University of Venda
Creating Future Leaders

UNIVERSITY OF VENDA
LIBRARY
CALL No.
ACC No.

University of Venda
Creating Future Leaders

Developing an Adapted HIV/AIDS Training Programme for Church Leaders in Limpopo Province, South Africa

By

Nndondeni Edson Malwela

Student Number: 11607101

A thesis submitted in fulfilment of the requirements for the degree of:

Doctor of Philosophy
in Health (PHDH)

Department of Advanced Nursing Science
School of Health Sciences
University of Venda

Promoter
Professor V.O. Netshandama

Co-Promoter
Professor M.L. Netshikweta

April 2019

UNIVEN LIBRARY
Library Item : 20190066

UNIVERSITY OF VENDA
LIBRARY

© University of Venda

University of Venda
Creating Future Leaders

DECLARATION

I, Nndondeni Edson Malwela, hereby declare that the thesis, **"Developing an adapted HIV/AIDS training programme for church leaders in Limpopo Province, South Africa",** for the Doctor of Philosophy in health (PHDH) degree at the University of Venda, hereby submitted by me, has not previously been submitted for a degree at this university or any other university, and that is my own work in design and execution and that all reference material contained therein has been duly acknowledged.

NEMalwela ..... 26/04/2019 .....

SIGNATURE **DATE**

© University of Venda

University of Venda
Creating Future Leaders

DEDICATION

This study is dedicated to United Apostolic Faith Church (UAFC) together with all Christian churches in Limpopo province who participated in this study.

© University of Venda

University of Venda
Creating Future Leaders

ACKNOWLEDGEMENTS

I would like to thank God who provided me with strength, wisdom and courage to carry out this study. He gives power to the faint; and to them that have no mighty, He increases strength.

I would like to thank the following people who contributed a lot to the success of this study:

- Prof. V.O. Netshandama, my promoter, for her kindness, patience, continuous supervision support and encouragement throughout the study,
- Prof. M.L. Netshikweta as co-promoter, from the Department of Advanced Nursing Science, University of Venda, for her support and understanding,
- Special gratitude to my dear wife, Doctor Thivhulawi, who kept on supporting me during this study.
- Leadership structures of different Christian churches in Limpopo for allowing me to conduct this study in their churches,
- All church leaders who participated in this study, and did not hesitate to give information,
- The Research and Innovation office of the University of Venda, for financial support,
- Mrs T.B. Mulaudzi, my statistician, for her dedication and support in the analysis of the questionnaires
- Dr. C. Hutchings, language editor, for editing my work, and
- The elders and members of Rock of the Living Hope assembly for their understanding and encouragement.

© University of Venda

University of Venda
Creating Future Leaders

ABSTRACT

The HIV/AIDS is a global epidemic which affects all people, regardless of their religion, race, age, ethnicity or geographic location. The church of Africa, which hosts the largest numbers of infected and affected people, is also challenged to be involved in the response against HIV/AIDS epidemic. Church leaders are experiencing difficulties in fulfilling their role in HIV/AIDS interventions of which they have not received training. The complexity of HIV/AIDS demands a training programme that does not simply deal with symptoms, but it must address the complexities behind and in front of the spread, and earnestly seek effective ways of controlling the spread, as well as various strategies of caring for the infected and those affected with HIV and AIDS. The purpose of this study was to develop an adapted HIV/AIDS training programme for church leaders in the Limpopo Province of South Africa. A convergent parallel mixed methods design was used; quantitative and qualitative data were collected during the same phase of the research process. The population comprised of church leaders from Christian churches in the Limpopo province. A non-probability purposive sampling was used for qualitative approach, while quota sampling was used for quantitative approach. Questionnaires were used to collect quantitative data, while in-depth interviews were used to collect qualitative data in this study. Data analysis was done separately and the two sets of results were merged into an overall interpretation of the study that informed the development of an adapted HIV/AIDS training programme. The findings of the study revealed that church leaders were not trained on how they can be involved in the response against HIV/AIDS epidemic in the Limpopo province. The current training programme did not clarify church leaders' role towards the HIV/AIDS epidemic. The curriculum development process structure by Meyer and Van Niekerk (2008), and elements outlined by Dickoff, James and Wiedenbach (1968), were adapted to develop the training programme. A developed training programme was then validated by HIV/AIDS trainers and experts in programme development. Relevant recommendations were made to encourage churches to work effectively in addressing the HIV/AIDS epidemic in the Limpopo Province.

Key words: Christianity, church, church leader, training programme.

© University of Venda

University of Venda
Creating Future Leaders

TABLE OF CONTENTS

DECLARATION.....ii
DEDICATION.....iii
ACKNOWLEDGEMENT.....iv
ABSTRACT.....v
TABLE OF CONTENTS.....vi
LIST OF ABREVIATIONS.....xiv
LIST OF FIGURES.....xv
LIST OF TABLES.....xvi

CHAPTER 1.....1
OVERVIEW OF THE RESEARCH STUDY.....1
1.1. Introduction.....1
1.2. Background to the study.....1
1.3. Problem statement.....5
1.4. Purpose of the study.....6
1.5. Research objectives.....6
1.6. Research questions.....7
1.7. Significance of the study.....8
1.7.1. Church.....8
1.7.2. Community.....8
1.7.3. Primary health care.....9
1.7.4. Policy makers.....9
1.7.5. Research.....9
1.8. Conceptual framework.....9
1.8.5. Knowledge.....10

© University of Venda

University of Venda
Creating Future Leaders

1.8.6. Attitudes 10
1.8.7. Practices 11
1.8.8. Limitations of KAP 11
1.9. Researcher's world view 12
1.10. Definitions of concepts 14
1.12. Research design and methodology 17
1.13. Population and sampling 17
1.14. Data collection 18
1.15. Pilot study 18
1.16. Data analysis 19
1.17. Research phases 19
1.18. Trustworthiness 22
1.19. Validity 24
1.20. Ethical considerations 24
1.21. Dissemination of the study findings 25
1.22. Outline of the remaining study chapters 25
1.23. Summary 26
CHAPTER 2 27
LITERATURE REVIEW 27
2.1. Introduction 27
2.2. Church leaders' knowledge on HIV and AIDS 27
2.3. Church leaders' attitude towards HIV and AIDS 30
2.3.1. Stigma and discrimination 30
2.3.2. Factors contributing to stigma and discrimination in the context of church leaders 31

© University of Venda

University of Venda
Creating Future Leaders

2.3.3. Impact of stigma and discrimination on HIV/AIDS epidemic. 33
2.3.4. Strategies to eradicate stigma and discrimination among church leaders . 34
2.3.5. Barriers to reducing stigma and discrimination 37
2.4. Church leaders' practices towards HIV and AIDS 38
2.4.1. Prevention 39
2.4.2. Home-based care 43
2.4.3. Counseling and supporting testing 46
2.4.4. Providing medication 47
2.4.5. Orphan support 47
2.5. Summary 48
CHAPTER 3 50
RESEARCH METHODOLOGY 50
3.1. Introduction 50
3.2. Research Design and methods for phase 1 50
3.3. Study setting 51
3.4. Quantitative research design 52
3.4.1. Research population 52
3.4.2. Sampling 53
3.4.2.1. Sampling methods and procedure 53
3.4.2.2. Sample size 55
3.4.3. Pre-testing of the data collection instrument 56
3.4.4. Data collection 56
3.4.5. Data analysis 58
3.4.6. Reliability and Validity 59
3.4.6.1. Reliability 59

© University of Venda

University of Venda
Creating Future Leaders

3.5. Qualitative research design 60
3.5.1. Research population 63
3.5.2. Sampling 64
3.5.2.1. Sampling methods and procedure 65
3.5.3. Pilot interviews 66
3.5.4 Data collection 67
3.5.5. Data analysis 72
3.5.6. Measures to ensure trustworthiness 75
3.5.6.1. Credibility 75
3.5.6.2. Transferability 78
3.5.6.3. Dependability 79
3.5.6.4. Confirmability 80
3.5.6.5. Authenticity 81
3.6. Ethical considerations 81
3.7. PHASE 2: Development of the training programme 85
3.7.1. Preliminary phase 85
3.7.2. Exploratory phase 86
3.7.3. Design phase 86
3.7.4. Develop programme phase 87
3.8. PHASE 3: Validation of the developed programme 87
3.1.1. Methodology for validating the adapted HIV/AIDS training programme 88
3.8.2. Data collection method 88
3.8.3. Data analysis 89
3.9. Summary 89
CHAPTER 4 90

© University of Venda

University of Venda
Creating Future Leaders

RESULTS AND DISCUSSION 90
4.1. Introduction 90
4.2. Presentation of the quantitative results 90
4.2.1. Demographic information 91
4.2.2. Church leaders' knowledge of HIV/AIDS. 97
4.2.3. Church leaders' attitudes towards HIV/AIDS 100
4.2.4. Church leaders' practices towards people living with HIV/AIDS 101
4.2.5. Chi square test and cross tabulations 104
4.3. Summary of the key results of the quantitative data 109
4.3.1. Demographic information 109
4.3.2. Knowledge of HIV/AIDS 109
4.3.3. Church leaders' attitudes concerning HIV/AIDS 109
4.3.4. Church leaders' practices towards people living with HIV/AIDS 110
4.4. Presentation of a qualitative findings 110
4.5. Discussion of the findings 113
4.5.1. THEME ONE: State of the current HIV/AIDS training programme 113
4.5.1.1. Knowledge of church leaders with regards to HIV/AIDS 113
4.5.1.2. Perception of stigma towards people living with HIV/AIDS 115
4.5.1.3. Multi-stakeholder approach 117
4.5.1.4. The role of church leaders regarding HIV/AIDS. 119
4.5.2. THEME TWO: Challenges experienced by church leaders regarding the implementation of the current HIV/AIDS training program 121
4.5.2.1. Challenges with regards to facilitation 121
4.5.2.2. Attitudes of facilitators towards Christianity 123
4.6. Summary of the qualitative key findings 128

© University of Venda

University of Venda
Creating Future Leaders

4.7. Summary 129

CHAPTER 5 131

AN ADAPTED HIV/AIDS TRAINING PROGRAMME FOR CHURCH LEADERS IN LIMPOPO PROVINCE, SOUTH AFRICA 131

5.1. Introduction 131

5.2. Development of an adapted HIV/AIDS training programme for church leaders 131

5.2.1. Elements of practice Theory 132

5.2.1.1. Who or what performs the activity? (Agent) 132

5.2.1.1.1. Qualities that the agent should possess/ characteristics of a facilitator 133

5.2.2. Who or what is the recipient of the activity? (Recipient) 135

5.2.3. In what context is the activity performed? (Framework and context). 136

5.2.4. What is the energy source of the activity? (Dynamics) 137

5.2.5. What is the guiding procedure or process? (Procedure) 140

5.2.5.1. Paradigm for learning 141

5.2.5.2. Different learning approaches 143

5.2.5.3. Assessment criteria 147

5.2.5.4. Pre-requisite for attending the programme 147

5.2.5.5. Implementation guidelines for an adapted HIV and AIDS training programme for church leaders 148

5.2.5.6. Implementation recommendations for an adapted HIV/AIDS training programme. 149

5.2.6. What is the end point of the activity? (Terminus) 150

5.2.6.1. Competent in responding to HIV and AIDS epidemic 150

© University of Venda

University of Venda
Creating Future Leaders

5.2.6.2. Empowered on an HIV and AIDS, leading to churches involvement in responding to the HIV/AIDS pandemic. 151

5.2.6.3. Autonomy in establishing HIV and AIDS intervention programmes 151

5.3. The developed adapted HIV/AIDS training programme for church leaders In Limpopo province, South Africa. 152

5.3.1. Name of the programme as a short course 152

5.3.2. Purpose of the programme 152

5.3.3. Duration of the programme 153

5.3.4. Learning assumed to be in place 153

5.3.5. Specific outcomes 153

5.3.6 Programme content. 153

5.3.6.1. Study Unit 1: HIV and AIDS in the context of the bible 154

5.3.6.2. Study unit 2: Church role towards HIV prevention and control 163

5.3.6.3. Study Unit 3: Church role towards PLWHA 173

5.3.6.4. Study unit 4: Counselling in an HIV and AIDS context 176

5.4. Validation of the developed training programme 186

5.4.1. Methodology for validation 186

5.4.2. Presentation of the findings 187

5.4.3. Discussion of findings 187

5.5. Summary 188

CHAPTER 6 189

EVALUATION OF THE STUDY, RECOMMENDATIONS, LIMITATIONS AND CONCLUSIONS. 189

6.1. Introduction 189

6.2. Overall purpose of the study 189

6.3. Evaluation of the study 190

© University of Venda

University of Venda
Creating Future Leaders

6.4. Recommendations 192

6.4.1. Recommendation to policy makers 192

6.4.2. Recommendation for practice 193

6.4.3. Ideas for Further Research 193

6.5. Limitations 193

6.6. Summary 193

7. REFERENCES 194

ANNEXURE 1A: Request for permission to conduct study: letter to the leadership structures of churches 206

ANNEXURE 1 (B) Permission letter to churches 207

ANNEXURE 2 (A): Informed consent letter 208

ANNEXURE 2 (B): Consent form 210

ANNEXURE 2 (C): Consent form for voice recording 211

ANNEXURE 3 (A): Questionnaire 212

ANNEXURE 4: Validation checklist 218

ANNEXURE 5: Ethical clearance certificate 219

ANNEXURE 6: Confirmation of language editing letter 220

© University of Venda

University of Venda
Creating Future Leaders

LIST OF ABREVIATIONS

AIDS:	Acquired Immune Deficiency Syndrome
ART:	Anti- Retroviral Therapy
FBO:	Faith –Based Organizations
HBC:	Home-Based Care
HBCs:	Home-based caregivers
HCBC:	Home and Community Based Care
HIV:	Human Immunodeficiency Virus
NGOs:	Non-Governmental Organizations
PLWHA:	People living with HIV and AIDS
SA:	South Africa
UNAIDS:	Joint United Nations program on HIV/AIDS
UNICEF:	The United Nations Children's Fund
WHO:	World Health Organization
PHC:	Primary Health Care

© University of Venda

University of Venda
Creating Future Leaders

LIST OF FIGURES

Figure 1.2: Summary of research phases.....21
Figure 3.1: Phases of programme development 86
Figure 4.1: Age range of respondents.....92
Figure 4.2: Marital status of respondents.....93
Figure 4.3: Nationality of respondents.....94
Figure 4.4: Home language of respondents 95
Figure 4.5: Denominational affiliation of respondents 97
Figure 4.6: Leadership position in the church.....97
Figure 4.7: Perception of church leaders involvement.....104

© University of Venda

University of Venda
Creating Future Leaders

LIST OF TABLES

Table 1.1: Trustworthiness strategies 22
Table 3.1: Quantitative sample stratum 55
Table 4.1: Highest qualification of the participants.....95
Table 4.2: Church leaders' knowledge of HIV/AIDS.....98
Table 4.3: Sources of information regarding HIV/AIDS.....99
Table 4.4: Church leaders' attitudes towards HIV/AIDS.....101
Table 4.5: Church leaders' involvement in HIV/AIDS activities.....102
Table 4.6: Number of years involved in HIV/AIDS activities.....102
Table 4.7: Impact of church's involvement in HIV/AIDS.....102
Table 4.8: Motivation of church leaders to be involved in AIDS ministry.....103
Table4.9: Biographic data for qualitative sample.....111
Table4.10: Qualitative themes 112
Table5.1 Validation findings 187

© University of Venda

University of Venda
Creating Future Leaders

CHAPTER 1

OVERVIEW OF THE RESEARCH STUDY

1.1. Introduction

The Human Immune Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) is a global epidemic which affects all people, regardless of their religion, race, age, ethnicity or geographic location. The epidemic continues to be most severe in southern Africa, with South Africa having more people living with HIV than any other country in the world. Almost half of the deaths from AIDS-related illnesses in 2010 occurred in southern Africa (UNAIDS, UNICEF & WHO, 2011). South Africa is facing a challenge of how to effectively address the impact of the HIV/AIDS pandemic, which claims the lives of people in its communities every day. Although HIV/AIDS in South Africa is a prominent health concern, the notion that public health measures alone can effectively address the HIV/AIDS is refuted repeatedly each year as the virus continues to claim millions of lives. The attention of all disciplines, governments, non-governmental organizations, the private sector, Faith Based Organizations (FBO), and churches is needed. All sectors of government and other stake holders in civil society should be involved in combating HIV/AIDS through intervention programs (Yu, Souteyrand, Banda, Kaufman & Perriens, 2008). A holistic approach to health which is the basis of primary health care insists that total good health and wellbeing can be achieved only by understanding the whole person in a perspective that includes physical, mental, social and spiritual dimensions (George, 2011). The Church of Africa, which hosts the largest numbers of infected and affected people, is also challenged to adopt a multi-sectorial approach.

1.2. Background to the study

Churches have the potential to play a much larger role, along with other institutions, like those of public health, political leadership and international non-governmental organizations in health promotion, disease prevention and caring for people living with

© University of Venda

HIV/AIDS. Churches are found in all communities and have a lot of influence over the people. According to Parry (2004), churches have the widest network coverage in the world, the largest constituency of people, and an enviable infrastructure, extending from the international communities to the most marginalized ones. Parker and Birdsall (2005), revealed that many international donors are channeling HIV and AIDS funding to churches and church-based organizations in the belief that their proximity to affected communities and relative cost-effectiveness make them logical conduits for assistance. This role of the church, as a result of the emergence of chronic illnesses like HIV/AIDS continues to receive attention.

The researcher's previous study on the role of churches in response to the HIV/AIDS epidemic in the Vhembe district of the Limpopo province in South Africa, revealed that most church leaders are reluctant to engage themselves due to lack of knowledge about HIV/AIDS (Malwela, 2013). This lack of knowledge leads to continued stigmatization of people living with HIV/AIDS. Moreover, some churches discourage their members and those who seek for help from them from continuing to take their treatments (Malwela, 2013). According to Statistics South Africa (2016), 79.9% of the population in the Limpopo province are Christians. By targeting this section which is the majority of the population, it could make a positive contribution towards HIV and AIDS interventions in the Limpopo province, as church leaders can use the trust and influence they have to change the course of the HIV/AIDS pandemic. Therefore, development of an adapted HIV/AIDS training programme will assist church leaders to work effectively as part of the multidisciplinary health team. A training intervention which is learner-centered cannot be under-estimated if the government training is to be effective in HIV/AIDS interventions.

Studies conducted in different countries reveal that where churches received training in HIV and AIDS, intervention strategies were extremely enhanced (Swanepoel, 2005). In America where national organizations provide HIV/AIDS training and resources to the African American churches, their interventions have been effective and sustained (Griffith, Campbell, Allen, Robinson & Stewart, 2010). The Ecumenical HIV & AIDS Initiative in

© University of Venda

University of Venda
Creating Future Leaders

Africa (EHAIA) became responsible for assisting both the academic and church institutions to mainstream HIV and AIDS in their programs (EHAIA, 2011). Without a doubt, in Africa, churches that have received training are at the forefront of care initiatives. A prevention campaign which is compatible with the general UNAIDS strategy, is the so-called 'Fleet of hope'. This prevention campaign was developed in Tanzania by Bernard Joinet, a lecturer in Clinical Psychology at Dar-es-Salaam University. He also served as a Roman Catholic Chaplain for many years. Joinet was distressed to see the epidemic spread dramatically, as various stakeholders sent conflicting messages about prevention. Joinet then advocated a campaign based on visual images, inspired by Noah's Ark (Tiendrebeogo & Buykx, 2004). This campaign, which started in a religious association, was promoted by UNAIDS all over the world, and it was adopted by many public health services, especially in Africa. The campaign has been used successfully by churches in various African countries. For example, in Burkina Faso, it was translated into French and adapted to a group discussion game with a tapestry and cartoon characters. In Angola, it was translated into Portuguese, and reposted on the internet. In the Democratic Republic of Congo, it was used to open discussion about behavior change and lead the public even to question the over simplified marketing slogans of condom sellers. In general, it is felt that the campaign in itself does not impose any moral view, and focuses precisely on circumstances and individual situations, in order to make moral decisions possible (Tiendrebeogo & Buykx, 2004).

Peer education training programs focused on HIV/AIDS prevention were pioneered by churches in Africa. In Uganda Dr. Miriam Duggan's 'Youth Alive' programme on 'Education for Life' has been very prominent. This training programme has been adopted by other countries and formed the basis for other similar programmes. With the facilitation of the Mormons, over 100 000 Zimbabwean school children have completed this course, and formed on going clubs, and over 12000 facilitators have been trained. The focus was to give youth the information to empower them with value systems, respect and responsibility, teach them negotiation skills and to withstand negative social and peer pressure (Parry, 2004).

© University of Venda

South Africa is no exception; the Evangelical Seminary of Southern Africa (ESSA) also developed a Christian HIV/AIDS training programme in Pietermaritzburg to equip church leaders with the knowledge and skills for ministering to people affected or infected with HIV/AIDS. The training focused on HIV/AIDS awareness, home-based care and orphan care to equip leaders and members of churches in the Pietermaritzburg area to intervene in the HIV/AIDS situation (Manda, 2006). The ESSA Christian AIDS program extended their efforts in HIV/AIDS awareness beyond the classroom into the surrounding communities. As a result of this training, a study conducted by Liebowitz (2004), in Kwazulu-Natal, found that home-based care and visitation were the common activities of many church leaders and members in KwaZulu-Natal. During visitation, those involved provide care, moral support, emotional support, food and treatment. In some cases, congregation members initiated such programmes and often are entirely responsible for carrying them out. Similarly, a project of River of Life Ministries based in Eastwood, Pietermaritzburg was developed. It is actively involved in home-based care and support of people and families infected and affected with HIV/AIDS. 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.

The current situation in the Limpopo Province of South Africa is that the existing HIV/AIDS training programme which caters for church leaders and traditional healers is based on traditional health practitioners act, 2007: No. 22 of 2007 (Government gazette, 2008). The act is targeting the stakeholders in the community who are involved with people living with AIDS so that they can have knowledge or be equipped enough to deal with the epidemic.

The purpose of the traditional health practitioners Act No. 22 of 2007 is to:

- Establish the interim traditional health practitioners' council of South Africa which will control the activities of the traditional healers,
- Provide for the registration, training and practices of traditional health practitioners in the republic, and

© University of Venda

University of Venda
Creating Future Leaders

- Serve and protect the interests of members of the public who use the services of traditional health practitioners.

The challenge with this training is that it combines people from different faiths and seeks to have a common approach, though they are from different religious backgrounds. This often leads to conflicting interests. At the moment, there is no specific training for church leaders in the Limpopo province. The act is mostly targeting traditional healers who use traditional medicines for their clients and seek to control their activities, with the aim of protecting those members of public who use their services.

Church leaders in Limpopo, like other church leaders on the continent, have the formidable task of preventing the spread of HIV and taking care for those infected and affected with HIV/AIDS in their churches and their surrounding communities. It was against this background that the study was conducted to develop an adapted HIV/AIDS training programme for church leaders in the Limpopo province to enhance their involvement and intervention strategies.

1.3. Problem statement

The current lack of involvement of the majority of church leaders in responding to the HIV/AIDS epidemic in the Limpopo province is concerning. The researcher's previous study on the role of churches in response to HIV/AIDS epidemic in the Vhembe district, Limpopo province of South Africa, confirmed that few church leaders are involved in the fight against the epidemic (Malwela, 2013). Furthermore, the researcher had the opportunity to attend some of the training sessions conducted for religious leaders, and observed with concern that the training programme did not take into consideration the inclusion of religious leaders as agents of response. The unwillingness of church leaders to undergo HIV/AIDS training could thus be attributed to the nature and content of the current HIV/AIDS training programme which is too generic and does not address the specific roles for each religious group. Furthermore, available learning material does not clarify the role that religious leaders can perform regarding the HIV/AIDS epidemic in the

© University of Venda

province. This poses a challenge because scholars of adult learning teach us that adults do not learn effectively if they do not relate to the content. Adults must see the reason for learning something and the learning must be applicable to their work or other responsibilities for it to be valuable (Knowles, Holton & Swanson, 2012; Wlodkowski & Gingsberg, 2017). Although the prescripts of the constitution of South Africa suggests a religious neutral training, the reality of how adults will learn better is when their training is learner-centered. Church leaders are experiencing difficulties in fulfilling their role in HIV/AIDS intervention for which they have not received training. There is thus a need to develop an adapted HIV/AIDS training programme to empower church leaders to enhance their response towards HIV/AIDS and ensure that all individuals and families infected and affected by HIV/AIDS have access to compassionate, non-judgmental care, respect, support and assistance.

1.4. Purpose of the study

The purpose of this study was to develop an adapted HIV/AIDS training programme for church leaders in the Limpopo Province of South Africa.

1.5. Research objectives

The study comprised of three phases, each of which had its own objectives, which are outlined below.

The objectives of phase one were to:

- Assess the level of knowledge among church leaders regarding HIV/AIDS in the Limpopo Province,
- Describe attitudes of church leaders towards people living with HIV/AIDS in the Limpopo Province,
- Identify practices of church leaders towards people living with HIV/AIDS in the Limpopo Province, and

© University of Venda

- Explore the experiences of church leaders regarding current HIV/AIDS training programme in the Limpopo Province.

The objective of phase two was to:

- Develop suitable HIV/AIDS training programme for church leaders in the Limpopo Province based on the findings.

The objective of phase three was to:

- Validate the developed HIV/AIDS training programme for church leaders in the Limpopo Province.

1.6. Research questions

The study addressed the following questions with regards to church leaders in the Limpopo province:

- What knowledge do church leaders in the Limpopo Province have regarding HIV/AIDS?
- How do church leaders in the Limpopo Province perceive people living with HIV/AIDS?
- What role do church leaders in the Limpopo Province play towards people living with HIV/AIDS?
- What are the experiences of church leaders regarding current HIV/AIDS training?
- Which HIV/AIDS training programme would be most suitable for church leaders in the Limpopo province?
- To what extent is the developed HIV/AIDS training programme relevant and appropriate to the needs of church leaders in the Limpopo Province?

© University of Venda

University of Venda
Creating Future Leaders

1.7. Significance of the study

The significance of a study is associated with its importance to the body of knowledge and the value that will be added (De Vos, Strydom, Fouche & Delport, 2011; Brink, Van der Walt & Van Rensburg, 2012). It is envisaged that the findings of this study and the developed HIV/AIDS training programme will have significance for the Church, the community, primary health care in general, as well as for policy makers and the related body of research. This is detailed below.

1.7.1. Church

Church members will benefit as the developed training programme may rejuvenate the active role of church leaders towards HIV/AIDS interventions. It will bring awareness in promoting the inclusion of HIV and AIDS topics during church services and other church meetings. The stigma and prejudices attached to HIV and AIDS could be reduced or eliminated in some individuals and groups in the church. The study conducted in the Limpopo province on the role of churches in response to HIV and AIDS epidemic confirmed that there are elements within church members of stigma and prejudice associated to HIV/AIDS (Malwela, 2013). The study might also overcome the different perspective with good information and help towards overcoming prejudices and stigma related to HIV/AIDS.

1.7.2. Community

Given that 80% of the population in Limpopo are church goers, the development of an adapted HIV/AIDS training programme which church leaders would find empowering would translate to maximizing access to compassionate, non-judgmental care, respect, support and assistance. Church leaders are still largely influential in the community. An empowered church leader would integrate the HIV/AIDS knowledge in the way they lead the church, preach and relate with HIV/AIDS families and individual affected or infected in the community.

© University of Venda

1.7.3. Primary health care

Primary health care may benefit as the developed training programme may assist churches to work effectively as part of a multidisciplinary health team in addressing the HIV/AIDS epidemic in the Limpopo province.

1.7.4. Policy makers

The study could provide data to policy makers which may influence modification and review of policy regarding HIV/AIDS interventions in the province. The Department of Health may benefit as the study might also serve as a foundation for incorporation of churches in the management of diseases in South Africa. A study conducted in Uganda by Ham (2004), is an example of the impact churches can have if they are incorporated into the management of diseases. As a result of the Uganda government working in partnership with the church, the national HIV infection rates for pregnant women declined from 21% in 1991 to just over 6% in 2000.

1.7.5. Research

The study may also benefit researchers as it will add to the body of scientific knowledge in primary health care services and HIV/AIDS interventions.

1.8. Conceptual framework

A conceptual framework is a logical grouping of related concepts or theories, usually created to draw together several different aspects that are relevant to a complex situation such as a practice setting or an educational programme (Chinn & Kramer, 2013). The study adopted the Knowledge, Attitudes and Practices (KAP) model based on Diffusion of Innovations (DOI) theory by Rogers. The KAP refers to Knowledge (cognitive), Attitude (affect) and Practices (psychomotor). This theory tries to describe the process that new ideas, or new methods, spread over time. In recent years, scholars have been conducting

© University of Venda

University of Venda
Creating Future Leaders

empirical research on innovation diffusion theory, and have integrated the innovation adoptions into three stages: knowledge, attitude and practice (Hubbard & Hayashi, 2003).

The KAP study measures the knowledge, attitude and practices of a community. It serves as an educational diagnosis of the community. The KAP model has explored church leaders' knowledge, attitudes and practices regarding HIV/AIDS when assessing the impact of existing HIV/AIDS training programme in the Limpopo Province. KAP served as a pre-assessment instrument to diagnose specific training needs of church leaders in Limpopo, in order to develop an adapted HIV/AIDS training programme for church leaders. Before beginning the process of developing an HIV/AIDS training programme for church leaders, a KAP study was necessary to assess the environment in which the training will take place. A KAP study tells us what people know about certain things, how they feel and also how they behave.

1.8.5. Knowledge

Knowledge is a set of understandings. Pearsall (2002) defines knowledge as awareness or familiarity gained by experience, a theoretical or practical understanding of a subject. It is also one's capacity for imagining or one's way of perceiving phenomena. The degree of knowledge assessed amongst church leaders helped the researcher to identify areas of need in order to develop an adapted HIV/AIDS training programme for church leaders in the Limpopo Province. HIV/AIDS knowledge in the study means the familiarity with the causes of HIV and AIDS, mode of transmission, how to prevent its spread and how it is treated.

1.8.6. Attitudes

Attitude is a settled opinion or way of thinking reflected in the behavior of a person (Pearsall, 2002). Attitude helps to explain that among the possible practices for a subject submitted to a stimulus, that subject adopts one practice and not the other. Determining the perceptions of church leaders regarding HIV/AIDS will help the researcher to understand the attitudes church leaders have that may influence their response towards

© University of Venda

the HIV/AIDS epidemic and their involvement in HIV/AIDS trainings. An attitude can be positive or negative; if negative then it can lead to reluctance to attend training. There is connection between attitude and practices. Attitude influences the behavior or practices. Attitude in the study refers to how Christians perceive HIV/AIDS as a disease, and their perceptions towards people living with HIV/AIDS.

1.8.7. Practices

Practices or behaviors are the observable actions of an individual response to a situation. It is in the church institution through which belief systems and practices become recognizable in particular practice tradition. This study described practices portrayed by church leaders towards people living with HIV/AIDS and identified training needs regarding good practices. Practices in the study refer to the ways in which church leaders demonstrate their knowledge and attitude through their actions in response to HIV/AIDS epidemic.

1.8.8. Limitations of KAP

KAP data is not always holistic and realistic and therefore it should be conducted together with a focus group or in-depth interview to cover the ground not covered by KAP. To overcome this weakness, a mixed method was used to triangulate the data. Another problem of a KAP survey is related to measurement of attitude. It becomes difficult to measure attitude with responses such as 'agree' or 'do not agree'. Collecting data on practices also is a problem because what people would answer on a paper might not be the same thing that one can observe if one remains with the people for a few days. As a result of these limitations, the researcher used both quantitative questionnaires and qualitative interviews to overcome the weaknesses of KAP survey.

© University of Venda

University of Venda
Creating Future Leaders

1.9. Researcher's world view

One's world view, according to Cobern and Loving (2008), defines the self, it sets the boundaries of who am I. My world view also defines my history, potential, competence, attributes, personal values and beliefs (Bergh and Geldenhuys, 2013). One's world view shapes one's view of the universe, one's conception of time and of space. One's world view is the way in which one views and experiences life (Nisbett, 2003). The important pointer to our world view is our set of values which are influenced by how we see ourselves in the world (Keane, 2011). The researcher is interested in sharing his world view for the reader to understand his choices of the research topic. It is on the basis of the researcher's world view that shapes his view of the world and influenced his values and beliefs. The researcher is a South African, who was born in the highlands of Mutale in a small village called Tshamulungwi in the far northern part of the Limpopo province. The only thing that the researcher could remember at his early age was a Christian church and primary school that was near the church. Some of the learners were accommodated by the church as the school did not have enough classes for the learners. At the age of fourteen years the researcher was converted to Christianity. In the late eighties when the researcher was following a career in the nursing profession, for all of the hospitals around the area in the former Venda homeland government, which is part of the Vhembe district today, there was a church attached to each hospital. This exposure created a link in the researcher's mindset that there is always a link between development, caring and the Christian church. Some of the teachers' training colleges were also started by Christian missionaries. A Christian church was always there for the community in times of need to provide solution. Christians are compelled by the love of Christ to respond to the needs of people (2 Corinthians 5:14).

At the age of twenty-two, the researcher had a pastoral calling, wherein one of his objectives besides pastoring a congregation, was to go outside South Africa into the neighboring countries as missionary to those countries. At the beginning of 1994, the researcher started fulfilling his first missionary journey to Mozambique where he resided in Gaza province, in a township called Chokwe for three years. Mozambique was

© University of Venda

University of Venda
Creating Future Leaders

devastated by war between Renamo and Freelimo during that time. There were poor road infrastructures, hospitals and clinics were only functional in some townships and main cities where security was much better and the majority of people were living in poverty. Due to insufficient health infrastructure, common causes of death were malaria, diarrheal diseases resulting from unhygienic conditions, maternal mortality resulting from complications of pregnancy and delivery due to lack of midwives and access to transport. The researcher, compelled by the love of Christ, felt that the involvement of the church in Mozambique during the time was important to improve people's lives in different ways according to their needs.

The researcher's main focus was preaching the gospel of Christ to all age groups, improving people's lives through self-help projects, caring for the sick people by making health services and medication accessible to them. Traditional birth attendance and community health workers were trained to close the gap that was created by shortage of nurses and midwives in the community. The researcher used his nursing experience and pastoral care to fulfil his calling as a Christian. Again, from 2003 till 2010, the researcher continued his mission activities in Malawi, Tanzania, northern and central parts of Mozambique, and Botswana.

The researcher's Christian background and mission exposure, coupled with nursing experiences influenced him on the choice of topic and the target population. A true Christian will always be willing to help other people compelled by the love of Christ not money, as Christ valued people' s well-being above Jewish laws. He healed people on the Sabbaths which was contrary to the Jewish law (Matthews 12:10-13). The researcher as a Christian has been influenced by his Christian world view to develop the context specific training to empower the church leaders from a Christian church to bring a solution for the HIV/AIDS epidemic in the Limpopo province, as caring and improving people's life is part of their Christian calling. According to Matthew (25:31-46), caring is central to the mission, ministry and identity of Christians. True Christians serve God in practical acts of love.

© University of Venda

University of Venda
Creating Future Leaders

1.10. Definitions of concepts

Church

The word 'church' assumes different meanings in different situations. Clowney (1995), defines 'church' as the actual gathering of Christians and not necessarily the building in which they use for public worship. Sexual Health Exchange (2004) defines a church as an organization or a group of Christians who have their own beliefs and forms of ownership. Clowney (1995), further defines the church from the Greek word ekklesia which, translated, means 'the called out', and originally signified a group of people assembled for civil purposes. The word was used in the New Testament to refer to:

a) The Church in a worldwide sense referring to all who have believed and obeyed the gospel (Ephesians 5:25). This group which Christ bought with his blood (Acts 20:28), is also called the spiritual body of Jesus Christ (Colossians 1:18), the Kingdom of God, the family (house) of God and the Bride of Christ.
   The Church local is used to designate a local congregation of Christians (I Corinthians 1:2, I Thessalonians 1:1). In this geographical sense, the word 'church' is often used in plural 'churches'.
b) The Assembled Local congregation (I Corinthians 11:18). Today it is customary to refer to the building where the church assembles as the church.

'Church' in this study refers to an organized group of Christians in a local congregation in a community whose attitudes and practices towards people are rooted in Christian principles.

© University of Venda

University of Venda
Creating Future Leaders

Christianity

Christianity refers to the religion of Christ. Luke (1:1-4) and John (20:30-31), in their gospels revealed that Christianity is a historic religion and cannot exist away from Christ of history. Christianity, if taken as a whole, is unarguably the largest world religion. Christianity is an umbrella term that comprises many different branches and denominations. For example, groups which self-identify as Christian include: African independent churches, the Aglipayan church, Amish, Anglicans, Armenian Apostolic, Assemblies of God, Baptists, Calvary Chapel, Catholics, Christadelphians, Christian Science, the Community of Christ, the Church of Jesus, Christ of Latter-day Saints ('Mormons'), Coptic Christians, Eastern Orthodox Churches, Ethiopian Orthodox, Evangelicals, Iglesias ni Cristo, Jehovah's Witness, the Local Church, Lutherans, Methodist, Monophysites, Nestorians, the New Apostolic Church, Pentecostals, Plymouth Brethren, Presbyterians, the Salvation Army, Seventh-Day Adventists, Shakers, Stone–Campbell Churches, (Disciples of Christ, Churches of Christ, the 'Christian Church and Churches of Christ', the International Church of Christ), Uniate Churches, United Church of Christ/Congregationalists, the Unity Church, Universal Church of the Kingdom of God, Vineyard Churches and others (Barrett, 1994 update). These groups exhibit varying degrees of similarity, co-operation and communion with other groups. None are known to consider all other Christian sub-groups to be equally valid.

Contemporary sociologists and religious leaders generally consider pan-denominational classifications as not based on historical denominational divisions but on current theological positions and organizational alignments, to be more relevant. Such groupings include: Evangelicals, Pentecostals, 'Great Commission Christians', 'C.S. Lewis Christians', Liberal Protestants, Conservative Protestants and Fundamentalists.

