwe, in 1994, a member of Parliament proclaimed that, 'If a pregnant woman is found to have AIDS she should be killed so that AIDS ends with her'. Otherwise, 'the woman would still continue to spread AIDS'. A similar example is given in Ghana where some of the respondents in a Knowledge, Attitudes, Beliefs and Practices (KAPB) survey advocated 'injectables to kill' for a PWA. In a sample of high school students in Gauteng 32 % felt that AIDS was a "punishment for the guilty."²⁶² Perhaps the most talked about incident that might have pushed many people living AIDS into hiding was the stoning of Gugu Dlamini.

In her village in KwaZulu-Natal, the South African province hardest hit by the Aids epidemic, Gugu Dlamini died because of the disease. But it wasn't the virus per se that killed her. She was accused by fellow-villagers of having brought shame on the community by talking publicly about being HIV-positive. When she was beaten by a neighbour who advised her to keep quiet, she went to the police but they did nothing to protect her. The next night, villagers attacked her house before stoning her and beating her to death.²⁶³

When these perceptions abide, people are afraid of disclosing their status and remain silent. However, the interviews revealed that change has taken place among ministers who years ago were part of the company that ostracized people living with AIDS because of their theological stand. Two of the ten ministers acknowledged that some of their members disclosed their status openly in the church.

People have come to understand that they don't have to be scared of PWA. Some PWA have come out openly that they are living with the disease. One day, in a church of 200-300 members, one lady came after preaching that she is HIV+ and was well received.²⁶⁴

Another minister said,

First people hid their status and said that someone has poisoned me, but we encourage them to disclose their status because AIDS is just like any other disease.²⁶⁵

In terms of behaviour towards PWA, one minister said,

²⁶¹ Ibid p.167

²⁶² Ibid p.167

²⁶³ Jean Dussault, member of the Canadian HIV/Aids Legal Network, *The stigma of AIDS*.
http://www.unesco.org/courier/1999_10/uk/dossier/txt35.htm accessed 16 November 2006.

²⁶⁴ Pastor C. Thenjwayo, interview conducted by Charles Manda on 23 October 2006 in Pietermaritzburg.

²⁶⁵ Ibid

In the church when we see a person living with AIDS everybody wants to assist that one because they learnt more. Now our minds are open while before the training you couldn't touch clothes, cups of a PWA. But now we can use the same cup when drinking.²⁶⁶

Another minister added,

There was great change after training. Even women here now pray for people with AIDS.²⁶⁷

Just as Webb sees the moral obligation for health workers to attack such a belief with education, ECAP has over the period of seven years vigorously attacked such beliefs either in churches, ministers' fraternal meetings or in class at ESSA. The result is a shift in people's attitude, thinking and behaviour towards PWA as evidenced from the survey and interviews conducted with ESSA graduates and church ministers.

4.3.3. Involvement in HIV and AIDS-related activities

This section analyses the answers to the question: What HIV and AIDS related activities are you doing in your church or community as a result of receiving training from ECAP?

A variety of answers were given depending on the respondent's involvement in HIV and AIDS activities. The main themes that were addressed in the responses were: awareness and prevention, home-based and orphan care, counselling, training of caregivers, teaching, early childhood education, youth ministry, fund raising, and feeding schemes. Some of the main ones are discussed below.

4.3.3.1. Awareness and prevention

One of the beacons of ECAP's training is HIV awareness and prevention. ECAP conducts several sessions in awareness through interactive drama, showing video, life skills training and giving of testimony by a person living with AIDS. It stresses the ABC method of preventing HIV transmission where A-means Abstinence, B means Be faithful, and C means Condomise. Harrison describes abstinence as "refraining from sexual activity for a limited period of time".²⁶⁸ Abstinence has been taken as the ideal method of prevention for HIV and AIDS. Harrison further states that there is 'secondary abstinence' which means "a prolonged period without sexual activity among those who

²⁶⁶ Ibid

²⁶⁷ Mrs V. Dlamini, interview conducted by Charles Manda on 18 October 2006 in Pietermaritzburg.

²⁶⁸ Harrison A. 2005. *Young people and HIV/AIDS in South Africa*. Cambridge University Press: p. 273.

have already been sexually active.”²⁶⁹ ECAP also promotes use of condoms but only to couples if one partner or both are HIV positive and not to young people. Nicolson asserts,

A major emphasis in most secular AIDS educational programmes is that those who have sexual relationships with a new partner or with a variety of partners should use condoms. Condoms are their major defence against AIDS. While most of the Church AIDS agencies, at least in Africa teach that abstinence is the major defence.²⁷⁰

Harrison argues, “The increase in condom use has been associated with changes in sexual behaviour.”²⁷¹ However, critiques of condom use argue that condom use is contrary to behavioural change. This position according to Philippe Denis is not only dangerous but also unjust “because it assumes that men and women who have many sexual partners do so by deliberate choice and thereby favours exclusion which contributes to conspiracy of silence and stigmatization”²⁷² HIV and AIDS is a crisis and must be approached radically and critically. A Pentecostal preacher once said, “we would better let them use the condoms and preach to them while alive than bury them honourably once they die”²⁷³

The use of condoms has already borne out some very encouraging results. In Uganda, for instance, ‘the use of condoms has led to a reduced spread of the epidemic’.²⁷⁴ However, the provision of these condoms should be done in a manner that is both accessible and inclusive. Many young people do not have the courage or the funds to buy condoms in public markets. These could be provided in the private corridors accessible to young people without fear of stigmatization.²⁷⁵

All the respondents to both questionnaires and interviews were involved in HIV and AIDS education and awareness either formally or informally. Other respondents were involved in bringing HIV awareness in schools and other places. Three respondents expressed the value of the training they got from ECAP and how they were using the knowledge and skills obtained to help people in their communities:

²⁶⁹ Ibid p. 273.

²⁷⁰ Nicolson R. 1996. *God in AIDS: Theological Enquiry*. London: SCM Press LTD. P. 138-139

²⁷¹ Harrison A. 2005. p. 272

²⁷² Denis P. 2003. “Sexuality and Aids in South Africa,” In. *Journal of Theology for Southern Africa*. no. 115: March 2003 P.73-74.

²⁷³ Barnett and Whiteside 2003 p. 67-86

²⁷⁴ Ibid p. 67-86

²⁷⁵ Ibid. p.67-86

I am teaching now and the course has really given me a foundation to teach from. I refer back to my course material when doing class lesson plans. This will continue for as long as I teach high school life orientation. Teaching is my ministry and the education department is placing a lot of emphasis on AIDS and HIV at school level. Besides just teaching about itI am also available to advise the kids on various aspects of the disease whether the person is infected or affected.²⁷⁶

Another respondent was bringing awareness through discussions.

I use it [the training she got] through my discussion with people who are or are not HIV positive. I share with them what I got from the course about the pandemic, and how everybody is concerned to respond to it.²⁷⁷

One minister was responsible for recruiting members of other denominations to join hands in his church's project of bringing awareness and care to people with AIDS.

The work is shared by all who have been trained by ECAP. The impact of training in TEARS has built awareness and changed attitudes and a willingness to help those infected and affected with the virus through counselling and care.

The care at is the level of home-based and bereavement.²⁷⁸

4.3.3.2. Voluntary counselling and testing

Barnett and Whiteside assert that voluntary counselling and testing is increasingly seen as an important component of prevention. The idea is to provide people with access to rapid testing in an environment where they will receive pre- and post-test counseling. If they are negative, then have an incentive to stay that way. If infected, the message is positive living.²⁷⁹ However, it is worth noting that "such an intervention only works in a supportive environment or one where levels of stigma are not high and ideally where people can access some form of care."²⁸⁰ ECAP is involved in training its beneficiaries in pre-test counselling and post-test counselling. Of the ten ministers interviewed, four were involved in counselling of some sort. One female minister who runs a drop-in centre for children said,

²⁷⁶ Respondent to questionnaire

²⁷⁷ Ibid

²⁷⁸ Rev Albert Chetty interview conducted by Charles Manda on 15 September 2006.