In this study, Christianity churches are classified according to three main locally understood classifications:

© University of Venda

University of Venda
Creating Future Leaders

1) **Pentecostal/Charismatic Churches**, referring to those churches which emphasize the centrality of the Holy Spirit in faith and in practice. Pentecostals are connected with overseas churches administratively. Charismatic Churches are of more recent origin. Most of these churches arose in the 1980s. These churches may be regarded as Pentecostal as they too emphasize the supernatural gift of the Holy Spirit in the church. They are independent churches which are inclined to reject what is perceived as denominationalism. Sometimes the terms Pentecostals and Charismatics are used interchangeably. In this study, they are classified as Pentecostal/Charismatic Churches because they both emphasize Spirit baptism and Spiritual gifts in their teachings.
2) **Non-Pentecostal Churches,** are those churches that do not emphasise the manifestations and gifts of the holy spirit in faith, but are connected with oversees churches administratively. In this study, non-Pentecostal churches include all evangelicals, Methodist, Catholics, Anglicans, Lutherans, church of Christ, salvation army, Presbyterians Nazarenes and Baptists
3) **African initiated Zionist churches**, which are African churches that are not connected with European churches administratively. Most members do not understand the Holy Spirit in a scriptural sense. These churches have probably adapted themselves to and focused on the traditional worldview more substantially than any other church groupings. For the purpose of this study, Zion Christian Church (ZCC) is part of this group, though there are some practices that are unique to ZCC which are not common to other Zionists.

Church Leader

A leader is someone who possesses power over others or has influence over them. Booyens (2014), defines a leader as someone in the action of leading a group of people. In the church context, leaders include pastors, elders, deacons and church board members who are established in authority over the other church members. In this study, a church leader refers to a Bishop, Apostle, Prophet, Evangelist, Pastor, Elder, Deacon,

© University of Venda

and church board members who are established in authority over the other church members in a church or congregation.

Training program

According to Coulson, Goldstone, Ntuli and Pillay (2010), a training programme refers to a formal or informal training plan for personnel which is part of a capacity building strategy for the improvement of professional competencies: knowledge, skills, values and attitudes. In this study, a training programme refers to a programme for improving the competencies of Church leaders in dealing with the HIV and AIDS epidemic in the Limpopo province.

1.12. Research design and methodology

In this study, the researcher used the convergent parallel mixed methods design to provide strength that offsets the weaknesses of both qualitative and quantitative design. Mixed methods provide a better understanding of research problems than a single approach. According to Grove, Burns and Gray (2013), it offers researchers the ability to utilize the strengths of both qualitative and quantitative research design. The quantitative design was used to assess church leaders' knowledge, attitudes and practices (KAP) towards HIV/AIDS in order to assess the impact of the existing training programmes, while qualitative design was used to explore church leaders' experiences regarding the existing training programmes.

1.13. Population and sampling

The target population of this study consisted of all church leaders in the Limpopo province. The accessible population comprised of church leaders from Christian churches in the Limpopo province. A non-probability purposive sampling was used to collect qualitative data, while quota sampling was used to get a sample that was more representative of the population to collect quantitative data. Fourteen percent (14%) of the population was

© University of Venda

University of Venda
Creating Future Leaders

sampled for questionnaires so that the sample is more representative of the population. In a qualitative approach, predetermination of the number of participants was therefore impossible. The size of the sample was considered satisfactory when data saturation occurred. Eight participants were interviewed and data saturation was reached as demonstrated by repetition of themes.

1.14. Data collection

Qualitative data was collected using the in-depth individual interviews to explore church leaders experience regarding the current HIV/AIDS training programme for church leaders in the Limpopo province. The researcher used reflexivity, bracketing and intuiting to exclude preconceptions of the phenomena in order to enter the world of the participants with an open mind. Interviews were conducted individually in churches and private houses where it was convenient to the participants. Permission was obtained from the participants to record the interviews with an audiotape. Interviews were continued until data saturation was reached. Quantitative data was collected using the self-administered questionnaires which the respondents completed themselves. Questionnaires were delivered personally to individual leader, and to a group of leaders during their regular meetings and gatherings as per arrangement.

1.15. Pilot study

In preparation for the study, the researcher conducted pilot studies for both qualitative and quantitative methodologies. In qualitative, the researcher conducted three pilot unstructured individual interviews with one church leader from the Zion, Pentecostal/charismatic and Non Pentecostal churches in order to detect possible flaws that could occur during data collection process.

In quantitative research, the instrument was pre-tested by requesting church leaders from Christian churches that were not part of the main study sample but have similar characteristics as the respondents from the main study sample. A pre-test allowed the

© University of Venda

researcher to identify questionnaire items that tend to be misunderstood by the respondents and hence fail to yield the information that is needed. A total of 18 participants were used; six from each church stratum. Based on the pre-test and feedback of the respondents, the researcher modified data collection instruments and methods of data collection to ensure the feasibility, validity, and reliability of the study (Grove et al., 2013).

1.16. Data analysis

Two data sets were analyzed concurrently. Qualitative data was analyzed using Tech's steps of open coding as described by Creswell (2014). Quantitative data was analyzed using the computerized Statistical Package of the Social Science (SPSS) programme version 23.0 with the help of a statistician from the department of statistic at the University of Venda. Details are discussed in chapter three.

1.17. Research phases

The study was done in three phases according to the objectives.

PHASE ONE

Phase one comprised of both quantitative and qualitative approaches. This phase involved situation analysis.

The quantitative approach covered the first three objectives:

- Assess the level of knowledge among church leaders in the Limpopo province regarding HIV/AIDS,
- Describe attitudes of church leaders in the Limpopo province towards people living with HIV/AIDS, and
- Identify practices of church leaders in the Limpopo province towards people living with HIV/AIDS.

© University of Venda

A KAP survey was adopted when developing the questionnaire.

The qualitative approach covered the fourth objective:

- Explore the experiences of church leaders in the Limpopo province regarding current HIV/AIDS training programme.

An in-depth individual interview was used in this phase to achieve the above objective. Phase one is discussed in detail in chapter 3 of this study.

PHASE TWO

Phase two covered the fifth objective of this study:

- Develop a suitable HIV/AIDS training programme for church leaders in the Limpopo Province, based on the findings.

The six step phases of the curriculum development process by Meyer and Van Niekerk (2008) were adapted for this study to a 5-step programme development process. The results of the study lead to the development of an adapted HIV/AIDS training programme for church leaders. Principles of adult learning were considered as well as the elements of practice theory by Dickoff. The South African Qualification Authority (SAQA) guidelines of programme development were also used in developing the HIV/AIDS training progamme.

The phases of programme development process by Meyer and Van Niekerk (2008) are outlined below:

The preliminary phase places the programme into context and was covered during the literature review.

In the exploratory phase, the situational analysis was done through the convergent parallel mixed methods in phase I. This phase ensured that the developed programme would be relevant and appropriate for the church leaders.

© University of Venda

The design phase described a framework for the development of a programme. Elements of the Dickoff practice oriented theory were adapted as the reasoning map that formed the conceptual framework for developing the programme.

In the develop programme phase, the focus was on the development of an adapted HIV/AIDS training programme, which involved goals, objectives, learning outcomes, learning activities and assessment methods that would be utilized in the training programme. SAQA guidelines of programme development were followed in developing the HIV/AIDS training progamme manual.

PHASE THREE

Phase three covered the sixth and last objective of this study:

- Validate the developed HIV/AIDS training programme for church leaders in the Limpopo Province.

A developed training programme was validated to ensure that it is relevant and appropriate for the HIV/AIDS practice situation in the Limpopo province and if it meets the specific learning needs for church leaders before its implementation.

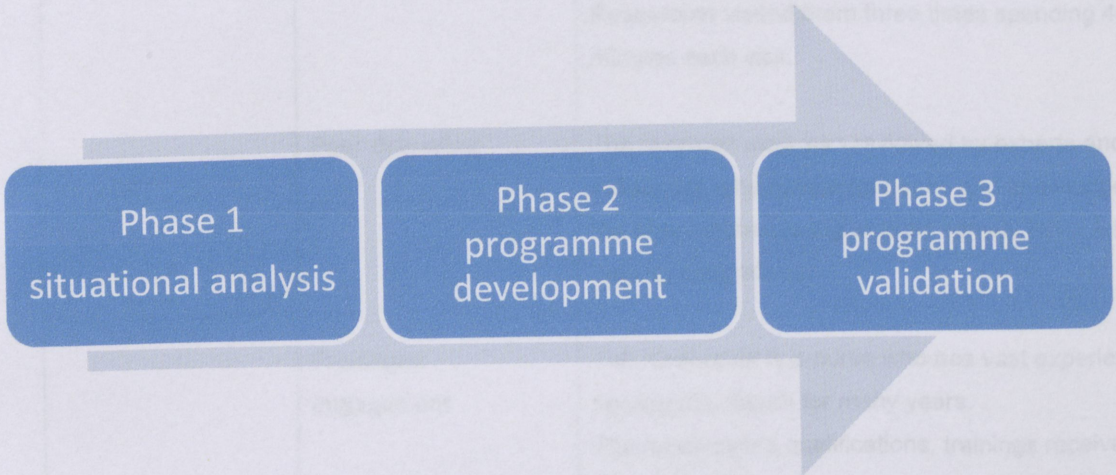


Figure 1.1 Summary of research phases

© University of Venda

University of Venda
Creating Future Leaders

1.18. Trustworthiness

To ensure that the findings of this study are a true reflection of the experiences of church leaders in the Limpopo province of South Africa, the model of Lincoln and Guba (De Vos et al., 2011) was used. The four criteria of trustworthiness, namely, credibility, dependability, transferability and confirmability were used to establish trustworthiness of this study as indicated in the table below as well as authenticity described by Polit and Beck (2014).

Table 1.1 Trustworthiness strategies

CRITEIA	STRATEGY	APPLICATION BY RESEARCHER
CREDIBILITY	Reflexivity	The researcher participated fully in the research as the principal investigator during development of research proposal, data collection, analysis and interpretation. Bracketing and intuiting in each phase of the research process was done.
	Persistent observation	Identification of characteristics and elements relevant to the problem. Sorting out irrelevances. Identification of participants' role while in their church environment. Researcher visited them three times spending 45-60 minutes each visit.
	Peer debriefing	The research work was reviewed by experts and colleagues who have experience and knowledge of the phenomenon being studied namely HIV / AIDS training programme.
	Prolonged engagement	The researcher is a nurse who has vast experience in serving the church for many years. The researcher's qualifications, trainings received in HIV and AIDS and the experiences gained were very important in establishing confidence in the data that was obtained.

© University of Venda

	Member checks	Adequate time was set aside to spend with the participants during data collection in order to build a trusting relationship. Feedback to study participants about Analytical categories, interpretations and conclusions were provided to obtain their realities.
TRANSFERABILITY	Purposeful sample Dense description	Sampling was purposive. Suitable participants with knowledge and experience were selected to represent group under study. Data about participants, research context and setting were adequately provided. A thick description of the research methodology was done in chapter 3
DEPENDABILITY	Stepwise replication Inquiring audit	The data and analyses were then checked for comparability, similarity, and discrepancies resolved through member checking with the participants. Supervisors of this study were responsible for examining the data, interpretations and recommendations in order to attest that they are supported by data.
CONFIRMABILITY	Confirmability occurs with: • Credibility • Transferability • dependability	The study established rigor with the decision trial and proved confirmability through credibility, transferability and dependability. Conclusions and interpretation derived directly from the data.
AUTHENTICITY	Ontological authenticity Educative authenticity	Was achieved by the researcher who demonstrated realities which depicted the concerns, issues, underlying knowledge, skills, and attitudes which the church leaders experienced during their HIV/AIDS training sessions.

© University of Venda

		The training programme was also aimed at empowering church leaders to become competent in their role regarding HIV/AIDS in the province.

1.19. Validity

Brink et al. (2012), define validity as the degree to which an instrument measures what it is intended to measure. Validity testing affirms the appropriateness of an instrument for a specific group or purpose rather than the instrument itself (Grove et al., 2013). The following criteria were considered in the construction of the instrument in order to standardize the evaluation:

- The questions were formulated as simple as possible to reduce any ambiguities.
- Instructions to the respondents were clear, the unclear statements were corrected during piloting of the questionnaire.
- Sufficient time was given for each respondents to complete the questionnaires.

After the construction of the research instrument, it was submitted to the following persons for correction and constructive criticism:

- The supervisor of this study at the Department of Advanced Nursing Science at the University of Venda.
- HIV and AIDS component in the Limpopo province.
- A panel of statisticians at the Department of Statistics at the University of Venda.

1.20. Ethical considerations

The major guiding ethical principles were observed throughout the study. Permission to conduct the study was obtained from the Ethical committee at the University of Venda, and the leadership of churches. Informed consent was obtained from each participant. Participants were told from the beginning that participation in the study is voluntary and they have the right to withdraw without fear of being victimized. Participants' names were

© University of Venda

University of Venda
Creating Future Leaders

not used in the interviews as well as in the questionnaires and their information was handled with dignity. The researcher protected participants from psychological, social harm and exploitation by carefully considering the phrasing of questions. The detailed ethical principles followed in this study were described fully in chapter 3 of this research report.

1.21. Dissemination of the study findings

Findings were disseminated to the participants and churches where the study was conducted in the form of a research report. A copy of the report was submitted to the University of Venda and the HIV/AIDS directorate in the Limpopo province's Department of Health. Oral presentation of findings will also be offered at national and international conferences. Results will also be submitted to peer reviewed journals for publications.

1.22. Outline of the remaining study chapters

Chapter 2: Literature review deals with the body of knowledge in the field of church leaders and HIV/AIDS.

Chapter 3: Research methodology discusses the research methodology in detail, which includes the research approach, study location, population, sampling, data collection and analysis, measures to ensure trustworthiness as well as ethical considerations.

Chapter 4: Results and Discussion, presents and discusses the qualitative and quantitative data and the findings.

Chapter 5: Development of an adapted HIV/AIDS training programme for church leaders. Here, a relevant and appropriate training programme for church leaders is developed and validated.

© University of Venda

Chapter 6: Evaluation of the study, recommendations, limitations and conclusions, in which the study is evaluated to see if all objectives of the study were achieved, followed by relevant recommendations.

1.23. Summary

This chapter outlined the overview of the study which included an introduction and background to the study, a problem statement, objectives, research questions, the significance of the study, a conceptual framework, the researcher's world view, and research design and methods. Relevant concepts were defined as used in the study.

© University of Venda

University of Venda
Creating Future Leaders

CHAPTER 2

LITERATURE REVIEW

2.1. Introduction

The previous chapter addressed the background of the study, problem statement, purpose, research questions, and objectives, significance of the study, conceptual framework and dissemination of the study findings. This chapter deals with the body of knowledge in the field of church leaders and HIV/AIDS. The purpose of literature review is to convey to the reader what is currently known regarding the topic under study (Burns & Grove, 2009).

In this study the researcher firstly undertook a narrative literature review to critique and summarize the body of literature that covers the first three objectives of this study, in order to direct the planning and execution of the quantitative research approach. The purpose of narrative literature review is to provide the reader with a comprehensive background for understanding current knowledge (Cronin, Ryan & Coughlan, 2008). Secondly, a review was done after data was analyzed to justify qualitative findings of the study in relation to the existing body of knowledge, as the study used both a quantitative and a qualitative research approach. This literature review section covered topics such as church leaders' knowledge on HIV/AIDS globally, church leaders' attitudes towards HIV/AIDS globally, and church leaders' practices towards HIV/AIDS globally.

2.2. Church leaders' knowledge on HIV and AIDS

It is not reasonable to assume that church leaders have all the information to adequately and effectively respond to the HIV/AIDS epidemic. A great number of church leaders still lack general knowledge on HIV/AIDS. Several studies conducted in different countries showed that there are still some religious leaders, who are not well informed about HIV/AIDS. This underscores the need for churches to get involved in activities related to

© University of Venda

University of Venda
Creating Future Leaders

HIV/AIDS within their churches and the community. A study done in Sokoto, in north western Nigeria revealed inadequate knowledge about HIV/AIDS among the religious leaders with only about half, (49%) of the respondents having adequate knowledge of HIV/AIDS (Umar & Oche, 2012). A study conducted in the Vhembe district in South Africa confirmed that many of the church leaders feel ill-equipped to address HIV/AIDS issues or know what to do or how to start AIDS ministries in their congregations (Malwela, 2013). Not much is being done by the church leaders to contain the epidemic due to lack of knowledge of HIV/AIDS. The capacity of church leaders has remained underutilized because they have not received adequate levels of knowledge to address the impact of the disease. Instead of providing care and hope, some church leaders and Christians have fueled the epidemic through their lack of knowledge. This lack of knowledge has contributed to misconceptions about the cause of HIV/AIDS. Many church leaders attribute AIDS to punishment from God for sins committed by an individual or his or her family (Otolok-Tanga et al., 2007). However, in John 9:1-7, Jesus told his disciples that a man's sickness had nothing to do with sin, for neither this man nor his parents sinned (Authorized King James, 2000). While on the other hand, some church leaders from the Zion, Pentecostals and Charismatic churches associate HIV/AIDS with witchcraft and demonic activities. These misconceptions contributed negatively to the use of antiretroviral drugs by those who are infected by the disease. The study conducted by Malwela (2013), revealed that there are church leaders especially from Zion, Pentecostals and Charismatic churches who hold similar beliefs that HIV/AIDS is caused by the activities of demons and witchcraft, hence the cure is by means of deliverance through prayer without the use of antiretroviral treatment.

Church leaders themselves need access to accurate information through training. Examples from Uganda and Senegal clearly demonstrate that even the most conservative clerics can become agents for change when properly informed and involved (Parry, 2004). Studies conducted in different countries revealed that where church leaders received information on HIV and AIDS, intervention strategies were enhanced to the utmost (Swanepoel, 2005).

© University of Venda

University of Venda
Creating Future Leaders

According to Paterson (2005), the story of church responses to AIDS has been a gradual process of moving 'out of the box'.

Phase 1 mirrors movements that have taken place in missiological thinking over the past half a century. In Africa, missionaries responded with great compassion by opening their mission hospitals to ways of assisting orphaned children and their carers. Here the 'model' or 'paradigm' of mission was 'the Church' going out into 'the World' to heal and save: *'Church' and 'World' being viewed, broadly, as separate theatres of activity'.*

Phase 2 saw 'the World' invading 'the Church', and 'the Church' struggling to come to terms with the fact. There was an appalled realisation that Christians themselves (even Christian clergy) were not immune from infection, and churches were being forced to acknowledge that they, too, are deeply affected by HIV or AIDS. The slogan that best characterises this stage is the statement that *'the Body of Christ has AIDS'* (Paterson 2005).

Phase 3 was triggered by the current focus on the eradication of stigma. Statements like the Nairobi Declaration (World Council of Churches (WCC), 2001) reveal a growing realisation that churches have contributed to the spread of the virus by their lack of knowledge contributing to judgemental and moralistic attitudes, by their approach to sex and sexuality, and by the non-inclusive character of many Christian communities. This forces us to ask questions about what Christians' knowledge and beliefs regarding HIV/AIDS and what their churches think and teach (UNAIDS, 2005). In the crisis precipitated by this epidemic, the Church cannot serve the world without asking searching questions about its own missiological, ethical and ecclesiological teachings, and about the theological assumptions that it uses to support those teachings.

Thus, phase 3 shows God calling the Church, through the HIV epidemic, to a process of transformation. This transformation came as a result of new knowledge acquired regarding HIV/AIDS. A study conducted in Uganda revealed that through participation in HIV/AIDS training, religious leaders have been armed with better information to address HIV/AIDS issues and to fight discrimination and stigma within their institutions and

© University of Venda

congregations (Otolok-Tanga et al., 2007). A number of literatures that were perused are confirming that many churches are not addressing HIV/AIDS issues in their churches and their communities, due to lack of knowledge.

2.3. Church leaders' attitude towards HIV and AIDS

Although there are church leaders and Christian based organizations that are involved in the fight against the spread of HIV and new infections, stigma and discrimination remain major obstacles to HIV/AIDS prevention and care initiatives.

2.3.1. Stigma and discrimination

Stigma and discrimination threaten the effectiveness of HIV/AIDS prevention, provision of treatment, support and care programmes. Stigma refers to attitudes and beliefs that lead people to reject, avoid, or fear those they perceive as different. Stigma is different from discrimination, while stigma is an attitude or belief, discrimination is a dynamic process that can occur as a result of stigma (Deacon, Prosalendis & Stephney, 2005). Discrimination includes different treatment on the basis of having HIV/AIDS. According to Parker and Birdsall (2005), discrimination involves some form of direct enactment of stigma which may be verbal or physical, and which is likely to be hurtful and or harmful to the person to whom it is addressed. The other associated practices and behaviours that relate to stigma and discrimination within churches include:

- Relegating an HIV positive member to less visible functions, and not allowing them to preach or to serve food, because they are seen as sinners who may contaminate the holy place (Malawi Interfaith AIDS Association [MIAA], 2007).
- Negative sanctions, such as forcing HIV-positive pastors and members out of parishes, and compelling them to confess the sins that led to their infection (Parker & Birdsal, 2005). In the Ugandan study conducted by Paterson (2005), indicated that people with HIV and their families have been excluded from churches, publicly exposed, refused pastoral care and funeral rites, and in extreme cases, have been killed. Orphans were thrown out of their homes, accused of being cursed.

© University of Venda

University of Venda
Creating Future Leaders

- Discriminatory languages and labelling of people living with HIV, for example naming of people as 'victims'; 'sufferers' and 'sinners' contributes to their stigmatization (Parker and Birdsall, 2005; MIAA, 2007).

Deacons et al. (2005), distinguish between two types of stigma; those of instrumental and symbolic stigma. Instrumental stigma is intended discrimination based on risk perception and resource concerns. Symbolic stigma relates to cultural or religious meanings which may be expressed in religious or moral judgments, or in emotional responses. Religion as a defender of the moral and social norms of a culture, often functions in such a way as to reinforce and ritualize symbolic stigma. In a language of religion, the infringement of cultural and social norms may be re conceptualized as 'sin' (Paterson, 2005).

2.3.2. Factors contributing to stigma and discrimination in the context of church leaders

Stigma and discrimination is fueled by silence, associating HIV with sin, lack of knowledge which leads to fear and denial

Culture of silence

A review of literature generally includes silence on HIV/AIDS in the church on the list of factors that contribute to stigma and discrimination. The church is accused of its silence which weakens the fight against the HIV/AIDS epidemic. The failure to openly discuss the root causes underpinning HIV transmission particularly differentials of power, have contributed to the stigmatization and discrimination of People Living With HIV and AIDS [PLWHA] within the church (Parker & Birdsall, 2005). Cochrane (2005), notes how religion feeds into the problem of stigma through the taboos, sanctions, and silences [about sexuality], much of it authorized by religious legitimations. Many church leaders, in spite of their awareness of HIV/AIDS, maintain a culture of silence and denial of its existence. The outbreak of HIV in Mali elicited a response of silence among both Muslim and Christian religious leaders. They felt that neither they, nor their congregations, were

© University of Venda

University of Venda
Creating Future Leaders

affected by issues related to HIV (USAID, 2007). This silence is also as a result of the harmful association between HIV infection and immoral behavior. Many Christians feel that if they talk about sex-related issues, it may pose questions about their moral or spiritual understanding, and this contributes to stigma and discrimination of people infected with HIV. A study conducted in Malawi affirms that silence in the church on issues of HIV and AIDS is, in itself, responsible for stigma and discrimination (MIAA, 2007).

The association of HIV infection with immoral behavior and sin

AIDS has acted as a Centre of attraction for all the negative meanings, when transmission is mainly sexual, and is associated with death. The stigmatization of people with HIV/AIDS is connected with the mistaken link that Christian thinking has often made between sexuality and sin (Paterson, 2005). A baseline study conducted in three districts in Malawi reported that close to 40% of religious leaders participated in the study felt HIV is a punishment from God (MIAA, 2007). A study done in Uganda by Otolok-Tanga et al.(2007), also confirmed that associating AIDS with sin or curse from God for wrong doings and sending out of mixed messages by religious leaders in line with the Christian concept of 'hate the sin, love the sinner' were found to be actions facilitating stigma. There are Christians and religious leaders who believe that AIDS is a punishment from God or that the sufferers contracted the disease because they had many sexual partners. Those who consider AIDS as a divine punishment for sin usually cite Deuteronomy 28:15-16. Hlongwane and Mkhize (2007), comment that there are three patterns of religious argument regarding the cause of HIV. The first views HIV as a virus sent by the devil. The second considers HIV as a virus which has been sent by God. The last pattern of argument interprets HIV as a negotiated settlement between God and Satan. The second pattern of argument is the one that most Christians, churches and general communities believe. It is this association between HIV/AIDS and sin that lead to stigma and discrimination. The Anglican Archbishop, Njogonkulu Ndungane of Cape Town South Africa, blamed the church for the stigma around the HIV/AIDS because of a destructive theology that linked sex with sin, guilt and punishment (Clifford, 2004). Otolok-Tanga et al. (2007) cited the use of religious teachings and moralistic attitudes to ascribe blame

UNIVERSITY OF VENDA
LIBRARY

© University of Venda

University of Venda
Creating Future Leaders

without regard to deeply entrenched societal vulnerabilities as fostering stigma amongst people living with HIV/AIDS.

Lack of knowledge of HIV/AIDS transmission

Lack of knowledge contributed to misconception about the cause of HIV/AIDS and has raised many fears relating to illness and death as AIDS is incurable. A review conducted in 2003 in South Africa identified inadequate training of religious leaders in the basics of HIV transmission as one of the causes of stigma and discrimination (Parker & Birdsall, 2005). The fears surrounding the emerging HIV epidemic in the 1980s largely persist today. At that time, little was known about how HIV is transmitted, which made people afraid to come near those who were infected, to avoid contagion. Lack of knowledge also lead to denial that HIV is a problem within the church and a false belief that HIV infection is transmitted through immorality that deserved to be punished ((Hlongwane & Mkhize, 2007). Most church leaders tended to think that AIDS is a disease that will happen to someone else, but not them, as they are living holy life. A study conducted in Malawi confirmed that lack of information and understanding of the disease, prejudice and myths about how HIV is transmitted contributes to stigma and discrimination (MIAA, 2007).

UNIVERSITY OF VENDA
LIBRARY

2.3.3. Impact of stigma and discrimination on HIV/AIDS epidemic.

Stigma and discrimination make positive people fear to seek care and support, and pretend as if things are normal. According to Lindsey et al. (2003), it has been found that stigma often prevents people from accessing health care services because they are afraid that people will know about their HIV-positive status, and therefore, continuous care and support is delayed. This finding is supported by Baker et al. (2005), who explain that stigma and discrimination discourage people infected with HIV and AIDS from seeking the services they need because it may lead to the revelation of their HIV status to their families, colleagues and community. A study conducted in the Limpopo province by Lesolang (2010), revealed that a number of religious leaders blame people living with AIDS as having no self-control, irresponsible and being sexually promiscuous. This

© University of Venda

University of Venda
Creating Future Leaders

situation puts the family in a predicament of either having to disown the infected, or to be discriminated against by society.

Stigma and discrimination also contribute to non-disclosure by HIV infected people, to reduce the likelihood of being discriminated. Parker and Birdsall (2005), in their review about stigma, indicated that some churches have been involved in denouncing or rejecting people living with AIDS, including their own pastors. According to Parker and Birdsall (2005), negative sanctions have included forcing HIV-positive pastor and members out of parishes, compelling them to confess the 'sins' that led to their infection.

Fear of stigma and discrimination, and worries about confidentiality, often make people feel reluctant to get tested; hence they are diagnosed late, when the virus may have already progressed to AIDS. When people are not getting tested, they may continue to spread HIV to others without knowing it. Stigmatization also serves as a strong deterrent to young people seeking HIV/AIDS counselling (Campbell, Foulis, Maimane & Sibiya, 2005).

2.3.4. Strategies to eradicate stigma and discrimination among church leaders

There is a growing realization amongst church leaders that by stigmatizing those who are living with HIV or AIDS, it contributes to a problem. Paterson (2005), indicates that church leaders are becoming aware of the damaging effects on testing, treatment and prevention programmes caused by stigma. It is the responsibility of Church leaders themselves to play an important role in reducing the stigma by showing love, care and compassion, and by providing a supportive environment for all people living with HIV and AIDS.

Capacity building

A reading of literature confirmed that there are churches which have taken a conscientious approach to educating their members about HIV/AIDS. A study conducted in Uganda by Otolok-Tanga et al. (2007), revealed that through participation in HIV/AIDS

© University of Venda

University of Venda
Creating Future Leaders

trainings, church leaders have been armed with better information to fight discrimination and stigma within their institutions and congregations. Both international and local studies concur that HIV/AIDS intervention programmes are aimed at changing the spread and the consequences of HIV/AIDS. An attitude of acceptance of people who are HIV positive improved due to participation in awareness programmes and HIV/AIDS training. Henry (2006) notes that the Anglican Church in Africa has begun offering Bible studies on safe sex and HIV. The more you educate people, the more you change their minds about the disease. Paterson (undated), confirmed that transformation will not happen by itself much will depend on training. She further indicates that many church leaders are now trying to include HIV/AIDS, in culturally sensitive ways, in clergy formation and theological education. The church must take responsibility to accommodate all people irrespective of their HIV status.

Church leaders themselves need access to accurate information and training to counteract irrational fears and discrimination. Studies conducted in different countries by USAID (2007) reveal that due to the emergence of HIV/AIDS, many countries developed HIV/AIDS training programme to equip church leaders to respond effectively to the epidemic. When health policy initiative's capacity building efforts included training of religious leaders in Mali, the aim was to increase religious leaders' knowledge of HIV, enhancing their leadership and advocacy skills, and strengthening their capacity for collaboration (USAID, 2007). For those church leaders who felt that they should be involved in HIV/AIDS, their churches have taken a conscientious approach to educate their members about AIDS. According to USAID (2007), when religious leaders in Mali reinforced their commitment to HIV/AIDS issues, they inspired their training with the Bible and the Koran, which proved to be persuasive in Malian society.

Breaking the silence

Paterson (undated) argues that churches cannot effectively address HIV and AIDS without first breaking the silence that surrounds the issues of sex, drug addiction, sin and death. The Global AIDS Interfaith Alliance document of 2005, reports that Ugandian

© University of Venda

University of Venda
Creating Future Leaders

president, Museveni believed his country's success in prevalence reduction, was primarily due to transparency, openness, and, in particular, frank discussions about HIV and AIDS and human sexuality. Ugandans came out in public using all sorts of forums, like political rallies, church congregations, school assemblies, sports festivals to always talk about HIV/AIDS (Ogden & Nyblade, 2006). Religious leaders in Mali have made an open declaration that recognizes HIV/AIDS as a development issue, rather than a divine curse, and they have called for increased support for people living with HIV/AIDS (USAID, 2007). This action has contributed to overcoming stigma and increased the participation of religious leaders in the national response to HIV/AIDS.

Encouraging self-disclosure and involvement of PLWHAs

Greater openness about one's HIV status, by both church leaders and church members, and the involvement of PLWHAs in prevention, care and advocacy are identified efforts by different researchers to eradicate stigma and discrimination (USAID, 2007). A Ugandan Anglican priest, Gideon Byamugisha, became the first African church leader to openly declare his HIV/AIDS-positive status. Church leaders in Kenya formed the 'Kenya Network of Religious Leaders infected and affected by HIV/AIDS' in 2004, following Byamugisha's approach. When it was established, it had forty-four religious leaders, but now the membership has grown to more than 1000 church leaders in eight provinces (Mbonu, Van den Borne, & De Vries, 2009). Similarly, Tanzania formed a Network of Religious leaders living with HIV/AIDS (TANARELA), which is composed of HIV positive religious leaders who publicly disclosed their status to the media (Zou, Yamanaka, John, Walt, Osterman & Thielman, 2009).

Studies conducted in Uganda reported an increasingly involvement of PLWHAs in their churches' activities as well as being supportive to those that declare their HIV status helped to reduce stigma and discrimination (Otolok-Tanga et al, 2007). Otolok-Tanga et al. (2007) further indicated that they have also launched a network of religious people who are HIV-positive and those who are directly affected by HIV to make a difference in the eradication of stigma. Some churches in Uganda have taken further step to include

© University of Venda

their leaders who are positive to do advocacy work, and to contribute to HIV/AIDS policy development (Otolok-Tanga et al, 2007). On the evaluation report on HIV and AIDS related stigma and discrimination conducted in three districts in Malawi, the youth and women in the Mangochi district felt that people living with HIV should not discriminate themselves but should participate in all activities in their faith communities and be free to disclose their status (MIAA, 2007). Willingness and commitment by church leaders and members is important in the eradication of stigma and discrimination.

Church leaders in the Limpopo province in South Africa should also take positive steps to encourage HIV/AIDS-positive church leaders and members of their congregations to reveal their status, as they could serve as powerful agents of change in their congregations and communities in combating stigma and discrimination.

2.3.5. Barriers to reducing stigma and discrimination

A 2003 review of HIV/AIDS-related stigma in Faith Based Organizations [FBOs] in South Africa, which included interviews and focus groups with both Christian and Muslim religious leaders, identified a number of practical issues and challenges which remain barriers to reducing stigma and discrimination within religious communities. These barriers, as listed by Parker and Birdsall (2005) include:

- Views of human sexuality as sinful;
- Inadequate training of religious leaders in the basics of HIV transmission;
- Failure to incorporate issues related to HIV/AIDS into theological training and curricula;
- A lack of specially-developed material resources for use in addressing HIV/AIDS in religious settings - e.g. interpretations of religious scriptures and reading through an HIV 'lens';
- Problems with confidentiality in relation to individuals' HIV status and lack of guidelines for pastors on how to deal with the disclosure; and
- Denial on the part of some religious leaders that AIDS is present within their faith or congregation.

© University of Venda

University of Venda
Creating Future Leaders

Current literature makes reference to the challenges of eradicating HIV-related stigma and discrimination within churches and faith based organization (Parker & Birdsall, 2005).

2.4. Church leaders' practices towards HIV and AIDS

Different Christians react differently to AIDS. Dixon (2004), mentions that there are Christian church leaders who say that Christians should have nothing to do with HIV and AIDS patients, whereas, there are those who feel that all Christians should make some sort of response to the epidemic.

Observers are largely in agreement that earlier on, church leaders constituted part of the problem rather than part of the solution (Dixon 2004). Church leaders have been faulted, for example, for their delayed responses, their failure to acknowledge the scope and implication of rising HIV and AIDS, which have contributed to silence and secrecy. Religious leaders' involvement in the fight against HIV/AIDS in Mali has evolved over time. They have moved from the initial position of observation and ideological opposition to the promotion of key prevention methods and to a sustained commitments to fighting the epidemic (USAID, 2007). Without a doubt, church leaders are in the forefront of care initiatives, especially in Africa. In South Africa, a review of faith-based organizations listed in the national HIV/AIDS data base found that FBOs that had AIDS activities at local level, predominately worked with people living with HIV/AIDS (33%) and orphans and vulnerable children (27%). The direct and concerted support to people living with HIV/AIDS and persons affected by HIV/AIDS suggest that the central tenets of compassion and shared humanity within faith-based organizations are frequently applied to the epidemic (Parker & Birdsall, 2005).

Some of the most common practices churches are involved in include, prevention, care of orphans, home-based care, providing medication, counselling and support testing.

© University of Venda

University of Venda
Creating Future Leaders

2.4.1. Prevention

Church leaders have traditionally been less involved with HIV prevention work in comparison to care and support activities, although the picture is not uniform. The critical condition for the involvement of church leaders as advocates for prevention is having access to information that will transform their opposition to support and commitment (USAID, 2007). Liebowitz (2004), for example, found that churches in Uganda and in the KwaZulu-Natal Province in South Africa, place a heavy emphasis on HIV awareness and education.

The role of church leaders and faith-based organizations in preventing the spread of HIV/AIDS has predominantly been characterized by the deadlock over condom use. Christian organizations for the most part do not promote condom use, and non-Christian stakeholders have questioned the efficacy of the church's emphasis on abstinence and fidelity (Tiendrebeogo & Buykx, 2004). A, similar view on condom use is provided by the Catholic bishops from African countries like Tanzania and Cameroon. In Tanzania, the Archbishop of Dar-es- Salaam said that the introduction of the use of condoms in schools apart from being sinful, is indeed justification and opening the door for immorality, while the Cardinal of Cameroon has endorsed the use of condoms as a protective measure against HIV/AIDS provided the couples using them are married. They agreed that fidelity and abstinence remained the best protection against HIV (Advancing Sexuality Studies Short Course, 2009).

Church leaders play an integral part in the combat against HIV and AIDS. For example, studies conducted in Uganda have revealed that the involvement of church leaders in AIDS in Uganda has received the most scholarly attention because it is regarded as a success story. In Uganda, the church, to its credit, stood side by side with the government and put its full weight behind the campaigns. While the secular response was condom promotion and responsible behaviour, the message from the church was abstinence and fidelity. Through these efforts, Uganda has experienced the most significant decline in HIV prevalence of any country in the world. National HIV infection rates for pregnant

© University of Venda

University of Venda
Creating Future Leaders

women declined from around 21% in 1991 to just over 6% in 2000 (Ham, 2004). In a study conducted by Columbia University Mailman School of Public Health, Johns Hopkins University and some Ugandan organizations, they found that the decline was chiefly attributable to initiatives promoting abstinence and faithfulness to one's sexual partner (Parkhurst, 2001).

Since church leaders have made a significant contribution to the Uganda success story in preventing and mitigating the impact of HIV and AIDS, some researchers, like Liebowitz (2004), chose to make a comparative study between churches in Uganda and the Kwazulu-Natal Province in South Africa, which has the highest HIV prevalence rate in South Africa. Liebowitz (2004) studied the impact of faith-based organizations on HIV/AIDS prevention and mitigation in Africa. In KwaZulu-Natal, Liebowitz's research focused on Durban, Ntuzuma and Newcastle. In all these areas, a wide variety of denominations exist. The study found that these churches and church organizations were involved in significant and positive activities in AIDS prevention, care and support at the community level. Liebowitz found that churches were involved in activities that ranged from communication during sermons to workshops, to crusades and peer education (Liebowitz, 2004). These activities are described under various labels, usually as awareness, education, or providing information in Kwazulu-Natal and as sensitization or education in Uganda (Liebowitz, 2004). The outspoken position regarding condoms by the Catholic Church and most Protestant churches complicates HIV/AIDS prevention campaigns aimed at reducing unsafe sexual practices. However, this doctrine does not necessarily render churches unfit to promote HIV/AIDS prevention (Tiendrebeogo & Buykx, 2004).