²⁷⁹ Barnett T. and Whiteside A. 2002. p.67-86.

²⁸⁰ Ibid p. 76-86.

We do bereavement counselling and skills for the youth [in her church] and children.²⁸¹
Another minister was involved in promoting testing amongst youth; teaching about HIV and AIDS; home-based care; counselling; feeding scheme; and providing clothes to the poor people²⁸²

Three of the fourteen graduates were involved in voluntary counselling in their daily ministry.

...pre and post test counselling as well as voluntary counselling training.

...Bereavement counselling for people affected with HIV.

..Besides just teaching about it, I am also in a position to offer counselling.²⁸³

According to ECAP, counselling includes listening, giving feedback/ reflecting what one hears, giving input to possible solutions. It may provide input on physical care, nutritional support and spiritual care from God's word and adding personal experience to the wisdom offered.²⁸⁴ ECAP has added nutrition to their training.

“He [ECAP's trainer] told us about diet that it was no good treating this if no good diet is taken.”²⁸⁵ In response to this teaching, one minister said,

We at St Marks are very fortunate because now we have a drop-in centre. We have donated sheets, comforters, food, cleaning agents. Through his help [ECAP's trainer] we now accept people with AIDS in the church; when they are strong they come, we also visit them in their homes. We have been trying to establish gardens but not yet. Counselling still takes place at the church.²⁸⁶

It is interesting to note that ECAP combines voluntary counselling and provision of basic materials needed by people living with AIDS. This gives a new dimension to counselling which for a long time has been seen as simply giving advice. It means giving encouragement as well, and this can come in any form either verbally or through provision of basics needs to people infected or affected with AIDS.

²⁸¹ Respondent to questionnaire.

²⁸² Ibid

²⁸³ Ibid

²⁸⁴ ESSA Christian AIDS Programme. (n.d.) Three- Day HIV/AIDS Training Manual.p. 29

²⁸⁵ Mrs V. Dlamini, interview conducted by Charles Manda on 18 October 2006 in Pietermaritzburg.

²⁸⁶ Ibid

4.3.3.3. Home-based care and orphan care

The need for home-based and orphan care cannot be overemphasized in South Africa given the skyrocketing prevalence of AIDS. The World Health Organization defines home care “as the provision of health services by formal and informal caregivers in the home.”²⁸⁷ Rising health care use and spiralling costs have everywhere led to a trend and the necessity to treat patients in the home. Nicolson says that the term ‘orphan’ means different things in different cultures. It may mean a child who has lost both parents. Generally, the term is better used, however, to mean a child who has lost his or her effective parent. In many African statistics, the term means a child who has lost one parent who provides care and support.²⁸⁸ The burden of AIDS is felt on two fronts. First, the burden of caring for the people suffering from AIDS-related illnesses; second, the burden of caring for orphans who have been left by the deceased. The burden of caregiving is primarily placed on women, who have very little access or control of the resources needed to assume this responsibility. Well-managed and supported home care, however, can improve the quality of life of patients of all ages and caregivers alike.²⁸⁹

In all countries, the family has always been and still is the major provider of long-term care. This is true for care of older persons as well as for care of patients with chronic conditions, including HIV and AIDS, TB and malaria.²⁹⁰ This proves Krakauer’s point that Africa’s faith community, which in many countries already provides most of the care and comfort for the sick and dying as well as the orphans and vulnerable children—has a significant role to play in the social and cultural treatment of AIDS.²⁹¹ However, the heavy burden of care cannot be shouldered by families alone. Due to a wide range of social, economic, demographic and epidemiological factors (for example, migration, changing rural and urban social environments, poverty, family members themselves being old or impaired, etc.), family resources are dwindling. Many people suffering from AIDS may not be able to take care of themselves in the sense of preparing meals, bathing,

²⁸⁷ World Health Organization. Home-Based Long-Term Care

http://www.who.int/chronic_conditions/ltc/en/ accessed 5 November 2006

²⁸⁸ Nicolson R. 1996. *God in AIDS: Theological Enquiry*. London: SCM Press LTD. P. 11

²⁸⁹ World Health Organization. *Home-Based Long-Term care* Accessed 5 November 2006

http://www.who.int/chronic_conditions/ltc/en/ accessed 5 November 2006

²⁹⁰ Ibid

²⁹¹ Krakauer. M. 2004. p. 10

washing and other things because of the condition of their bodies or the lack of resources. This is where the need for home-based care comes to bear.²⁹² Jacobs asserts,

The one common denominator in caring for people living with AIDS is functional dependency and the growing need to manage every day living (bathing, eating, shaving, dressing, exercising, etc). It is very important for people living with AIDS to regain their health and maintain it for long term survival. Studies have shown that victims of HIV/AIDS who take care of their health stay healthy for many years after infection by the AIDS virus. Nutrition is a fundamental pillar of human life, health and development. Proper food and good nutrition are essential for survival, health and well-being.²⁹³

In response to the burden that AIDS has placed on South African population in Pietermaritzburg area, ECAP started facilitating the Church and AIDS course which aims at training home-based and orphan care volunteers. ESSA students are taught how to care for patients at home since hospitals do not have enough space to accommodate so many people suffering from HIV and AIDS related sicknesses. All the fourteen graduates went through the theory part of home-based and orphan care and not the practical part. Two of the fourteen indicated that they were involved in home-based care. One said:

I go with the team in the community to visit the patients, to bathe them, to show love and support; to give groceries; to pray with them, counsel those who need counseling; to give clothes; and to bring the gospel news to them.²⁹⁴

The second one stated,

I am working as a pastor on site with my husband at Project Gateway which has an orphanage for HIV/AIDS infected and affected children.²⁹⁵

All the ten ministers had volunteers from their churches trained in practical home-based care either at Community Care Project or with SAHECO.²⁹⁶ Of the ten ministers interviewed, six were doing home-based care projects in their churches or communities.

²⁹² World Health Organization. Home-Based Long-Term Care
http://www.who.int/chronic_conditions/ltc/en/ accessed 5 November 2006

²⁹³ Jacobs Sol. (n.d.). Methodist Church of Southern Africa (Mission Unit). *The Methodist Response to HIV/AIDS in Southern Africa: Strategy and implementation plan*. Connexional task force on HIV/AIDS.

²⁹⁴ Respondent to questionnaire

²⁹⁵ Respondent to questionnaire

²⁹⁶ SAHECO is an abbreviation for the South Africa Health Care Organization. It is an organization that trains caregivers in home-base care and orphan care in Pietermaritzburg. This is where ECAP sends its caregivers after the basic three-day training.

.....They [the volunteers] do home-based care, and sometimes get linen from Project Gateway. At the moment we are being helped by Project Gateway. We do collection in the church to get groceries for PWA and Benson has been coming.²⁹⁷

.....Women visiting the sick have changed also because at first they could do visits without kits but now they use gloves and a kit. Now they don't go to preach and pray only but also to counsel the people living with AIDS.²⁹⁸

While volunteers are engaged in home-care some ministers do follow-up visits to people with AIDS.

I make follow up, after the women, to homes of those who are sick, pray and motivate them, show them the love of God and spiritual mentoring.²⁹⁹

One of the goals of ECAP is to network with other organizations that are involved in HIV and AIDS work. It even encourages its client churches to network with other community based organizations for more efficiency in service delivery. One minister said,

Home-based care was done by ECAP and after there was no follow-up. Now we have a support group. Whatever happened was initiated by ECAP. Now we partnered with another church in HIV-related work.³⁰⁰

The impact of AIDS can not be born by one church or by individuals only; a network is needed to provide concerted efforts. Nicolson concurs with this view by asserting,

AIDS is yet another sign that our human community is disintegrating, but as AIDS bites deeper, those traditional networks begin to collapse. People in the Third World will be forced to develop new networks of relationship beyond immediate kinsfolk and neighbours. The church will have a role to play in providing basis for these new networks.³⁰¹

4.4. Church initiating projects

The ultimate goal of ECAP in training churches in HIV awareness, prevention and home-based and orphan care is that the volunteers go back to their churches and start HIV and AIDS related projects. These projects range from income generating activities and

²⁹⁷ Pastor C. Thenjwayo, interview conducted by Charles Manda on 23 October 2006 in Pietermaritzburg.