A prevention campaign which is compatible with the general UNAIDS strategy, is the so-called 'Fleet of Hope'. It was developed in Tanzania by Bernard Joinet, a lecturer in Clinical Psychology at Dar-es-Salaam University, where he served as well as a Roman Catholic Chaplain for many years. He saw, in distress, how the epidemic spread dramatically whereas various stakeholders sent conflicting messages of prevention. He then elaborated a campaign based on visual images, inspired by Noah's Ark

© University of Venda

University of Venda
Creating Future Leaders

(Tiendrebeogo & Buykx, 2004). The message consists of 4 sections, in all 44 posters discussed below:

AIDS is like a Flood (posters 1-18)

The AIDS pandemic is being compared to a flood that rises up and swallows up millions of people. One can escape only if one climbs on board of the 'Fleet of Hope': an inseparable combination of three boats that may save from death by AIDS: "the Fidelity", "the Abstinence", "the rubber lifeboat" (condom). These boats are options in determined situations. When the situation changes, it is better to change boats rather than to get into the water. Therefore if you cannot abstain or remain faithful to one partner the better option is to use condom to avoid getting HIV. You can either use one of the three boats depending on the situation.

Different responsibilities (posters 19- 24)

The national government should encourage people to board one of these boats. Groups in society, for example families or religious groups, are not under any obligation to present all options as equal alternatives in view of their values. Furthermore religious groups that do not approve the use of condom are not obliged to speak about condom but can stick to Fidelity amongst couple and abstinence amongst the youth.

Individual options (posters 25-36)

Looking closer who is on board of any of the boats in a determined situation helps to do away with stereotypes. The 'Abstinence' is not only for monks, but an option everyone can stay on, at least in his early youth. The 'Condom' is not only for sex workers: also a faithful discordant couple may decide to use it when the "Fidelity" option is no longer safe. Everyone may at a determined moment have to change from one boat to another to avoid the risk of drowning. The typical example is of the "condomizing womanizer' who runs out of stock: he can either drown or board the 'Abstinence' until the pharmacy opens next morning. There are situations where in even those who opt for condoms can abstain if condoms are not available until they get them to avoid risk of infection. Individual options

© University of Venda

University of Venda
Creating Future Leaders

are determined by the situation and one can change to a safer option if the commonly used option is no longer safe.

Psychological constraints (posters 37- 44)

The real problem lies with those who do not want to board a boat, for irrational convictions like 'AIDS is punishment for sin' or 'I am bewitched"' Unfortunately, many people especially women, cannot board a boat, being too poor and too dependent on their partners to make free choices. Psychological constraints are barriers that prevent people from making free choices to protect themselves from the HIV infection. Prejudice, myths, financial standing and culture can provide psychological constraints hence the risk of infection is higher if these constrains are not dealt with.

This campaign, which started in a religious association, was promoted by UNAIDS all over the world, through its branches, and adopted by many public health services, especially in Africa. It has been used successfully by churches in various African countries: in Burkina Faso, it was translated into French, and adapted to a group discussion game with a tapestry and character cartoons. In Angola, it was translated into Portuguese, and reposted on the internet. In the Democratic Republic of Congo, it was used to open discussion about behavior change and lead the public even to question the over simplified marketing slogans of condom sellers.

In general, it is felt that the campaign in itself does not impose any moral view, and focuses precisely on circumstances and individual situations, in order to make moral decisions possible. This openness has helped to overcome the deadlock on both sides, since no party likes to be compared to a war-ship wasting her energy in shooting torpedoes at other boats instead of saving lives (Tiendrebeogo & Buykx, 2004). The church and secular services do not operate in isolation.

With regards to prevention of mother-to-child transmission, many faith-based organizations' health services have implemented this program even before governments have moved beyond pilot projects. They have shown that it works even in the poorest of

© University of Venda

University of Venda
Creating Future Leaders

settings with illiterate people, such as at St. Theresa's in Chirumazi, Zimbabwe, where over 70% of all antenatal mothers request testing and appropriate follow-up, as do many of the husbands and youth - even without the incentive of ARV therapy (Parry, 2004).

2.4.2. Home-based care

Home–based care programmes for people living with HIV/AIDS (PLWHA) in sub-Saharan Africa have evolved over the past two decades in response to the roll out of antiretroviral therapy. Community/Home-based care (CHBC) programmes were developed through the early 1990s providing nursing and palliative care, as well as general support for households affected by HIV (Catalado et al., 2010).

In sub-Saharan Africa and other developing countries, CHBC programmes were developed as unsystematic and need-based efforts when it became evident that other options of care were necessary to deal with the effects of HIV and AIDS (Ncama, 2005). CHBCs were mainly initiated by non-governmental organizations, community-based organizations, church-based organizations and concerned individuals (Cullinan, 2000). In South Africa, as in many African countries, many people are becoming increasingly chronically ill, requiring care over long and extended periods and thereby necessitating to be taken care of at home (Uys, 2003). Many CHBC in South Africa were started by church organizations or concerned individuals, particularly retired nurses (Cullinan, 2000).

The Ndola Catholic Diocese in the north of Zambia runs a ground–breaking programme of home-based care for AIDS patients who are very ill. It operates in the poorest neighbourhoods, where every day is a struggle to find food. Some 700 volunteers, coordinated by Ndola Diocese, offer basic health care, home visits and friendship to people at home. Since its establishment in 1991, this home-based care has 7000 registered clients in 23 townships (some 450,000 people), which are served by 750 community volunteers and 34 professional nurses. To overcome stigmatization right from the start, the churches train people to visit anyone they know to be sick in their

© University of Venda

University of Venda
Creating Future Leaders

neighbourhoods. In the second stage, these volunteer 'visitors' focus on AIDS patients, providing nursing, care and material assistance, such as food or schooling for children. The visitors rely on professionals for instruction, provision of medicines and commodities, and a referral network (Tiendrebeogo & Buykx, 2004).

The South African Council of Churches (SACC) has helped to establish a number of home-based AIDS care groups. This arrangement relieves overcrowding in hospitals and allows patients to receive dignified treatment. It also helps to remove some stigma. Many churches undertake 'unglamorous' charity work such as collecting food for AIDS victims and their families, and caring for children with AIDS and AIDS orphans, such as Cape Town's Nazareth House, a Catholic outreach programme (Ruden, 2000). This home care model aims to provide a continuum of care for PLWHA from diagnosis to death and it includes counselling and support for people who are relatively symptom free while placing emphasis on palliative and terminal care. The model specifically aims at developing a care system that is effective and sustainable in the context of a developing country (Uys, 2003).

Liebowitz (2004), in his study in Kwazulu-Natal, found that home-based care and visitation were the common activities of many FBOs in KwaZulu-Natal. During church visits, those involved provide care, moral support, emotional support, food, and treatment. In some cases, congregation members initiated such programs and often are entirely responsible for carrying them out. An example, is River Life Community Centre, 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. 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 the River Life Community Centre to report on their visit. If one reports, for example, that he or she found a sick child who needs treatment, River Life sends that child to a doctor and pays for the medical bills. If the child is school-going, River Life reports to the school and pleads with the school to keep the child's place while

© University of Venda

University of Venda
Creating Future Leaders

the child gets hospital treatment. In cases where a patient has died, volunteers come to report to River Life, 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 cannot afford to pay for burial so the hospital pays for burial). Another FBO involved in home-based care is the Community Care Project, which is part of the many programmes that are part of Project Gateway Houses.

The project focuses on caring for, assisting and equipping care-givers and children, paying particular attention to widows and orphans. The 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 (Liebowitz, 2004).One of the recommendations from the study conducted by Sapepa (1998), in the Eastern Cape on a description of home-based care for PLWHA was to modify the health care delivery system to incorporate CHBC programmes into existing primary health care programmes and to develop an intersect oral approach to management. Campbell and Foulis (2004) argue that the major problem facing CHBC programmes is promoting and sustaining linkages and partnerships with the more powerful groupings and agencies (locally, nationally and internationally) to support caregivers and patients. Very little has been written on the cost of home-based care. A study by Uys and Hensher (2002), attempted to calculate what it would cost to roll out home-based care across South Africa. This was based on careful costing of current projects and allowed for different scenarios in terms of transport of such workers. It accepted that even when home-based care was available, clients still used both the hospital and clinics. This study concluded that CHBC shows considerable potential to deal cost-effectively with growing palliative care needs in the face of the HIV and AIDS epidemic. However, more studies are necessary to establish the extent to which CHBC can be a substitute for hospitalization.

© University of Venda

2.4.3. Counseling and supporting testing

Many churches also regularly undertake counselling and provide advice and encouragement to those infected and others in need of advice and support. In the early stage of the pandemic, many pastors avoided getting involved with HIV/AIDS. Today, every pastor in Africa must assist many people dying from AIDS. Some pastors have been recruited as HIV/AIDS counselors. For counselling to succeed, the recipient must have confidence in the counselor. Many people in Africa already have a trusting relationship with their pastor, making them potential recruits and the natural allies of counselors (Tiendrebeogo & Buykx, 2004). Catholic AIDS Action in Namibia provides voluntary counselling and testing precisely because it recognizes the need and its trusted role and potential to influence in a positive way (Haendler, 2001). According to Parry (2002), several Mission Hospitals are already providing this service. The FBOs that offer training in counselling such as in Botswana and Namibia, have been opening their facilities to voluntary counselling and testing using trained volunteers, including pastors, to accompany the clients on their sero-status journey.

In KwaZulu-Natal, Liebowitz (2004) 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 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 which 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". 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 lack of resources.

© University of Venda

2.4.4. Providing medication

There is substantial evidence of the important role that religious organizations are playing in providing treatment and care services in Africa. It has been documented, for example, in a report commissioned by UNAIDS that 70% of health services in the Democratic Republic of Congo (DRC) are delivered by churches and church related institutions, 50% of hospitals in the DRC are owned and managed by local churches, and the Roman Catholic Church alone provides 25% of all HIV/AIDS care including home-based care and support of orphans in the DRC (Haddad et al., 2008).

The Treatment Action Campaign in South Africa is courageous, widely supported by faith-based organizations, as it keeps the international spotlight on the need for Anti-Retroviral (ARV) drugs for the country (Parry, 2004). In Kwazulu-Natal, 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 (Liebowitz, 2004).

2.4.5. Orphan support

Another ministry of churches is supporting orphans. Churches and faith-based organizations have taken the lead in many countries with the provision of care for orphans and vulnerable children. This care has taken the form of institutional care, community based, fostering and adoption, day care centers, street children programmes and hospices for abandoned and HIV positive children (Parry, 2004). The explosion in the number of AIDS orphans has gone far beyond the capacity of the church orphanages. Catholic AIDS Action (CAA) in Namibia trains volunteers to include care of orphans in their home-based care programmes. They provide material support so that the children can stay in their own communities. They also provide psychological support, especially in cases of child abuse or neglect. By December 2001, CAA had registered 9,922 orphans, of whom 5,645 had received material assistance from the programme (Byamugisha, Steinits, Williams & Zondi, 2002).

© University of Venda

University of Venda
Creating Future Leaders

According to Liebowitz (2004), FBOs' involvement in HIV and AIDS mitigation in KwaZulu-Natal, churches 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, a Pentecostal Church in Pinetown. This project has 'adopted' the Kwadabeka Township. Other FBOs in the 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. 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. 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.

2.5. Summary

Studies conducted in different countries revealed that due to the emergence of HIV/AIDS, many Churches have emerged as auxiliary partners of the government in preventing and mitigating the impact of the HIV/AIDS pandemic. While some churches are making contribution to the reduction of HIV and AIDS, others are struggling to engage due to lack of knowledge. Lack of knowledge regarding the transmission of HIV is still a major contributory factor to stigma and discrimination which threatens the effectiveness of HIV/AIDS prevention, provision of treatment and care amongst the churches. A capacity

© University of Venda

building for church leaders seems to be important to maximize churches' involvement in HIV/AIDS and to enhance their intervention strategies.

© University of Venda

University of Venda
Creating Future Leaders

CHAPTER 3

RESEARCH METHODOLOGY

3.1. Introduction

The previous chapter reviewed and discussed literature on church leaders' knowledge, attitudes and practices regarding HIV/AIDS. The purpose of this chapter is to describe the research design and methods for the study, which have led to the development of an adapted HIV/AIDS training programme specific to the needs of church leaders in the Limpopo province. The design and methods will be described according to the three phases of the study.

3.2. Research Design and methods for phase 1

According to Babbie and Mouton (2010), a research design is a plan or blueprint of how one intends to conduct the study. It includes the methods and techniques used to collect, analyze and interpret data. A research design maximizes control over factors that could interfere with the validity of the findings and therefore guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal (Burns & Grove, 2009).

The study used the convergent parallel mixed methods design (also referred to as a triangulation mixed methods design). Convergent parallel mixed methods is a form of mixed methods design in which the researcher converges or merges quantitative and qualitative data in order to provide a comprehensive analysis of the research problem (Creswell, 2014). This is a one phase design in which the researcher uses both quantitative and qualitative methods during the same time frame and with equal weight to best understand the research topic (De Vos et al., 2011). In this study the researcher collected and analyzed quantitative and qualitative data simultaneously, with equal weight. Then the two sets of results were compared and interpreted.

© University of Venda

University of Venda
Creating Future Leaders

Mixed methods provide a more complete understanding of research problem than either quantitative or qualitative data alone (Creswell, 2014). According to Grove, Burns and Gray (2013), it offers researchers the ability to utilize the strengths of both qualitative and quantitative research design. A mixed methods design is practical in the sense that researchers are free to use all methods possible to address a research problem. In addition, it combines inductive and deductive reasoning processes (De Vos et al., 2011). Deductive reasoning moves from the general to the specific, while inductive reasoning moves from the particular to the general (De Vos et al., 2011). The quantitative design used deductive reasoning while the qualitative design used inductive reasoning process. The quantitative design was used to assess Church leaders' knowledge, attitudes and practices (KAP) towards HIV/AIDS in order to assess the impact of the existing training programme, while the qualitative design was used to explore church leaders' experiences regarding the existing training programmes. This method was appropriate in this study because the researcher managed to capture the essence of HIV/AIDS training needs specific to church leaders, which led to the development of an adapted HIV/AIDS training programme for church leaders.

3.3. Study setting

Burns and Grove (2009), define setting as the location where a study is conducted. There are three common settings for conducting nursing research: natural, partially controlled, and highly controlled (Burns & Grove, 2009). A natural or field setting is an uncontrolled, real life situation or environment. A partially controlled setting is an environment that is manipulated or modified in some way by the researcher. A highly controlled setting is an artificially constructed environment developed for the sole purpose of conducting research, for example, laboratories.

The study was conducted amongst church leaders in the Limpopo Province. The province covers a geographical area of 123 910 square kilometers, with a population of 5 518 000 people (Statistics S.A., 2013). The province is situated in the north east of South Africa and is made up of five districts, namely: Vhembe, Mopani, Capricon, Waterberg and

© University of Venda

Sekhukhune. The province is considered the most rural province in South Africa comprising mainly of poor communities. It shares borders with three countries, Botswana, Zimbabwe and Mozambique. The study was conducted in a natural setting as there was no manipulation of the environment. No changes were made which could have affected the results. For the purpose of this study, the naturalistic setting was in participants' churches, and their homes, depending on where participants felt comfortable.

3.4. Quantitative research design

According to Burns and Grove (2009), quantitative research is a formal, objective, systematic process in which numerical data is used to obtain information about the world. Quantitative research is classified as a structured approach because everything that forms the research process is predetermined (De Vos et al., 2011). As a structured approach, it was more appropriate for conducting a KAP survey to assess the impact of existing HIV/AIDS training programme amongst church leaders and to determine the specific training needs of church leaders in the Limpopo Province.

3.4.1. Research population

Research population refers to the entire aggregation of cases in which the researcher is interested in (Polit & Beck, 2014). Grove et al. (2013) describe population as all the elements that meet certain criteria for inclusion in a given universe. Furthermore, a population is a group of potential participants to whom the researcher wants to generalise the results of the study. The target population of this study comprised of all church leaders in the Limpopo Province. An accessible population is the portion of the target population to which the researcher has reasonable access (Burns & Grove, 2009). The accessible population of this study comprised of all church leaders from Christian churches, as they are found in almost every village and constitute the majority of churches in the Limpopo Province.

© University of Venda

University of Venda
Creating Future Leaders

3.4.2. Sampling

Sampling refers to the process of selecting a portion of the population to participate in the study in order to obtain information regarding phenomena in a way that represents the interest of the population (Polit & Beck, 2014). Since it is generally impossible to study an entire population, it is therefore important that the group selected be representative of the population, and not biased in a systematic manner.

3.4.2.1. Sampling methods and procedure

Sampling in this study was done in three stages, which are described below.

Stage 1: Sampling of district

A non-probability purposive sampling was preferred in this stage because it involves conscious selection of a certain district to be included in the study by the researcher. The Vhembe district was purposively selected to be representative of the population. The Vhembe district is one of the five districts of the Limpopo Province in the Republic of South Africa. The Vhembe district is located in the most rural Northern part of the Limpopo Province. The district is made up of four municipalities, namely, the Collins Chabane, Musina, Makhado and Thulamela. According to Statistics South Africa (2013), the Vhembe district has a population of 1381041, spread across 603 villages and townships, and has 1824 Christian churches spread in four different municipalities. In my own observations, I counted the average of up to 15 churches in several villages of not more than 5000 households. However, it is possible that there might be many churches that are not registered, especially in rural areas where church sites are allocated by local traditional leaders and in townships where they are renting a place. The data-base at the municipalities reflect only churches that have church sites and those who have applied for church sites. The reasons for selecting the Vhembe district were that:

- The Vhembe district has churches that are involved in the fight against the HIV/AIDS epidemic.

© University of Venda

- Statistics of churches are readily accessible.
- Churches are organized in fellowship groups and forums which make it easy to contact church leaders through their well-defined leadership structures.
- Churches in the Vhembe district are found in almost every village, including remote areas.
- Christian churches constitute the majority of churches in the Vhembe district.

Stage 2: Sampling of churches

Non-probability quota sampling was used to get a sample that was more representative of the population. Quota sampling identifies population strata and determines how many participants are needed from each stratum (Polit & Beck, 2014). Strata can guarantee the appropriate representation of different segments of the population. In this study, Christian churches are classified according to the three main locally understood classifications. The three classifications were adopted to enhance representativeness as reflected below:

- Pentecostal/Charismatic,
- Non–Pentecostal, and
- Zion.

In this study, the sample was distributed in proportion to the size of the stratum in the sub-population. Then the participants were conveniently selected until the required number in the sub-population was reached.

Stage 3: Sampling of church leaders

Eligibility criteria was used in selecting the church leaders because it specify the characteristics that people in the population must possess in order to be included in the study (Polit & Beck 2014). To be included in the study, the criteria for inclusion and exclusion in the study was used. The sampling method considered the following criteria for inclusion in the study:

- A church leader who is in leadership for at least a period of not less than six months,

© University of Venda

- A church leader from a Christian church, and
- A church leader who is able to read and write.

Church leaders who met the criteria for inclusion in the study and have consented to participate in the study were included in the sample.

Exclusion criteria were all church leaders who are in leadership for less than six months because they may not be fully exposed to leadership roles; church leaders from Islam, Hindus and other minority religions that are not part of Christianity as the study is focused on Christian churches only and those leaders who cannot read and write as they have to respond to a written questionnaire alone in order for the researcher to can obtain reliable information.

3.4.2.2. Sample size

According to the Vhembe District Municipality data base for churches, the total number of churches registered are 1824, with 1140 Pentecostal/Charismatic Churches, 422 Non-Pentecostal Churches and 262 Zion Churches. Quantitative data from large samples are often strong in generalizability, precision and control over extraneous variables (Polit & Beck, 2014). In this study, guidelines for sampling were adopted as reflected in De Vos et al. (2011). Table 3.1 represents the sample size of church leaders from each church stratum.

Table: 3.1 sampling stratum

Strata	**Population**	**Quota Sample (14% of population)**
Pentecostal/Charismatic	1140 (63%)	159 (63%)
Non-Pentecostal	422 (23%)	59 (23%)
Zion	262 (14%)	37 (14%)
Total	**1824 (100%)**	**255 (100%)**

© University of Venda

University of Venda
Creating Future Leaders

3.4.3. Pre-testing of the data collection instrument

A pre-test of an instrument is a trial run for detecting inadequacies and unforeseen problems before going to the expense of a full scale study (Burns & Grove, 2009). According to Polit and Hungler (2004), a pretest is done with individuals who have similar characteristics to those who are used in the study.

In this study, a pre-test was done to refine the data collection instrument, whereby the researcher had the opportunity to check the questionnaire for clarity of questions making sure that no offensive language is used, effectiveness of instructions, completeness of the response set, and the time to complete the questionnaires (Brink et al., 2012). Spaces were provided on the questionnaires for comments. The instrument was pre-tested by requesting pastors from Christian churches in the Mopani district municipality, which was not part of the main study sample but has similar characteristics as the respondents from the main study sample.

A pre-test allowed the researcher to identify questionnaire items that tended to be misunderstood by the respondents and hence failed to yield the information that is needed. In this study, a total of 18 respondents was used, six from each church stratum. The decision to use eighteen participants for pre-testing was informed by the number suggested by Sheatsley (1983) who said that pilot tests can be conducted with a minimum of six (6) to a maximum of one hundred (100) participants. Based on the pre-test and feedback of the respondents, the researcher modified data collection instruments to ensure the feasibility, validity, and reliability of the study (Grove et al., 2013). The rationale for doing a pre-test was to verify the level of inclusivity and acceptability of the questionnaire before carrying out the main study.

3.4.4. Data collection

In quantitative research, data collection involves obtaining numerical data to address the research objectives and questions (Grove et al., 2013). During this phase, data was collected through self-administered questionnaires. Self-administered questionnaires

© University of Venda

University of Venda
Creating Future Leaders

were used because they allow respondents to complete the instrument themselves. According to Brink et al. (2012), questionnaires are a quick way of obtaining data from a large group of people; respondents feel a greater sense of anonymity and are more likely to provide honest answers. Since data was collected from many respondents, questionnaires enabled the researcher to collect enough data within a short space of time. Questionnaires are also some of the easiest research instruments for testing reliability and validity (Brink et al., 2012). The data was collected from a sample of 255 respondents. The researcher collected data from the respondents using structured questionnaires.

The questionnaire was six pages long, with thirty items to be responded to by respondents. Items were distributed in four different sections:
Section 1: Demographic information, (9 items),
Section 2: Church leaders' knowledge of HIV/AIDS, (11 items),
Section 3: Church leaders' attitudes concerning HIV/AIDS, (5 items), and
Section 4: Church leaders' practices towards people living with HIV/AIDS, (5 items).

Questions about demographic information covered the participants' age, gender, marital status, race, nationality, home language, educational qualification, denominational affiliation and position of leadership in the church. Section 2 contained questions designed to check the level of church leaders' knowledge on causes of HIV/AIDS, modes of transmission and sources of information regarding the knowledge they have.

Section 3 contained questions that were designed to elicit information about the respondents' attitude towards HIV/AIDS as a disease and attitudes towards people who are infected with HIV, as well as those suffering from AIDS. The researcher also wished to determine perceptions of risk of getting HIV/AIDS amongst church leaders from different denominational backgrounds. Section 4 included questions to determine church leaders' involvement in HIV/AIDS activities, for how long have they been involved and to assess the impact of their involvement. A complete questionnaire is included as annexure 3A. In each question, a series of responses were given, from which the respondents were allowed to choose. The questions that were formulated were guided by the study

© University of Venda

University of Venda
Creating Future Leaders

objectives as well as the questions of the study. The literature relevant to the study, as well as guidance from other questionnaires used in similar studies also provided valuable insight to the researcher. In this study, questionnaires were distributed in the following ways: Zion leaders were from the Thulamela and Makhado municipalities, Non-Pentecostal church leaders were from the Musina and Thulamela municipalities, while Pentecostals were from all four municipalities, as they are the majority in all municipalities. Questionnaires were divided accordingly within the respective municipalities in the Vhembe District as indicated above. Questionnaires were delivered personally to all the church leaders of the participating churches by the researcher.

Arrangements to meet church leaders were done through their main leaders (pastors' forum and networks' leaderships). The majority of the questionnaires were distributed to leaders during their normal scheduled meetings, such as conferences, seminars, interdenominational gatherings, forums and fellowship gatherings. Individual leader was given an anonymous self-administered questionnaire in an envelope to complete on their own in the presence of the researcher. All completed questionnaires were sealed in the provided envelopes for confidentiality and then handed over to the researcher. Completed questionnaires were collected and kept in a locked steel cabinet by the researcher. Data collection process took six months starting from July to December 2016 as the researcher was targeting main scheduled meetings for church leaders according to their programmes.

3.4.5. Data analysis

Data analysis is the systematic organization and synthesis of the collected data (Creswell et al., 2007). Quantitative data was analyzed by using the computerized Statistical Package for the Social Science (SPSS) Programme version 23.0. A statistician from the Department of Statistics at the University of Venda analyzed the data. Descriptive statistics were used to obtain frequency distribution. The relationships between variables were identified using Pearson's chi-square and Cross tabulations. Numbers, tables and graphs were used to help the researcher in describing, explaining, and exploring data.

© University of Venda

3.4.6. Reliability and Validity

Reliability and validity demonstrate the effectiveness of measurements.

3.4.6.1. Reliability

Reliability refers to the degree to which the instrument can be depended upon to yield consistent results if used over time on the same person, or if used by two researchers (Brink et al., 2012). Polit and Beck (2014) define reliability as the degree of consistency or dependability with which an instrument measures the attribute it is designed to measure. The following steps were taken to enhance reliability of this study:

- As time could affect the stability of a measure, data collection was over a short period of three months and responses were examined for similarities.
- The respondents were also requested not to confer with each other. Brink et al. (2012) termed this method 'test-retest'.
- To ensure internal consistency, the researcher used items adapted from previous researches on HIV and AIDS amongst the faith healers in the Vhembe District of the Limpopo Province.
- A pre-test was conducted with 18 respondents who have similar characteristics to the study sample but were not part of the actual study, to determine the clarity of items and consistency of the responses; to help the researcher to ascertain whether the instrument would yield the same results.

3.4.6.2. Validity

Brink et al. (2012) defines validity as the degree to which an instrument measures what it is intended to measure. Validity testing affirms the appropriateness of an instrument for a specific group or purpose rather than the instrument itself (Grove et al., 2013). The following criteria were considered in the construction of the instrument in order to standardize the evaluation:

- The questions were formulated as simple as possible to reduce any ambiguities.

© University of Venda

University of Venda
Creating Future Leaders

- Instructions to the respondents were as clear as possible.
- Sufficient time was allowed for respondents to complete the questionnaires.

After the construction of the research instrument, it was submitted to the following persons for correction and constructive criticism:

- The supervisors of this study at the Department of Advanced Nursing Science at the University of Venda,
- HIV and AIDS component in the Limpopo province, and
- A statistician at the Department of Statistics at the University of Venda.

3.5. Qualitative research design

The research design for this phase was qualitative, explorative, descriptive and contextual in nature because it attempts to describe human experiences as provided by people involved (Brink et al., 2012). Qualitative research refers to inductive, holistic, emic, subjective and process–oriented methods used to understand, interpret, describe and develop a theory on a phenomena or setting. It is a systematic, subjective approach used to describe life experiences and give them meaning (Grove et al., 2013). Qualitative research is associated with words, language and experiences rather than measurements, statistics and numerical figures. Qualitative research involves the systematic collection and analysis of subjective data provided by participants about the phenomena, including how they interpret the experiences and the meaning attached to the experiences (Brink et al., 2012; Creswell, 2014).

General characteristics of qualitative research design as described by Polit and Beck (2014) are as follows, it

- Often involves a merging together of various data collecting strategies (i.e. triangulation),
- Is flexible and elastic, capable of adjusting to what is being learned during the course of data collection,

© University of Venda

- Tends to be holistic, striving for an understanding of the whole,
- Requires researchers to become intensely involved, often remaining in the field for lengthy periods of time, and
- Requires ongoing analysis of the data to formulate strategies and to determine when fieldwork is done.

This design was preferred because it studies people in terms of their own definitions of the world. In the case of this study the emic perspective of church leaders. The study focused on the subjective experiences of individual church leaders regarding current HIV/AIDS training programme and it is sensitive to the context in which people interact with each other. This design allowed the researcher to explore the experiences of the church leaders in their natural setting. The researcher therefore becomes involved and immersed in the phenomenon to become familiar with it. The immersion of the researcher helps to provide dense descriptions from the narrative data gathered from the participants and to interpret and portray their experiences. However, immersion cannot be obtained without a researcher-participant trusting relationship. The relationship was built through basic interviewing and interpersonal skills.

Exploratory research design

Exploratory research begins with phenomena of interest; but rather than simply observing and describing it, exploratory research investigates the full nature of the phenomenon and other factors to which it is related (Polit & Beck, 2014). According to Grove et al. (2013), explorative studies examine relatively unknown phenomena in order to gain new insights and to understand the phenomena with the aim of determining priorities for further research. The challenge with this method is the preconceived ideas which the researcher might have. This study was concerned with exploring the experiences of church leaders regarding existing HIV/AIDS training programme they have attended in the Limpopo Province. The exploratory design facilitated the researcher to gain insight and understanding to the experiences of church leaders with regard to the current HIV/AIDS training programme. Furthermore the researcher used this design to generate probing

© University of Venda

University of Venda
Creating Future Leaders

questions based on the responses of the participants after the central question was asked. The probing questions elicited data about the problems encountered during the HIV/AIDS training and challenges met; the success stories and topics that ought to be included in the adapted HIV/AIDS training programme as suggested by church leaders themselves.

Descriptive research design

Descriptive studies are a way of discovering new meaning, describing what exists, determining the frequency with which something occurs, and categorizing information (Grove et al., 2013). According to Polit and Hungler (2004), descriptive research refers to studies that have information as their main accurate portrayal of the characteristics of reasons, situations or groups. Pope and May (2006) refer to descriptive research as a non-experimental design that is used to observe and measure a variable when there is little conceptual background.

The researcher chose descriptive research because it summarizes the findings of the problem investigated as they exist without introducing changes (Polit & Beck, 2014). A descriptive study also focuses on the situation as it is, without manipulating variables. This focus might include conditions that exist, practices that prevail, beliefs and attitudes that are held on ongoing process and developing trends (Brink et al., 2012). The use of a descriptive design in the study was justified on the basis of the flexibility in promoting in-depth descriptions of the church leaders experience with regard to HIV and AIDS training programme they have attended. According to De Vos et al. (2011), descriptive studies are designed to enable the researcher to gain more information (thick description) about the characteristics within a particular field of study with purpose of providing a picture of the situation as it naturally occurs.

A qualitative descriptive design was used to gather data by giving the participants time to describe their experiences about the HIV/AIDS training programme they have attended. This design enabled the researcher to describe experiences of church leaders with

© University of Venda

University of Venda
Creating Future Leaders

regards to the current HIV/AIDS training programme and classify the phenomena under study. In-depth individual interviews were conducted in order to understand and generate information on how the church leaders feel about the current HIV/AIDS training programme as individuals. The design was aimed at capturing the experiences of the church leaders in their context in order to understand and interpret their present realities from their point of view. The descriptive part of the study was achieved by providing a detailed account of the context, activities and the processes that occurred during the HIV/AIDS training programme for church leaders in the Limpopo province.

Contextual research design

The study is contextual when the phenomenon is studied for its intrinsic and immediate contextual significance (Mouton, 2006). Contextual studies focus on specific events in a 'naturalistic setting' (Lobiondo-Wood & Haber, 2011). Context can include physical settings such as homes or churches or less concrete 'environments', such as the context cultural understandings and beliefs brought to an experience (Lobiondo-Wood & Haber, 2011). The contextual design in this study was to facilitate the understanding by the researcher of the events, which were part of the HIV/AIDS training programme for church leaders in Limpopo as described by the participants in their lived world. This study focused on the development of an adapted HIV/AIDS training programme for church leaders in their own context, without their situation having been manipulated. According to Babbie and Mouton (2010), it is important to conduct the study in the context of the participants to avoid separating participants to their context.

3.5.1. Research population

A population consists of individuals who fit the description of the research phenomenon and to whom the analysis and specific conclusions of the researcher would apply (Welma, Kruger & Mitchell, 2008). A population is sometimes referred to as the target population which is the entire set of individuals or elements that meet the criteria that the researcher is interested in studying (Burns & Grove, 2009).

© University of Venda

University of Venda
Creating Future Leaders

The population of this study comprised of all Church leaders in the Limpopo Province. The accessible population is the portion of the target population that is accessible to the researcher (Polit & Beck, 2014). The church leaders who participated in any of the existing HIV/AIDS training programmes in the province served as the accessible population of the study.

3.5.2. Sampling

Sampling refers to the process of selecting a portion of the population to participate in the study in order to obtain information regarding phenomena in a way that represents the interest of the population (Polit & Beck, 2014). Since it is generally impossible to study an entire population, it is therefore important that the group selected be representative of the population, and not biased in a systematic manner. Sampling designs are classified as either probability sampling or non-probability sampling (Polit & Beck, 2014).

During this qualitative phase, non-probability sampling was preferred, because elements are selected by non-random methods. A non-probability purposive sampling was preferred in this study because it involves the conscious selection by the researcher of certain subjects, elements, events or incidents to include in the study based on the belief that researcher's knowledge about population can be used to hand-pick sample members (Polit & Beck, 2014). The researcher might decide purposely to select subjects who are judged to be typical of the population or particularly knowledgeable about the issues under study (Polit & Beck, 2014). Four purposeful sampling techniques were used in this study: a typical case, convenience, criterion, and maximum variation sampling for small cases, as defined by Patton (Patton, 2002; Polit & Beck, 2014). Purposeful sampling allows the most to be learned from the sample selected about the issues that are central to the research.

UNIVERSITY OF VENDA
LIBRARY

© University of Venda

3.5.2.1. Sampling methods and procedure

Sampling in this phase was done in two stages. The first stage was sampling of churches and the second stage was sampling of leaders from the participating churches.

Stage 1: Sampling of churches

The maximum variation principle was adopted. It allows descriptions of major themes that cut across a number of categories of participants or program variations. In small samples, this can be done by identifying diverse characteristics or criteria for constructing a sample. A form of maximum variation sampling was used as described by Patton (Patton, 2002; Polit & Beck, 2014) for small samples. To obtain a maximum variation of sample, a liberal classification of churches was adopted as reflected below and as discussed in the definition. Three churches were a starting point, stratified as follows:

- Non-Pentecostal,
- Pentecostal /Charismatic, and
- Zion.

A typical case sampling was also used to select churches that illustrate or highlight what is typical or average (Polit & Beck, 2014). Only churches that have participated in the existing HIV/AIDS training programme were sampled for this phase in order to explore their experiences with regard to the training.

Stage 2: Sampling of church leaders

Criterion sampling and convenience sampling were used in selecting participants for interviews. Criterion sampling involves studying cases that meet a predetermined criterion of importance to the study (Polit & Beck, 2014). Church leaders who were sampled for in-depth interviews were those who have attended the current HIV/AIDS training programme so that they can relate their experiences with regard to the training they have attended. Church leaders who met the criteria for inclusion in the study were then conveniently

© University of Venda

University of Venda
Creating Future Leaders

sampled until data saturation was reached. Church leaders who were most readily available to participate in the study were interviewed.

3.5.2. Sample size

Sample size refers to the number of participants needed in the study (Polit & Beck, 2014). Patton, in De Vos et al. (2011), says that there are no rules for sample size in qualitative inquiry. In qualitative research, sample size is determined by data saturation. Data saturation is sampling to the point at which no new information is obtained and redundancy is achieved (Grove et al., 2013).

Eight church leaders from different churches who have attended the current HIV/AIDS training programme were interviewed. The size of the sample was considered satisfactory when data saturation was reached as demonstrated by repetition of themes.

3.5.3. Pilot interviews

Barker, in De Vos et al. (2011) defines a pilot study as a procedure for testing and validating an instrument by administering it on a small group of participants from the intended test population. Those who participate in the pilot study should not participate in the main inquiry (Unrau, Gabor & Grinnell, 2007). In qualitative research the pilot study is usually informal, and a few respondents possessing the same characteristics as those of the main investigation can be involved in the study (De Vos et al., 2011). The researcher conducted three pilot in-depth individual interviews with one church leader from Zion, Pentecostal/charismatic and Non Pentecostal churches in order to detect whether the data collection methods and the central question needed to be modified. Three participants were asked one central question, followed by probing questions based on the responses they gave in relation to the central question asked. The pilot interviews revealed that the data collection method and the central question were appropriate.

© University of Venda

University of Venda
Creating Future Leaders

3.5.4 Data collection

Data collection is the process of collecting information from the participants which is needed to address the research problem (Creswell, 2009). After the ethical clearance and permission to conduct the study was obtained, the in-depth individual interview was used to collect data during this phase. Data was collected from July to December 2016 concurrently with quantitative data. This period gave the researcher enough time to engage with the participants.

In-depth individual interviews

In-depth individual interviews were used in this study to explore and obtain information leading to the development of an adapted HIV/AIDS training programme for Christian churches to enhance their interventions. In-depth interviews helped the researcher to get the opportunity to clarify some concepts; to get meaning of some statements in relation to the church leaders' experiences regarding current HIV/AIDS training programmes. Furthermore, the researcher asked some participants to elaborate some statements in order to get clarity and avoid misunderstandings (Henning et al., 2004). This type of interview process has two potential strengths. One is the hope that participants are more likely to reveal themselves, providing unfiltered personal views of their experiences. Secondly, it has the potential to provide rich, highly specific perspectives of participants' experiences, perceptions and or attitudes (Stommel & Wills, 2004). The in-depth interview is a flexible interview procedure. The length of the interviews can vary substantially because of participants' personalities which might differ, in influencing their willingness to communicate their experiences, attitudes, perceptions and feelings.

In this study interviews lasted for 45 minutes to 60 minutes per participant. The purpose of interviewing was to allow the researcher to get more in-depth information on beliefs, practices and attitudes that could not be obtained through any other data gathering procedure (Brink et al., 2012). An in-depth interview is near the heart of qualitative inquiry because it allows the participant to use their own language to fully describe their

© University of Venda

University of Venda
Creating Future Leaders

experiences. The process of an in-depth interview is therefore non-restrictive and participants have control of the interview agenda and how they relate their experiences. The participant answers in whatever way he/she wants, the researcher then tries to gain understanding of the emotions and behaviours of the participants as they tell about their experiences. The leading question for the participants during data collection was: "**What are your experiences regarding current HIV/AIDS training programme for church leaders in the Limpopo Province?"** Subsequent questions followed, as the researcher continued to probe. Interviews were conducted in a quiet place in the churches and some at participant's homes as arranged. The dates for in-depth individual interview sessions were scheduled with the participants based on the dates and times which did not interfere with their work schedule. Most interviews were conducted late in the afternoon between 16:00 and 18:00 to avoid interference with their work schedule.

Eight individual in-depth interviews were conducted. Eight church leaders from eight different churches who have attended the current HIV/AIDS training programme were interviewed. Maximum variation sample of churches was considered when participants were interviewed. Amongst the eight, four were Pentecostals, two non-Pentecostals and two Zionists. Amongst the participants, two were qualified professional nurses who worked for the government in the past but resigned to become full time pastors in the church. The other participants were three senior pastors; one Dean and two Bishops. In this study, the researcher aimed at gathering a rich, deep description of what the research participants' experienced from their perspective. The central question was posed to each participant in the same manner. The communication techniques that were used throughout the interview to encourage the participants to continue talking are explained below.

Paraphrasing

Paraphrasing involves a verbal response in which the researcher enhanced meaning by stating the participant's words in another form with the same meaning (De Vos et al., 2011). The researcher paraphrased clearly and concisely what has been said with the

© University of Venda

aim of conveying to the participants that he is with them and that he understands what they were explaining. On the other hand, the researcher checked his own perceptions to make sure that he really understands what the participants were describing.

Reflective Summary

Reflective summary involves summarizing the participant's ideas, thoughts and feelings verbalized so far to see if you really understand what the participant was saying. The reflective summary has a structuring function and stimulates the participant to give more information (De Vos et al., 2011).The researcher then summarized the responses to condense and crystallize the essence of the participants' statements.

Probing

According to De Vos et al. (2011), when responses lack sufficient detail, depth or clarity, the interviewer puts out a probe to complete or clarify the answer, or to request further examples and evidence. The purpose of probing is to deepen the response to a question, to increase the richness of the data being obtained, and to give clues to the participant about the level of response that is desired. It is a technique to persuade the participant to give more information about the issue under discussion.

The researcher applied probing methods throughout, probing questions were also asked during the interview in order to get more information from the participants and listened carefully to the participants' messages and responded to the meaning behind these messages accurately (Rubin & Rubin, 2005). The researcher also requested more information from the participants during the interview by making vague comments that could have multiple meanings.

© University of Venda

researcher as an instrument for data collection engaged himself in an open description by seeing, listening and bracketing in order to avoid bias and being judgmental.

Bracketing

Bracketing is a technique used in qualitative research when the researcher put aside what is known about the research phenomenon, to allow the data to covey undistorted information as described by the participants themselves (Brink et al., 2012). Polit and Beck (2014), added that bracketing is a process when the researcher suspends; and or put aside beliefs, opinions and what was known about the phenomenon being studied. In this study the researcher had to identify and write down her own beliefs, assumptions, biases, descriptions of his own perceptions, and what was known about the topic before beginning the interview sessions with the purpose of bracketing these factors during interview sessions. During data collection, the technique enabled the researcher to deal with own preconceived ideas by bracketing out himself and by examining his own prejudgment in order to obtain new information of the research phenomenon based on descriptions of the participants.

Voice recording

A voice-recorder was used to record narrative information during all the interview sessions which was transcribed verbatim. The researcher prepared the voice recorder by creating a new file which indicated the number of interview session. No participant names were used in naming the files, to protect their identity and to maintain confidentiality. After recording each interview session, back-up copies were created by transferring the voice recordings to the researcher's lap top computer and compact disk. The voice recordings were made available to the research promoters by creating a controlled copy on a disk.

© University of Venda

Field notes

Field notes are written in the field (or research environment), and they are temporary key words, cues or drawings that help trigger the memory of the researcher of what was happening during data collection. It is a system for remembering, retrieving and analyzing observations (Neuman, 2004). The researcher took notes of observations that cannot be picked up by an audio-tape recorder on a notepad in the presence of participants after explaining the purpose to them. Observations, key words and non-verbal cues were recorded and used as the basis for analysis (De Vos et al., 2011). It was important to take field notes to make sure that no information was lost.

3.5.5. Data analysis

Qualitative analysis is the non-numerical examination and interpretation of observations, for the purpose of discovering underlying meanings and patterns of relationships (Babbie, 2015). It is not a linear process, nor do all qualitative forms of inquiry take the same approach to data analysis (Holloway & Wheeler, 2002). Data analysis in qualitative research actually begins when data collection begins (Streubert et al., 2003). Brinks et al. (2012), describe this type of analysis as a 'hands on process' during which the researcher becomes deeply immersed in the data; it is also sometimes referred to as 'dwelling' with the data. Collected data in this study includes transcripts from tape recordings of interviews and field notes. Once the researcher left the field, the textual data (in the form of field notes or transcripts) were subjected to content analysis.

Data analysis process

In this study, data was analyzed using Tech's steps of open coding (Creswell, 2014). In open coding, data are broken into parts and compared for similarities and differences (Polit & Beck, 2014). Data collected through in-depth interview was broken down into discrete parts, closely examined, compared for similarities and differences reflected in the

© University of Venda

data. Themes and sub-themes were developed. The following eight steps, as described by Creswell (2014), were followed during data analysis.

Step 1: Getting a sense of the whole

Step 1 involved organizing and preparing data where in data is sorted and arranged into different types. The researcher read through all of the transcriptions several times carefully in order to understand the information provided by participants. The researcher immersed himself in details trying to get a sense of the interview as a whole before breaking it down into parts. Some ideas were jotted down as they came to the researcher's mind.

Step 2: Picking one document

The researcher picked up the most interesting, shortest interview and read through it, analyzing its underlying meaning. Thoughts that came to mind were written in the margin.

Step 3: Making a list of all topics

Step 3 involved organizing the text data or pictures gathered during data collection into categories which were labeled with a term based in the actual language of the participants. After reading several interview documents from participants, the researcher made a list of all topics derived from the interview reports. Similar topics were clustered together, and formed in columns that were arranged as major topics, unique topics and left-overs.

Step 4: Involves the coding process

The researcher took a list of the topics, and went back to the data, abbreviated topics as codes and then the codes were written next to the appropriate segments of the text. The researcher then observed the organization of data to check if new categories or codes emerged.

© University of Venda

Step 5: Turn topics into categories

Topics derived from the interview that relate to each other were grouped together, then the researcher classified the qualitative information by looking for categories, themes or dimensions of information. General themes and sub-themes were identified. The researcher drew columns between categories to show how they are interrelated. The categories were abbreviated into codes that were then written next to the appropriate segments of the text. The researcher tested this preliminary organizing scheme to establish whether new themes and codes were emerging.

Step 6: Making a final decision

The researcher made a final decision on the abbreviation of each category and the codes were arranged alphabetically so that they could be easily identified. Themes were made by assembling data material belonging to each category.

Step 7: Preliminary analysis

The data material belonging to each theme was assembled in one place and a preliminary analysis was performed.

Step 8: Re-coding

Re-coding of the existing data was done as the researcher found it necessary during the process of analysis. The researcher was able to generate themes, and sub-themes from collected data. The promoter was used to verify and approve the emerging themes and sub-themes. Two major themes were finally developed with sub-themes as a result of a consensus discussion with the promoter. The promoter was used as the inclusion of external view to give process credibility.

Literature control

According to Grove et al. (2013), the researcher conducts a literature control after the collection of data and analysis to prevent information in the literature from influencing his objectivity in qualitative research. According to Creswell (2014), in qualitative research,

© University of Venda

University of Venda
Creating Future Leaders

literature is used inductively towards the end of the study to help substantiate the research problem, but it does not constrain the views of participants. The literature control was conducted after the data analysis had been finalized to embed and re-contextualize the results in existing primary and secondary literature. A literature control is presented in chapter 4 during the discussion of results.

3.5.6. Measures to ensure trustworthiness

Trustworthiness refers to establishing validity and reliability of qualitative research. Polit and Beck (2014), refer to trustworthiness as the degree of confidence qualitative researchers have in their data and analyses, assessed using the criteria of credibility, transferability, dependability, confirmability, and authenticity. Qualitative research is trustworthy when it accurately represents the experience of study participants (Streubert et al., 2003). According to Denzin and Lincoln (2008), trustworthiness endeavor to establish confidence in the truth of the findings and determines the degree to which the findings or equity may have applicability in other contexts, as well as whether the findings would be consistently repeated on replication of research in similar contexts. Polit and Beck (2014), and De Vos et al. (2011), adopted the four criteria developed by Lincoln and Guba (1985), to measure trustworthiness of data which are as follows:

3.5.6.1. Credibility

This is the alternative to internal validity in which the goal is to demonstrate that the inquiry was conducted in such a manner as to ensure that the subject was accurately identified and described (De Vos et al., 2011). Credibility is demonstrated when participants recognize the reported research findings as their own experiences (Streubert et al., 2003). It is the truth of how the participants know and experience the phenomenon (Talbot, 1995). To ensure credibility the researcher must make sure that those participants are identified and described accurately (Holloway, 2005). Activities increasing the probability that credible findings will be produced are: prolonged engagement and persistent observation in the field; peer debriefing; and member checks.

© University of Venda

In this study credibility was established through prolonged engagement, persistent observation, reflexivity; member checking procedures that allow participants to check and verify the accuracy of the information recorded; and peer debriefing that enable the research facilitators to articulate and reflect on research procedures with a colleague.

Prolonged engagement

Prolonged engagement refers to investment of sufficient time in the data collection activities to achieve certain purposes: learning the 'culture'; testing for misinformation introduced by distortions either of the self or of the participants; and building trust (Denzin & Lincoln, 2008). Prolonged engagement also requires that the investigator must be involved with a site long enough to detect and take into account distortions that might otherwise creep into the data (Creswell, 2014). The investigator must first deal with personal distortions. The mere factor of being "a stranger in a strange land" draws undue attention to the inquirer, with its attended overreaction (Denzin & Lincoln, 2008).
The researcher of this study is a nurse who has vast experience in serving the church as a church leader for many years and he is not a stranger to the majority of church leaders in Limpopo province. The researcher's qualifications, trainings received in HIV and AIDS and community/ home-based care (CHBC), and the experiences gained were very important in establishing confidence in the data that was obtained. Adequate time was set aside to spend with the participants during data collection period of six months in order to build a trusting relationship.

Persistent observation

The purpose of persistent observation is to identify those characteristics and elements in the situation that are most relevant to the problem or issue being pursued and to focus on them in detail. Focusing on the issues also implies sorting out irrelevancies – the things that do not count (Denzin & Lincoln, 2008).

© University of Venda

To satisfy this criterion of trustworthiness, persistent observation was done on the participants in their natural environment, in other words, data were collected from church leaders home and from the places where churches gather. Conversations which were in-depth were only those that were relevant to the phenomenon being studied. The researcher visited participants at least three times and spent about 45 minutes to an hour each time.

Reflexivity

The researcher is part of, and not divorced from the phenomenon under study and, in the study, was constantly taking the position of a main research tool. The researcher explored personal feelings and experiences that might influence the study and integrated this understanding into the study to promote objectivity (Burns & Grove, 2009; Polit & Beck, 2014). The analysis of the researcher's experience made the researcher aware of possible biases and preconceived ideas. Bracketing was implemented throughout the study and each phase of the research was carefully approached using bracketing (to lay aside what is known) and intuiting (looking at the phenomenon) to avoid bias and approach the phenomenon with an open mind.

Peer debriefing

In qualitative research, peer debriefing refers to discussion of the researcher`s interpretations and conclusions with another person not directly involved (Burns and Grove, 2009). Peer debriefing exposes a researcher to the searching questions of others who are experienced in the methods of enquiry, the phenomenon or both (Polit & Beck, 2014). In this study, the research work was reviewed by experts and colleague who have experience and knowledge of qualitative research and of the phenomenon being studied namely HIV and AIDS. These experts reviewed and explored various aspects of the inquiry. The experts and colleague critically looked at the degree to which the study variables adequately represented the phenomenon being studied. Feedback was given after debriefing session and issues that needed attention were clarified.

© University of Venda

Member checks

Member checking is also one of the most important techniques for establishing the credibility of qualitative data. It entails providing feedback to the study participants regarding the data and the researcher's emerging findings and interpretations in order to secure participants` reaction (Polit & Beck, 2014). In this research, in order to be sure that participants` reality had been presented, the researcher continually asked participants for clarification on what they had said. By doing this, participants were provided with an opportunity to change information which was given by mistake and at the same time assessed the researcher's understanding and interpretation of the data. At the end of the interview, the participants were given a summary of what they had said and an interpretation of the interview to check on the researcher's accuracy and understanding of the information. When the study was concluded the final report was taken back to the participants to confirm the results.

According to Creswell (2014), member checking involves conducting a follow-up interview with participants in the study and providing an opportunity for them to comment on the findings. In this study member checking was also done with the participants to assess data, interpretations and conclusions for correction of errors. Participants were given the opportunity to summarise the data.

3.5.6.2. Transferability

Lincoln and Guba, in De Vos et al. (2011) view this as the alternative to external validity or generalizability in which the burden of demonstrating the applicability of one set of findings to another context rests more with the investigator who would make the transfer, than with the original investigator. Transferability refers to the degree to which the results of qualitative research can be generalized or transferred to other contexts or settings (Burns & Grove, 2009). Generality and applicability is irrelevant in qualitative research because the researcher want to describe the particular phenomenon.

© University of Venda

The researcher had the responsibility to provide adequate descriptive data in the research report in order for people to evaluate the applicability of the data to other settings or groups. When transferability is considered, the participants should be representative (Polit & Beck, 2014; Creswell, 2014). In this study researcher presents the findings with a rich, dense description of the research phenomenon in chapter 4 and a thick description of the research methodology was detailed in this chapter. The study findings were not generalised to all church leaders including the Muslims, in the Limpopo province, but were limited to church leaders from Christian churches only. In this study, a purposive sampling was used so that participants were suitable and representative of the group under study. These participants provided rich data on the phenomenon under study.

3.5.6.3. Dependability

This is an alternative to reliability in which the researcher attempts to account for changing conditions in the phenomenon chosen for study as well as changes in the design created by increasingly refined understanding of the setting (De Vos et al., 2011). According to Streubert et al. (2003), dependability can be met once researchers have demonstrated the credibility of the findings. In other words, there can be no dependability without credibility as there can be no validity without reliability. In this study, the findings of the research were checked and audited by external checks in order to be dependable. Two more techniques are Guba's stepwise replication and inquiry audit. Stepwise replication is a process that builds on the classic notion of replication as a means of establishing reliability (Denzin & Lincoln, 2008). In this study the data and analysis were then checked for comparability and similarity, and discrepancies resolved through member checking with the participants.

The inquiry auditor examines the product which is the data, findings, interpretations, and recommendations and attests that it is supported by data and is internally coherent so that the bottom line may be accepted. The process establishes the conformability and dependability of an inquiry. Thus, a single audit is used to determine dependability and conformability simultaneously (Denzin & Lincoln, 2008).

© University of Venda

The supervisors of this study were responsible for examining the data, interpretations and recommendations in order to attest that they are supported by data. The researcher has also done peer debriefing with other research colleagues in the work place. The transcripts from tape recordings of interviews and field notes were also sent to an independent coder, who is a qualitative research expert to ensure confidence in the truth of data and interpretation. In this study, all these activities were establishing the dependability of the study.

3.5.6.4. Confirmability

Confirmability is a criterion for evaluating data quality and refers to neutrality or objectivity of the data by an agreement between two or more independent persons that the data is similar (Polit & Beck, 2014). In qualitative research, neutrality refers to data neutrality and not the researcher's neutrality. Confirmability is a neutral criterion for measuring the trustworthiness of the qualitative research. If a study demonstrates credibility and fittingness, the study is also said to possess confirmability (Denzin & Lincoln, 2008; Streubert et al., 2003). In qualitative research, the issue of confirmability does not focus on characteristics of the researcher but rather on characteristics of the data. Inquiry audits can be used to establish both dependability and confirmability of the data.

Holloway and Wheeler (2002) suggest that the following auditing criteria be utilised for examining the information of the study:

- The raw data; namely, tape recording and field notes,
- Findings of the study through analysed data,
- How the significant statements, themes, codes and categories were reconstructed,
- The research process, designs and procedure used,
- Early intentions of the study, for instance proposal and expectations, and
- The development of the data collection instruments, for instance open-ended questions and early interviews.

Confirmability occurs in the presence of credibility, transferability and dependability (Holloway & Wheeler, 2002).

© University of Venda

In this study, reflexivity assisted the researcher to be free of bias in processing the data. The findings of this study were the product of the inquiry and not the researcher's biases. This was done by making sure that information was audio taped and transcribed and therefore this minimized researcher bias and it also ensured that data can be confirmed. Research process, research design, sampling design and data collection process were carefully planned. The researcher made sure that the conclusions of the study's findings are supported by the analysed data. In qualitative research, objectivity or neutrality of the data, which brings an agreement between two or more independent people about the data's relevance or meaning, is necessary (Polit & Hungler, 2004).

3.5.6.5. Authenticity

Polit and Beck (2014), also included authenticity as a criterion for trustworthiness. Authenticity refers to the extent to which researchers fairly and faithfully show a range of different realities (Polit & Beck, 2014). Tobin and Begley (2004), indicated three forms of authenticity which are: ontological, educative and tactical authenticity. Authenticity emerges in a report when it conveys the feeling tone of participants' lives as they are lived. In this study, ontological authenticity was achieved by the researcher who demonstrated realities which depicted the concerns, issues, underlying knowledge, skills, and attitudes which the church leaders experienced during their HIV/AIDS training sessions. The developed HIV/AIDS training programme aimed at getting church leaders to appreciate the point of view and construction of the agent during the implementation to achieve educative authenticity. The developed training programme aimed at empowering church leaders with information to enhance their competency during their involvement in the fight against HIV/AIDS in the church and community. This approach ensures the tactical authenticity of this study.

3.6. Ethical considerations

Ethics is regarded as a system of moral values to ensure that the research procedures adhere to professional, legal and social obligations of the study participants while

© University of Venda

protecting their rights, balancing the benefits and risk in the study by obtaining informed consent and submitting a research proposal for institutional review (Burns & Grove, 2009; Polit & Beck, 2014). The following major guiding ethical principles were observed when conducting this study:

Permission to conduct the study

Permission to conduct this study was sought from the University Higher Degree Committee as well as the Ethics committee of the University of Venda. The ethical clearance (SHS/16/PDC/08/2904) was then obtained before the study was conducted and a copy of the ethical clearance certificate is annexed (annexure 5). Further approval was granted from the leadership of churches in the Limpopo Province (annexure 1B) and from participants through an informed consent form.

Informed consent

Informed consent means that participants have adequate information about the study, comprehend the information, and have the power of free choice, enabling them to consent to or decline participation voluntarily (Polit & Beck, 2014). Participants were given full information about the study procedures using the language that they understand (annexure 1 A) and consent forms (annexure1B) were provided to those who were willing to participate for signing. Participants were made aware that they have a right to withdraw from the study at any time and was given assurance that participation is voluntary. Permission to use a voice recorder was requested from each participant before qualitative data collection sessions. The consent form for recording (annexure 2C) was then provided for signing. The researcher considered the participants' comprehension when explaining.

© University of Venda

University of Venda
Creating Future Leaders

The right to self-determination

The principle of self-determination means that prospective participants have the right to decide voluntarily whether to participate in the study, without risking penalty or prejudicial treatment (Polit & Beck, 2014). Slowther et al. (2006) included avoidance of coercion during the process of obtaining informed consent; and the way in which the participants were identified, approached and recruited. Participants in this study were told from the beginning that participation in the study was voluntary without any element of force, fraud, deceit, duress or other form of constraint or coercion and that they have the right to withdraw from the study at any time without fear of being victimized (LoBiondo-Wood & Haber, 2011).

Right to anonymity and confidentiality

Confidentiality involves the non-disclosure of the information that was discussed by the participant and the researcher. A promise of confidentiality is a pledge that any information participants provide will not be publicly reported in a manner that identifies them and will not be made accessible to others (Polit & Beck, 2014). Anonymity is the most secure means of protecting confidentiality. According to De Vos et al. (2011), anonymity means that no one, including researcher, should be able to identify any subject afterwards. The researcher cannot link participants to their data.

In this study all the questionnaires used during quantitative phase to collect data were returned without the names of the respondents as it was explained to them not to write their names. The signed informed consent forms were kept in a separate box before the administration of questionnaires and were finally kept in a safe locked place to ensure confidentiality. Those who participated in an unstructured interview, were assured that their names will not be used in the study. The information provided by participants was not linked with their names and that raw data was limited to the promoters only for the purpose of analysis and report writing (Burns & Grove, 2009). The use of a voice-recorder was agreed by participants and they were also informed that the recordings will only be

© University of Venda

made available to the researcher, the research promoters and the independent coder. The list of people who participated was kept confidential by the researcher. A list was compiled using coding system that allocates a code to each participant's transcripts. Participants were informed that they would be allocated numbers and their real names would not be used. No participants' names were used in naming the files containing voice recordings of all the interview sessions, and for the sake of confidentiality the participants' names were not mentioned during recordings. The voice recorder was kept safe by the researcher until completion of the report.

The right to privacy and dignity

The rights of the participants to privacy and dignity were respected throughout this study. Participants were interviewed in a private quite place some at their homes and others at their church's offices. Participants' private information was not shared without the participant's knowledge or will. Participants were informed that cassettes used will be destroyed after the results have been published.

Freedom from exploitation

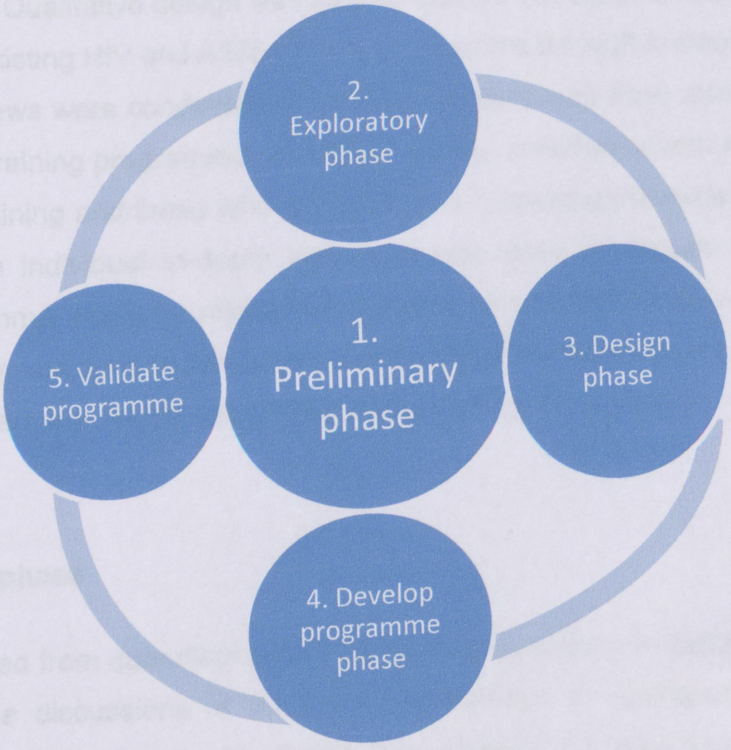
The researcher protected participants from psychological, social harm and exploitation by carefully considering the phrasing of questions. Participants were informed that if they are unable to proceed with the interview due to emotional strain, the interviews will be stopped immediately and counselling will be provided. Participants were assured that the information they will provide will not be used against them (LoBiondo-Wood & Haber, 2011). The researcher recognized and appreciated the local culture and traditions when interacting with the participants, the use of local language was also respected and they were informed that there are no financial or rewards of any form for participating in this study.

© University of Venda

3.7. PHASE 2: Development of the training programme

After data have been analyzed the training needs for church leaders were identified. The programme development was a process. The curriculum development 6- step process structure of Meyer and Van Niekerk (2008) was adapted to a 5-step process development in this study to develop the programme.

Figure3.1: Phases of programme development process structure by Meyer and Van Niekerk (2008).



3.7.1. Preliminary phase

This phase was covered during literature review on knowledge, attitudes and practices of church leaders regarding HIV and AIDS in chapter 2.

© University of Venda

University of Venda
Creating Future Leaders

3.7.2. Exploratory phase

This phase was covered when carrying out a situational analysis during phase one of the study. A convergent parallel mixed method was used to explore the situation. Both quantitative and qualitative designs were used concurrently to analyze the situation in order to develop the adapted training programme. Quantitative design was used to assess knowledge, attitudes & practices of church leaders regarding HIV/AIDS using questionnaires. Qualitative design was used to explore the experiences of church leaders regarding the existing HIV and AIDS training programme through in-depth interviews. The in-depth interviews were conducted with church leaders who have attended the existing HIV and AIDS training programme, while KAP survey included church leaders who have attended the training and those who did not attend. Exploring the experiences of church leaders through individual in-depth interviews was done to ensure that the adapted training programme would be relevant and appropriate to the needs of church leaders. The KAP survey was done to can have an overview of the situation in general, as to also be able to determine which information was lacking for inclusion in the developed programme.

3.7.3. Design phase

The data obtained from quantitative KAP survey and qualitative in depth interviews were compared in the discussions of themes for similarities or discrepancies in order to integrate the results from both sets of data. New insights that were specific to the needs of the church leaders were identified for inclusion in the adapted HIV/AIDS training programme. The approach to design the training was also based on inductive reasoning, data was obtained from the exploration of the views of the church leaders who attended the existing HIV/AIDS training programme. Using qualitative analysis allowed the researcher to dissect the church leaders' views into themes and sub-themes that can be better understood (Walker and Avant, 2005). Literature control during discussion of themes operationalized the inductive processes needed for the training programme.

© University of Venda

Furthermore, the findings of the study informed the development of a reasoning map based on the practice Oriented Theory of Dickoff et al. (1968) and Malcolm Knowles' Adult Learning Theory (Knowles, Holton and Swanson, 2012). Elements of the Dickoff practice oriented theory were adapted as the reasoning map that formed the conceptual framework for designing the developed programme. The survey list questions were used as the reasoning map to identify the practical activities that should be performed. The following questions are answered in chapter 5:

- Who is the agent?
- Who is the recipient?
- What is the context?
- What are the dynamics?
- What is the guiding procedure?
- What is the end point?

3.7.4. Develop programme phase

This phase focus on the development of the programme which involve the purpose statement, outcomes, pre-requisite for attending the programme, duration of the programme, training methods and assessment methods that should be utilized in the programme. The developed training programme was based on the SAQA framework for programme development. An adapted HIV/AIDS training programme for church leaders was then developed.

3.8. PHASE 3: Validation of the developed programme

Phase 3 took place after phase 1 and 2 and it was the third and last phase of this study. Phase 3 covers the last objective of this study which is to validate the developed HIV/AIDS training programme for church leaders in the Limpopo province. Validation is a strategy done to determine the credibility of empirical knowledge in relation to practice (Chinn & Kramer, 2013). The developed programme needs to be trustworthy which is validating the authenticity, importance and truthfulness to the context in which it was developed (Da

© University of Venda

University of Venda
Creating Future Leaders

Silva de Souza & Guerreiro Vieira da Silva, 2011). The aim of this phase was to check the extent in which the developed HIV/AIDS training programme was relevant and appropriate to the needs of church leaders in the Limpopo Province?

3.1.1. Methodology for validating the adapted HIV/AIDS training programme

A quantitative descriptive design was used to validate the developed HIV/AIDS training programme manual. The HIV/AIDS trainers in Limpopo and experts in programme development were the key informants who formed the population. Purposive sampling was used to select the key informants. HIV/AIDS trainers were selected from five districts and provincial office in the Limpopo province because they are agents who implement the HIV/AIDS training in the province and will also be involved in training church leaders in the developed adapted training programme. The five districts in Limpopo are Vhembe, Mopani, Sekhukhune, Waterberg and Capricon. The purposive sampling arrived at sampling 8 HIV/AIDS trainers and 2 experts in programme development. HIV/AIDS trainers were purposively selected in the following way: three from Vhembe district, one from each of the following districts: Mopani, Sekhukhune, Waterberg and Capricon. The eighth one was from the provincial office at Polokwane. Five and more years of training experience was considered to arrive at the selection of those participants. The two experts in programme development were from institutions of higher learning, and were selected because of their experience in developing programmes and curriculum. Involving variety of experts was to make sure that the developed training programme is free of errors.

3.8.2. Data collection method

A checklist questionnaire was designed with a space of comments for each participant to complete. Each participant was given a developed training manual together with the checklist to respond and comment on the provided spaces. The training manual and checklist questionnaires were delivered personally to Mopani and Vhembe district, while

© University of Venda

province and other districts received the documents via email. Each participant was given a week to go through the manual and respond to the checklist provided.

Fundamental questions answered were:

- Are the training programme goals consistent with HIV/AIDS practice goals?
  Is the intended context of the training programme in line with the current HIV/AIDS practice situation?
- Is the content of the training programme appropriate for church leaders?
- Are the explanations of the content of the training programme sufficient to be used as a basis for HIV/AIDS response?
- Is the training programme addressing the needs of the church leaders based on the research evidence?
- Will the use of this training programme influence the response against HIV/AIDS epidemic in the Limpopo province?

A complete validation checklist questionnaire is annexed (annexure 4).

3.8.3. Data analysis

Completed checklists were collected and analyzed quantitatively by the use of simple descriptive statistics. Results were presented in a frequency distribution table with responses in percentages. Presentation and discussion of validation results was done in chapter 5 of this study.

3.9. Summary

Descriptions of research design and methods, sampling, data collection, data analysis, as well as measures to ensure trustworthiness were explained. The researcher ensured strict compliance with ethical standards relevant to protect human rights of the participants. Methodologies for programme development and validation were also described. Provision of detailed data analysis of study findings, programme development process and validation will be in the next chapters.

© University of Venda

University of Venda
Creating Future Leaders

CHAPTER 4

RESULTS AND DISCUSSION

4.1. Introduction

In the previous chapter, the research design and methods were discussed. In this chapter, the analysis of both quantitative and qualitative study is presented and discussed. It presents the findings of the study derived from the following research questions:

- What knowledge do church leaders in the Limpopo Province have regarding HIV/AIDS?
- How do church leaders in the Limpopo Province perceive people living with HIV/AIDS?
- What role do church leaders in the Limpopo Province play towards people living with HIV/AIDS?
- What are the experiences of church leaders regarding current HIV/AIDS training?

The data was analyzed concurrently, as the researcher used the parallel convergent mixed methods. The two data sets (quantitative and qualitative) were analysed separately, and results were merged in the discussion sections. The mixed methods assisted the researcher to see the situation from multiple perspectives and enhanced the development of the training programme. In this chapter the quantitative results are presented first, followed by the qualitative findings. The quantitative results addressed the first three research questions.

4.2. Presentation of the quantitative results

The quantitative results are divided into four sections: Demographic data, Knowledge of HIV/AIDS, Attitudes concerning HIV/AIDS and Practices towards people living with HIV/AIDS.

© University of Venda

University of Venda
Creating Future Leaders

4.2.1. Demographic information

The demographic information included respondents' age, gender, marital status, race, nationality, home language, educational status, denominational affiliation and leadership position. Figure 4.1 presents the age range.

Figure 4.1: Age distribution of respondents



The age group with the most respondents has found to be between 50-59 years, with eighty-eight respondents, followed by 40-49 years with eighty-six respondents. The age group with the least respondents is under 20 years, with only one respondent. All age groups were represented in the study. This figure 4.1 shows that the most common age where people enter into church leadership is from 20 years, while the number of leaders increases from the age of 30 years and above.

© University of Venda

University of Venda
Creating Future Leaders

Gender of respondents

Majority of the respondents were male at 64.3%, while only 35.7% were female. Three respondents did not indicate their gender. This clearly indicates that although there are women in church leadership, the majority of church leadership in the Limpopo province is male.

Figure 4.2: Marital status of respondents

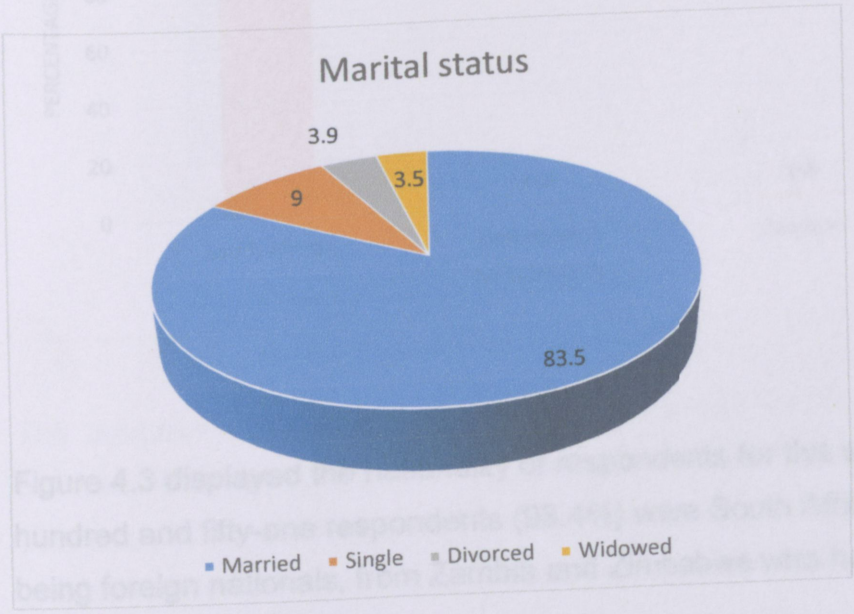


Figure 4.2 shows that the marital status of the respondents varied from single, widowed, divorced and married, while 83.5% of church leaders who participated in the study were married, 9% were single and a low percentage were widowed and divorced (below 4% for each group).

Race

All respondents were Africans, which reflect that the Limpopo province is dominated by Africans in church leadership positions.

© University of Venda

University of Venda
Creating Future Leaders

Figure 4.3: Nationality of respondents

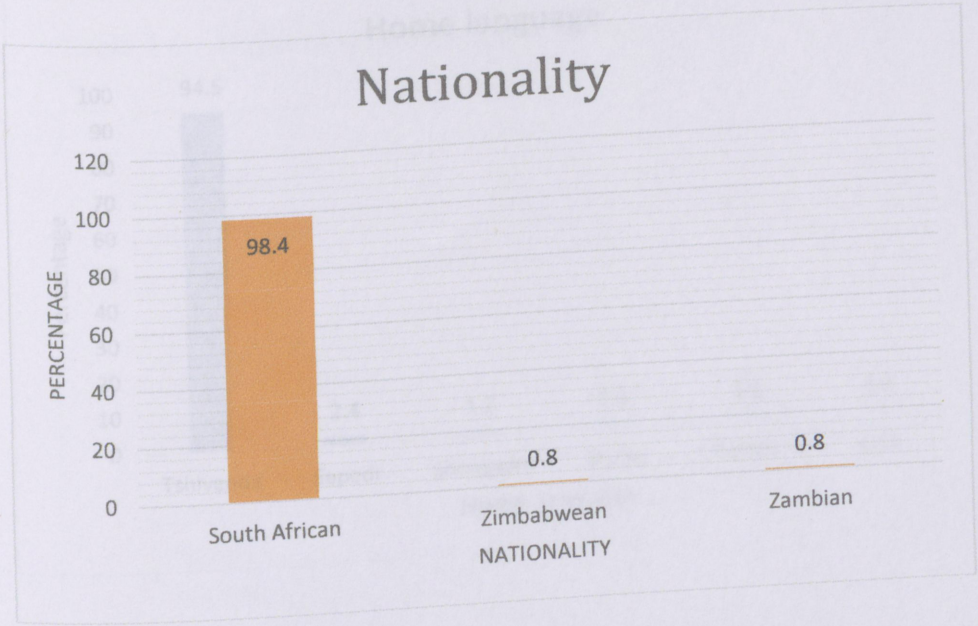
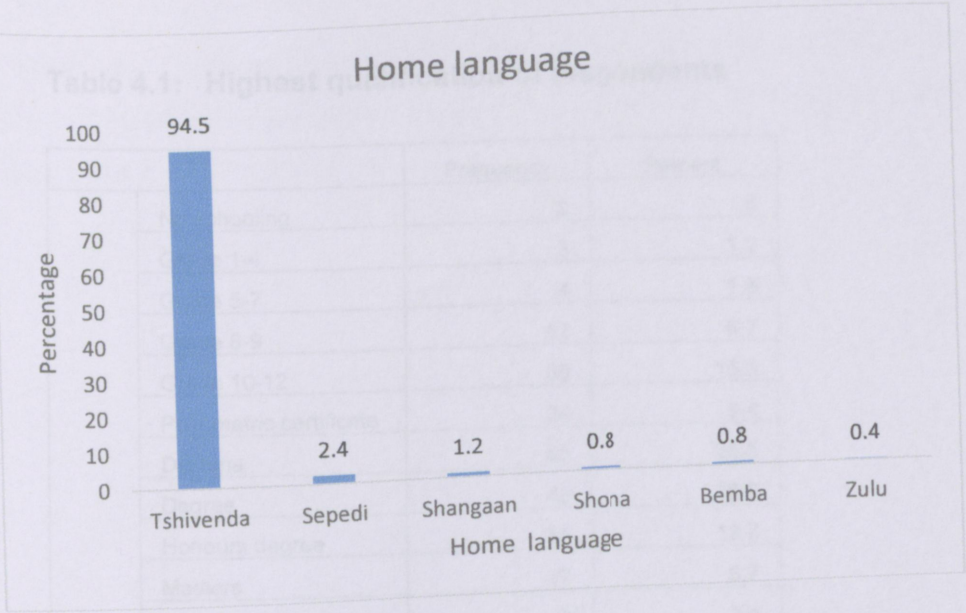


Figure 4.3 displayed the nationality of respondents for this study. As many as two hundred and fifty-one respondents (98.4%) were South Africans and only four leaders being foreign nationals, from Zambia and Zimbabwe who have churches in the Limpopo Province.