²⁹⁸ Pastor P.S. Phoswa, interview conducted by Charles Manda on 23 October 2006 in Pietermaritzburg.

²⁹⁹ Ibid

³⁰⁰ Pastor C. Thenjwayo, interview conducted by Charles Manda on 23 October 2006 in Pietermaritzburg.

³⁰¹ Nicolson R. 1996. *God in AIDS: Theological Enquiry*. London: SCM Press LTD. p. 202-203.

vegetable gardens to home-based care for people living with AIDS in their communities. So far ECAP has helped churches in the Pietermaritzburg area to establish thirty-five projects but not all of them are running efficiently for lack of human or financial resources. Maranatha and Sobantu AFM churches, are among many churches whose volunteers were trained in home-based care but were unable to carry out their work with the few personal resources they had. ECAP had promised to help with funds and materials like toiletries for helping the people living with AIDS but it was not able to honour its promises.

Question ten in the questionnaire was a follow-up to question 9 which asked respondents to list the HIV and AIDS related activities in which they were involved after receiving training from ECAP. Nine of the fourteen respondents indicated that they were involved in HIV and AIDS related projects

Table 4.6: Activities involving ESSA graduates

Activity	Frequency (N=14)
Voluntary counselling	3
Teaching and awareness	3
Youth ministry	3
Fundraising	1
Home-based and orphan care	2
Feeding scheme	2

The frequency does not correspond with the total number (9) of the respondents who indicated that they were involved in some activities because some respondents were doing one or more activities at the same time.

4.4.1. Training of volunteers

One of ECAP’s goals was to train volunteers in home- based care and orphan care so that they can in turn train their fellow members in the church. The expectation is that they

will launch projects in home-based care in their communities. Two of the fourteen graduates were involved in training home care volunteers and ministering to orphans.

I am involved in training of carers, in how to take good care of HIV positive people as well as orphans.³⁰²

From the interviews conducted, volunteers were trained in all the ten churches but volunteers in only a few churches established the projects. When asked why they have not implemented home-based care, different answers were given. Some volunteers had no funds to start the projects. Others left their churches to look for employment. Two ministers said that ECAP had promised to help them with funds to establish these projects but that this did not materialize.

ECAP promised volunteers to help with skills training and promised some funds to help volunteers start projects like sewing to raise funds to help in home-based care but that did not happen which is very bad.³⁰³

Some churches get so little income from the offerings that they are not even able to support their ministers let alone start an AIDS-related project.

4.4.2. Early childhood education

One of the ten ministers runs a children's drop-in centre which was started on 19 January 2005 and caters for about forty children. Most of these children come from homes whose parents or parent are suffering from AIDS related illnesses. This centre also works as a crèche where children receive early childhood education. Bethany House gives them two hundred food parcels per month.

Most of the children have no parents so we give them love, and education to prepare them for the future like any other children have a privilege to.³⁰⁴

When asked whether the children pay fees for their daycare she responded,

We have more than forty children, but five of them pay so that I can get transport because going to Grange or to town on foot is far.³⁰⁵

³⁰² Respondent to questionnaire

³⁰³ Pastor S. Yuma, interview conducted by Charles Manda on 22 October 2006 in Pietermaritzburg.

³⁰⁴ Rev Mrs D. Msomi, Interview conducted by Charles Manda on 19/10/06 in Pietermaritzburg.

³⁰⁵ Ibid

During my interview with her, I learnt that she leads a group of volunteers in her community to minister to around forty 'clients' (HIV positive people), and a good fraction of the children attending the crèche belong to these clients. Other volunteers help her with caring and teaching the children in the crèche.

We have orphans, children affected and infected with HIV. We give them food, breakfast, lunch. If nobody comes to fetch them they sleep here until social workers come to take them especially those who have lost their parents. We feed them when they are going home they go full stomach; we also take sick children to the Grange clinic.³⁰⁶

4.4.3. Youth ministry

ECAP puts much emphasis on empowering young people with life skills that should help them to make right choices for their lives and futures. As a result of its facilitating an AIDS course, some graduates were motivated to work with young people in bringing them awareness and life skills. Three respondents listed the activities they were involved in: "education to young people"; "sessions of discussions open to any topic including HIV/AIDS during youth meetings"; and "training the young people in the whole issue of HIV."³⁰⁷

4.4.4. Fundraising

Another objective of ECAP is to help community projects that it helps to establish in the communities, to raise their own funds to sustain themselves. As a result ECAP includes this fundraising element in its training package. One respondent mentioned how he has used his training in Church and AIDS to work as a consultant in fundraising and evaluation of projects in his country.

In 2005 I was using the training I got from ESSA in World Relief Rwanda to build capacity of churches in Rwanda to mitigate the impact of AIDS.³⁰⁸

He has been "raising awareness" and "helping associations to write up the proposals and measure their impact".

³⁰⁶ Ibid

³⁰⁷ Respondents to questionnaire.

³⁰⁸ Respondent to questionnaire.

4.4.5. Feeding scheme

Although the feeding scheme goes hand-in hand with home based care, it also looks into the needs of poor people in the communities who may be HIV positive or not. In this study, two respondents made mention of their involvement in feeding scheme where food parcels or soup are taken to the poor people, especially those suffering from HIV related sicknesses, since most of them cannot fend for themselves because of their conditions.

Entabeni Community Church recruited persons from other churches and formed AIDS project called TEARS (The Entabeni AIDS Relief Sanctuary). They operate a weekly feeding scheme for the community. It collects clothes and distributes to the poor, toys for children and distributes food parcels.³⁰⁹

This church also gives out its premises free for funerals and assists families in the time of bereavement. This is a major contribution to the community, especially with the influx of deaths of people due to AIDS. This saves the community some money for paying for halls for funerals. Letting out the church to the community to use for funerals is a good gesture of a church in a community, and this demonstrates the role of Africa's faith communities in HIV and AIDS intervention.

4.5. Conclusion

This chapter has presented the results of the survey which was conducted among ESSA graduates. The survey has revealed that the Church and Aids course facilitated by ECAP at ESSA made some impression on ESSA graduates as seen from their responses and also the activities in which they were engaged in after the completion of their training. It should be noted here that all success cannot be exclusively attributed to ECAP because the ESSA graduates undergo three year training at ESSA where many different courses are covered. The Church and AIDS course is just one of them. The interviews with the ministers show tremendous change, considering how churches were struggling with myths and strange theologies a few years ago. Today they are involved in HIV and AIDS- related projects in their churches and communities.

³⁰⁹ Rev Albert Chetty, interview conducted by Charles Manda on 15 September 2006 in Pietermaritzburg.

CHAPTER 5: SUMMARY OF FINDINGS AND CONCLUSION

5.1. Introduction

This chapter concludes the study. The study assessed whether the ESSA Christian AIDS Programme has made any contribution to the fight against HIV and AIDS in the Pietermaritzburg area through its training programmes in the churches and at ESSA in HIV awareness and prevention, home-based and orphan care, and assisting the churches to initiate AIDS-related projects (Community Based Organizations). The population comprised three different samples. The first sample was ESSA graduates who attended the Church and AIDS course at the Evangelical Seminary of Southern Africa, in Pietermaritzburg. The second sample comprised church ministers. And the third sample comprised six stakeholders of ECAP who have been part of the founding of ECAP or have worked as staff at one point or another. Of the seventy-eight churches that were trained by ECAP between 1999 and 2005, ten were sampled from eight communities of Pietermaritzburg. Ten ministers representing each of the ten churches were sampled and face-to-face interviews were conducted. Of the one hundred and forty one ESSA graduates that took the Church and AIDS course between 1999 and 2005, twenty graduates were sampled and questionnaire was sent to them to complete. Fourteen out of the twenty graduates completed the questionnaires were and returned it to the collection point and all of them were usable for analysis of the study. All the ten ministers were interviewed and had four specific questions to answer. Both the results from the questionnaire and the interviews were analysed. This study tested Krakauer's above-mentioned theory that,

Africa's faith community, which in many countries already provides most of the care and comfort for the sick and dying as well as the orphans and vulnerable children has a significant role to play in social and cultural antecedents of AIDS.³¹⁰

Since ECAP is a faith community in Africa engaged in empowering other faith communities, in this case churches, in the fight against AIDS, it was a useful case to study.