© University of Venda

University of Venda
Creating Future Leaders

Figure 4.4: Home language of respondents



The language distribution of church leaders was 94.5% Tshivenda speaking, 2.4% Northern Sotho (Pedi) speaking, followed by 1.2% Shangaan (Tsonga), then Bemba, Shona and Zulu are below 1% in each group. The Vhembe district, which is predominantly Tshivenda speaking was purposefully sampled for quantitative study. In addition to their home languages, other languages spoken in the province include English and Afrikaans.

© University of Venda

University of Venda
Creating Future Leaders

Table 4.1: Highest qualification of respondents

		Frequency	Percent
	No schooling	2	.8
	Grade 1-4	3	1.2
	Grade 5-7	4	1.6
	Grade 8-9	17	6.7
	Grade 10-12	39	15.3
	Post matric certificate	24	9.4
	Diploma	65	25.5
	Degree	43	16.9
	Honours degree	35	13.7
	Masters	17	6.7
	Doctorate	6	2.4
	Total	255	100.0

Table 4.1 shows that 99.2% of church leaders have attended formal school, with 74.6% of leaders having post matric qualifications. Only two leaders (0.8%) indicated no schooling. The post matric qualifications ranged from certificate to doctorate, with 25.5% having diplomas, followed by bachelors' degree at 16.9%. Majority of church leaders in Limpopo can read and write.

UNIVERSITY OF VENDA
LIBRARY

© University of Venda

University of Venda
Creating Future Leaders

Denomination of respondents

Figure 4.4 below shows that the denominational affiliation of respondents was predominantly Pentecostals at 62.4% followed by Non-Pentecostals at 23.1% and the least was Zion at 14%.

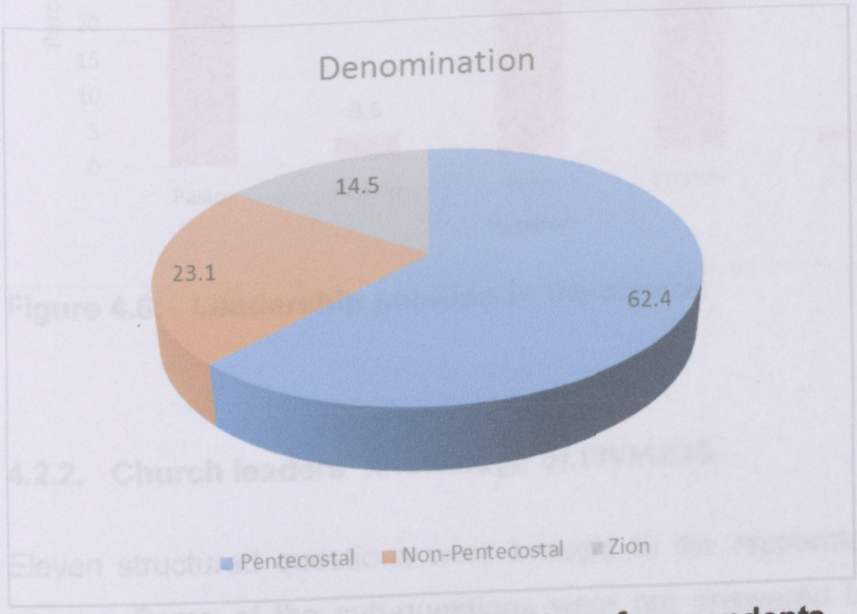


Figure 4.5: Denominational affiliation of respondents

Position in the church of respondents

Church leaders who participated in the study included: Bishops, Pastors, Elders, and Deacons. Majority 46.3% were Pastors, followed by Elders at 26.3%, Deacons 22% and Bishops at 3.5%. The 'other' represents youth leaders and committee members in a church congregation. There is diversity in church leadership position in the Limpopo province.

© University of Venda

University of Venda
Creating Future Leaders

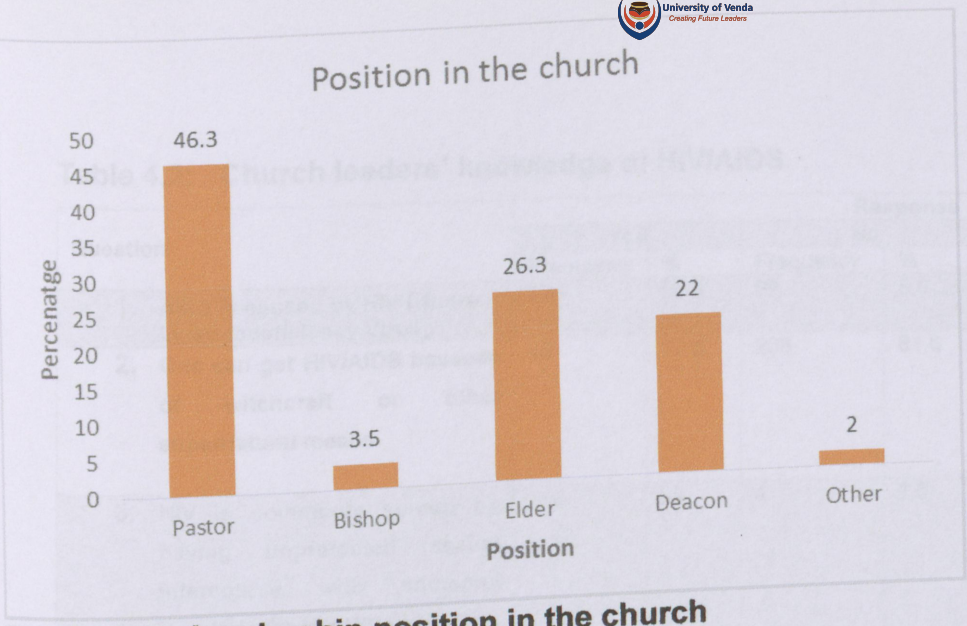


Figure 4.6: Leadership position in the church

4.2.2. Church leaders' knowledge of HIV/AIDS.

Eleven structured questions were brought to the respondents of the questionnaire to answer. Some of the sub-questions were not answered because the majority of the questions were having two responses to choose, those who were not sure of the answer did not respond to some of the questions. Those who did not tick on the responses provided were between 1 and 4 out of 255 respondents in total.

© University of Venda

University of Venda
Creating Future Leaders

Table 4.2: Church leaders' knowledge of HIV/AIDS

Question	Response					
	Yes		No		Non-response	
	Frequency	%	Frequency	%	Frequency	%
1. AIDS is caused by HIV (Human Immunodeficiency Virus).	226	88.6	22	8.6	7	2.7
2. One can get HIV/AIDS because of witchcraft or other supernatural means.	45	17.6	208	81.6	2	0.8
3. HIV is commonly spread by having unprotected sexual intercourse with someone infected with the HIV virus.	250	98	4	1.6	1	0.4
4. HIV is commonly spread by sharing needles or syringes with someone who has the virus.	226	88.6	27	10.6	2	0.8
5. HIV is commonly spread by getting HIV-infected blood, semen, or vaginal secretions into open wounds.	252	98.8	2	0.8	1	0.4
6. HIV can also be passed from an infected pregnant woman to her unborn baby during pregnancy, birth and breast feeding.	223	87.5	30	11.8	2	0.8
7. HIV is not transmitted by simple casual contact such as kissing, sharing water glasses or hugging.	186	72.9	67	26.3	2	0.8
8. There is no cure for AIDS	221	86.7	31	12.2	3	1.2
9. One can avoid getting HIV.	242	94.9	10	3.9	3	1.2
10. Have you attended any HIV/AIDS training?	145	56.9	108	42.4	2	0.8

Table 4.2 above shows that 88.6% of the church leaders know that AIDS is caused by HIV, while 8.6% do not know. Seven participants (2.7%) were not sure of the correct

© University of Venda

University of Venda
Creating Future Leaders

answer. Few respondents 17.6% still believe that HIV/AIDS is caused by witchcraft or other supernatural powers, while 81.6% do not associate HIV/AIDS with witchcraft. Majority of church leaders as many as 98% understand that unprotected sexual intercourse predisposes one to HIV infection. In response to question number 4, majority (88.6%) of the respondents understood that sharing needles and syringes with an infected person can spread the HIV virus, while only 10.6% did not understand. Church leaders who participated in the study (98.8%) are in agreement that blood, semen and vaginal secretions can spread the virus. Majority (87.5%) of the respondents knew that HIV can be passed from mother to the unborn baby during pregnancy, birth and breast feeding while only 11.8% did not know this mode of transmission. Responses from the respondents showed that 26.3 % of church leaders still believe that casual contact like kissing, hugging or sharing water glasses can transmit HIV, while 72.9% of church leaders understand that simple casual contact cannot transmit HIV. Up to 86.7% of church leaders believe that there is no cure for AIDS, while 12.2% believe there is cure. Many respondents (94.9%) indicated that HIV infection is avoidable only 3.9% believe one cannot avoid getting HIV. The statistical results further indicated the training gap of 42.4% of church leaders who did not attend any formal HIV/AIDS training.

Table 4.3: Sources of information regarding HIV/AIDS?

		Frequency	Percent	Valid Percent
	Radio	99	38.8	39.4
	Television	22	8.6	8.8
	Friends	14	5.5	5.6
	Training	82	32.2	32.7
	other	1	.4	.4
	Clinics	5	2.0	2.0
	Work	3	1.2	1.2
	Reading	9	3.5	3.6
	More than one source	16	6.3	6.4
	Total	251	98.4	100.0
Non-response		4	1.6	
Total		255	100.0	

© University of Venda

Sources of information vary from Radio, at 39.4%, followed by training at 32.7%, then television at 8.8%. Sixteen respondents indicated to have been getting information from more than one source. Only 3.6% indicated reading as their source of information.

4.2.3. Church leaders' attitudes towards HIV/AIDS

In this section, five questions were asked from church leaders who have responded to the questionnaires. The researcher wished to determine the respondents' attitude towards HIV/AIDS as a disease and attitudes towards people who are infected with HIV, as well as those suffering from AIDS. The researcher also wished to determine perception of risk of getting HIV/AIDS amongst church leaders from different denominational background.

Table 4.4: Church leaders' attitudes towards HIV/AIDS

Question	Response					
	Yes		No		Non-response	
	Frequency	%	Frequency	%	Frequency	%
1. Is HIV/AIDS desirable/ acceptable in the Church?	119	46.7	129	50.6	7	2.7
2. Do you perceive yourself at risk of getting HIV/AIDS?	105	41.2	147	57.6	3	1.2
3. Are you willing to care for a relative/church member/ friend who is suffering from AIDS?	246	96.5	8	3.1	1	0.4
4. Will you accept a church member who is HIV positive to continue to lead a church music band or to lead a committee?	249	97.6	4	1.6	2	0.8
5. Do you associate people who have HIV/AIDS with sin?	42	16.5	212	83.1	1	0.4

Table 4.4 shows that 50.6% of respondents felt that HIV/AIDS is not desirable in the church, while 46.7% felt it is acceptable. Seven respondents (2.7%) did not answer this question. As many as 57.6 % of the church leaders felt that they are not at risk of getting

© University of Venda

HIV/AIDS while 41.2% perceived themselves at risk of getting the disease. Although HIV/AIDS is not desirable in the church, 96.5% indicated their willingness to care for a relative/church member or friend suffering from AIDS. Table 4.4 further revealed that the element of stigma and discrimination is low within Christian churches in the Limpopo province with 97.6% of the church leaders accepting that a church member can continue to lead music band or a committee, irrespective of his or her HIV status. The table further revealed that 83.1% of the respondents do not associate HIV/AIDS with sin, while the minority of church leaders (16.5%) still associate HIV/AIDS with sin.

4.2.4. Church leaders' practices towards people living with HIV/AIDS

In this section, five questions were asked. The researcher wished to determine the church leaders' involvement in HIV/AIDS related activities in their churches and communities, how long have they been involved and what impact do they have through their involvement.

Table 4.5: Church leaders' involvement in HIV/AIDS activities in the church/community.

		Frequency	Percent	Valid Percent
Valid	Yes	100	39.2	39.7
	No	152	59.6	60.3
	Total	252	98.8	100.0
Missing	System	3	1.2	
Total		255	100.0	

Table 4.5 shows that 60.3% of church leaders are not involved in HIV/AIDS activities in their churches and communities, only 39.7% are involved. The majority of church leaders in Limpopo are not involved in any response to HIV/AIDS epidemic.

© University of Venda

University of Venda
Creating Future Leaders

Table 4.6: Number of years involved in HIV/AIDS activities

		Frequency	Percent	Valid Percent
Valid	less than a year	24	9.4	19.7
	1 to 5 years	37	14.5	30.3
	More than 5 years.	61	23.9	50.0
	Total	122	47.8	100.0
Missing	System	133	52.2	
Total		255	100.0	

Table 4.6: shows that 23.9% of church leaders have been involved for more than five years, those involved for one to five years are 14.5%, while those involved for less than one year is 9.4%. The 52.2% who did not mark any of the responses are those who have indicated "No" on the previous question in table 4.5.

Table 4.7: Description of the impact of church's involvement in HIV/AIDS

		Frequency	Percent	Valid Percent
	we are losing ground	9	3.5	7.1
	it is tiny compared to the need	27	10.6	21.4
	it is starting to penetrate the community; our influence is growing	51	20.0	40.5
	it is having widespread influence in the community; meeting a lot of need	39	15.3	31.0
	Total	126	49.4	100.0
Non-response		129	50.6	
Total		255	100.0	

© University of Venda

University of Venda
Creating Future Leaders

Table 4.7 describes the impact of church leaders' involvement in HIV/AIDS. Majority (40.5%) of church leaders who are involved see their impact as starting to have influence; 31% having wide spread influence in the community, while 21.4% felt they are not doing enough compared to the need.

Table 4.8: What motivated you to become involved in the AIDS ministry in the first place?

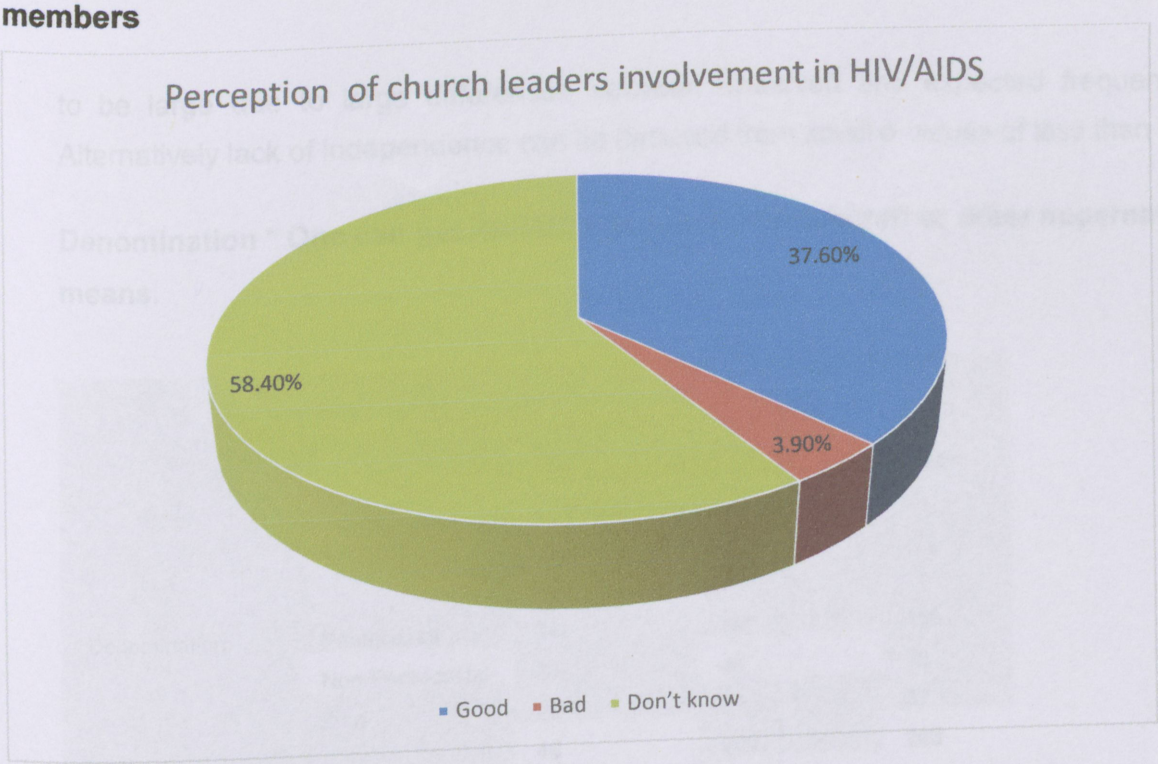
		Frequency	Percent	Valid Percent
Valid	passion to help people	64	25.1	50.8
	recruited by a friend	7	2.7	5.6
	attended HIV/AIDS workshop/training	49	19.2	38.9
	a church member/ relative who got AIDS	6	2.4	4.8
	Total	126	49.4	100.0
Non-response		129	50.6	
Total		255	100.0	

Table 4.8 shows that 50.8% of the church leaders who are involved in HIV/AIDS activities indicated passion to help people as their motivation, while 38.9% indicated attendance to HIV/AIDS workshop or training. Those recruited by friends were 5.6% and those who were motivated by a relative/church member who got AIDS were 4.8%.

© University of Venda

University of Venda
Creating Future Leaders

Figure 4.8: How is your involvement in HIV/AIDS perceived by community/church members



Of all the respondents, 58.4 % of the respondents indicated that they do not know how their involvement is perceived; only 37.6% respondents indicated a good perception by the community. While 3.9% of the respondents indicated that their involvement is badly perceived by the community/ church members. The results clearly indicates the need to empower church leaders to improve their role towards HIV/AIDS in their churches and community.

4.2.5. Chi square test and cross tabulations

A chi-square test was performed to determine if the response given for each question by the respondents is depended on their denominational affiliation. In this case the null hypothesis is that the response given is independent of the denominational affiliation of the respondent. The alternative hypothesis is that there is an association between two variables. When there is an association between the variables, the value of the test tends

© University of Venda

to be large due to large differences between observed and expected frequencies. Alternatively lack of independence can be deduced from small p-values of less than 0.05.

Denomination * One can get HIV/AIDS because of witchcraft or other supernatural means.

		One can get HIV/AIDS because of witchcraft or other supernatural means.		Total
		Yes	No	
Denomination:	Pentecostal	31	127	158
	Non-Pentecostal	10	48	58
	Zion	4	33	37
Total		45	208	253

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	1.606[a]	2	.448
Likelihood Ratio	1.758	2	.415
Linear-by-Linear Association	1.491	1	.222
N of Valid Cases	253		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 6.58.

There is statistical no significance differences (P>0.05). The response given is not independent of the denominational affiliation; there is an association between three denominational affiliations. The expected count is less than 5% which means the results are reliable.

© University of Venda

University of Venda
Creating Future Leaders

Denomination * Have you attended any HIV/AIDS training?

		Have you attended any HIV/AIDS training?		Total
		Yes	No	
Denomination:	Pentecostal	91	67	158
	Non-Pentecostal	31	27	58
	Zion	23	14	37
Total		145	108	253

Chi-Square Tests	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	.715[a]	2	.699
Likelihood Ratio	.717	2	.699
Linear-by-Linear Association	.054	1	.816
N of Valid Cases	253		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 15.79.

Here, P>0.05; there is no significant difference in the way denominations attended the training. There is an association between the denominations in the way they have attended the training.

© University of Venda

Denomination * Are you involved in HIV/AIDS related activities in your church/ community

		Are you involved in HIV/AIDS related activities in your church/ community?		Total
		Yes	No	
Denomination:	Pentecostal	63	95	158
	Non-pentecostal	22	35	57
	Zion	15	22	37
Total		100	152	252

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	.042[a]	2	.979
Likelihood Ratio	.042	2	.979
Linear-by-Linear Association	.000	1	.998
N of Valid Cases	252		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 14.68.

No statistical significance differences in the way leaders from different denominations have responded (P>0.05). Because the p-value is large there is an association between variables. The nature of the association is revealed in the above graph where it is apparent that in the comparison to the leaders from different denominations, a larger percentage of church leaders in each denominational affiliation are not involved in HIV/AIDS related activities in their churches.

© University of Venda

University of Venda
Creating Future Leaders

4.3. Summary of the key results of the quantitative data

4.3.1. Demographic information

The results of the study showed that there are more males than females in church leadership positions. The highest number of respondents was between 40 and 59 years. The majority (84%) of respondents were married. The qualification level with the highest number of respondents was a diploma. The denominational affiliation of respondents was predominantly Pentecostals 62.4%, followed by Non-Pentecostals 23.1% and lastly Zionists 14.5%. The type of church leadership who participated in the study included: Bishops, Pastors, Elders and Deacons. Pastors formed the majority of participants at 46.3%, followed by Elders at 26.3%.

4.3.2. Knowledge of HIV/AIDS

Results revealed that more than 80% of church leaders in Limpopo do have knowledge about HIV/AIDS. The information they have was acquired from different sources, with radio (39.4%) being the main source of knowledge, followed by training (32.7%). Very few (3.6%) church leaders indicated that they got information through reading. Although the results depict increased knowledge there is still 43% of church leaders who have not attended formal HIV/AIDS training. The results further revealed that there was no significance difference regarding knowledge of HIV/AIDS amongst the Pentecostal, non-Pentecostal and Zion church leadership.

4.3.3. Church leaders' attitudes concerning HIV/AIDS

The results showed that in general, church leaders in Limpopo depict a positive attitude towards those who are infected with HIV/AIDS. The highest number (96.9%) of church leaders indicated that they can take care of a relative or church member who is suffering from AIDS. The findings further revealed that 98.4% felt they can accept a church member to continue to lead any activities in the church, if HIV positive. Very few church leaders (16.5%) associate HIV/AIDS with sin. The association of HIV/AIDS with sin contributes to

© University of Venda

University of Venda
Creating Future Leaders

stigma and discrimination. This means that some elements of stigma and discrimination still exist in the church. The results of the study further indicate that 58.3% felt that they are not at risk of getting HIV/AIDS. There is a statistical significance on the risk perception, Pentecostals felt that they are at low risk followed by non-Pentecostals while Zionists perceived themselves to be at higher risk. This might be due to the Zionist practice of polygamy, while Pentecostals & non-Pentecostals believe in one man one wife, and encourage abstinence and faithfulness to one partner.

4.3.4. Church leaders' practices towards people living with HIV/AIDS

There were no statistical differences amongst Pentecostals, Non-Pentecostals and Zionists when it comes to their involvement. The majority of the respondents (60%) indicated that they are not involved at all in any of the HIV/AIDS activities in their churches and their communities. The few church leaders who are involved indicated that their involvement is having influence and they are meeting a lot of need. The findings revealed that although we have so many Christian churches in Limpopo province, their contribution in the fight against HIV/AIDS is lacking.

4.4. Presentation of a qualitative findings

The qualitative study has been used to answer the research question number four:

- What are the experiences of church leaders regarding current HIV/AIDS training?

The findings were derived from in-depth interviews conducted with church leaders' who have attended an HIV/AIDS training programme. The central question was formulated in order to explore the experiences of church leaders regarding the current HIV/AIDS training programme in the Limpopo province. The focal point of the in-depth interview sessions was supplied by the central question "**What are your experiences regarding the current HIV/AIDS training programme for church leaders in Limpopo Province?**" Individual interviews were conducted in order to generate more information on how church leaders experienced the current HIV/AIDS training program as individuals.

© University of Venda

University of Venda
Creating Future Leaders

The field notes were incorporated in the transcribed data to complement the collected data.

Eight church leaders from eight different Christian churches who have attended the current HIV/AIDS training conducted by the Foundation of Professional Development (FPD) in partnership with the department of health were interviewed.

Table 4.10 summarizes biographic data of interviewed church leaders.

Table 4.9: Biographic data of interviewed church leaders

Variables	N=8	N (%)
Age 40-49 50-59	 3 5	 37.5 62.5
Sex Male Female	 7 1	 87.5 12.5
Marital status Married Widow	 7 1	 87.5 12.5
Race African	 8	 100
Nationality South African	 8	 100
Educational level Diploma Degree Masters Doctorate	 4 2 1 1	 50.0 25.0 12.5 12.5
Denomination Pentecostal Non Pentecostal Zion	 4 2 2	 50.0 25.0 25.0
Position in the church Pastor Bishop Dean	 5 2 1	 62.5 25.0 12.5
Attended HIV/AIDS training	8	100.0

The findings are presented following the themes and categories that emerged during data analysis. The broad categories of churches discussed in chapter one were maintained throughout the analysis process namely Pentecostal, Non-Pentecostal, and Zion Christian churches. The findings were thereafter compared through a constant comparison method. The promoter was used as the inclusion of external view and consensus discussions were held with the promoter. Eventually, it was noted that there

© University of Venda

was no significant variation in the way the different categories of participants responded. The findings were categorized into two major themes and related subthemes. The quantitative findings provided the researcher with a better insight and holistic view of the situation than the qualitative approach alone. Themes from the qualitative data were also influenced by quantitative findings when results were merged. Two major themes that emerged from the interviews are:

- The state of current HIV/AIDS training programme;
- Challenges experienced by church leaders regarding the implementation of the current HIV/AIDS training programme.

The following table presents the themes and sub-themes that emerged

Table 4.10: Themes and sub-themes that emerged in the study

THEMES	SUB-THEMES
1 State of the current HIV/AIDS training programme	1. Knowledge of church leaders with regards to HIV/AIDS
	2. Perception of stigma towards people living with HIV/AIDS
	3. Multi-stakeholder approach
	4. The role of church leaders with regards to HIV/AIDS
2 Challenges experienced by church leaders regarding the implementation of the current HIV/AIDS training programme	1. Challenges with regards to facilitation
	2. Attitudes of facilitators' towards Christianity
	3. Information on condom use
	4. Lack of access to training materials
	5. Poor logistics
	6. Lack of follow up after the training

© University of Venda

University of Venda
Creating Future Leaders

4.5. Discussion of the findings

A narrative account of the themes and subthemes, supported by direct quotations from participants follows. The direct quotations are presented in italics, and represent the experiences of the participants. Literature control was done simultaneously with the discussions of the findings. The quantitative findings were merged in the discussion of qualitative themes concurrently.

4.5.1. THEME ONE: State of the current HIV/AIDS training programme

This theme includes how the current training program is structured and how the church leaders have benefitted from the program. Four sub-themes emerged under this theme. The emerging themes are as follows:

4.5.1.1. Knowledge of church leaders with regards to HIV/AIDS

Through participation in HIV/AIDS trainings, participants stated that they have been armed with better information to enable them to understand HIV/AIDS. Participant B said, "*The training has broaden our knowledge and has helped us not to be ignorant about HIV/AIDS*". While participant C indicated, "*The good thing with this training is that we were equipped, we have learnt many things which we did not know about HIV/AIDS*".

In a quantitative approach, the results on the knowledge of HIV/AIDS concurs with the qualitative findings that church leaders in the Limpopo agreed to have gained knowledge through their participation in the current HIV/AIDS training. A statistical analysis based on the responses of the respondents revealed that 32.7% of leaders indicated training as their source of information regarding HIV/AIDS. It is clear that the current training program contributed to 32.7% of knowledge amongst church leaders. This is supported by the USAID study in Mali that revealed that having access to information on HIV/AIDS will transform the church leaders' opposition to support and commitment (USAID, 2007).

© University of Venda

University of Venda
Creating Future Leaders

Participant C remarked, *"Most of us as church leaders we used to think that HIV/AIDS is only caused by involvement into sexual immorality"*. Participant A confirmed by saying, *"Some pastors including myself used to see a person having HIV/AIDS as somebody who has committed sin or not living righteous life, without thinking that a person can be infected through many different ways than sexual intercourse"*. The quantitative findings in section 4.2.3.5 of the questionnaires confirmed that 83.5 % of church leaders no longer associate HIV/AIDS with sin. A study conducted in Mali reported that during the initial outbreak of HIV, religious leaders both Christians and Muslims believed that AIDS was a divine curse (USAID, 2007). This lack of knowledge caused more harm to church members and community as they were not well received. Participant A apologetically said, *"After I have attended the training, I felt so sorry that I went back and apologized to church members for the careless remarks I have uttered without proper knowledge of the disease"*.

The quantitative results confirmed that as knowledge of people increase, the people become more receptive to those who are HIV positive. Respondents' responses to section 4.2.3.4 about accepting a church member who is HIV positive to continue to lead a church music band or to lead a committee showed that 98.4% indicated their willingness to accept. A study conducted in Uganda by Otolok-Tanga et al. (2007), revealed that through participation in HIV/AIDS trainings, church leaders have been armed with better information to fight discrimination and stigma within their institutions and congregations. The participants who attended the training were in agreement that topics covered included the nature of HIV/AIDS, mode of spread, prevention and how to accept people living with HIV/AIDS without discrimination. This information helped church leaders to deal with fears related to the mode of transmission and HIV/AIDS as a disease.

Participant H said, "*I was so enlightened by the training and after the training I encouraged church members to go for HIV test so that they can know their status and I was also encouraged to go for HIV test without fear of being categorized as sinners*".

According to Lindsey et al. (2003), it has been found that stigma often prevents people from accessing health care services because they are afraid that people will know about

© University of Venda

University of Venda
Creating Future Leaders

their HIV-positive status, and therefore continuous care and support is delayed. Inputs from the participants confirmed that the aspects that were covered by training helped them to increase their knowledge on HIV/AIDS. This is supported by quantitative results in section 4.2.2.1 that show that 91% of church leaders understand that AIDS is caused by HIV. Although the majority of church leaders have their knowledge increased through training, there is still a small percentage that needs to get the right information as reflected by the quantitative results in section 4.2.2.10, that 42.7% of leaders never attended any formal HIV/AIDS training. Lack of knowledge in some church leaders is still a concern to be addressed.

Participant G confirmed this by saying, "*There are church leaders who discourage people to use HIV/AIDS treatment and I am saying this because I got this information from the Vhembe district mayor who wanted to meet pastors to discuss issues around that, so it is important that pastors be trained to avoid such problems*".
This statement is supported by the quantitative results in section 4.2.2.2, that 17.8% of church leaders still believe that HIV/AIDS is caused by witchcraft or other supernatural powers, although 82.2% do not associate HIV/AIDS with witchcraft. These beliefs about supernatural powers compel church leaders to discourage people from taking treatment, believing that the cure will be by means of prayers and deliverance ministries. The remaining 42.7% who did not attend any form of training should also be trained to avoid these problems.

4.5.1.2. Perception of stigma towards people living with HIV/AIDS

Stigma and discrimination perpetuated by lack of knowledge was addressed. Participant G said, "*The information we have received has also helped us to accept those who are living with HIV/AIDS without judging them*". The notion that HIV/AIDS is caused by sin contributed to stigma and discrimination amongst the church communities. Majority of the participants concur that before they received the training they associated HIV infection with sexual sin and could not accept those who are infected. Participant C stated, *"Most of us as church leaders we used to think that HIV/AIDS is caused by involvement into*

© University of Venda

University of Venda
Creating Future Leaders

sexual activities only, hence we stigmatize the person infected as a person who is not faithful and has fallen into sin". Participant D affirmed by saying, "*Those people who are infected by HIV are regarded as sinners and are not accepted by others".*

The quantitative results in section 4.2.3.5 confirmed that there is still 16.5% of church leaders who associate HIV/AIDS with sin. These findings concur with the baseline study conducted in three districts in Malawi which had reported that close to 40% of religious leaders who participated in the study felt HIV is a punishment from God as a result of a sin committed (MIAA, 2007). A study done in Uganda also showed that associating AIDS with sin or curse from God for wrong doings and sending out of mixed messages by religious leaders in line with the Christian concept of 'hate the sin, love the sinner' were found to be actions facilitating stigma (Otolok-Tanga et al., 2007).

Fear of contracting the disease also contributed to stigma and discrimination. Participant D indicated to me how people who are HIV positive are treated in some congregations as a result of fear of getting the disease by saying, "*In some churches where they use one cup for serving holy communion wine, other church members would not like to use the same cup with a member who is known to be HIV positive. Others will not even sit next to this person due to fear of getting the disease".*

This is also confirmed by quantitative results in section 4.2.2.7 that revealed *that* 26.5 % of church leaders still believe that casual contact like kissing, hugging or sharing water glasses can transmit HIV. There is still a minority group that lack the correct information addressed by the current training. The reason for this lack of knowledge is supported by the statistical analysis that indicated that 42.7% of church leaders were not exposed to formal training on HIV/AIDS. Participants agreed that knowledge of church leaders on HIV/AIDS need to be increased to fight the disease without hurting those who are infected. To those who have attended the training their thinking were transformed and their attitude are gradually changing into accepting those who are infected and affected by HIV and AIDS.

© University of Venda

University of Venda
Creating Future Leaders

Participant C said, "*Our way of thinking towards HIV/AIDS was changed by the information we got through the training*". Participant B affirmed by saying that "*I now understand that it does not necessarily mean that all the people who are sick or infected is because they were unfaithful*". The quantitative results confirmed that as a result of church leaders acquiring knowledge regarding HIV/AIDS, 83.5% of church leaders who participated in the study no longer associate HIV/AIDS with sin. An attitude of acceptance of people who are HIV positive improved due to participation in awareness programmes and HIV/AIDS training. The quantitative results also have shown improvements in the attitude of leaders due to increased knowledge. As many as 98.4% of church leaders in section 4.2.3.4 indicated that they can accept a church member who is positive to can continue to lead a church music band or to lead a committee, while 96.9% in section 4.2.3.3 of quantitative results confirmed that they are even willing to care for a relative or church member who is suffering from AIDS. The more you educate people the more you change their mind about the disease. Paterson (2005), confirmed that transformation will not happen by itself; much will depend on training.

4.5.1.3. Multi-stakeholder approach

The current HIV/AIDS training programme in Limpopo province is designed for different religious groups. Church leaders and traditional healers attended the same training. Some participants reported that in some of the training sessions traditional healers were mixed with church leaders while others had their training with church leaders only.

One participant who attended training where pastors and traditional healers were together said, "*I think combining traditional healers and pastors may have advantages to those who are conducting the training as they could be able to get perception from both groups but it needs proper planning to avoid conflict of interest*".

This approach if used well may have some benefits to both groups as they can also exchange their experiences and their collaboration can be strengthened. The experiences of church leaders during training sessions that included more than one faith group pointed

© University of Venda

University of Venda
Creating Future Leaders

more to the disadvantages than advantages. Participant D, who attended the training and a workshop related his experience by saying, "*In one workshop where both pastors and traditional healers were combined, during the time of opening the workshop a traditional healer was asked to open a session by a prayer when the session ended the facilitator asked one of the pastor to pray of which the requested pastor refused to pray claiming that the traditional healer who have started should again close as the two groups operate from different faith background*". The participant further said, "*I observed that there was a rift between the two groups before the programme was even started*".

The mixing of traditional healers together with church leaders seemed to be a problem in Limpopo province of South Africa as the two groups do not have forums where they meet outside the training. It seemed that the two groups have their own history outside the training which makes it difficult to combine them in a training session before resolving those other issues. Participant C said, "*Looking at the experiences we had with the last training, I would recommend that it is better if traditional healers and church leaders attend the trainings in separate groups due to differences in our backgrounds and the way we look at HIV/AIDS from different faith background*". Another participant affirms by saying, "*We used to have unnecessary dialogues between pastors and traditional healers during the training as a result of different ways of looking at HIV/AIDS*".

The majority of participants suggested that it would be better to train each group separately based on their previous experience. Mixing groups that are opposed to each other seemed to have many disadvantages than advantages. Participants felt that this approach affected training in many ways hence our fight against HIV/AIDS epidemic becomes fruitless. Participant D confirmed this by saying, "*Some of the pastors said plainly that if the situation remains this way they may decide not to attend those trainings*". The issue here is not about the information on HIV/AIDS but issues of faith that are creating division. To can engage all groups in the fight against HIV/AIDS epidemic the current approach need to be revisited and each group equipped separately targeting their specific area of concerns, without provoking them.

© University of Venda

University of Venda
Creating Future Leaders

4.5.1.4. The role of church leaders regarding HIV/AIDS.

The church leaders felt that this training does not address their specific needs as church leaders. The information they have received focused on general knowledge about HIV/AIDS which can suite everybody. The information was very basic and could be used as foundation for further development. The information they received was not enough to can get church leaders to get involved in HIV/AIDS interventions. Participant E said, "*The information we got was basic knowledge that serve as a foundation for further development, but was not enough to can enable pastors to start HIV/AIDS ministries in their churches*". Participant G confirmed, "*The knowledge we have received can only help us to accept PLWHA, but the information on how we can help others was not addressed*". Pastors are finding it difficult to be actively involved due to lack of knowledge and skills on HIV/AIDS interventions which the current training is not able to provide.

The training information alone was not enough to can help a church leader to get involved with HIV/AIDS activities. This is confirmed by quantitative results in section 4.2.4.1 that though (57.3%) of church leaders confirmed to have attended HIV/AIDS training, 60.3% which is majority are not involved in HIV/AIDS related activities in their churches or communities. Those church leaders who after the training started to have some HIV/AIDS ministry indicated that they continued to equip themselves further to can be able to start HIV/AIDS activities in their churches. One of the participants chose to research on HIV/AIDS as part of his master's study in theology. He said, "*I was eager to get knowledge and as a result, I did my master's degree on HIV/AIDS*. While others stated that they have attended other trainings somewhere after that one. The inputs from those who are involved in HIV/AIDS activities in their churches after attending additional trainings or have equipped themselves further through studying confirmed that the content of the current training material did not manage to get church leaders involved in the HIV/AIDS ministry.

UNIVERSITY OF VENDA
LIBRARY

© University of Venda

Participant C when asked about his involvement in HIV/AIDS ministry said,*"I have started a programme dealing with health issues including HIV/AIDS prompted by the background I have from Salvation Army church".*

None of the participants stated that they started some HIV/AIDS activities as a result of this training which they received through the department of health. In the quantitative approach, respondents' responses to what motivated them to become involved in the AIDS ministry in section 4.2.4.4 showed that 50.8% of church leaders who are involved were motivated by passion to help people. It is clear that the content of the training material failed to empower church leaders to can start HIV/AIDS activities in their churches. This knowledge gap justifies why majority of those church leaders who have attended the current training are not involved in the fight against HIV/AIDS epidemic. The findings further revealed that the training material failed to address the specific role that church leaders can play with regards to HIV/AIDS. Information was general and not specific to church leaders' needs.

Participant D commented, "*It is important that the content of the training programme should help the pastors to understand their role so that they can go back and implement".* According to Coulson, Goldstone, Ntuli and Pillay (2010), the capacity development process should have a wide range of topics to obtain an accurate picture of the capacity required for any programme.

One participant said, "*The aim of the training must be revisited*". When asked further he indicated clearly that the aim of the training was not clear, and they did not know what was expected from them to do after the training. Participant H confirmed, "*The content of the training should be able to help pastors to understand their role so that they can go back and implement".* Participant C concurred by saying "*the training did not give us mandate on what to do as church leaders".* If the aim of the training was to give basic knowledge about HIV/AIDS, church leaders felt that their goal was not met by this training. Participant H said, "*Of course church leaders need to have knowledge of HIV/AIDS but I think it is also important that church leaders should be trained to help people who are already infected".* For the training to be successful it must address the target group and

© University of Venda

University of Venda
Creating Future Leaders

be able to clarify their role. The current training failed to address how church leaders can be involved in HIV/AIDS interventions.

The participants wanted to learn what would be useful to them and their situation not just general information. According to Graig (1996), adult wanted to learn what would be useful to them because attending any training they asked themselves questions whether the training is worth attending. The number of church leaders who have attended the training is much higher than the number of people involved in HIV/AIDS activities as confirmed by quantitative results. The inputs from the participants confirmed that the role of church leaders was not clarified by the current training program.

4.5.2. THEME TWO: Challenges experienced by church leaders regarding the implementation of the current HIV/AIDS training program

The current training program does have challenges that participants who have attended the training sessions indicated. Six sub-themes discussed under this theme are as follows:

4.5.2.1. Challenges with regards to facilitation

Facilitation is a process during which an adult learner is engaged in acquiring knowledge by interacting with colleagues and facilitators during training. The role of the facilitator in the learning process includes the provision of guidelines on the required information, and on how and where learners should obtain outcomes (Meyer & Van Niekerk, 2008). The facilitator should make it easy for the learner to understand the learning material, than to force the leaners to learn what they did not want. During the roll out of the current training, facilitation strategy used did not accommodate principles of adult learning. During the training, some participants felt that they were not given chance to voice out what they know about the disease as in the training mainly lecture method was used. The participants preferred participatory rather than lecture method only. One participant when asked about his experiences during the training responded by saying, "*The training should not be structured like we are in a primary school*". For training to be effective

© University of Venda

University of Venda
Creating Future Leaders

principles of adult learning should be dealt with effectively. Participant D concurs by saying, *"Leaders who are being trained, should also be engaged in group discussions rather than being lectured the whole day".* It has been proven that more is learnt if people participate in the learning and if the learning process can be applied to a real-life situation (Wlodkowski & Gingsberg, 2017). Though the information they have received was important, church leaders seemed not to be interested in the way this information was presented to them. The church leaders felt that their views and what they know about HIV/AIDS should have been addressed during group discussions of which they were not given that opportunity to discuss. These findings concur with Knowles adult learning theory that adult need to be free to direct their learning and facilitators should guide the adult learner to their own knowledge rather than supplying them with all the information (Knowles et al., 2012). The facilitators should allow learners to organize themselves and assume responsibility of their learning by engaging them in discussions, presentations, role play and group-based task. Knowles et al. (2012) further argues that there is convincing evidence that people who take the initiative in learning learn more things, and learn better, than do people who sit at the feet of teachers passively waiting to be taught.

Furthermore, Participant F supported by saying, "*Discussions would have helped church leaders to share the knowledge they have rather than just taking in what the trainers have".* Church leaders somehow felt they were undermined and treated as primary school children, while they were expecting to be treated as adults. This is supported by Meyer and Van Niekerk (2008), when critiquing lecture as a teaching strategy. The authors indicated the following disadvantages of lecturing which are similar to what participants has experienced:

- Lectures can lead to the mere transfer of knowledge,
- If the educator is not skilled, learners tend simply to try to memorize the content,
- Lectures' enhance passiveness in leaners, and
- Learners' ability to think, reason and judge might be ignored.

© University of Venda

University of Venda
Creating Future Leaders

Some participants have the knowledge and experience in HIV/AIDS related topics and they want the training to accommodate that. It is therefore important that facilitation strategies be reviewed for the training program to be effective.

Some participants questioned the competency of the facilitators during the training rather than only looking at principles of adult learning. Participant B said, "*During the training I observed that people who were training us seemed to have a lack of knowledge in other aspects. That was more evident when we asked questions and they battled with them*". The participant elaborated further by saying, "*The facilitators have knowledge but I think they needed some improvements in other aspects of the training material*". Another participant supported this idea by saying, "*Some of us have acquired knowledge of HIV/AIDS before attending this training and we felt that there are some aspects that were not well done by our trainers, they seemed to lack that knowledge*".

The lack of competence in other aspects of HIV/AIDS and lack of facilitation experience by facilitators might also have contributed to the use of lecture method only during training than the organization of training material itself.

4.5.2.2. Attitudes of facilitators towards Christianity

The participants attended training in different places and at different times. Few participants complained about the attitudes of the facilitators toward Christian faith. Attitudes of facilitators' towards Christianity were perceived as negative by participants. Participant H argued that, "*The facilitators were partial showing no respect to our Christian faith though we expected them not to be Christians but at least to respect the fact that church leaders are Christians*". Participant F supported this by saying, "*The facilitator was very negative to Christian faith to an extent where some of the pastors were forced to defend our faith leading to arguments that were not necessary".* While participant D recommended that, *"The facilitators should show interest and respect to our Christian faith to gain our co- operation".* The participants felt that the attitudes of the facilitators can have a negative impact on the training if not taken into consideration. Their argument

© University of Venda

was that even if the facilitator is not a Christian, he/she should at least show interest and respect to the Christian faith for the training to continue smoothly without unnecessary tensions. It is important for the facilitator to know and understand the philosophy of their target group to avoid clashes of interest and unnecessary arguments. Adult learners wish for a learning environment and facilitators who appreciate their life experience and address their needs; not an environment that disrespects their existing competence and their contributions during the process of their learning (Tshiula & Stone-Jimenez, 2005).

Besides the attitude of facilitators that was negative towards Christianity, church leaders felt that for training to be effective and attract churches to be involved, it must be branded with the word of God. Participant G said, "*If you want to involve many church leaders it will be important to brand the training with the word of God, which is the basis of our faith*". Participant F added, "*If the word of God forms the basis of the training, pastors will also value the training*". The current training does not have platform for the bible as it is not designed specifically for church leaders. The approach is general and not specific to the church leaders, hence church leaders felt they cannot own it as theirs. Once it is branded with the word of God they would feel it is their training and they will be motivated to attend.

4.5.2.3. Information on condom use

The information on condom use provoked different perceptions amongst church leaders during the training. Some of the participants complained that facilitators over emphasized the use of condom as if HIV/AIDS is only spread through sexual intercourse, hence this over emphasis may perpetuate stigma to those infected with HIV. Participant A said, "*In the training emphasis was more on sexual intercourse as if is the only way to get HIV/AIDS, which in turn may create stigma to those who have the disease*". He elaborated further by urging that, "*Once the emphasis is on sex many people may think that those who got the disease are promiscuous*". Participants did not deny the use of condoms as a method of prevention but were not comfortable with the way it was addressed.

© University of Venda

University of Venda
Creating Future Leaders

Despite the fact that the condom message was over-emphasized, church leaders seemed to differ in the way they perceive condoms. Participant A said, "*At first when I heard about condom, I associated it with sinful actions but later on I started to accept it on the basis that though I may have people who are members not all of them are faithful*". Other participants felt that they can advocate for condom only amongst couple while youth has to abstain. Participant H said, *"Condom is not a church's main message, the church stresses abstinence amongst youth and faithfulness amongst the couples*". These findings are supported by Tiendrebeogo and Buykx (2004), that the role of church leaders and faith-based organizations in preventing the spread of HIV/AIDS has predominantly been characterized by the deadlock over condom use. Christian organizations for the most part do not promote condom use, the church's emphasis is on abstinence and fidelity.

The participants did not deny the fact that there are situations where they should openly speak about condoms. Participant B strongly suggested that, "*The Department of Health should stress the condom, while churches stress abstinence and faithfulness*". When it comes to one on one discussions the church leaders agreed to can address the condom message. Participant E confirmed this by saying, "*On one to one counselling condom message can be addressed especially to couples but also bearing in mind that sometimes our youth engage in sexual activities early*". The main challenge that church leaders are facing is that they find it difficult to advocate for condom openly because they feel as if they are encouraging young people to engage in sexual activities. Participant G said, "*It is difficult for pastors to advocate for condoms openly as it would appear as if they are encouraging premarital sex and promiscuous behavior*". It is clear that church leaders perceive condom message differently. However, when it comes to couples they strongly feel that if the other partner is infected condom must be used to protect the partner who is not infected. These findings concurs with the study done in Uganda, that Anglicans and Muslims allow the use of condom within a marriage setting, while among Catholics the use of condoms is strictly prohibited (Sexual Health Exchange, 2004).

© University of Venda

The condom message has some controversy amongst church leaders, participant F confirmed by saying, "*Condom for sure have some controversy in the church, but while the culture and knowledge of the church leaders is gradually changing condom is more accepted than before*". In addition, Participant C said, *"The problem I saw was that pastors themselves have different backgrounds, others do accept the condom message while others do have a problem"*. Narratives from participants indicated that church leaders perceive condom differently. The use of condoms as one of the HIV prevention is still not yet accepted by many church leaders.

4.5.2.4. Lack of access to training materials

The participants expected to get materials to refer to while at home after the training, which did not happen. One participant commented, "*They trained us but they did not give us any materials to read at home*". The training did not provide handouts for church leaders, of which church leaders felt it was necessary to reinforce their learning while they are at home. This might have contributed to lack of feedback to other church members by leaders who attended the training as a result of poor retention of information after the training. One participant complained that people who attended the training did not go back and report to their churches by saying, *"My challenge is about people who attend training but when going back to their churches they did not give feedback"*. Some of those leaders who attended the training were elderly and of low educational status who cannot be able to recall all the information unless they have handouts to refer to or which they can give others to read. Other participants suggested that if handouts can be provided with future trainings it will be good if they are translated into local languages so that many people can read them. Participant C added, *"There is a need to translate HIV/AIDS material into local languages for better understanding"*. If materials are only in English many people will not be able to read and understand especially those who are not well educated.

© University of Venda

University of Venda
Creating Future Leaders

4.5.2.5. Poor logistics

The participants indicated that they have attended the training in different places per arrangements of the organizers of the training from the department of health. Most of those trainings where conducted in the hotels where all church leaders were transported and accommodated free by the department of health. Accommodation and transport arrangements were poor in some of the trainings. Few participants reported poor arrangements in transport and accommodation.

Participant C complained that accommodation was not well arranged on time in the training he has attended by saying, "*Accommodation was not well arranged on time, some of us did not have accommodation and arrangements were made while we were there waiting*". While participant E complained of transport arrangements on training he has attended. Participant E said, "*Another challenge I have observed on the side of the department of health is that sometimes they let us down by not organizing transport and those who are to attend the training will have to use their own money for transport without any compensation*". The accommodation and transport arrangements need to be done properly and on time to avoid poor attendance to the future trainings.

4.5.2.6. Lack of follow up after the training

Participants complained about a lack of follow up after the training to see if what they were taught is implemented. Participant D posed his concern that, "*The Department of Health is also not making follow up to monitor the implementation of the knowledge given through the training*". If the aim of the training was to get church leaders to be involved in the fight against HIV/AIDS, mechanism to monitor implementation was necessary. Participant C indicated that, "*Follow up is not done as there is also no provision for feedback to the department by church leaders who received the training*". Another participant recommended that, "*There must be a monitoring system to see if those who are trained are involved*". It is important that the training should give mandate to church leaders on what they should do and monitor if it is done to avoid fruitless expenditure by the department.

© University of Venda

University of Venda
Creating Future Leaders

Participant B when responding to the issue of follow up after the training said, "*It was just a matter of training people and giving them certificates without considering how the knowledge could be used to help other people*". Follow up after the training does not seem to happen effectively. Inputs from participants revealed that there are no organized structures so far to co-ordinate and monitor the implementation of knowledge acquired during training. This compromises the knowledge of church leaders on how they can maximize their contributions towards HIV/AIDS intervention. The participants therefore suggested that follow up mechanism should be established to monitor the implementation of the knowledge gained through training.

4.6. Summary of the qualitative key findings

The key findings are the outcome of the discussions emanated from the two themes. The first theme was addressing the state of current HIV/AIDS training Program. The current training is structured in a way that it combines both church leaders and traditional healers. Participants expressed their dissatisfaction about this arrangement and have preferred separate trainings for the church leaders to avoid clash of interest based on their different faith background. The training found to have addressed aspects on HIV/AIDS knowledge and perception of stigma, but did not cover the aspects on the role that church leaders can play with regard to HIV/AIDS interventions.

The second theme addressed the challenges experienced by the church leaders regarding the implementation of the current HIV/AIDS training program. Challenges experienced where on the side of facilitation, facilitators, information on condom, learning materials and training logistics. Facilitation strategy that was used during the training was lecture method only. Church leaders preferred participatory methods than lecture method alone. The attitude of facilitators was also perceived as negative towards Christianity and that was also a major concern as church leaders expected somebody who will show respect towards their Christian faith to gain their cooperation. The over-emphasis on condom use by facilitators also raised a concern, as church leaders felt that condom use

UNIVERSITY OF VENDA
LIBRARY

© University of Venda

University of Venda
Creating Future Leaders

is not the only way to prevent HIV/AIDS. The training did not distribute reading material to reinforce learning after the training. Mechanism to monitor the implementation of knowledge received after training is a concern to be addressed. Church leaders also complained about poor arrangements on the side of transport and accommodation.

4.7. Summary

This chapter described the study results about the knowledge, attitudes and practices (KAP) of church leaders regarding HIV/AIDS, as well as the experiences of those church leaders who have attended the current HIV/AIDS training programme. Combining quantitative and qualitative approach provided the researcher with more complete understanding of the research problem than either approach alone. A needs assessment is important before decisions are taken about type of activities to be included in the programme. Development of a progamme should be based on the needs assessment of people who are going to be trained to can address their specific needs.

The results from the quantitative study confirmed the qualitative themes on knowledge, attitudes and role of the church leaders regarding HIV/AIDS. It became clear when results were compared in the discussion that the current training has some gaps which will be addressed by an adapted training programme to be developed.

The following gaps were identified:

- Content of the training programme failed to clarify the specific role of church leaders with regards to HIV/AIDS,
- Issues of Christian faith were not considered to brand the training, and
- Facilitation strategy did not consider principles of adult learning.

The gaps identified will be addressed by the new training programme to make it suitable and fit to address church leaders' needs in the Limpopo province. The findings from both

© University of Venda

University of Venda
Creating Future Leaders

quantitative and qualitative studies confirmed that there is a need for an adapted HIV/AIDS training programme to address specific needs for church leaders in Limpopo province. Administration issues like reading material, follow up mechanism, logistics will also be taken into consideration when implementing an adapted training programme for church leaders.

© University of Venda

University of Venda
Creating Future Leaders

CHAPTER 5

AN ADAPTED HIV/AIDS TRAINING PROGRAMME FOR CHURCH LEADERS IN LIMPOPO PROVINCE, SOUTH AFRICA

5.1. Introduction

Chapter 4 dealt with the presentation and discussion of both quantitative and qualitative findings. This chapter describes phase two and three of the study which is the development and validation of an adapted HIV/AIDS training programme for church leaders in Limpopo province. This chapter addressed the fifth and sixth objectives of the study which were to:

- Develop suitable HIV/AIDS training programme for church leaders in the Limpopo province based on the findings.
- Validate the developed HIV/AIDS training programme for church leaders in the Limpopo province.

PHASE 2

5.2. Development of an adapted HIV/AIDS training programme for church leaders

The results that emanated from analysis and synthesis of both quantitative questionnaires and qualitative in-depth individual interviews were the basis for the development of an adapted HIV/AIDS training programme for church leaders. When results were compared during discussions of findings in chapter 4, the process led to the structured composition of the training programme to be developed. The following gaps were identified when results were synthesized:

- The content of the training programme failed to clarify the specific role of church leaders with regards to HIV/AIDS. This is also confirmed by quantitative findings that 60% of church leaders are not involved in HIV and AIDS activities in their churches and community as they do not know what to do.

© University of Venda

University of Venda
Creating Future Leaders

- Issues of Christian faith were not considered to brand the training, yet statistics show that 79.9% of the populations in the area are Christians (Statistics SA, 2016).
- The facilitation strategy did not consider principles of adult learning as evidenced by the qualitative findings in section 4.5.2.1 of the results.

The description followed the reasoning map outlined by Dickoff et al. (1968) and the six step phases of the curriculum development process by Meyer and Van Niekerk (2008). The development of the training programme was further based on the guidelines of programme development by SAQA. The training programme is aimed at enhancing church leaders' response towards HIV/AIDS epidemic and enables them to effectively work as part of a multidisciplinary health team in addressing HIV/AIDS epidemic in the Limpopo province.

5.2.1. Elements of practice Theory

The six elements of practice theory as described by Dickoff et al. (1968) were used as the basis of the development of an adapted HIV/AIDS training programme. These are: agent, recipient, context, dynamics, procedure and terminus. The survey list questions were used as the reasoning map to identify the practical activities that should be performed. The aspects of activity corresponding to the six questions are six elements from which to survey activity. The researcher looked at the developed training programme in six different dimensions in the hope of revealing different features as point of view shifts.

5.2.1.1. Who or what performs the activity? (Agent)

The activity in this study referred to a training programme which is aimed at equipping church leaders to be fully involved in HIV/AIDS interventions' programmes. Activities involved in the training programme include the curriculum, teaching methods and assessments. The agent is someone who performs an action to realize the goal (Dickoff et al., 1968). The agents in this programme are trainers, the Health Care Professionals

© University of Venda

University of Venda
Creating Future Leaders

who have appropriate expertise in HIV and AIDS and with good facilitation skills. The health care professionals are qualified professionals who are accredited to train by the South African Qualification Authority and they are involved in HIV/AIDS training in the province. The health care professionals were selected because of their qualifications and expertise in the area of HIV/AIDS training. They are currently training HIV/AIDS counsellors, community health workers and health care professionals in the province.

5.2.1.1.1. Qualities that the agent should possess/ characteristics of a facilitator

Qualification, skill and experience are internal resources that are appropriate in implementing the adapted HIV/AIDS training programme. The Health care professionals must be those who are working within the directorate of HIV/AIDS in the province and are involved in training others on HIV/AIDS related topics within the department of health. The agent who will facilitate should be knowledgeable, skillful in the area of HIV/AIDS, an effective communicator, committed, compassionate, resourceful, well- organized and inventive. The agent's qualification and experience are internal resources which are appropriate for enabling the creative and constructive attitudes towards the implementation of the adapted HIV/AIDS training programme. The agent should be involved in the HIV/AIDS activities within the province and should be able to understand the principles of adult learning.

- **Empowering potential**

The agent should be a good facilitator, who would assist the recipient of the programme with achieving all the specific expected outcomes of the training programme. Facilitation is a process in which an adult learner is engaged in building up knowledge, skills and values by interacting with colleagues and facilitators (Meyer and Van Niekerk, 2008). The facilitator should be able to recognize different adult learning styles and should consider these varieties when delivering the content. The facilitator, as a change agent, is the most important variable in the achievements of effectiveness of the training programme (Bergh & Geldenhuys, 2013). The following qualities are therefore, viewed to be necessary for

© University of Venda

the agent to empower the recipients during the implementation of an adapted HIV/AIDS training programme:

Ambassador: The agent has to know how to handle variety of situations in church leaders from Christian background in such a way that church leaders will accept the training and understand their role towards people living with HIV and AIDS. Qualitative findings revealed that some of the facilitators of the existing HIV and AIDS training were displaying negative attitude towards Christianity. The facilitator of a developed adapted HIV and AIDS training should be able to handle issue of Christian faith in a dignified manner.

Creative builder: Creativity is generally defined as the ability to produce work that is novel, useful and adaptive to the needs of church leaders (Bergh & Geldenhuys, 2013). The agent has to understand that it is not only about the implementation of a developed adapted HIV and AIDS training programme to church leaders, but is also presenting the training as close as possible to the real needs of church leaders. The agent should be able to make Church leaders see a need to be involved in an HIV/AIDS as part of their Christian ministry. The approach would ensure that the implementation realized the purpose of its inception. This calls for the urgent to be creative with the view of achieving the goals of implementing the training programme (Galford & Maruka, 2010).

Communicator: The agent should communicate effectively by initiating conversations focused on items that should be implemented for the adapted HIV/AIDS training programme. According to Basavanthappa (2009), the following guidelines are important for the agent to communicate effectively:

- Know your audience,
- Understand the idea you want to communicate to recipients with the view of expressing yourself effectively,
- Avoid the use of ambiguous words when communicating,
- Limit too much talk because people will lose interest in your talk,
- Gestures and tone of voice must support the message that you want to communicate to people,

© University of Venda

University of Venda
Creating Future Leaders

- Emphasize the purpose during communication, and
- Avoid communicating topics not related to each other.

5.2.2. Who or what is the recipient of the activity? (Recipient)

Basavanthappa (2009) defines a recipient as an individual who is seeing and hearing transmitted messages from the sender. The recipient of the activity are all those persons or things who receive action from agents (Dickhoff et al., 1968). This training programme is expected to address gaps identified and experienced by church leaders who attended the current HIV/AIDS training programme pioneered by FPD and the department of health. The church leaders in the adapted HIV/AIDS training programme are the recipients of the activity because they have influence in their churches and communities. Church leaders can therefore use the trust and authority they have to change the course of HIV/AIDS pandemic in the Limpopo province. Recipients in this study are not all leaders in the church, but leaders who are established in authority over the other church members in a church or congregation who can be able to have influence on others in the church. Church leaders include Bishops, Apostles, Prophets, Evangelists, Pastors, Elders, Deacons, and church board members. The recipients should possess a minimum of grade 10. Findings from the quantitative methodology confirmed that 75% of church leaders had post matric qualifications, while 15% have grade 10, and only 10% of the population have qualification below grade 9. Therefore, a minimum of grade 10 will cover 90% of the church leaders with the training information.

The training programme is expected to enhance church leaders' involvement towards HIV/AIDS activities in the province as churches have credibility and are grounded in the communities. The training will offer them the opportunity to make difference in responding to HIV/AIDS crises by bringing healing, hope and care to all affected by HIV/AIDS.

Recipients are expected to be independent while exercising their role with regard to people living with HIV and AIDS in the church and in the community interacting positively with other governmental and non-governmental organizations dealing with HIV/AIDS in

© University of Venda

University of Venda
Creating Future Leaders

the province. Galer, Vriesendorp and Ellis (2005), outline that the recipients are responsible to cultivate and maintain positive working relationships in the training environment because it results in marked respect, honesty and commitment to the mission of the training programme by all members. People living with HIV and AIDS would confirm that the training was effective in empowering the recipients based on the positive interaction and care they receive from trained church leaders. The effective interpersonal relationships are fostered by high levels of emotional intelligence. The recipients who are church leaders should possess components of emotional intelligence and leadership characteristics. Bergh and Geldenhuys (2013) define emotional intelligence as the ability to monitor one's own and others' feelings and emotions, to discriminate amongst them, and to use this information to guide one's thinking and actions. According Bergh and Geldenhuys (2013), the four interrelated components of emotional intelligence are:

- Self- awareness which is the ability to accurately perceive one's own emotions,
- Self-regulation which is the ability to manage disruptive impulses and fostering self-control, tolerance and constructive anger management,
- Motivation which is the ability to use one's emotions to focus and stimulate your actions and thoughts in a positive and productive manner, and
- Being able to accurately read the emotions of others and manage them effectively. This involve skills such as conflict resolution, negotiation, communication, participation and leadership.

The adapted HIV and AIDS training programme was based on the specific needs emerged during data analysis and inputs made by participants during the qualitative interviews because it needs to address the gaps that were identified in the current HIV and AIDS training programme.

5.2.3. In what context is the activity performed? (Framework and context).

According to Dickoff et al. (1968), to view activity from the aspect of framework is to view activity from the aspect of the matrix of that activity. It is seen in relation to other things, including persons, and other activities, and see the interrelation of these other factors as

© University of Venda

University of Venda
Creating Future Leaders

constituting an organism, unity, or total context of activity. The training programme considered the matrix in which the training takes place. Both physical and non-physical were recognized as parts of the framework. The context of this training include the health care context because HIV/AIDS is a disease and the community environment as the church is an institution in the community setting. This framework in the community is also within other minority faith context that may have influence on the outcome of the training. Attention should be given where minority religions are conflicting with Christian faith to address their concerns as the constitution of South Africa embraces all religions. It is hoped that church leaders who will receive training will also include all people in their response against HIV/AIDS epidemic without looking at their religious background. This training programme is expected to be implemented in the context where the church leaders are operating in the community. The community is regarded as important because that is the environment where churches are operating, and church leaders have influence to church members and community members. Christian faith beliefs shared by church leaders and members in the community have influence on how the HIV/AIDS training programme will be conducted. Activity is produced within a framework, then can be viewed as produced by agent and received by a recipient. Training will be implemented to church leaders in a community environment than in the health institution.

5.2.4. What is the energy source of the activity? (Dynamics)

The dynamics refers to forces that stimulate movement towards change and development, it is the power sources for an activity (Dickoff et al., 1968). The agent, recipient and the context are expected to own these forces in order to drive the implementation of an activity.

The underlying dynamics during the implementation of the programme should address the identified challenges and gaps experienced by church leaders who have attended the HIV and AIDS programme conducted by FPD in collaboration with the department of health. The qualitative findings of this study have identified poor facilitation characterized by lecture method only, lack of competency by facilitators and some elements of negative

© University of Venda

University of Venda
Creating Future Leaders

of the HIV and AIDS training programme and also give support to the recipients during the training process. The empathetic attitude of the agent will create a conducive environment for the implementation of an adapted HIV and AIDS training programme for church leaders in the Limpopo province of South Africa.

Knowledge of Christian faith: The agent should be able to understand bible verses and basic issues relating to Christian faith to avoid clash of interest with the recipient. The qualitative findings revealed that church leaders were not happy with the attitude of the facilitators towards Christian faith and recommended that the facilitator should at least show interest and respect to Christian faith even if he/she is not a Christian. Basic knowledge of the bible and Christian faith is important for the agent to achieve the goal of training church leaders successfully and effectively.

Promotion of interpersonal relationships: There should be a trusting relationship amongst all elements involved in the implementation of an adapted HIV and AIDS training programme. The agent, recipient and the context should be integrated to ensure that the effort achieves the goal.

The agent has a part to play in developing a healthy interpersonal relationship with recipients for them to understand all aspects of the developed HIV/AIDS training programme. The agent needs to have qualities that are necessary for building positive interpersonal relationships with the recipients and stakeholders involved in the HIV/AIDS activities in the province, both governmental and non-governmental organizations. According to Bergh and Geldenhuys (2013), the agent should be a good listener who communicate effectively with all members of the team and be able to give feedback to the group on group dynamics, meaning, communication, leadership, roles, status, norms and conflict. Building good interpersonal relationships is a positive force to drive the implementation of the programme. The agent should ensure that the recipients are supported, guided, given direction, encouraged and provided with relevant competencies and material resources in the programme (Dickhoff et al., 1968; Meyer & Van Niekerk, 2008).

© University of Venda

University of Venda
Creating Future Leaders

Beside the skills and qualities, the agent should have, the recipient who is a church leader must also have the motivation to learn. Motivation forms the source of encouragement for church leaders during the HIV and AIDS training process. The recipient will be motivated to learn by the nature of the adapted training programme which is aligned to Christian beliefs and values, because they want to achieve the set goals in order to get the results and to know that their efforts enable them to effectively work as part of a multidisciplinary health team in addressing HIV/AIDS epidemic in Limpopo province (Galer et al., 2005).

It was assumed that the topics included in this training programme would address the gaps identified within the current training as cited by participants during qualitative interviews and also confirmed by quantitative findings. The outcomes of the aspects that should be learnt by church leaders ought to be seen as realistic, important and specific to their learning needs in their context for them to commit themselves to learning (Graig, 1996). Theme four of the qualitative findings revealed that church leaders felt that for the training to be effective and attract churches to be involved, it must be branded with the word of God. The adapted HIV and AIDS training programme will give church leaders the impetus and direction to performance of the activity, as well as sustenance for that performance.

UNIVERSITY OF VENDA
LIBRARY

5.2.5. What is the guiding procedure or process? (Procedure)

Procedure, according to Dickoff et al. (1968), is to view the activity from the vantage point of the principle, rule, routine, or protocol governing the activity, and to emphasize the path, steps and pattern according to which the activity is performed. The procedure provides details sufficient to enable activity to be carried out. Procedure is a general rule rather than a directive to a specified agent at a specified time and place. The guiding procedure in the training programme is the processes to be included in the implementation of the adapted HIV and AIDS training programme for church leaders. The procedure should also confirm the competencies which the agent needed to function effectively during the implementation of an adapted HIV and AIDS training programme

© University of Venda

University of Venda
Creating Future Leaders

should possess. The timeframe for the realization of the program will be three days as the programme is a short course to close the identified skills gap. The paradigm for learning, different learning approaches, assessment criteria, pre-requisite for attending the progamme and implementation guidelines will be aligned to the goals of the programme. Administration challenges like lack of reading material, lack of follow up mechanism and poor logistics identified during the in-depth individual interviews should be addressed when implementing an adapted training programme for church leaders. The expected procedure for the achievement of the target goal included:

5.2.5.1. Paradigm for learning

The paradigm for implementing the programme was based on Knowles' andragogical learning theory because it focused on adult learners. The procedure for implementing the adapted HIV and AIDS training programme should be based on principles of adult learning. A comprehensive understanding of adult learning principles by the agent is critical for the success of an adapted HIV and AIDS training programme. The researcher assumed that for the implementation of an adapted HIV and AIDS training programme to achieve the set goals, an adult learning theory could be appropriate. Knowles' Adult learning theory as described by Knowles et al. (2012) should be considered when programme is offered.

It is acknowledged that adult's learners:

- Need learning to be relevant and practical. Before attending any training, adults ask themselves questions whether the programme is worth attending; otherwise it would be a waste of time. Adults must see the reason for learning something. Therefore, learning engagements must identify objectives for adult participants before the course begins. The adapted HIV and AIDS training programme addressed the church leaders needs based on the quantitative and qualitative findings of this study.
- Are autonomous and self-directed. The facilitator must actively involve adult participants in the learning process, guiding them to their own rather than supplying

© University of Venda

University of Venda
Creating Future Leaders

them with all the facts. The church leaders' experiences captured during qualitative interviews pointed to the fact that facilitators were unable to engage adults' learners, only lecture method was used. Facilitators for the adapted HIV and AIDS training programme should allow the participants to assume responsibility for their learning and engage them in discussions, presentations and group based tasks.

- Bring knowledge and experience to each learning activity. Linking new material in a course to learners' existing knowledge and experience creates a powerful and relevant learning experience. Facilitators should link the new material to the existing knowledge and experiences of church leaders.
- Are goal-oriented. Adults are ready to learn if the aspects of training are close to what would assist them in their working environment. The adapted HIV and AIDS training programme was developed to assist church leaders in carrying out their HIV and AIDS interventions activities. The facilitators should be able to clearly define learning objectives early in the course to engage adult learners.
- Are problem-oriented and want to apply what they have learned. Adult learners want to be able to apply their learning to their work or personal life immediately. The facilitators of the adapted HIV and AIDS training programme should use examples to help them see the connection between classroom theories and practical application; utilizing problem solving activities as part of the learning experience, and creating action plans together with learners are important concepts that enable life application.
- Are motivated by intrinsic and extrinsic factors. Motivation is high when they are faced with learning a new work process or approach to a problem. The facilitators of an adapted HIV and AIDS training programme should clearly demonstrate to the learners how the training would benefit them in their area of work.
- Are pressed for time. Church leaders have demanding church work, family responsibilities, and community commitments. Even if they are highly motivated to learn, the pressures of life often limit the time they can invest in learning. Therefore, in many cases learning must be available when it is convenient for the learner and delivered in a manageable content.

© University of Venda

- Have different learning styles. Each church leader may have preferred learning styles. In training the facilitators should consider each of these styles when delivering the content of an adapted HIV and AIDS training programme.

In order to facilitate actions that result in learning among adults, it is critical for facilitator to have a fundamental knowledge of all of the above principles as well as an understanding of how to implement them during the roll out of the training.

5.2.5.2. Different learning approaches

The qualitative findings revealed that church leaders during the previous training they have attended were not treated as adults who were expected to direct their learning. With the adapted training programme, church leaders are expected to be actively involved in directing their learning. Therefore, the following training methods are adapted to facilitate the implementation of the training programme:

Self-directed learning

Self-directed learning is an effective learning approach that will be used for an adapted training programme. Adults need to be free to direct their own learning. The learning engagement will be classroom-based for this programme, therefore the facilitator must actively involve adult participants in the learning process. Specifically, they have to be sure to act as facilitators, guiding participants to their own knowledge rather than supplying them with all of the facts (Meyer & Van Niekerk, 2008). Facilitator should allow the participants to assume responsibility for their learning and engage them in discussions, presentations and group-based tasks. The qualitative findings on the experiences of church leaders with regard to the training programme they have attended confirmed that church leaders were not in favour of having facilitator who will only lecture them without giving them opportunity to discuss or present what they know. The adapted training programme will consider self-directed learning approach to engage adults during training.

© University of Venda

University of Venda
Creating Future Leaders

Facilitation

Facilitation is a process during which an adult learner is engaged in acquiring knowledge by interacting with colleagues and facilitators during training. The role of the facilitator in the learning process includes the provision of guidelines on the required information, and on how and where learners should obtain outcomes (Meyer & Van Niekerk, 2008). The facilitator should make it easy for the learner to understand the learning material, than to force the leaners to learn what they do not want. To accommodate learners with slower tempo of learning the facilitator should also use more examples. During the roll out of the current training, facilitation strategy used did not accommodate principles of adult learning. The facilitator will also be expected to assist, reassure, encourage and motivate the church leaders during the roll out of the programme. It is therefore necessary that the adapted training progamme be facilitated by someone with relevant knowledge and skills in HIV and AIDS field.

The tentamen

The tentamen is a unique learning opportunity for learners in which the facilitator and learners share thoughts actively and creatively (Meyer & Van Niekerk, 2008). Tentamen is instrumental in the development of problem solving skills, of an attitude of critical questioning, and of the creative thinking skills necessary for church leaders to get involved in responding to HIV and AIDS epidemic in the Limpopo province. Church leaders would learn to solve HIV and AIDS issues in their churches and give their own point of view regarding prevention of HIV infections and care of people living with HIV and AIDS. Advantages of the tentamen as a teaching method for church leaders in line with Meyer and Van Niekerk (2008) are as follows:

- Learners' independent thinking is developed.
- Learners discover their own abilities, and learn to assess other learners' inputs and sources of information.
- Facilitators actively accompany learners in interpreting principles and applying theory.

© University of Venda

University of Venda
Creating Future Leaders

- Learners use their comprehensive thinking skills effectively.
- Facilitators get feedback on the quality of the training programme, and learner interaction is enhanced.

This strategy will enhance church leaders' involvement in HIV and AIDS activities.

Small group discussion

Small group discussion is valuable when dealing with adult learners. According to Killen (2007) adult learners learn more in a group context than in whole class teaching. The qualitative findings in section 4.5.2.1 confirm that the church leaders who have attended training programme conducted by the department of health felt that their views and their knowledge regarding HIV and AIDS should have been shared during group discussions. The emphasis here is on participation rather than being passive recipients. The aim for group discussion in the adapted training is to encourage an exchange of views and enhance socialization amongst church leaders. The church leaders in the adapted HIV and AIDS training programme will be divided into small groups with group leader to look at problems in a non-judgmental way and to interact with colleagues in active problem solving. The facilitator should act as the resource, who also initiates the discussion by posing pre-prepared questions to guide learners' thoughts (Meyer & Van Niekerk, 2008). Killen (2007) identified factors that ought to be observed in small group discussions as follows:

- A group leader and a secretary should be chosen for the group.
- The facilitator should express clear guidelines for the learners.
- The facilitator should assist the learners by providing direction.
- There should be a clear focus on learning amongst the group members.
- Learners should assist each other in the careful management of the learning environment to enable them to learn effectively.
- All learners should be willing to actively participate during group discussion.
- The facilitator should monitor the progress of the learners while the learner should know that it was their responsibility to give the facilitator feedback of the work completed.

© University of Venda

University of Venda
Creating Future Leaders

- Learners and facilitators alike should monitor time.

According to Meyer and Van Niekerk (2008), group discussion can become ineffective if:

- Outcomes are not well formulated
- Learners do not prepare, and thus the facilitator takes over and the group discussions become a lecture
- Some learners dominate the discussion
- Groups are too big, then not all learners can participate

The facilitator of the adapted programme will carefully plan the execution of small group discussions.

Reflective teaching

Reflective teaching is a step in experiential learning. This approach will assist the facilitator and the learner to look back, think about what had happen in the past and the reason why it had happened in order to plan for the future by using what has happened in the past (Killen, 2007). A reflective practitioner according to Bruce, Klopper and Mellish (2011) is characterized by a range of personal qualities and abilities, such as the ability to:

- Engage in self-assessment;
- Criticize the existing state of affairs;
- Promote changes and adapt to change; and
- Practice as an autonomous professional.