³¹⁰ Krakauer. M. 2004 p. 10

5.2. Summary of findings

ESSA is one of the pioneers among the evangelical institutions in Africa to engage in HIV and AIDS- related programmes. ECAP's main goal was to bring HIV and AIDS education and awareness to congregations in Pietermaritzburg and to ESSA graduates who generally come from many different countries in the world especially in Africa. Nicolson recommends that an important aspect of AIDS education is to make people aware not only that AIDS can be contracted through unprotected sexual activity, but also that it cannot be contracted in any other way. He sees that AIDS ministry in South Africa has been seriously hampered by the fear that people with AIDS pose a general health hazard to the population.³¹¹ This perception makes it difficult for any HIV positive person to disclose his or her status for fear of discrimination or stigma. This rests the responsibility on "churches, who can appropriately talk about the need for courage and acceptance, have an important role to play in reducing popular fears and prejudices. Church ministers can set an example in the matter."³¹² The study revealed that prior to ECAP's training there were many myths and beliefs which hindered the churches in Pietermaritzburg to engage themselves in HIV and AIDS related work in their communities. Some of the common beliefs were: the doctrine that AIDS is a punishment from God; AIDS is sin; AIDS is for promiscuous people. These beliefs reinforced stigma and discrimination against people living with AIDS. People living with AIDS found it difficult to seek help as that meant disclosing their status. When ECAP started its awareness programmes, which it presented in forms of interactive drama, engaging congregations in discussion sessions, testimonies of people living with AIDS, watching videos on HIV and AIDS, teaching life skills among the youth, engaging trainees in theological debate about HIV and AIDS and gender issues, there was a notable change in the attitude, thinking and behaviour of the respondents towards people with AIDS, as presented in chapter four. The results of the study have shown that many respondents received enlightenment which impacted on their attitude, thinking and behaviour towards people living with AIDS. Some people were set free from the phobias that hindered them from interacting and sharing utensils with a person living with AIDS. Almost all

³¹¹ Nicolson R. 1995. *AIDS: A Christian response*. Pietermaritzburg: Cluster Publications.p.73

³¹² Ibid. n. 73

ministers that were interviewed expressed a shift in their churches from a judgmental attitude to an attitude of accompanying, inclusivity and compassion. This shift was manifested through their involvement in helping people suffering from AIDS through community support programmes like home-based care, orphan support, schools for children, pre-test and post-test voluntary counselling, feeding schemes, training of volunteers, fundraising projects like vegetable gardens which generate income to use for supporting AIDS patients, and counselling AIDS clients. Nicolson recommends that the church be involved in educating populations to dissipate the ignorance that reinforces stigma and discrimination,³¹³ ECAP engaged in equipping churches through awareness, home-based and orphan care, and assisting them to initiate projects which can assist people living with AIDS. The result has been the dissipation of ignorance and embracing people with AIDS, making the church a healing, and supporting community. From its trainings in the churches and at ESSA, many church ministers, as deduced from the interviews and questionnaire, have been informed about HIV and AIDS and they are already engaged in a variety of HIV and AIDS-related activities. This is a positive response to its trainings by ECAP's beneficiaries.

5.3. Recommendations for ECAP

UNICEF in its document *What Religious leaders can do about HIV/AIDS: Action for Children and Young People* states,

HIV and AIDS is a crisis of enormous spiritual, social, economic and political proportions. And, increasingly, it is a problem of the young. Overcoming HIV and AIDS and the stigma that fuels its spread is one of the most serious challenges of our time. It requires courage, commitment and leadership at all levels especially among religious leaders who can use the trust and authority they have in their communities to change the course of the pandemic.³¹⁴

Therefore, the role of faith-based organizations in equipping members of the community to get involved in HIV and AIDS intervention strategies is of paramount importance.

Green, in a paper titled: "Faith-Based Organizations: Contributions to HIV Prevention", argues that experience has shown that national leadership and open discussion about HIV and AIDS are key factors in attaining stable or declining national HIV seroprevalence

³¹³ Nicolson R. 1995. *AIDS: A Christian response*. Pietermaritzburg: Cluster Publications. P.73

³¹⁴ The United Nations Children's Fund (UNICEF), *What Religious leaders can do about HIV/AIDS: Action for Children and Young People*. New York, 2003

rates, but so is the involvement of religious leaders and FBOs in HIV prevention. He adds that in countries where religion is important, faith-based involvement may prove to be as necessary as condom social marketing, treatment for sexually transmitted infections, voluntary counselling and testing, and other state-of-the-art interventions in HIV prevention efforts. This is especially true in highly religious countries and in those in which FBOs comprise a major part of the nongovernmental sector. It makes little sense to mobilize only secular resources in such countries.³¹⁵ Since Green gives such weight to FBOs, it is vital that ECAP considers the following recommendations:

5.3.1. Gender

ECAP needs to revise its strategy for recruiting churches for training. From the interviews I had with some of the ECAP's staff, and the list of churches that ECAP has trained since 1999 to 2005, it has been revealed that ECAP has trained two women ministers out of the seventy-eight ministers it trained. Thus two female ministers and seventy-six male ministers have received training. These figures do not reflect the quest for gender equality as President Thabo Mbeki advocates 50-50 participation of men and women in every sector of South Africa. The World Alliance of Reformed Churches asserts that,

Working towards an inclusive community that is based on partnership of equals rather than on power structures, women should be present in every aspect of church structures, including the ordained ministry.³¹⁶

Besides, women bear most of the burden of caring for the sick and dying. Nicolson is of the opinion that

Women in Third World countries in many ways endure the major impact of AIDS. More women than men get AIDS. They contract the virus younger than men. Those who do not have the virus must care for relatives who are ill with AIDS, and when the sick die, they must care for and support those left behind.³¹⁷

³¹⁵ Green E.C. Faith-Based Organizations: Contributions to HIV Prevention. Harvard Center for Population and Development Studies. U.S. Agency for International Development. September 2003. p. 17. This report was produced by The Synergy Project, implemented by TvT Global Health and Development Strategies, a division of Social & Scientific Systems, Inc., under USAID Contract Number: HRN-C-00-99-00005-00.

³¹⁶ World Alliance of Reformed Churches. Women's ordination. Available online

<http://warc.jalb.de/warc.jsp/side.jsp?news_id=453&navi=29&part_id=36 accessed 14 November 2006.

³¹⁷ Nicolson R. *God in AIDS* p.224

5.3.2. Venues for training

Every organization has its goals and priorities in whatever service they offer and must develop strategy to best meet the objectives. Sometimes it is the question of human or other resources that hold organizations back from fulfilling what they intend to achieve. Both human and financial resources are major limitations for ECAP. At first ECAP was taking training to the people in their communities. From the interviews I had with the church ministers, all the ministers where ECAP conducted training in their local churches indicated more awareness and involvement in HIV and AIDS related activities, than ministers who just sent volunteers to ECAP office for training. For example, one minister said the training only benefited the volunteers who attended it. Two other ministers blamed ECAP for not fulfilling the promises made to their churches that it would give them funds to start home based care projects. If awareness still remains at the heart of ECAP's work, then perhaps going back to training whole congregations would bring awareness to a larger community than just recruiting and training a few volunteers in the city. I also gathered that some churches are not doing any HIV-related activity despite their volunteers being trained. The reasons given included the fact that the volunteers are not employed and so some have left to look for employment. It is more likely that eight volunteers would go and look for employment than the whole congregation would do so, which suggests to me that if whole congregations are trained, at least some members will remain in the church who can engage in HIV and AIDS- related activities while the others go to look for employment elsewhere.