In the adapted training programme reflection would be within the group context, where in within the group, individuals who have participated in the experience, share with colleagues and peers what they saw and felt during the activity. The facilitator can then guide participants along a systematic analysis by asking a series of broad questions (Bruce et al., 2011). Reflective teaching will actively involve the church leaders in their learning and promote changes that will engage them in dealing with HIV and AIDS epidemic in the Limpopo province.

© University of Venda

University of Venda
Creating Future Leaders

Role play

Role play is based on simulation techniques and it requires the spontaneous acting out of a situation by two or more participants under the direction of the facilitator (Bruce et al., 2011). Role play will allow church leaders to explore realistic situations by interacting with each other in order to develop experience in a supported environment. This strategy can incorporate drama, simulation, games and demonstrations of real life cases related to HIV and AIDS topics to be covered by the training. Role play would enable church leaders to immediately apply the content in a relevant, real world context. Church leaders will also engage in higher order thinking and learn content in a deeper way.

5.2.5.3. Assessment criteria

Tentamens, peer assessment and feedback during small group discussions will be used to assess learners. Tentamen will be carried out as part of facilitation. Tentamens will assess learners' ability to apply the theory in the practice situation (Meyer and Van Niekerk, 2008). The facilitator of the programme will include written questions which learners will use in preparing their thoughts, with a framework of the possible answers as the memorandum. Peer assessment and feedback during small group discussion will also be used to enhance church leaders to deepen their understanding of the training programme content. No formal summative assessment will be carried out as the programme is a non-credit bearing course.

5.2.5.4. Pre-requisite for attending the programme

The following aspects were considered for church leaders' inclusion in the adapted HIV and AIDS training programme:

- Should have a minimum schooling of grade 10
- Should possess basic knowledge on HIV and AIDS

© University of Venda

University of Venda
Creating Future Leaders

5.2.5.5. Implementation guidelines for an adapted HIV and AIDS training programme for church leaders.

The adapted HIV/AIDS training programme needs guiding principles for the accomplishment of its objectives. Guidelines address the learning needs of the church leaders identified during the data analysis. These guidelines implied the course of action to be followed for achieving the set goals of the adapted training programme. These steps should be taken into account:

General purpose of the programme

The purpose of the programme should be based on the findings of the experiences of church leaders who have attended the current training programme conducted by FPD and department of health.

Programme outcomes

Outcomes describe learning that are expected at different levels of the programme. The outcomes should be achievable.

Programme content

The content of the programme should cover all the outcomes.

Technique to deliver the programme

The techniques chosen to facilitate the programme should be congruent to the outcomes.

© University of Venda

University of Venda
Creating Future Leaders

Assessment methods

The utilized assessment methods should assist with evaluating whether the outcomes of the programme are achieved or not.

5.2.5.6. Implementation recommendations for an adapted HIV/AIDS training programme.

The following challenges were experienced by church leaders who have attended the previous training: Lack of access to training materials, poor logistics on the side of transport and accommodation and lack of follow up after training.

To overcome administrative challenges experienced by church leaders during the implementation of the previous training, the following recommendations should be considered when implementing the adapted training programme.

- Learning materials must be made available to all church leaders who are attending the training in the form of a learner manual or package.
- Mechanism for feedback after the training should be established to monitor the implementation of the training in churches and communities. The trainers and all stakeholders involved in the training should encourage and assist church leaders to form HIV/AIDS forums that will monitor the implementation of training knowledge into the real situation and will also liaise with the department of health for feedback and support.
- Organizers of the training from the department of health should work together with church leaders when planning the training sessions to overcome inconveniences on the side of transport, meals, venue and accommodation.

© University of Venda

University of Venda
Creating Future Leaders

Concluding remarks about the procedure

An adapted HIV and AIDS training programme for church leaders is necessary for the accomplishment of study objectives. Paradigms for learning and different learning approaches were outlined in relation to how they could be utilized during the implementation of the training programme. Implementation guidelines steps and recommendations outlined should be taken into account while working towards the attainment of the outcomes of the programme.

5.2.6. What is the end point of the activity? (Terminus)

The terminus is to view the activity from the perspective of the end point or accomplishment of the activity (Dickoff et al., 1968). The end point of an adapted HIV and AIDS programme is the outcome, which confirms whether goals which were set for the activity in question were achieved or not. The outcomes are consistent with the purpose of the training programme and are expected to yield the anticipated results. The purpose of the programme is to empower the church leaders with the necessary knowledge and skills to be involved in HIV and AIDS intervention activities effectively within their churches and communities. The acquired knowledge will also result in personal and professional growth of the recipients.

The outcome of the programme focuses on the church leader being:

5.2.6.1. Competent in responding to HIV and AIDS epidemic

The expected outcome of the activity in this study would be competent church leaders after successful implementation of the adapted HIV and AIDS training programme. All the outcomes of the training programme activities will be assessed to establish the competency level of the church leaders on HIV and AIDS. The facilitators of the training are expected to successfully implement the training programme and to achieve all set goals. In order to achieve the set goals, the facilitators must have the resources to perform the activity, plan the manner in which the resources will be applied during the execution

© University of Venda

University of Venda
Creating Future Leaders

of the activity, record all that was done and to give feedback about the completion of the activity. The recipient should be able to visualize the end goal of the implemented activity.

5.2.6.2. Empowered on an HIV and AIDS, leading to churches involvement in responding to the HIV/AIDS pandemic.

The involvement of churches in HIV and AIDS response in the Limpopo province can be achieved if there is personal and professional growth, and accountability assumed by the church leaders who have attended the training programme. The church leaders need to be empowered with information, which will lead to personal and professional growth, and in turn they should empower church members. The information should enhance church leaders' skills in dealing with church members and community members who are living with HIV and AIDS. The church leaders can disseminate the information to church members and community that can empower them to accept and care for those people who are living with HIV and AIDS.

5.2.6.3. Autonomy in establishing HIV and AIDS intervention programmes

The training programme should be context specific with the aim of empowering church leaders with knowledge and skills to be autonomous when developing and managing their HIV and AIDS intervention programmes in their respective congregations. Autonomy in this context means that church leaders are afforded the power to be creative and to put their own potential to good use while involved in HIV and AIDS intervention strategies in their churches without the interference by the department of health. However the department of health can provide guidance, material resources and support during the process. Church leaders will then be able to be fully accountable and responsible for their interventions programmes without shifting responsibility to other stakeholders who are involved in the management of HIV and AIDS in the Limpopo province. After the completion of three days training the church leaders will be awarded with a certificate of attendance as there will be no formal assessment at the end of training.

© University of Venda

University of Venda
Creating Future Leaders

5.3. The developed adapted HIV/AIDS training programme for church leaders In Limpopo province, South Africa.

The adapted HIV/AIDS training programme is a short learning programme for church leaders from Christian churches. It is a non-credit bearing short programme which covers less than 1 credit towards a unit standard according to SAQA requirements for National Qualification Framework (NQF) levels. The programme is focusing specifically on closing the gaps that were identified during data collection in phase one of this study in order to provide church leaders with information that will enable them to can be involved in HIV and AIDS epidemic response in the Limpopo province.

There will be no formal assessment of the module; only oral/written assessment-tentamens will be carried out during facilitation as well as peer assessment and feedback during small group activities. The description of the adapted HIV/AIDS training programme adopted the relevant SAQA guidelines for short programme.

- Name of the programme
- Purpose of the programme
- Duration of the programme
- Learning assumed to be in place
- Specific outcomes
- Programme content

5.3.1. Name of the programme as a short course

The Role of church leaders in response to HIV and AIDS

5.3.2. Purpose of the programme

This programme is aimed at empowering the church leaders from Christian background with the necessary competencies to be involved in HIV and AIDS interventions activities effectively within their churches and communities in the Limpopo province of South Africa.

© University of Venda

University of Venda
Creating Future Leaders

5.3.3. Duration of the programme

The Programme is a three-day course.

5.3.4. Learning assumed to be in place

Rules for admission to the programme are set for the programme. In order to enroll to this programme a church leader should:

- Have a minimum schooling of grade 10
- Possess basic knowledge on HIV and AIDS

5.3.5. Specific outcomes

Specific outcomes were developed to address gaps identified on the emerged qualitative themes during data analysis which was confirmed by quantitative findings.

At the end of the training programme the church leaders should be able to:

- Analyze HIV and AIDS in the context of the bible
- Identify strategies to prevent and control HIV infection
- Implement caring strategies to PLWHA
- Apply basic skills of counselling in the context of HIV and AIDS

5.3.6 Programme content.

The learning content of the adapted HIV and AIDS programme is consolidated in one module with four study units. The content in the programme refers to:

- Study unit purpose
- Specific outcomes
- Content of the subject matter
- Teaching approaches
- Assessment methods
- Learning material

© University of Venda

University of Venda
Creating Future Leaders

Content of the module in the programme

Module: The Role of church leaders in response to HIV and AIDS

Study Unit 1: HIV & AIDS in the context of the bible

- Definition of HIV and AIDS
- Difference between HIV positive and AIDS
- Jesus healing ministry and HIV and AIDS
- Biblical framework of the disease
- Moral dilemma regarding HIV and AIDS

Study Unit 2. Church leaders' role towards HIV prevention and control

- Modes of transmission of HIV
- HIV and AIDS related stigma
- Effect of HIV and AIDS stigma on individual and community
- Role of the church in reducing stigma related to HIV and AIDS.
- Prevention and control strategies relevant to Christian churches

Study Unit 3: Church leaders' role towards caring PLWHA

- Biblical guiding principles towards caring PLWHA
- Caring strategies

Study unit 4: Counselling in an HIV and AIDS context

- Definition of counselling.
- Difference between counselling and advice
- Goal of HIV/AIDS counselling
- Qualities needed for an effective counsellor
- stages and steps of counselling process

5.3.6.1. Study Unit 1: HIV and AIDS in the context of the bible

© University of Venda

Purpose of the study unit

The purpose of the unit is to equip church leaders with competences, to have knowledge, attitudes and values regarding aspects in HIV & AIDS and the Bible for effective involvement of churches in response to HIV and AIDS epidemic.

Learning outcomes

At the end of this study unit the learners should be able to:

- Define and differentiate between HIV and AIDS
- Examine biblical framework of understanding the disease
- Evaluate HIV and AIDS in the context of Jesus healing ministry
- Explore the moral dilemma regarding HIV and AIDS

Group activity 1.1

Answer the following questions:

1. What is HIV?
2. What is AIDS?
3. How do the two differ from another?
4. How can you tell if someone has HIV?

Content

The content includes what is HIV and AIDS, Biblical framework of understanding the disease, Jesus healing ministry and HIV and AIDS, and moral dilemma regarding HIV and AIDS.

Definitions of HIV and AIDS

HIV

- HIV is an acronym for Human Immunodeficiency Virus, which causes AIDS. The HIV infection undergoes different stages before it leads to AIDS. HIV causes

© University of Venda

University of Venda
Creating Future Leaders

severe damage to the immune system and eventually destroys it. It accomplishes this by utilizing the DNA of CD4+ lymphocytes to replicate itself.

- HIV is a retrovirus (therefore drugs are called antiretroviral)
- . Like other retroviruses, HIV infection has a long incubation period (8-10 years) before signs and symptoms of AIDS appears.
- HIV is so small and can only be seen under very powerful microscope
- HIV is not very strong
  - Does not live long outside a human host
  - Sensitive to detergents and soaps

Types of HIV

There are two types of HIV that causes AIDS

HIV-1

- First isolated in 1983
- The first populations to be affected were:
  - Men and women with multiple sexual partners in East and Central Africa
  - Men who have sex with men (MSM) in some urban areas of Western Europe, the Americas and Australia
- Three (3) types of HIV-1 isolates - M (major), N (non-M, non-O) & O (outliers)
- Majority of HIV-1 infections are caused by M type viruses
- M further divided into 10 subtypes A to J (also known as clades or genotypes).
- The major subtype in Central and Southern Africa is HIV-1 subtype C
- The major subtype in Western Europe and the Americas is HIV-1 subtype B
- Closely related to Simian (monkey) immune deficiency virus (SIV) found in Chimpanzees in Central Africa.

HIV-2

- HIV-2 was 1st isolated in1986
- Until recently, has been confined to West Africa
- Mainly acquired heterosexually
- Five HIV-2 subtypes (A to E) have been described so far

© University of Venda

University of Venda
Creating Future Leaders

- Closely related to Simian (monkey) immune deficiency virus (SIV) found in Sooty Mangabey Monkey in West Africa

How the crossover occurred from monkey to human is uncertain but may have been related to certain hunting practices, rituals and even the handling and consumption of monkey meat as part of the diet. When man became infected, SIV evolve to become HIV. Additional speculation is that HIV could also have originated in Southern America where monkeys also exist.

Stages of HIV infection

- Infection
- Window period
- Sero-conversion
- Asymptomatic HIV
- Symptomatic HIV
- AIDS

What is AIDS?

AIDS means an Acquired Immune Deficiency Syndrome caused by HIV.

- **Acquired** – it cannot be inherited from parents but it is a condition that has to be contracted.
- **Immune** – it affects the body immune system, the part of the body that protects us against diseases.
- **Deficiency** – it makes the immune system to stop working properly.
- **Syndrome** – a collection of a number of different symptoms and opportunistic diseases.

AIDS was first recognized in 1981 among homosexual men in the United States of America, although it is now known that there were AIDS cases much earlier than 1981 (Kaplan & Sadock, 1998).

© University of Venda

University of Venda
Creating Future Leaders

WHO stages of AIDS

Stage 1: No symptoms (a-symptomatic stage)
Stage 2: Symptoms but patient generally well
Stage 3: HIV-related problems but in bed less than 50% of time
Stage 4: AIDS, in bed most of the time

Difference between HIV positive and AIDS

If a person is HIV positive it does not necessarily mean that the person has AIDS. HIV positive means an individual has the virus but can still live many years without the severe illness or infections.

AIDS is the last stage of HIV infection and is often associated with a group of diseases acquired as a result of a weakened immune system. It generally occurs when the CD4 cell count is below 200/mm3 and is characterized by the appearance of serious opportunistic infections. Normal CD4 cells ranges between 500 and 1500 cells/mm3 of blood.

How can we tell if someone has HIV?

You cannot tell someone's HIV status by just looking at him or her. The only way to know is through an HIV test. The test will confirm if someone has the virus in his or her body.

Biblical framework of understanding the disease

The Bible does not specifically mention AIDS, so will have to understand what relevant principles are found in the Bible. The response of the Christian church to HIV/AIDS was largely interpreted within the framework of disease as punishment for an individual's sin. This understanding fueled the HIV/AIDS stigma and prevented the church to minister to those affected and infected with HIV and AIDS.

© University of Venda

University of Venda
Creating Future Leaders

Framework of the disease as a punishment in relation to the Old Testament

- Disobedience, punishment and death (Genesis 3)
- Disobedience and the plagues of Egypt (Exodus 1-12)
- Individual, leadership and community disobedience (Numbers 12,14 & 21:4-9)
- Obedience as blessing and disobedience as disaster (Deuteronomy 7:12-16, & chapter 28)

The framework of disease as a punishment was challenged by Job and Jesus

Job challenges the framework of disease as punishment

- The righteous do suffer (Job 1-2)
- Job is righteous, but he suffers (Job 38:42)

Jesus challenged the framework of disease as sin

- Neither has this man sinned, nor his parents (John 9:1-3).

Diseases may well be the results of our actions, and not punishment from God for our sin

Jesus healing ministry and HIV and AIDS

The centrality of healing ministry of Jesus is reflected in the gospels. In his ministry wherever he went he played the role of a religious healer. The majority of the recorded healings of Jesus Christ were either physical (damaged bodies, infections and organic diseases), psychological (mental illness), or spiritual (demonic activities). Physical, psychological and spiritual illnesses overlap and influence each other.

Jesus Christ healing methods

- Jesus uttered some words (Luke 4:33-34, 39)
- Touched the sick with his hands (Luke4:40)
- Sometimes used saliva alone or mixed with mud (Mark 7:33-34, John 9:6-7)

© University of Venda

University of Venda
Creating Future Leaders

- Touching Jesus Christ or his Garments (Mark 6:56)
- Prayer (John 11:41-44)
- Faith of a person was important factor in healing (Mark 5:34)
- There were instances where forgiveness of sin was associated with healing (Mark 2:1-12; Matthews 9:1-3)

Characteristics of Jesus approach to sick people

- Jesus had compassion (Mark 6:34)
- Jesus accepted people without condemning them (John 9:1-3)
- Jesus gave people worth (Matthews 12:10-13). People were top priority and he put their needs before the rules and regulations the religious leaders had constructed
- Jesus sought to have people accept responsibility for their healing (John 5:5-6).
- Jesus encouraged people (Matthews 11:28-30)
- Jesus break the stigma by touching lepers (Luke 12:13-14). According to Crowther (1991) people suffering from AIDS are often treated like people who suffered from leprosy.

Moral dilemma regarding HIV and AIDS

Group activity: 1. 2

Debate these questions in small groups, at the end each group will present their discussions.

1. Are all who are infected with HIV guilty of immorality?
2. What about those who are infected due to immorality?

Guide to responses to questions

© University of Venda

There are Christians and church leaders who believe that AIDS sufferers contracted the virus because they had many sexual partners. To address this section, church leaders need to respond to the two questions listed above.

1. Are all who are infected with HIV guilty of immorality?

Throughout the scripture, we read that the innocent often suffers along with the guilty. In Matthews 5:43-48 talks about the fact that the sun shines on all God's people, the righteous and the unrighteous, and the rain also falls on both the righteous and unrighteous. As Christians we are called to love unconditionally and accept people without judging them as Jesus served as an example for us to follow. Not all people infected with HIV are guilty of immorality. If it were that easy, everyone who lived immoral lives would have had AIDS. They are those who contracted HIV through unfaithful husband or wife, through blood transfusion, mother to child during birth and breast feeding, needle prick of health care workers. These people are suffering from AIDS but they are not immoral. Job was righteous man yet he suffered greatly from disease and calamities. In all his troubles God was with Job and Job did not turn his back on the Lord. As church leaders we are called to show our Lord Jesus's love and compassion to all those who suffer, regardless of the cause of that illness.

2. What about those who are infected due to immorality?

Many people who have been infected with HIV have not been immoral; however others were infected because of immoral sexual practices.
What does the bible say about those who sinned?

Romans 3: 21-24
We must remember that we were once sinners and Christ saved us from sin.

Luke 5:27-31
Christ came to the world to call sinners to repentance.

© University of Venda

University of Venda
Creating Future Leaders

As church leaders and Christians, we must look upon those infected with HIV with the eyes of Jesus Christ, who desires that every person know his forgiveness and grace.

Teaching approaches

This unit will be taught through facilitation, tentamen, group discussions and self- directed learning

Assessment methods

The learners will be assessed through prepared tentamens oral questions and feedback during group discussions

Learning material

Baylor International Pediatric AIDS Initiative. 2001. *HIV Nursing Curriculum*. Baylor College of Medicine. Houston, Texus, USA.

Crowther, C.E. 1991. *AIDS: A Christian Hand Book*. London: Epworth press.

Department of Health. 2013. *HIV Counselling and Testing Manual*. National Department of Health: Pretoria

Dixon, P. 2004. *The Truth about AIDS and A Practical Christian Response*. ACET International Alliance & Operational Mobilisation.

Foundation of Professional Development (FPD). (2008). *Introduction to HIV*. Department of Health. Pretoria

Kaplan, H.I. & Sadock. B.J. 1998. *Kaplan and Sadock Synopsis of Psychiatry*. Williams & Wilkins.

© University of Venda

University of Venda
Creating Future Leaders

Stample, C.D. 2000. *The Holy Bible Authorized King James Version*. Charlotte North Carolina: Bible House.

5.3.6.2. Study unit 2: Church role towards HIV prevention and control

Purpose of the study unit

The purpose of the unit is to equip church leaders with competences, to have knowledge, regarding transmission of HIV, stigma related to HIV/AIDS and to be able to apply prevention and control strategies to contain the HIV/AIDS epidemic amongst church members and community members effectively.

Learning outcomes

At the end of this study unit the learners should be able to:

- Describe ways in which HIV can be transmitted
- Discuss how HIV is not transmitted
- Address factors contributing to HIV and AIDS stigma within the Christian churches.
- Explain the effect of HIV and AIDS stigma on individuals and community
- Explain the role of a church leader in reducing stigma related to HIV and AIDS.
- Identify prevention and control strategies relevant to Christian churches

Individual activity 2.1

Mark with a tick next to the activity that you think transmits HIV and mark with cross the activity that you think do not transmits HIV.

Activity	Tick / cross
Using the same holy communion cup	
Sharing toilet with the infected person	

© University of Venda

Breastfeeding	
Shaking hands and hugging	
Coughing	
Using public Swimming pool	
Blood transfusion	
Sharing clothing and bed linen with infected person	
From mother to the baby during delivery	
Unprotected sexual intercourse with an infected person	
An infected pregnant mother to her unborn baby	

Content

Modes of Transmission of HIV

These fluids from infected person transmit HIV:

- Blood
- Semen (including pre-seminal fluid)
- Vaginal fluid
- Breast milk

HIV is usually transmitted:

- By having sex with an infected person
- From exposure to the blood of infected person, either through blood transfusion, improperly cleaned needles and syringes, sharing of unclean razors during cutting practices e.g. through performing male and female circumcisions, or other mechanisms
- During pregnancy, child birth, and breastfeeding from infected mother to child.

Routes through which HIV is not transmitted:

- Sharing food, water, holy communion wine, eating utensils, drinking utensils with the infected person

© University of Venda

- sharing toilets, showers/baths with the infected person
- eating food that has been prepared by infected person
- Handshaking and hugging
- Telephones
- Using public swimming pool
- Sharing clothes and bed linen with an infected person
- Playing team sport (provided there is no contact with blood)
- Donating blood if instruments used are clean
- Living with an AIDS patient and sharing household equipment
- There is no evidence that mosquito bites or other insect bites can transmit HIV.

Non-HIV infectious bodily fluids

- Saliva
- Tears
- Urine
- Sweat

NB HIV found in these fluids (saliva, urine and tears) is not concentrated in an amount sufficient for transmission; the only possible risk would be if blood was present.

Stigma related to HIV and AIDS

What is stigma?

Stigma is described as attaching a negative label or passing judgement on someone because they are perceived to be different.

We stigmatise people for different reasons, such as; appearance; occupation; divorce, being in prison, dressing differently, using drugs or alcohol or having a disease such as HIV. HIV/AIDS-related stigma is a real or perceived negative response to a person or persons by individuals, religious groups, communities or society.

- ➢ It is characterized by rejection, denial, and discrediting, disregarding, underrating and social distance.

© University of Venda

- It frequently leads to discrimination and violation of human rights. People are treated negatively and denied opportunities on the basis of their HIV status.

Sources of stigma

There are two sources of stigma:

External Stigma (societal stigma): This comes from others (external) such as neighbours, friends, parents, doctors, nurses, church leaders, church members etc. It is other people judging or discriminating against us.

Internal Stigma (self-stigma): This comes from within us. It is what we believe about our situation and ourselves. Self-stigma refers to a process whereby people living with HIV impose feelings of difference, inferiority and unworthiness upon themselves. It comes about due to feelings of rejection, fear of disclosure, denial, guilt and shame, high level of stress and anxiety. We often feel we deserve it! Self-stigma is worse when an individual:

- Is first diagnosed
- Has a limited support system
- Already feels minimal self-worth
- Has mythical beliefs about HIV and AIDS

Group activity 2.2

Divide participants into three small groups

Group 1: Discuss the factors contributing to HIV and AIDS related stigma within the Christian churches.

Group 2: Discuss the effects of stigma on individuals and groups

Group 3: Discuss possible ways of eliminating stigma among people infected and affected by HIV and AIDS.

© University of Venda

University of Venda
Creating Future Leaders

Why do we need to deal with stigma?

- It can prevent clients from accessing appropriate health care, social and personal support
- Stigma fuel the spread of HIV, as people are afraid to be discriminated against their HIV status. The fear can stop a married man from raising the subject of condom use with his wife, fear of advertising her HIV status may prevent an infected woman from giving her baby replacement feeding to avoid transmitting the virus through breast milk.
- People may simple not want to know if they are HIV infected even when counselling and testing are offered
- People who are tested positive will not be willing to disclose their status

Factors contributing to HIV and AIDS stigma within the church

- Culture of silence on sexual matters,
- Associating HIV with sin that deserves punishment from God,
- Myths about how HIV is transmitted,
- Lack of knowledge which lead to fears and denial,
- Moral judgments about people and assumptions about their sexual behavior
- Associations with sex and or drugs
- Fear of death and disease
- Prevention messages suggesting that it is all about individual's choice and vigilance to avoid contracting HIV

Role of church leaders in the reduction of stigma

- Encourage church members and the community members to know their status
- Encourage healthy disclosure to partners, friends, relatives and the public
- Community sensitization and mobilization through health education
- Upholding and advocating human rights

© University of Venda

- Establishing and maintenance of support groups
- Referral to support groups and other psychosocial services

Group Activity 2.3

Discuss in your small groups how as church leaders you can be involved in prevention and control of the spread of HIV/AIDS epidemic within your churches and communities.

Prevention and control strategies

Preventing and controlling the spread of HIV/AIDS requires behavioral messages and interventions for different age groups and different target populations in a community. Some of the strategies include:

1. Behavioral change
2. Empowerment
3. Voluntary counselling and Testing

Behavioral change strategies

The key to preventing the spread of AIDS is behavior change. The biblical sound HIV/AIDS behavior change prevention strategies are:

1. Safe sexual practices

Safe sexual practices include all risk avoidance and risk reduction strategies:

Risk avoidance strategies include:

- Abstinence
- Faithfulness to one partner
- Delay in first sexual debut / experience
- Reduce number of sexual partners

© University of Venda

University of Venda
Creating Future Leaders

- Know HIV status through testing.

Risk reduction strategies are:

- Correct and consistence use of condoms
- Early detection and treatment of Sexual Transmitted Diseases (STIs)

Guidelines for effecting behavior change

Behavior change is a complex process, dependent on many factors.
'Changing human behavior requires knowledge, commitment, prayer, hard work and miraculous grace' (Mostert, Ball & Cerullo, 2011:92).

Three guidelines according to Mostert et al. (2011) include:

- Example of parents

God has chosen the family to be the school in which we learn about right and wrong. Proverbs 22:6, train up a child in the way he should go, even when he is old he will not depart from it. In the war against AIDS, our behavior change strategy begins with the family. There is a need to restore biblical standards in our families, so that our children feel safe, trusting their parents and grow up to respect the way of the Lord.

- Accepting attitude

Unconditional love which reflects Christ in our life

- Power of the Holy Spirit

People need more than their will power to live differently. Romans 12:2 transformation follows the renewal of mind by the Holy Spirit power.

© University of Venda

University of Venda
Creating Future Leaders

Empowerment

Empowerment strategies include:

- Comprehensive knowledge and skills, especially women to protect themselves against HIV infection. Inaccurate information and ignorance are two of the greatest factors driving HIV/AIDS related stigma.
- Correct, non-judgmental information needs to be disseminated to all, inside and outside churches. This will assist people to live positively irrespective of whatever their HIV status and to break down barriers which HIV has created between people and within communities. The information can be shared during church services, on Sundays and during church conferences or any other organized gathering for church and community members, trained church leaders on HIV/AIDS can be used, as well as health care professionals who are members of the church.

UNIVERSITY OF VENDA
LIBRARY

Voluntary counselling and testing (VCT)

The aim of this strategy is to encourage church members and community members to know their HIV status, and by doing so help to stop the spread of the HIV virus. Church leaders need to encourage people to be tested. These services are free in all government institution in South Africa. Pastors and church leadership can set an example and be tested first to encourage church members and community to be tested. Those who are tested and are positive should be supported with love.

Who should be tested?

Information on who should be tested must be clear to all people. Discussion of the reasons for testing is primarily focused on risk factors.

- Anyone who believes for whatever reasons they may have been exposed to HIV should be tested
- All pregnant women, even those who believe their husband is faithful

© University of Venda

- Anyone who is experiencing any of the symptoms of HIV infection, such as unexplained weight loss, prolonged diarrhea, cough or fever, sexual infections such as sores or genital warts etc. should be tested
- Spouse who believes their sexual partners cue to marital unfaithfulness or having multiple partners before marriage assume that they may have been exposed to HIV
- Both partners should be tested if either have had another sexual relationship
- Couples before they are married should undergo pre-marital testing

Advantages of knowing your HIV status

When people know their status:

- They can seek out and receive anti-retroviral therapy
- They can make healthy life style choices
- They can reduce the risk by ceasing to engage in sex outside of marriage
- They can abstain from sexual intercourse
- They can minimize the risk by using condoms
- Mothers who know their status can receive medications that will increase the chances of having HIV negative babies
- In marriage partners can protect their loved ones from infection

Teaching approaches

This unit will be taught through facilitation, reflective teaching, and self- directed learning

Assessment methods

The learners will be assessed through prepared tentamens questions and feedback during group based task and presentations.

© University of Venda

University of Venda
Creating Future Leaders

Learning material

Ackermann, D.M. 1998. Becoming a Fully Human: An ethic of relationship in difference and otherness. *Journal for Theology for Southern Africa,* 102 (November): 13-27

Baylor International Pediatric AIDS Initiative. 2001. *HIV Nursing Curriculum.* Baylor College of Medicine. Houston, Texus, USA.

Crowther, CE. 1991. *AIDS: A Christian Hand Book.* London: Epworth Press.

Department of Health. 2013. *HIV Counselling and Testing Manual.* National Department of Health: Pretoria

Dixon, P. 2004. *The Truth about AIDS and A Practical Christian Response.* ACET International Alliance & Operational Mobilisation.

Foundation of Professional Development (FPD). (2008). *Introduction to HIV.* Department of Health. Pretoria

Mostert, J., Ball, M. & Cerullo, J. 2011. *How to Become HIV+ Guidelines for the Local Church.* KERUS Global Education.

Stample, C.D. 2000. *The Holy Bible Authorized King James Version.* Charlotte North Carolina: Bible House.

© University of Venda

University of Venda
Creating Future Leaders

5.3.6.3. Study Unit 3: Church role towards PLWHA

Purpose of the study unit

The purpose of the unit is to equip church leaders with competences, to apply knowledge regarding Biblical guiding principles towards caring PLWHA and to identify caring strategies relevant to their situation.

Learning outcomes

At the end of this study unit the learners should be able to:

- Outline Biblical guiding principles towards caring PLWHA
- Identify caring strategies relevant to their situation.

Group Activity 3.1

1. Read: James 1:27, Matthew 25:31-46 and Outline the biblical guiding principles towards caring people living with HIV and AIDS based on those scriptures. Also reflect back and on how were you applying those scriptures in a real life situation.
2. Discuss caring strategies for PLWHA which you think may be relevant to your situation as a church and reflect upon what you were doing currently.

Biblical guiding principles towards caring PLWHA

Caring for PLWHA is central to the mission, ministry and identity of the Christian church as the body of Christ. According to Matthew 25:31-46, caring is not an option but a must. In this passage Christ presents himself as identical to the suffering and oppressed regardless of their faith. The measure of Christian faith according to this passage shall be judged according to the individual Christian' capacity to show compassion for the poor, hungry, strangers, the sick and the imprisoned by taking efforts to meet their needs.

© University of Venda

University of Venda
Creating Future Leaders

James 1:27 urges Christians to serve God in practical acts of love and compassion. Serving those in need is not an alternative but part and parcel of the gospel.

A church is called to be helpful, to care and express love to those affected by HIV/AIDS. A true Christian caring response is based on how we understand God's calling for his church and his children. The Bible, which is the word of God, provides the guiding principles for caring PLWHA.

Caring strategies relevant to Christian church

In addition to what the group will come up with, here are some of the caring strategies:

Home based care

This refers to any form of care given to sick people in their homes, which includes physical, psychological, palliative and spiritual activities. Church can select volunteers amongst non-working members and organized for them to be trained to become home based careers. These volunteers will then visit patients in their homes and spend time educating them and their families about basic care needs. The volunteers can also provide support with cooking, cleaning and errands, including accompanying patients to health facilities. The volunteers encourage patient to take medication, as well as giving moral, emotional and spiritual support.

Spiritual support

Seek to provide strength and encouragement to the infected and affected with HIV/AIDS. Spiritual health of an individual plays an important role in the client's positive response towards HIV/AIDS.

Spiritual support activities may include:

- House visitation to the infected and affected with HIV/AIDS.
- Offering prayers

© University of Venda

University of Venda
Creating Future Leaders

- ❖ Using the bible as the basic guide for dealing with life's problems
- ❖ counselling

Orphans support

Provision of care to AIDS orphans and vulnerable children can be done through fostering, formation of day care centers and by providing direct material support like food, money clothing etc.

Financial support

When breadwinner is infected and terminally ill, the family income will be affected and lead to degradation of the house hold's economic status. Church can arrange welfare collections as part of their freewill offering to assist orphans and all in need as a result of HIV/AIDS.

Formation of HIV/AIDS Support groups

Those who have accepted and disclosed their status can be used to form support groups to assist others to cope with the disease.

Teaching approaches

This unit will be taught through facilitation, small group discussions, reflective learning and self- directed learning

Assessment methods

The learners will be assessed through peer assessment and feedback during small group discussions.

© University of Venda

University of Venda
Creating Future Leaders

Learning material

Catalado, F., Musheke, M., Kulman, K., Mburu, G. & South, A. 2010. *New Challenges faced by Home Care Givers*, Evidence for Action Research: International HIV/AIDS Alliance.

Liebowetz, J. 2004. *Faith-based Organisations and HIV/AIDS in Uganda and Kwazulu-Natal. Durban*. Health economics and HIV/AIDS research division (HEARD). University of Kwazulu-Natal.

Stample, C.D. 2000. *The Holy Bible Authorized King James Version*. Charlotte North Carolina: Bible House.

5.3.6.4. Study unit 4: Counselling in an HIV and AIDS context

Purpose of the study unit

The purpose of the unit is to equip church leaders with competences, to apply basic counselling knowledge on the emotional and spiritual care of PLWHA.

Learning outcomes

At the end of this study unit the learners should be able to:

- Define counselling.
- Distinguish between counselling and advice
- Explain goals of HIV/AIDS counselling
- Develop qualities needed for an effective counsellor
- Identify the necessary steps, skills and attitudes in each stage of the counselling process.

© University of Venda

Definition of counselling

Individual activity 4.1

1. Ask for two volunteers to participate in a brief exercise with you. Tell them to think of any ordinary problem that they might take to a counsellor, but not a real problem from their own lives. Then role-play a counselling session with each of them in turn. In the first be directive, uninterested and generally display poor counselling skills and attitudes. In the second, role-play an 'ideal' counsellor. Each counselling session should be no more than five minutes. At the end of both sessions discuss with the group what you did right/wrong and what they need to learn from this for their own counselling in the future.
2. After the role-play, give them about 15-25 minutes to complete the exercise. Once they have completed the exercise have discussion in large group to address their responses.

ANSWER THE FOLLOWING QUESTIONS:

1. What is counselling?
2. What is counselling not?
3. What does giving advice involve?
4. What is easier for you to do: give advice or give information, and why?
5. If you have a tendency to give advice in your counselling, how do you think you can change this?

What is counselling?

Counselling is an interactive process characterized by a unique relationship between the counsellor and the client that leads to change in one or more of the following areas:

- Behavior – many sexual partners, drug abuse etc.

© University of Venda

University of Venda
Creating Future Leaders

- Personal constructs - ways of constructing reality which include ways in which the person sees him/herself. The mentality of: "It won't happen to me"
- Ability to cope with life situations - married couple, partner who is HIV positive etc.
- Decision making skills – careful planning of the future, Safer sex, pregnancy etc.

Counselling must always be based on the needs of a client. According to Egan (1998) counselling has dual purposes:

- To help client manage their problems more effectively and develop unused or underused opportunities to cope more fully.
- To help and empower clients so that they become more effective self-helpers in their everyday lives.

What counselling is NOT

- Giving advice
- Making decisions on behalf of clients
- Judging clients
- Blaming clients
- Preaching or lecturing to clients
- Making promises that you cannot keep
- Imposing your own beliefs on clients
- Arguing with clients
- Solving problems for the clients
- Interfering

How counselling differs from other activities

- Clients are not considered mentally ill, as in the case of psychotherapy.
- The focus is on the present and the future, not the past.

© University of Venda

- The counsellor is a partner not authority figure.
- The counsellor focuses on assisting the client to change behavior, not just create insight.

Counselling and advice

Dictionaries define counselling as 'advice or guidance", but the word 'advice' poses challenge to many counsellors. Advice frequently entails telling people what they would do or ought to do; this has no place in counselling. Advice takes the problem away from the client and a sense of dependency, helplessness and low self-esteem is created.

Differences between advice and counselling

ADVICE	COUNSELLING
Fails to consider the client's emotions	Empathy
Short term	On-going process
Directive	Directed by the client
Subjective	Strives to be objective
No working relationship	Structured working relationship
Imposes beliefs and values	Explores alternatives and options
Based on opinions and facts	Informative
May be a one-way communication	Always a two-way communication

Group activity 4.2

Ask participants to work in groups to discuss the following statement: although there are goals attached to all forms of counselling, the discussions should be specifically related to HIV counselling and its unique attributes. Get the small groups to give feed back to the main group, while you facilitate discussion.

Use flip chart paper/ slides to discuss and give input on definition of counselling, the goals of counselling in HIV and AIDS context, how counselling differ from other activities, qualities and skills of an effective counsellor.

© University of Venda

The goals of HIV and AIDS counseling

- Understanding the clients' beliefs, attitudes and misconceptions
- Correcting wrong information with regard to HIV/AIDS.
- Identifying clients' risk and assist the client to reduce risk factors associated with HIV infection or re-infection.
- Helping the clients' understand what behavioural changes need to be made to safeguard themselves and others.
- Assisting the clients, and others, to adjust emotionally as they are worried about being infected with HIV.
- Assisting the clients with practical problems and linking them to resources (support groups, health monitoring etc.).

Types of counselling in HIV and AIDS context

- Individual counselling: One-to-one interaction
- Couple counselling: counsellor counselling a couple

Qualities needed for an effective Christian counsellor

- An accepting attitude
  The attitude of the counsellor reflects his/her belief systems about the factual world around them. An attitude of unconditional acceptance is essential. Accepting people without judging them or attaching stigma to people who are HIV positive and those who are suffering from AIDS

- Respect
  Respecting the client as a person with the right to feel and to think differently from the way we do.