ECAP started with pastors' seminars to bring awareness to pastors who later opened the doors of their churches for ECAP to go and train whole congregations. This was a good strategy because it put the pastors, who hold the key to the churches, in a strategic position. So whatever was happening, the minister was in the lead. As explained in chapter three, ECAP changed this strategy and started training ministers and their congregations together in one place so that pastors could connect with their members. The latest change of recruiting eight people per congregation generally leaves the pastor out as he or she decides whether to send eight or be part of the eight who go to ECAP's

office. When these volunteers come back from training they depend on the voice or “the keys” of the minister to undertake any action. Truly speaking, it is not easy for volunteers to sit the whole church down and teach them all the things that they learnt at ECAP. ECAP staff are highly trained and skilled to do their work among communities and to expect volunteers trained for three days to teach their congregations all that they learnt from ECAP from awareness to home-based and orphan care is a big challenge.

As the community of donors and implementers moves more substantively into care and support, FBOs become important partners. Their capacity to reach communities and work with them to provide support for orphans and other children made vulnerable by HIV, to provide home-based care, and to deliver of high quality clinical services is unparalleled across much of Africa.³¹⁸

5.3.3. Condoms and prevention

The use of condoms as a preventative measure is a contested issue especially among Christian faith-based organizations. ECAP is a case in point. Liebowitz in his study of the faith-based organizations and HIV and AIDS in Uganda and KwaZulu-Natal, say that

FBOs also have constraints based on their belief system, leadership, and exclusiveness.³¹⁹

ECAP has its own belief system and recommends the use of condoms for couples only if one of the two is infected. But it does not condone the use of condoms among the youth, though some studies have shown that the use of condoms can be effective in preventing HIV transmission among the youth.³²⁰ In his study Liebowitz argues, on the use of condoms, that

In several cases, however, respondents rated condomising as an effective technique. Those who did rate condomising as successful argued that many youth had dramatically increased their use of condoms and that this was limiting the spread of HIV and AIDS in their congregation. Zionists in Ntuzuma claimed that many were condomising and this reduced the spread of HIV within the congregation. Anglicans in Luuka saw condom use as an effective strategy, where youths increased their condom use and limited the spread of HIV among sexually active members of the youth. In this

³¹⁸ HIV/AIDS prevention, care and support across faith-based communities: an annotated bibliography of resources. This document has been funded by USAID/REDSO through FHI's Implementing AIDS Prevention and Care (IMPACT) project, cooperative agreement. HRN-A-00-97-00017-00.

³¹⁹ Liebowitz 2004 p.24

³²⁰ Ibid p.24

case, proper and consistent use of condoms was still a concern, but these concerns did not invalidate the overall strategy.³²¹

However, he also acknowledges that many people do not use condoms in spite of their availability.

Of the small number of FBOs that either supplied condoms or encouraged their use, few received positive responses from their communities on the success of the strategy. While the number of cases is relatively small, as most FBOs did not promote condomising, the majority saw the promotion of condom use as an ineffective strategy. First of all, in many cases, people were reluctant to use condoms.³²²

In other cases, those who did use condoms used them seldom, improperly and or only with non-regular partners. Finally, many respondents pointed to cases where AIDS continued to increase despite the encouragement of FBOs to condomise and the availability of condoms. For these reasons, therefore most informants did not rate condomising as a highly successful strategy.

Shorter and Onyancha say that many church organizations have consolidated their efforts to promote AIDS awareness programmes in the communities within which they operate. These vary from the insertion of AIDS information into ordinary preaching and instruction to the elaboration of information, education and communication (IEC) programmes operating in a number of communities.³²³ They say “the ultimate goal of awareness campaigns is AIDS prevention and care.” He adds that awareness programmes also include the call to show compassion to people living with HIV and AIDS and their families. The issue of condoms thus still needs to be further examined and tackled by ECAP.

5.4. Recommendations for further research

Further research is needed in the churches. Members of congregations need to be interviewed to assess what they received from ECAP’s training and how, if anything was received, that has influenced their lifestyle, attitude, and behaviour towards people living with AIDS. This study was only limited to English speaking ministers because the

³²¹ Liebowitz J. 2004. P.24

³²² Ibid p. 24.

³²³ Shorter A. and Comanche E. 1998. *The Church and AIDS in Africa: A case study*: Nairobi City. Nairobi: Paulines Publications Africa.

researcher is not fluent in isiZulu, the language commonly spoken in KwaZulu-Natal province. It would be interesting to interview ministers who speak and understand isiZulu only or to interview bilingual ministers in their mother-tongue.

5.5. Conclusion

This study set out to assess the role of faith-based organizations in the fight against HIV and AIDS. The findings from this research demonstrate that FBOs, ECAP in particular, make a significant contribution to the fight against the HIV and AIDS pandemic. They carry out meaningful and effective activities in HIV and AIDS prevention, care and support. ECAP's activities in home-based care, education and awareness raising, and nutritional support were particularly valued in the communities where ECAP worked.

6. References

6.1. Primary sources

6.1.1. Oral Sources

Church ministers

Rev Sibusiso Dladla, interview conducted by Charles Manda on 23 October 2006 in Pietermaritzburg.

Rev D. Msomi, Interview conducted by Charles Manda on 19/10/06 in Pietermaritzburg.

Pastor Hadebe, interview conducted by Charles Manda on 21 October 2006 in Pietermaritzburg.

Pastor C. Thenjwayo, interview conducted by Charles Manda on 23 October 2006 in Pietermaritzburg.

Mrs V. Dlamini, interview conducted by Charles Manda on 18/10/06 in Pietermaritzburg.

Rev Albert Chetty, interview conducted by Charles Manda on 15 September 2006 in Pietermaritzburg.

Pastor P.S. Phoswa, interview conducted by Charles Manda on 23 October 2006 in Pietermaritzburg.

Pastor S. Yuma, interview conducted by Charles Manda on 22 October 2006 in Pietermaritzburg.

Rev Ngcamu, interview conducted by Charles Manda on 19 October 2006 in Pietermaritzburg.

Mr Ndaba, interview conducted by Charles Manda on 18 October 2006 in Pietermaritzburg.

ECAP Stakeholders

Rev. Albert Chetty interview conducted by Charles Manda in June, July, August, 2006 in Pietermaritzburg.

Mr Israel Ndlovu, interview conducted by Charles Manda on July, August, September in Pietermaritzburg.

Mrs Sibongile Goba, interview conducted by Charles Manda March 2006 in Pietermaritzburg.

Rev Jim Johnston, interview conducted by Charles Manda on 17 July 2006 in Pietermaritzburg.

Pastor Benson Okyere-Manu, interview conducted by Charles Manda on 23 September 2006.

Mr Bill Houston, interview conducted by Charles Manda on 2 November 2006 in Pietermaritzburg.

6.1.2. Theses

Garner, Robert C. "Safe Sects? Dynamic Religion and Aids in South Africa." *Journal of Modern African Studies* 38, no. 1 (2000): 41-69.

Liebowitz, Jeremy. *The impact of faith-based organizations on HIV/aids prevention and mitigation in Africa*: For the Health Economics and HIV/AIDS Research Division (HEARD), University of Natal with the support of the Department for International Development Knowledge Programme. October 2002.

Mark Krakauer. *Churches' Responses to AIDS in two Communities in KwaZulu-Natal, South Africa: Thesis submitted in partial fulfillment of the requirements for the Degree of Master of Philosophy in Development Studies*. International Development Centre Queen Elizabeth House St. Antony's College Oxford University April 2004.

Mawindo Diana 2005. *Evaluation of students' use of print and electronic resources at the University of Malawi College Of Medicine*. Masters thesis submitted to the School of Information Studies, The University of KwaZulu-Natal.

Ntsimane, Radikobo. "The Challenge of Aids in the Rural Aics [African Initiated Churches or African Independent Churches]." *Bulletin for Contextual Theology* 7, no. 1 (2000): 22-25. He is a Lutheran Church minister, a lecturer in History of Christianity and a Doctor of Philosophy (History of Christianity) student at the School of Religion and Theology, the University of KwaZulu-Natal.

Project Gateway brochure accessed 8 September 2006.

Xaba, Thandeka. *Community Involvement in the fight against HIV/AIDS: a critical analysis of ESSA Christian AIDS Programme in Pietermaritzburg*. Unpublished Honours research project. Pietermaritzburg: The School of Religion and Theology, University of KwaZulu-Natal. October 2005.

6.1.3. Archives

ECAP's annual quarterly report 1999. Located at ECAP's office in Pietermaritzburg.

ESSA Christian AIDS Programme. (n.d.). brochure.

ESSA Christian AIDS Programme (ECAP). (n.d.) Three Day HIV/AIDS Training Manual.

Letter written to Mr. David Cunningham of AID for AIDS- Scripture Union, Bulawayo, Zimbabwe on 1st October 1998 by Pastor Paulos Nkonyane. It is preserved in ECAP's file of Minutes.

Minutes of the AIDS Committee of 21 May 1998 held at ESSA, Pietermaritzburg.

Minutes of All Staff Meeting held on 12 March 1999 at 11.35 am in Pietermaritzburg.

Minutes are located at ECAP office, 10 Long Market Street, Pietermaritzburg South Africa.

6.2. Secondary sources

Adegbola, O., and O. Babatola. "Premarital and Extramarital Sex in Lagos, Nigeria." In *The Continuing African HIV/AIDS Epidemic*, edited by J.C. Caldwell, I.O. Orubuloye and J.P.M. Ntozi. Canberra: Australian National University, 1999.

Amuyunzu-Nyamongo, "Barriers to behaviour change as a response to STDs including HIV/AIDS: The East African Experience," pp. 1, 7-9. In. Liebowitz Jeremy. 2002. *The impact of faith-based organizations on HIV/aids prevention and mitigation in Africa*: For the Health Economics and HIV/AIDS Research Division (HEARD), University of Natal with the support of the Department for International Development Knowledge Programme. October 2002.

Art Exhibition displayed by Sam Nhlengethwa at a conference titled: "Aids in South Africa: The Social Expression of a Pandemic" held in South Africa on April 19 and 20, 2002 organized by Wellesley College.

Babbie, E., and Mouton, J., 2001. *The practice of social research* (South African Edition). Cape Town: Oxford University Press Southern Africa.

Babbie E. 2004. *The Practice of Social Research*. 10th Edition. Spain: Thomson Wadsworth.

Barnett T. and Whiteside A. 2003. *Aids in the Twenty – Century: Disease and globalization*. London: Palgrave Macmillan.

Blanche and Durrheim (eds). 1999. *Research in practice: applied methods for the social sciences*. Cape Town: University of Cape Town

Borque, Linda B. and Eve P. Fielder. 1995. *How to conduct self-administered and mail surveys*. London: Sage Publications.

Busha, Charles H. and Stephen P. Harter. 1980. *Research methods in librarianship: techniques and interpretation*. New York: Academic Press.

Casley, D. J., and D. A. Lury. *Data Collection in Developing Countries*. 2nd ed. Oxford: Clarendon Press, 1987

Civil Society and Public Policy PDS 804. : Seminar five: Civil Society in Agenda Setting and Policy Formulation. Class notes, Policy and Development Studies. Pietermaritzburg: University of KwaZulu-Natal, 2005. *TAC: Treatment Action Campaign: An Overview*. p.4

Dorrington R. and Johnson L 2002. Epidemiological and Demographic. In eds. Gow J., and Desmond C., *Impacts and interventions: The HIV/AIDS epidemic and the children of South Africa*. Pietermaritzburg: University of Natal Press. p.13-14

Fowler F.J. 1993. *Survey research methods*. 2nd ed. Newbury Park, Ca.: Sage Publications.

Gomm, R., Hammarsley, M. and Foster, P. (eds.) 2000. *Case study methods: key issues, key texts*. London: Sage.

Green E.C. Faith-Based Organizations: Contributions to HIV Prevention. Harvard Center for Population and Development Studies. U.S. Agency for International Development. September 2003.

Green, E.C., V. Nantulya, R. Stonburner, and J. Stover. "*What Happened in Uganda? Declining HIV Prevalence, Behavior Change, and the National Response*." edited by J. Hogle, 1-13: Synergy Project, USAID, 2002.

Harrison A. 2005. Young people and HIV/AIDS in South Africa: Prevalence of infection, risk factors and social context. In eds. Karim A. and Karim Q.A. *HIV/AIDS in South Africa*. Cambridge: Cambridge University Press.

HIV/AIDS prevention, care and support across faith-based communities: an annotated bibliography of resources. This document has been funded by USAID/REDSO through FHI's Implementing AIDS Prevention and Care (IMPACT) project, cooperative agreement. HRN-A-00-97-00017-00.

Huberman, A. M. and Miles, M. B. 2002. *The qualitative researcher's companion*. Thousand Oakes: Sage.

Ian Smillie and Larry Minear, *The Charity of Nations*, Kumarian Press, Inc, Bloomfield, USA, 2004.

Jacobs Sol. (n.d.). Methodist Church of Southern Africa (Mission Unit). The Methodist Response to HIV/AIDS in Southern Africa: Strategy and implementation plan. Connexional task force on HIV/AIDS.

Kiernan, James P. "African and Christian: From Opposition to Mutual Accommodation." In *Christianity amidst Apartheid: Selected Perspectives on the Church in South Africa*, edited by Martin Prozesky, 9-27. Basingstoke: Macmillan, 1990A.

Makahye 2005. In eds. Karim A. and Karim Q.A. *HIV/AIDS in South Africa*. Cambridge: Cambridge University Press.

Nichols, J. B., 1998. *The Uneasy Alliance: Refugee Work and US Foreign Policy*, Oxford University Press, New York,

Nicolson R. 1995. *AIDS: A Christian response*. Pietermaritzburg: Cluster Publications.

Nicolson R. 1996. *God in AIDS: Theological Enquiry*. London: SCM Press LTD.

Powell, Ronald R. 1997. *Basic research methods for librarians*. 3rd ed. Greenwich, Conn.: Ablex

Soul City Institute and Khomanani. 2005. *HIV and AIDS Prevention, Prevention, Care and Treatment*.

South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005. Fact Sheet 2 Date: 30 November 2005.

Statistics obtained from a printed document containing a list of churches that were trained by ECAP from 1999 to 2005.

Shorter A. and Comanche E. 1998. *The Church and AIDS in Africa: A case study: Nairobi City*. Nairobi: Paulines Publications Africa.

The Synergy Project, implemented by TvT Global Health and Development Strategies, a division of Social & Scientific Systems, Inc., under USAID Contract Number: HRN-C-00-99-00005-00.

The United Nations Children's Fund (UNICEF), *What Religious leaders can do about HIV/AIDS: Action for Children and Young People*. New York, 2003

Webb Douglas 1997. *HIV and AIDS in Africa*. Pietermaritzburg: University of Natal Press.

William Headley "International faith-based initiatives: Can they work?" as cited by Elizabeth Ferris. In "Faith-based and secular humanitarian organizations".....p 316. HIV/AIDS prevention, care and support across faith-based communities: an annotated bibliography of resources. This document has been funded by USAID/REDSO through FHI's Implementing AIDS Prevention and Care (IMPACT) project, cooperative agreement HRN-A-00-97-00017-00.

Weinreich, S. and Benn C. 2003. *AIDS- Meeting the challenge: Data, facts, background*. Geneva: WCC Publications.

Weisberg, Krosnick and Bowen 1996 *An introduction to survey research, polling and data analysis*. 3rd ed. Thousand Oaks: Sage Publications

Whiteside A. and Sunter C. 2000. *AIDS the challenge for South Africa*. Tafelberg: Human & Rousseau.

Yin, R. K. 1984. *Case study research: design and methods*. Beverly Hills, CA: Sage.

6.2.2. Journals

Balcomb T. "Sex, sorcery, and stigma- Probing some no-go areas of the denial syndrome in the AIDS debate." In. *Journal of Theology for Southern Africa* 125 July 2006 p.104-114

Denis P. 2003. "Sexuality and Aids in South Africa," In. *Journal of Theology for Southern Africa*. no. 115: March 2003

Haddad B. 2002. "Gender violence and HIV/AIDS: A deadly silence in the Church." In. *Journal of Theology for Southern Africa* 114 (November 2002) p. 93—106.

Garner, Robert C. "Safe Sects? Dynamic Religion and Aids in South Africa." In. *Journal of Modern African Studies* 38, no. 1 (2000): 41-69.

Green, Edward C., V. Nantulya, R. Stonburner, and J. Stover. "*What Happened in Uganda?: Declining HIV Prevalence, Behavior Change, and the National Response*." edited by J. Hogle, 1-13: Synergy Project, USAID, 2002.

Ngulube, Patrick. 2005. Research procedures used by Master of Information Studies students at the University of Natal in the period 1982-2002 with special references to their sampling techniques and survey response rates: a methodological discourse. *The International Library and Information Review* 37(2)

Parkhurst, J. "The Crisis of Aids and the Politics of Response: The Case of Uganda." In. *International Relations* 15 (2001): 69-87.

Varga, C.A. "Sexual Decision-Making and Negotiation in the Midst of Aids: Youth in Kwazulu-Natal, South Africa." In. *Health Transition Review* 7, no. Supp 3 (1997):45-67.

6.3. Internet Sources

Aitchison, J.J.W. 1999. The seven days war (25 March to 31 March 1990): background, course and questions. In. Levine, L. (Ed) *Faith in turmoil. The seven days war*. Pietermaritzburg: Pietermaritzburg Agency for Christian Social Awareness, pp 109-135.

<http://www.pacsa.org.za/publications.html>

AVERT (2006)

<http://www.avert.org/aidssouthafrica.htm> accessed 16 July 2006

Background Note: South Africa"- South African Government official website

<<http://www.state.gov/r/pa/ei/bgn/2898.htm>> accessed 31/07/06

Doyle, James K. 2001. *Handbook of IQP advisors and students*.

<<http://www.wpi.edu/Academics/Depts/IGSD/IQPHbook/ch10.html#10>> 23 March 2004.

ECAP brochure available online

www.ecap.co.za accessed 04/03/06.

Elizabeth Ferris. "Faith-based and secular humanitarian organizations". *International review of the Red Cross*. Volume 87 Number 858 June 2005. Available online

www.icrc.org/Web/eng/siteeng0.nsf/htmlall/review-858

p311/\$File/irrc_858_Ferris.pdf – Accessed 12/11/06

Epstein, D., Morrell, R., Moletsane, R., and Unterhalter, E. Gender and HIV/AIDS in Africa south of the Sahara: interventions, activism, identities. Transformation 54 (2004) Isss 0258-7696. Available online

<<http://muse.jhu.edu/journals/transformation>> accessed 16/11/06

God's Golden Acre

<http://www.godsgoldenacre.nl/uk/index.html> accessed 08/10/06

HIV/AIDS Statistics.

WEB20%stats.pdf accessed 24/10/06

Imisebenzi Yekholo. Defining 'Faith-based Organization' p.28. Available online

www.globalhealth.org/images/pdf/faith_in_action/defining/pdf accessed 29 October 2006

Jean Dussault, member of the Canadian HIV/Aids Legal Network, *The stigma of AIDS*. http://www.unesco.org/courier/1999_10/uk/dossier/txt35.htm

Accessed 16/10/06

Kenosis <http://www.kenosis.org.za/sisters.html> accessed 20/09/06

Marilyn Linton ABC of AIDs Aug. 13, 2006

http://chealth.canoe.ca/columns.asp?columnistid=7&articleid=18280&relation_id=3224 accessed 19/10/06

SIM Hope for Africa.

(<http://www.hopeforaids.org/prevention.asp>) accessed 21/10/06

South African Press Association. *Kwazulu-Natal's Seven-Day War Claimed At Least 80 Lives*. Pietermaritzburg Nov 18, 1996 available online

< <http://www.doj.gov.za/trc/media/1996/9611/s961118b.htm>> accessed 20/11/06

South African Map. Source: University of Texas Perry-Castaneda Library Map Collection. Available online

http://www.lib.utexas.edu/maps/africa/safrica_provinces_95.jpg

Soy, S. 1996. *The case study as a research method*.

<<http://www.gslis.utexas.edu/~usesuers/1391d1b.htm> > accessed 01/09/05.

UNAIDS2005. Global Summary of the Aids Epidemic December 2005

http://www.unaids.org/epi/2005/doc/EPIupdate2005_pdf_en/Epi05_02_en.pdf

Accessed 11/03/06

UNAIDS/WHO. *Uniting the world against AIDS: UNAIDS/WHO AIDS Epidemic Update: December 2005*.

<http://www.unaids.org/epi/2005/doc/report_pdf.asp> accessed 10/05/06.

World Alliance of Reformed Churches. *Women's ordination*. Available online

<http://warc.jalb.de/warcajsp/side.jsp?news_id=453&navi=29&part_id=36 accessed

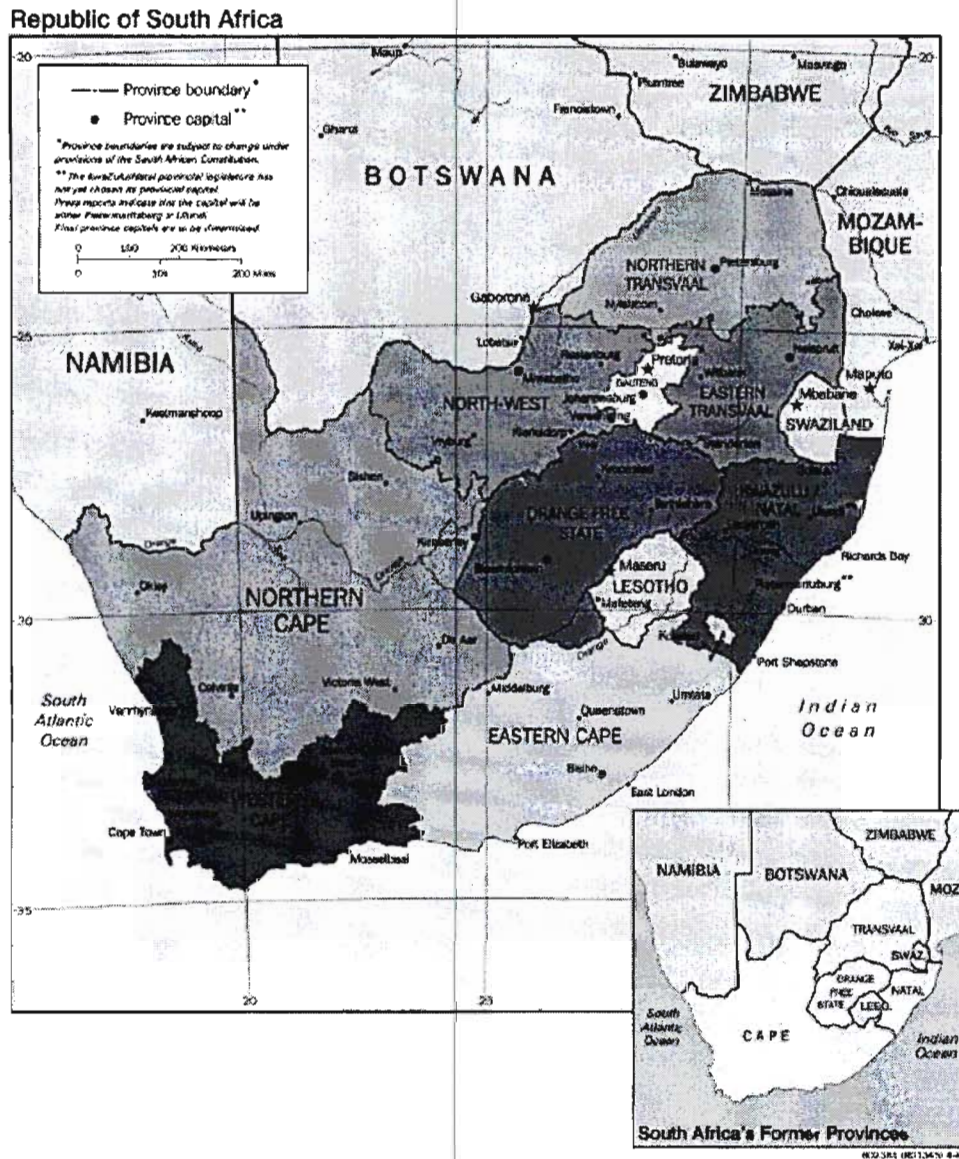
14/11/06.

World Health Organization. Home-Based Long-Term Care

http://www.who.int/chronic_conditions/ltc/en/ accessed 05/11/06

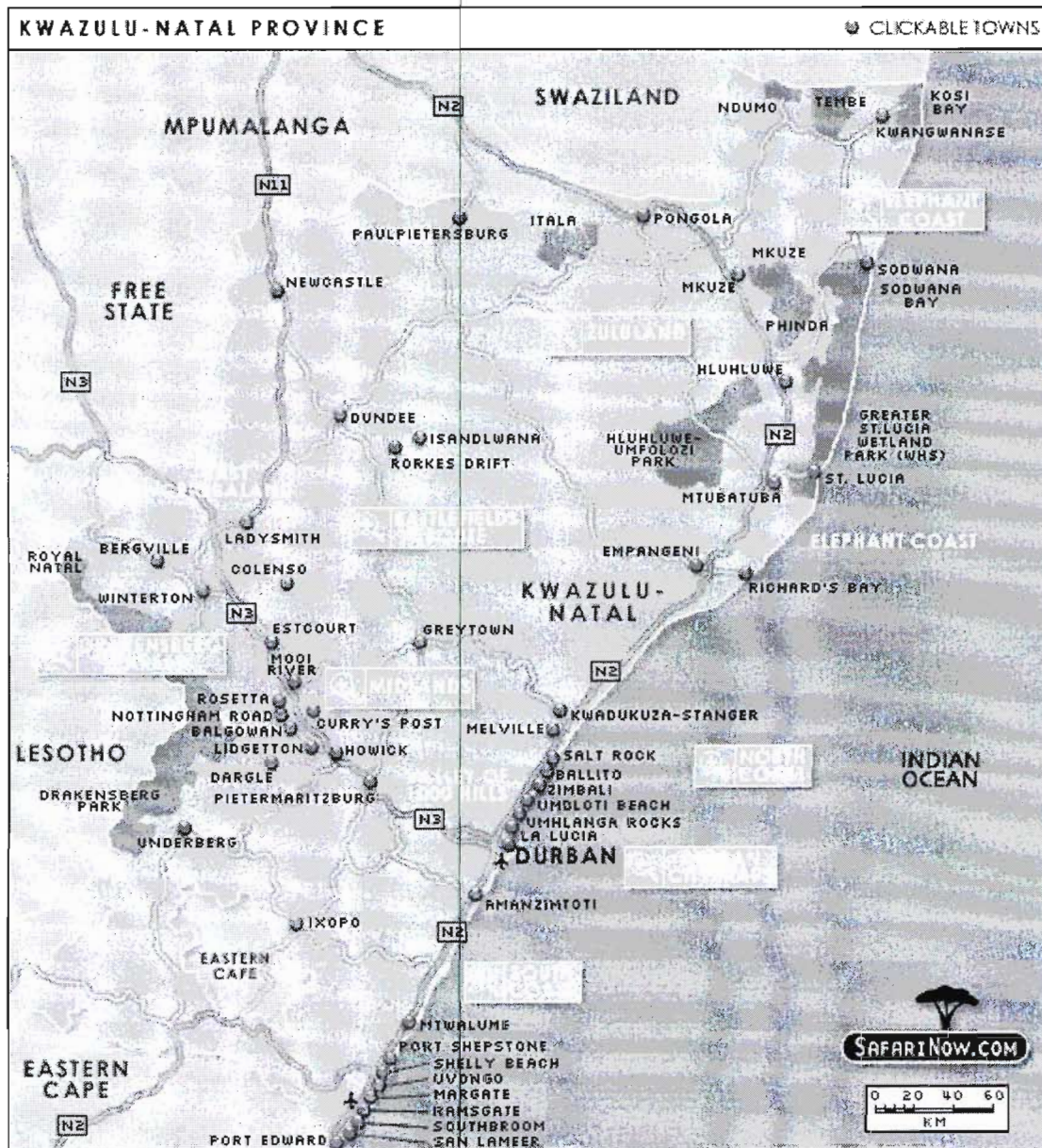
Appendix 1. Maps

1.1. Map of South Africa with its neighbouring countries locating KwaZulu-Natal Province



Source: University of Texas Perry-Castaneda Library Map Collection
http://www.lib.utexas.edu/maps/africa/safrica_provinces_95.jpg

1.2. Map of KwaZulu-Natal Province locating Pietermaritzburg



Source: Kwazulu-Natal Travel Guide

<https://www.safarinow.com/destinations/kwazulu-natal/map.aspx> accessed 30 November 2006

Appendix 2. Questionnaire for ESSA graduates

I am a student at the University of KwaZulu-Natal doing Masters in Theology and HIV/AIDS. I am seeking your assistance in my study. The aim of the study is to assess the ESSA Christian AIDS Programme (ECAP) in HIV and AIDS intervention of which one of them is facilitating Church and AIDS course at the Evangelical Seminary of Southern Africa (ESSA). I realize that there are many other demands on your time, but please can you take some few moments of your time to complete this questionnaire and return it promptly to me. All replies will be treated in the strictest confidence and no names will be published in the study. So please feel free to answer the following questions as honestly as possible. Thank you in advance for your assistance.

Instructions for completing the questionnaire

- a) Tick applicable answer(s).
- b) Use spaces provided to write your answers. Please print.
- c) Should you need more space please use the back side of the pages.

SECTION A: Background Information

1. Name (optional)

..... Title.....

2. Gender: Male Female

3. Race (optional): White African Indian/Asian Coloured
Other

4. Nationality.....

SECTION B: Assessing usefulness of the Church and AIDS course

5. Which year did you graduate from ESSA (Evangelical Seminary of Southern Africa)?

.....
6. Did you take Church and AIDS course at ESSA?

Yes No

7. If your answer is 'yes' to question 6 above, did you find the course helpful to you?

Yes No

8. Please give a reason(s) for your answer in question 6 above.

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.....

SECTION C: Assessment of how the knowledge and skills obtained were used

9. How has the course influenced your attitude, behaviour and thinking towards people living with HIV and AIDS?

.....
.....
.....

10. Are you using your training in 'Church and AIDS' course in your church/community or in whatever you are doing?

Yes No

11. If your answer to question 9 above is 'yes', please list down the activities you are involved in.

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.....

Appendix 3. Interview Schedule with ECAP stakeholders

1) When was the ECAP programme started?

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2) What is the overall purpose of ECAP?

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3) What are the specific objectives of the programme?

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4) Who are the beneficiaries of the programme?

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5) How does ECAP recruit churches and clergy for training?

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6) What strategies and methods does ECAP use to provide its services?

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7) To what extent has ECAP achieved its objectives?

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8) What problems is ECAP facing to deliver its services, and how does it intend to overcome them?

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Appendix 4. Interview Schedule for clergy

1. What is the name of your congregation?

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2. When did ECAP facilitate HIV/AIDS training in your congregation?

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3. What knowledge and skills did you obtain from the training?

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.....
.....

4. How has the training affected your attitude, thinking and behaviour towards people living with AIDS?

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.....

5. What HIV and AIDS related activities are you doing in your church as a result of receiving training from ECAP?

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Appendix 5. List of ESSA graduates who responded to the questionnaire

Serial Number	Name of respondent	Gender of respondent
1	Shaun	M
2	Delipher	F
3	Penine	F
4	Charlotte	F
5	Pascal	M
6	Christal	F
7	Bongani	M
8	Justice	M
9	Matihno	M
10	Beatrice	F
11	Adiel	M
12	Thobile	F
13	Audrey	F
14	Sandra	F

M= Male

F= Female