© University of Venda

- Warmth/ unconditional positive regard

  Warmth describes the sensitive, friendly, considerate and responsive elements of the counselor personally. Relating easily to people often used to describe our aspect of warmth.

- Knowledge of proper technique

  Knowing the proper approach and the appropriate time to use it. At times a probing question will be accepted when a direct statement would be rejected. It is always important to always focus on the client as a person and not on the techniques that are being used. Untimely advice often evokes resistance in the client who feels that the counsellor does not really understand or that "I don't want to be told what to do". Counsellor should guard against the ineffective verbal responses which prevent the clients from exploring problems and sharing these openly with a counsellor. Ineffective verbal responses include:

  - ❖ Moralizing: The moralist
  - ❖ Using questions inappropriately: The policeman
  - ❖ Interrupting inappropriately or excessively
  - ❖ Dominating interaction: The commander
  - ❖ Responding infrequently
  - ❖ Dwelling on the remote past
  - ❖ Using self- disclosure inappropriately
  - ❖ Judging, criticizing or placing blame: The judge
  - ❖ Using sarcasm or makes light of client' s problems, ridicule and insult: The belittler and critic
  - ❖ Giving logical arguments, lecturing, instructing, arguing: The wise person
  - ❖ Reassuring, sympathizing, consoling, excusing: The comforter

- Appropriate use of scripture and prayer

Use scripture and prayer wisely. Be careful not to deliver a sermon instead of counselling.

© University of Venda

University of Venda
Creating Future Leaders

- Un-shockable response

  An effective counsellor is not shocked by anything people tell them. A client must feel free to share their problems and guilt. A shocking response on the side of a counsellor might prevent the client to share intimately and thus be prevented from dealing with their problems. The ability of the counsellor to demonstrate warmth and interest in the patient encourages trust and openness.

- Confidence

  Having confidence in Christ, in their ability through Christ, and in what Christ is able to accomplish in someone else. Counsellors should offer people realistic hope that they can be helped.

- Self-awareness

  Awareness of one's own values and believes is essential. Personal values influence the nonverbal and verbal responses of a counsellor, which in turn, influence how the client will respond. The church leader must be aware that his or her values and believes might differ from those of the client. The awareness will prevent the church leader's opinion from negatively affecting the counselling session.

- Empathy

  Empathy is an important personality quality essential for HIV counsellor. Empathy is the ability to have understanding for another person's feelings without this necessarily being expressed in words and without the two people having to experience exactly the same emotions or experiences. Empathy helps the counsellor to connect with the client because the counselor is able to relate emotionally. Empathy is achieved through accurate observation and listening attentively to the client. Empathy makes it possible for the counsellor to relate positively with clients. A Christian counsellor is emphatic when he/she:

  - ❖ Enters into the client's world
  - ❖ Develops a feeling for what that world entails

UNIVERSITY OF VENDA
LIBRARY

© University of Venda

- ❖ Can view the world outside from the client's point of reference
- ❖ Is able to communicate the above to the client.

Individual activity 4.3

Answer the following questions:

1. What qualities do you feel you have in order to become an effective HIV and AIDS counsellor?
2. What qualities do you feel you need to improve on or acquire?

Stages of counselling process

Study the following Models:
TASO counselling Model
Egan's counselling Model

Stages and steps of the counselling process

Stage 1: the current scenario: what is going on?
In this stage exploration and clarification of problems take place. The counsellor helps the person to tell their stories.

Attitudes	Skills
• Welcome the person warmly • Introduce yourself • Assure the person of confidentiality	• Listen, do not rush • Check understanding-exploring & clarifying • Open-ended questions

Steps

- Help clients tell their stories: What are the client's problems?

© University of Venda

- Help clients to explore their resources: how has the client tried to cope with the problem?
- Helping the clients challenge their blind spots and develop new perspectives: what information does the client have about the problem?
- Help clients to identify their most compelling concerns, or opportunities that will make a difference.

Stage 2: helping the person consider options: developing a new and preferred scenario.

Attitudes	Skills
• Confidentiality • Caring • Empathy • Acceptance • Non-judgmental	• Check understanding • Defining the problems • Asking questions • Listening carefully • Answering questions

Steps

- Select the problem that needs to be worked on first
- Explore all the possible ways in which the problem could be resolved
- Help the client consider all the implications and possible outcomes of each option
- Provide information if needed

Stage 3: strategies for action: helping the person make a plan

Attitudes	Skills
• Caring • Confidentiality • Accepting the person's plan	• Asking questions to help the person decide • Listening • Checking that you have understood

© University of Venda

University of Venda
Creating Future Leaders

Steps

- Help the client to identify the problem and course of action they wish to take (brainstorming).
- Help client choose action strategies that best fit their needs and resources.
- Help client draw up a plan for accomplishing the goal. The plan is a step-by-step procedure showing exactly how the client is going to act.
- Summarize the plan and encourage the person to come back and discuss their progress.

Proper counselling will assist the client to accept their HIV status, to disclose willingly and to be ready to seek medical help.

Teaching approaches

This unit will be taught through facilitation, tentamens, role play, reflective teaching, small group discussion and self- directed learning

Assessment methods

The learners will be assessed through prepared tentamens oral questions, peer assessment and feedback during role play

Learning material

Collins, G.R. 1988. *Christian Counselling: A Comprehensive Guide*. Dallas: Wood.

Department of Health. 2001. *HIV/AIDS Counselor Training Course*. Department of Health: Pretoria.

Department of Health. 2013. *HIV Counselling and Testing Manual*. National Department of Health: Pretoria

Egan, G. 1990. *The Skilled Helper*. Moneterey, California: Brooks/Cole

© University of Venda

University of Venda
Creating Future Leaders

Hepworth, D., Rooney, R.H. & Larsen, J.N. 2002. *Direct Social Work Practice*. 6th edition: Brooks/Cole-Thomson learning

PHASE 3

5.4. Validation of the developed training programme

This phase covers the sixth and the last objective of the study. The purpose of this phase was to validate whether the developed programme will be applicable to correct the gaps identified during this research study. Content validation was done after the training programme was developed to check its applicability to the target group and to the practice situation in the Limpopo province.

5.4.1. Methodology for validation

A quantitative descriptive design was used to validate the developed HIV/AIDS training programme content. A check list questionnaire was used to obtain the information. Population included the HIV/AIDS trainers in Limpopo and experts in programme development. Purposive sampling was used to select the key informants. The size of the sample comprised 8 HIV/AIDS trainers and 2 experts in programme development. Checklist was analyzed quantitatively by the use of simple descriptive statistics.

© University of Venda

University of Venda
Creating Future Leaders

5.4.2. Presentation of the findings

Table 5.1 Validation findings

Validation questions	Yes	%	No	%
1. Are the training programme goals consistent with HIV/AIDS practice goals?	10	100	0	0
2. Is the intended context of the training programme in line with the current HIV/AIDS practice situation?	10	100	0	0
3. Is the content of the training programme appropriate for church leaders?	10	100	0	0
4. Are the explanations of the content of the training programme sufficient to be used as a basis for HIV/AIDS response?	10	100	0	0
5. Is the training programme addressing the needs of the church leaders based on the research evidence?	10	100	0	0
6. Will the use of this training programme influence the response against HIV/AIDS epidemic in the Limpopo province	10	100	0	0

5.4.3. Discussion of findings

It was noted that there was no significant variation in the way the HIV/AIDS trainers and programme developer expects responded. Findings support that the developed training programme is relevant to the church leaders and appropriate to address the gaps identified during this research study. One respondent was concerned about the detailed information on the definition of HIV, where types of HIV were explained in detail under study unit 1. The respondent commented that the information might be more relevant to health care professionals than to pastors, only a brief outline should be given to suite

© University of Venda

University of Venda
Creating Future Leaders

church leaders than putting all the details on the types of HIV. The other respondents felt that the training programme is unique, interesting and relevant to church leaders. Comment on study unit 1 on the definition of HIV was not effected as majority felt that the information is necessary for church leaders to know. No adjustments were done after validation of the content.

5.5. Summary

An adapted HIV/AIDS training programme was developed and validated in this chapter. The developed training programme was based on the study results which emerged from data analysis of both quantitative and qualitative approach described in chapter 4 of this study. It was evident from the study results that, in order for the church leaders to execute their role in response to HIV/AIDS pandemic in the Limpopo province, they ought to undergo an adapted HIV/AIDS training programme to assist them in their role. The validation results confirmed that the developed HIV/AIDS training programme is suitable for church leaders and appropriate for HIV and AIDS practice situation in the Limpopo province, hence it will motivate church leaders to be involved in the response against HIV and AIDS epidemic. The next chapter evaluate if all study objectives were met and conclude the study with the necessary recommendations.

© University of Venda

University of Venda
Creating Future Leaders

CHAPTER 6

EVALUATION OF THE STUDY, RECOMMENDATIONS, LIMITATIONS AND CONCLUSIONS.

6.1. Introduction

Chapter one of this study dealt with the overview of the study followed by literature review. Detailed research methodologies were outlined in chapter three. Chapter four presented findings of both quantitative and qualitative research approaches used. Chapter 5 dealt with the development and validation of an adapted HIV/AIDS training programme for church leaders in Limpopo province. The purpose of this chapter is to evaluate the study to establish whether the objectives of the study have been met. It provides overall purpose of the study, evaluation, recommendations and limitations of the study.

6.2. Overall purpose of the study

The overall purpose of this study was to develop an adapted HIV/AIDS training programme for church leaders in the Limpopo Province of South Africa.

To meet this purpose, the following objectives were formulated:

- Assess the level of knowledge among church leaders regarding HIV/AIDS in the Limpopo Province.
- Describe attitudes of church leaders towards people living with HIV/AIDS in the Limpopo Province.
- Identify practices of church leaders towards people living with HIV/AIDS in the Limpopo Province.
- Explore the experiences of church leaders regarding current HIV/AIDS training programme in the Limpopo Province.
- Develop suitable HIV/AIDS training programme for church leaders in the Limpopo Province based on the findings.

© University of Venda

University of Venda
Creating Future Leaders

- Validate the developed HIV/AIDS training programme for church leaders in the Limpopo Province.

A convergent parallel mixed methods design was used. Both qualitative and quantitative data were collected in parallel, analyzed separately, and then merged to realize the purpose of the study. Quantitative approach was used to achieve the first three objectives, while qualitative approach explored the fourth objective. The conclusion drawn from the study findings pointed to the need to develop an adapted HIV/AIDS training programme for church leaders to enhance their involvement into HIV and AIDS activities in their churches and communities. The adapted HIV/AIDS training programme for church leaders was then developed.

6.3. Evaluation of the study

The objectives of the study that were set in chapter one are now evaluated to establish whether they were achieved.

Objective 1: Assess the level of knowledge among church leaders regarding HIV/AIDS in the Limpopo Province. Eleven structured questions were brought to the respondents of the questionnaires to answer. Statistical findings revealed that more than 80% of church leaders in Limpopo do have knowledge about HIV/AIDS. The information they have was acquired from different sources with radio (39.4%) being the main sources of knowledge followed by training (32.7%).

Objective 2: Describe attitudes of church leaders towards people living with HIV/AIDS in the Limpopo Province. Five questions were asked from church leaders who have responded to the questionnaires to determine their attitude towards HIV/AIDS as a disease and towards people who are infected with HIV and AIDS. The findings showed that in general the church leaders in Limpopo depict positive attitude towards those who

© University of Venda

University of Venda
Creating Future Leaders

are infected with HIV/AIDS. The highest number 96.9% of church leaders indicated that they can take care of a relative or church member who is suffering from AIDS.

Objective 3: Identify practices of church leaders towards people living with HIV/AIDS in the Limpopo Province. Section four of the questionnaire addressed this objective. In this section, five questions were asked. The researcher wished to determine the church leaders' involvement in HIV/AIDS related activities in their churches and communities. The findings revealed that 60% of church leaders are not involved at all in any of the HIV/AIDS activities in their churches and their communities. The findings confirmed that though we have so many Christian churches in Limpopo province, their contribution in the fight against HIV/AIDS is lacking.

Objective 4: Explore the experiences of church leaders regarding current HIV/AIDS training programme in the Limpopo Province. Qualitative interviews led to the development of two major themes with sub-themes that described church leaders' experiences. The first theme was addressing the state of current HIV/AIDS training Programme. The second theme addressed the challenges experienced by the church leaders regarding the implementation of the current HIV/AIDS training program. The current training is structured in a way that it combines both church leaders and traditional healers. Participants expressed their dissatisfaction about this arrangement and have preferred separate training for the church leaders to avoid clash of interest based on their different faith background. The training found to have addressed aspects on HIV/AIDS knowledge and perception of stigma, but did not cover the aspects on the role that church leaders can play with regard to HIV/AIDS interventions. The qualitative interviews confirmed that the current training conducted for leaders from different religious groups have some gaps that need to be addressed by an adapted HIV/AIDS training programme to can get maximum participation from church leaders in response to HIV/AIDS epidemic in the province.

Objective 5: Develop suitable HIV/AIDS training programme for church leaders in the Limpopo Province based on the findings. By analyzing the results of the quantitative

© University of Venda

University of Venda
Creating Future Leaders

questionnaires and qualitative themes emanated from experiences of church leaders who attended the current training programme, the researcher was able to capture the essence of HIV/AIDS training needs specific to church leaders. The training programme was then developed to close the identified gaps. The complete adapted HIV/AIDS training programme was developed in chapter 5 of this study.

Objective 6: Validate the developed HIV/AIDS training programme for church leaders in the Limpopo Province. Content validation was done after the training programme was developed in chapter 5. The developed HIV/AIDS training programme was validated by programme developer experts and HIV/AIDS trainers who critically reflected on the developed training programme for church leaders. The validation results confirmed that the developed HIV/AIDS training programme is suitable for church leaders and appropriate for HIV and AIDS practice situation in Limpopo province. Validation addressed the sixth objective of the study and has brought the study to a conclusion. Recommendations can be made because all objectives and purpose of the study have been achieved.

6.4. Recommendations

The recommendations that evolve from this study will be discussed according to policy, practice and research as follows:

6.4.1. Recommendation to policy makers

Policy guidelines should be developed in relation to the national AIDS framework and global principles on PLWHA, to guide churches, primary health care and other community based organization on how they can work effectively as part of a multidisciplinary health team in addressing HIV/AIDS epidemic in the Limpopo Province.

© University of Venda

University of Venda
Creating Future Leaders

6.4.2. Recommendation for practice

The primary health care component should provide organized structures and platforms to incorporate churches in the management of diseases in Limpopo province.

The department of health should identify ways to ensure frequency and regular provision of HIV and AIDS related information to update church leaders.

6.4.3. Ideas for Further Research

Further research is needed to include other minority religions using a larger sample size and to develop a coordinated programme on HIV/AIDS amongst all the religious groups in the Limpopo province. A further study can also be done to pilot the developed training programme before it is officially launched.

UNIVERSITY OF VENDA
LIBRARY

6.5. Limitations

The results of the study cannot be generalized to all churches in South Africa, but limited to Christian churches in the Limpopo Province of South Africa. However, the training programme might be applicable in a similar setting in other provinces.

6.6. Summary

This chapter marks the conclusion of this study. It gives an account of how the overall purpose and the objectives of the study were achieved. The conclusions that emanated from phase one of the study endorsed the significance of the developed HIV/AIDS training programme for church leaders to enhance their response towards HIV/AIDS epidemic in Limpopo province. The study has been concluded with a number of recommendations towards policy makers, practice and research. The study was challenging and yet fulfilling at the same time to me as a researcher who is also a Christian and a church leader.

© University of Venda

University of Venda
Creating Future Leaders

7. REFERENCES

Advancing Sexuality Studies short course. (2009). *Handout Christianity and HIV/AIDS.* http://wwrn.org/articles/30519/?&place=western –Africa Accessed 29/04/2015.

Authorized King James Version. (2000). *The Holy Bible*. International Bible Society. Cambridge University Press.

Babbie, E. & Mouton, J. (2010). *The Social Practice of Social Research*. 10th edition, Cape Town: Oxford University Press.

Babbie, E. (2015).*The Basics of Social Research*. 14th edition, Toronto: ENGAGE Learning, Wadsworth.

Baker, S., Williams, E., Juma, M. & Mahindra, V. (2005). *Population council, HIV and AIDS stigma and discrimination*. http://www.popcouncil.org/hivaids/stigma.html.accessed 06 April 2016.

Barret, D.B. (1994). Update. *World Christian Encyclopedia. What part of the world believes in Christianity*? http://www.wiki.answer.com.(Accessed 10 January 2015)

Basavanthappa, B.T. (2009). *Nursing Administration*. New Delhi: Jaypee Brothers Medical publishers.

Bergh, Z. & Geldenhuys, D. (2013). *Psychology in the Work Context*. 5th edition, Oxford University Press: U.K.

Booyens, S. (2014). *Dimensions of Health Care Management*. 3rd edition. Juta & Company: Cape Town.

© University of Venda

University of Venda
Creating Future Leaders

Brink, H.I., Van der Walt, C. & Van Rensburg, G. (2012). *Fundamentals of Research Methodology for Health Care Professionals.* 2nd edition. Cape Town: Juta & Company.

Bruce, J.C., Klopper, H.C. & Mellish, J.M. (2011). *Teaching and Learning the Practice of Nursing.* Heinermann: Cape Town.

Burns, N. & Grove, S.K. (2009). *The Practice of Nursing Research. Appraisal, Synthesis, and Generation of Evidence.* 6th edition. Philadelphia: W.B. Saunders.

Byamugisha, G., Steinits, L., Williams, G. & Zondi, P. (2002). *Journeys of Faith: Church-based Responses to HIV and AIDS in Three Southern African Countries.* St. Albans, UK: TALK.

Campbell, C. & Foulis, C. (2004). Creating contexts for effective home-based care of people living with HIV/AIDS. *Curationis,* 27(3):5-14.

Campbell, C., Foulis, C.A., Maimane, S. & Sibiya, Z. (2005). "I have an Evil Child at My House": Stigma and HIV/AIDS Management in a South African Community. *American Journal of Public Health*, 95(5).

Catalado, F., Musheke, M., Kulman, K., Mburu, G. & South, A. (2010). *New Challenges Faced by Home Care Givers.* Evidence for Action Research: International HIV/AIDS Alliance.

Chinn, P.L. & Kramer, M.K. (2013). *Integrated Theory and Knowledge Development in Nursing.* 8th edition. Mosby: ELSEVIER.

Clifford, P. (2004). *Theology and the HIV/AIDS epidemic*: Christian AID

Clowney, E.P. (1995). *The Church Contours of Christian Theology.* Intervarsity Press, Downers Grove, Illinois.

© University of Venda

University of Venda
Creating Future Leaders

Cochrane, J. (2005). 'Reconceptualising religion and public health'. Opening address to the African Religious Health Assets Programme Colloquim, Johannesburg.

Corben, W.W. & Loving, C.C. (2008). "An essay for educators: Epistemological realism really is common sense." *Science & Educatio,n* 17(4):425-447.

Coulson, N., Goldstone, C., Ntuli, A. & Pillay, N. (2010). *Developing Capacity for Health: A Practical Approach*. Sandton: Heinemann.

Creswell, J.W. (2009). *Research Design. Qualitative, Quantitative and Mixed Methods Approaches*. Thousand Oaks, California; Sage.

Creswell, J.W. (2014). *Research Design. Qualitative, Quantitative and Mixed Methods Approaches*. 4th edition, California; Sage.

Creswell, J.W., Ebersöhn, L., Eloff, I., Ferreira, R., Ivankova, N.V., Jansen, J.D., Nieuwenhuis, J., Pietersen, J., Clark, V.L.P & Van der Westhuisen, C. (2007). *First Steps in Research*. Pretoria: Van Schaik.

Cronin, P., Ryan, F. & Coughlan, M. (2008). Undertaking a literature review: A step-by-step approach. *British Journal of Nursing*, 17(1):38-41

Cullinan, K. (2000). Community–based care [Editorial, Health system trust series]. Issue no. 58, P. *Health Systems Trust,* 58:1-12.

Da Silva de Souza, S. & Guerreiro Vieira da Silva, D.M. (2011). Validation of a theoretical model: Knowing the interactive processes within the support network for people with tuberculosis. *Acta Paulide de Enfermagem*, 24(6): 1-9.

UNIVERSITY OF VENDA
LIBRARY

© University of Venda

University of Venda
Creating Future Leaders

De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (2011). *Research atGgrassroots. For the Social Sciences and Human Service Professions.* 4th edition. Pretoria: Van Schaik.

Deacon, H., Prosalendis, S. & Stephney, I. (2005). *Understanding HIV/AIDS stigma: A Theoretical and Methodological Analysis.* Cape Town HSRC press.

Denzin, N.K., & Lincoln, Y.S. (2008). *Landscape of Qualitative Research (Vol.1).* Sage.

Dickoff, J., James, P. & Wiedenbach, E. (1968). Theory in practice discipline part 1: Practice Oriented Theory. *American Journal of Nursing Company.* 17(5):415-451.

Dixon, P. (2004). *The Truth About AIDS and A Practical Christian Response.* (4th ed). ACET International Alliance & Operational Mobilisation.

EHAIA. (2011*). Impact Assessment 2002-2009.* World Council of Churches: Geneva.

Galer, J.B., Vriesendorp, S. & Ellis, A. (2005). *Managers Who lead: A Handbook for Improving Health Services.* Cambridge: M.S.H. Bookstore

Galford, R. & Maruka, R. (2010). How legacy thinking makes better leaders Today. *Boston Business Journal.* Retrieved from: http:www.yourleaderlegacy.com. (Accessed January 2016)

George, J.B. (2011). *Nursing Theories: The Base for Professional Nursing Practice.* 6th edition. Pearson: New Jersey.

Government Gazette. (2008). Traditional Health Practitioners Act no. 22 of 2007. Republic of South Africa: Cape Town.

© University of Venda

University of Venda
Creating Future Leaders

Graig, R.L. (1996). *The ASTD Training and Development Hand Book.* New York: McGraw-Hill

Griffith, D.M., Campbell, B., Allen, J.O., Robinson, K.J. & Stewart, S.K. (2010). YOUR Blessed Health: An HIV-Prevention Program Bridging Faith and Public Health communities. *Public Health Reports*. 125(1):4-11

Grove, S.K., Burns, N. & Gray, J.R. (2013). *The Practice of Nursing Research*: *Appraisal, Synthesis, and Generation of Evidence*. 7th edition. Elsevier: St Louis, M.O.

Haddad, B., Olivier, J. & De Gruchy, S. (2008). 'The potential and perils of partnership: Christian religious entities and collaborative stakeholders responding to HIV and AIDS in Kenya, Malawi and DRC'. Study commissioned by Tearfund and UNAIDS. Interim report. African Religious Health Assets program.

Haendler, R. (2001). "Pastoral roles in HIV and AIDS prevention and Care" in UNAIDS Round Table on 'Faith-based strategies, achievements and challenges in their response to the HIV/AIDS pandemic'. *International Conference on STDs and AIDS*, Burkina Faso.

Ham, F. (2004). *AIDS in Africa: How did it Ever Happen*? Zomba: Kachere series.

Henning, E., Van Rensburg, W. & Smith, B. (2004). *Finding your Way in Qualitative Research.* Pretoria: Van Schaik.

Henry, J.K. (2006). Reuters SA examines African Anglican church and HIV/AIDS accessed 15 March 2015 from www.kaizernetwork.org/daily reports/hiv

Hlongwane, K. & Mkhize, S. (2007). HIV/AIDS through the lens of Christianity: Perspectives from a South African urban support group. *Journal of Social Aspects*, 4(1): 556-563.

© University of Venda

University of Venda
Creating Future Leaders

Holloway, I. & Wheeler, S. (2002). *Qualitative Research in Health Care*. London: Open University Blackwell Science.

Holloway, I. (2005). *Qualitative Research in Health Care*. London: Open University Press.

Hubbard, S.M. & Hayashi, S.W. (2003). Use of diffusion of innovations theory to drive a federal agency's program evaluation. *Evaluation and Program Planning*, *26*(1), 4956.

Kaplan, H.I. & Sadock. B.J. (1998). *Kaplan and Sadock Synopsis of Psychiatry*. Williams & Wilkins.

Keane, M. (2011). Science curriculum design: a model based on who we are. *International Conference on Science & Technology Education with A Focus on the Islamic World.* 10-12 July 2011, Kish Island, Iran.

Killen, R. (2007). *Teaching strategies for Outcomes Based Education*. Cape Town: Juta & Co.

Knowles, M.S., Holton, E.F. & Swanson, R.A. (2012). *The Adult Learner*. Routledge.

Lesolang, G.N. (2010). Stigmatization of HIV/AIDS patients in the context of indigenous healers and spiritual faith healers in Limpopo province: PHD thesis: University of Limpopo.

Liebowitz, J. (2004). *Faith-based organizations and HIV/AIDS in Uganda and Kwazulu-Natal. Durban*: health economics and HIV/AIDS research division (HEARD), University of KwaZulu-Natal.

Lincoln, Y.S & Guba, E.G. (1985). Naturalistic inquiry. Beverly Hills, California: Sage.

© University of Venda

University of Venda
Creating Future Leaders

Lindsey, Y.S., Hirschfield, M., Tlou, S. & Ncube, E. (2003). Home based care in Botswana: Experiences of older women and young girls. *Health Care for Women International*, 24(6): 486-501.

LoBiondo-Wood, G. & Haber, J. (2011). *Nursing Research: Methods and Critical Appraisal for Evidence-based Practice*. Elsevier Health Sciences.

Malawi Interfaith AIDS Association. (2007). *HIV and AIDS related Stigma and Discrimination within the Faith Communities in Malawi*. Norwegian Church Aid Evaluation Summary: Malawi

Malwela, N.E. (2013). The role of churches in response to HIV and AIDS epidemic in Vhembe district of South Africa. Unpublished Masters Dissertation: University of Venda.

Manda, C.B. (2006). A review of ESSA Christian AIDS programme in Pietermarinzburg. Masters dissertation: university of KwaZulu Natal.

Mbonu, N.C., Van den Borne, B. and De Vries, N.K. (2009). Stigma of people with HIV/AIDS in Sub-Saharan Africa: a literature review. *Journal of Tropical Medicine*, 2009.

Meyer, S.M. & Van Niekerk, S.E. (2008). *Nurse Educator in Practice*. Cape Town: Juta

Mouton, J. (2006). *How to Succeed in Your Master's and Doctoral studies: A South African Guide and Resource Book*. Pretoria: Van Schaik.

Mostert, J., Ball, M. & Cerullo, J. 2011. *How to Become HIV+ Guidelines for the Local Church*. KERUS Global Education.

Ncama, B.P. (2005). Models of community/home-based care for people living with HIV/AIDS in Southern Africa. *Associations of Nurses in AIDS Care Journal*, 16(3):33-40.

© University of Venda

University of Venda
Creating Future Leaders

Neuman, W.L. (2004). *Basics of Social research. Qualitative and Quantitative Approaches*. Boston. Pearson Education.

Nisbett, R.E. (2003). *The geography of Thoughts: How Asians and Westerners Think Differently… and Why*. New York: Free press.

Ogden, J. and Nyblade, L. (2005). *Common at its Core: HIV-related Stigma Across Contexts*. USAID

Otolok-Tanga, E., Ayatumbe, L., Murphy, C.K., Ringheim, K.E. & Woldehanna, S. (2007). Examining the actions of faith-based organizations and their influence on HIV/AIDS-related stigma: A case study of Uganda. *African Health Sciences*. 7(1):55-60.

Parker, W. & Birdsall, K. (2005). *HIV/AIDS, Stigma and Faith-based Organizations: A Review*. Johannesburg: CADRE.

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

Parry, S. (2004). Response of the faith-based organization to HIV/AIDS in sub-Saharan Africa. World council of churches, ecumenical HIV/AIDS initiative in Africa: Geneva.

Paterson, G. (2005). *AIDS Related Stigma. Thinking outside the Box: The Theological Challenge*. Geneva: Ecumenical Advocacy Alliance and World Council of Churches.

Patton, M.Q. (2002). *Qualitative Research & Evaluation Methods*. 3rd edition. Thousand Oaks: Sage publications.

Pearsall, J. (2002). *The Concise Oxford English Dictionary*, Oxford University Press Oxford.

© University of Venda

University of Venda
Creating Future Leaders

Polit, D.F. & Beck, C.T. (2014). *Essentials of Nursing Research Methods, Appraisal and Utilization*. 8th edition. Philadelphia. New York: Lippincott.

Polit, D.F. & Hungler, B.P. (2004). *Nursing Research. Methods, Appraisal and Utilization*. Philadelphia. New York: Lippincott.

Pope, C. & May, N. (2006). *Qualitative Research in Health Care*. 2nd edition. Oxford: Blackwell.

Rubin, H.J. & Rubin, I.S. (2005). *Qualitative Interviewing. The Art of Hearing Data*. Routledge & Keegan Paul: London.

Ruden, S. (2000). AIDS in South Africa: Why the church matters. *The Christian Century*, 17:566-570.

Sapepa, P. (1998). Description of home-based care (HBC) for people living with AIDS (PLWHA) in region E of the Eastern Cape. Unpublished Master's dissertation. University of Natal, Durban, South Africa.

Sexual Health Exchange. (2004). Published by the South African AIDS information dissemination service & the Royal Tropical Institute.

Sheatsley, P.B. (1983). Questionnaire construction. In P.H. Rossi, J.D. Wright & B. Anderson (Eds), *A Handbook of Survey Research* Orlando: Academic Press, Inc.

Slowther, A., Boynton, P. & Shaw, S. (2006). Research Governance: Ethical Issues. *Journal of the Royal Society of Medicine*, 99:65-72

Statistics S.A. (2013). *2012 Survey by Province and Municipalities*. Statistics S.A: Vhembe District.

© University of Venda

University of Venda
Creating Future Leaders

Statistic S.A. (2016). *2015 South African Statistics on Religion - The Numbers.* Secular Society: Statistic South Africa: Pretoria.

Stommel, M. & Wills, C.E. (2004). *Clinical Research: Concepts and Principles for Advanced Practice Nurses.* Philadelphia. Lippingcott. William and Wilkins.

Streubert, H.H., Speziale, S.H.J. & Carpenter, D.R. (2003). *Qualitative Research in Nursing Advancing the Humanistic Imperative.* 3rd edition Philadelphia: Lippincott.

Swanepoel, E. (2005). Exploring the impact of HIV/AIDS prevention messages. New voices in psychology, 1:151-158

Talbot, L.T. (1995). *Principles and Practices of Nursing Research.* St Louis: Mosby.

Tiendrebeogo, G. & Buykx, M. (2004). *Faith-Based Organisations and HIV/AIDS Prevention and Impact Mitigation in Africa.* ROYAL TROPICAL INSTITUTE: Amsterdam.

Tobin, G.A. & Begley, C.M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing*, 48(4):388-396

Tshiula, J. & Stone-Jimenez, M. (2005). *Training Methodologies and Principles of Adult Learning.* Application for training in infant and young child nutrition and related topics. Training of trainers' course. USAID, AED/LINKAGES/ Washington.

Umar, S.A. & Oche, O.M. (2012). Knowledge of HIV/AIDS and use of mandatory premarital HIV testing as a prerequisite for marriages among religious leaders in Sokoto, North Western Nigeria. *Pan African Medical Journal.* AFENET 11(27)

UNAIDS, UNICEF & WHO. (2011). "Global HIV/AIDS response: Epidemic update and health sector progress towards universal access: Progress report 2011". Geneva. WHO/UNAIDS.

© University of Venda

University of Venda
Creating Future Leaders

UNAIDS. (2005). *A Report of a Theological Workshop Focusing on HIV and AIDS Related Stigma.* Geneva: UNAIDS.

Unrau, Y.A., Gabor, P.A. & Grinnell, R.M. (2007). *Evaluation in Social Work: The Art and Science of Practice*, London: Oxford University Press.

USAID. (2007). Involvement of religious leader in the national response to HIV/AIDS in Mali: A path breaking initiatives. *Health Policy Initiative*: Washington, DC USA.

Uys, L. (2003). Aspects of the care of people with HIV/AIDS in South Africa. *Public Health Nursing*, 20(4):271- 280.

Uys, L.R. & Hensher, M. (2002). The cost of home based terminal care for people with AIDS in South Africa. *South African Medical Journal*, 92(8): 624-628.

Walker, L.O. & Avante, K.C. (2005). *Strategies for Theory Construction in Nursing*. 4th Edition. Norwaik: Appleton & Lange

Welma, C., Kruger, F. & Mitchell, B. (2008). *Research Methodology*. Cape Town: Oxford University press

Wlodkowski, R.J. & Ginsberg, M.B. (2017). *Enhancing Adult Motivation to Learn: A Comprehensive Guide for Teaching All Adults*, John Wiley & Sons: USA.

World Council of Churches (WCC). (2001). The Ecumenical Response to HIV/AIDS in Africa (EHAIA), *Plan of Action, Global Consultation on Ecumenical Response to the Challenges of HIV/AIDS in Africa*. Nairobi, Kenya.

Yu, D., Souteyrand, Y., Banda, M.A., Kaufman, J. & Perriens, J.H. (2008). "Investment in HIV/AIDS programs: Does it help strengthen health systems in developing countries?" *Globalization and Health* 4(1):8.

© University of Venda

University of Venda
Creating Future Leaders

Zou, J., Yamanaka, Y., John, M., Walt, M., Ostermann, J. & Thielman, N. (2009). Religion and HIV in Tanzania. Influence of religious beliefs on HIV stigma, disclosure, and treatment attitudes. *BMC Public Health*, 9(1):75.

UNIVEN LIBRARY
Library Item : 20190066

© University of Venda

University of Venda
Creating Future Leaders

ANNEXURE 1A: Request for permission to conduct study: letter to the leadership structures of churches

P.O Box 3179
Sibasa
0970

To the leadership in charge

Dear Sir/ Madam

REQUEST FOR PERMISSION TO CONDUCT A RESEARCH

I am a PhD student at the University of Venda. I am conducting the study titled: 'Developing an adapted HIV/AIDS training programme for church leaders in Limpopo Province, South Africa'. I am requesting permission to conduct a study in your churches. The study will be conducted amongst church leaders. The purpose of the study is to develop an adapted HIV/AIDS training programme for church leaders to empower church leaders on how they can effectively contribute to the fight against HIV/ AIDS epidemic in the Limpopo Province.

I hope that the results of the study will guide the establishment of a collaborative network for Christian churches and primary health care on HIV/AIDS interventions and will provide data to policy makers and other community based organizations on how HIV/ AIDS interventions can be enhanced in the province.

Thanking you in anticipation.

Yours sincerely

Pastor Malwela N.E.

© University of Venda

University of Venda
Creating Future Leaders

ANNEXURE 1 (B) Permission letter to churches

IRON SHARPEN IRON
Ministers Network International

PROVERBS 27:17

STAND NO 2020
MAUNGANI VILLAGE
0950

P.O. BOX 7090
THOHOYANDOU
0950

Date : 15/06/2016

Enq : Dr Mbadi ME
Cell : 072 2763 878

Pastor Malwela N.E

P.O Box 3179
Sibasa
0970

Dear Pastor Malwela NE

"Developing an adapted HIV/ AIDS Training Programme for Church leaders in Limpopo Province, South Africa"

Permission is here by granted to Pastor Malwela ne to conduct a study amongst churches affiliated to Iron Sharpen Iron and Vhembe District pastors forum as mentioned above.

- You are expected to make arrangements with individual churches and leaders for convenient time to conduct your study.
- You are welcomed to come during our regular church leaders gatherings to meet leaders for arrangements and where possible to collect data at the same time.

Yours in Christ
Bishop Dr Mbadi M.E

IRON SHARPEN IRON
UNDER DR MMBADI M.E
P.O. BOX 7090
THOHOYANDOU, 0950
CELL NO: 072 276 3878

© University of Venda

University of Venda
Creating Future Leaders

ANNEXURE 2 (A): Informed consent letter

Dear participant

I am a PHD student at the University of Venda. I am conducting a study titled: 'Developing an adapted HIV/AIDS training programme for church leaders in Limpopo Province, South Africa'. The purpose of this study is to develop suitable HIV/AIDS programme to empower church leaders on how they can effectively contribute to the fight against HIV/AIDS epidemic in Limpopo. You are requested to participate in the study. Please understand that you are not being forced to take part in this study and the choice whether to participate or not is yours entirely. However, I would really appreciate it if you do share your thoughts with me. If you choose not to take part in the study, you will not be affected in any way whatsoever. There is no risk involved for participating in this study. Please understand that the name and dignity of each participant will be preserved. Names of the participants and their churches will not be mentioned anywhere during discussions and no one will be able to link you to the answers you gave. Only the researchers will have access to the linked information. The information will remain confidential and there will be no "come-backs" from the answers you gave. Data will be kept under lock and key till the study is concluded for verification by my promoters.

I would also like to ask permission to audio record the interview because it is not possible to write down all your answers quickly enough to capture all the important information. I might misrepresent your responses in some of the questions that you will be asked if a recording is not done. It is important for you to know that the digital voice data and notes will remain confidential and your identity will not be disclosed. I am only interested in your honest responses to the questions. Recordings and digital data of the interview will be listened to only by the researcher and the co-coder and will bear no names of the interviewees. The information will be analyzed and organized into a report according to themes. The recordings and digital data files will be kept in a locked safe. The voice recordings and digital data will be destroyed immediately after the publication of the research findings.

© University of Venda

University of Venda
Creating Future Leaders

The summary of the research will be made available to the participants if they wish. The results of the study will benefit Church members as the developed training programme may rejuvenate the active role of church leaders towards HIV/AIDS interventions. Community members may benefit as the developed training programme may assure that all individuals and families infected and affected by HIV/AIDS have access to compassionate, non-judgmental care, respect, support and assistance. The study might also overcome the different perspective with good information, and help towards overcoming prejudices and stigma related to HIV/AIDS. The study may assist churches to work effectively as part of the multidisciplinary health team in addressing HIV/AIDS epidemic in Limpopo province. The study might again provide data to policy makers which may influence modification and review of policy regarding HIV/AIDS interventions in the province

I would appreciate it if you do share your thoughts with me. There will be no reward, financial or otherwise for participating in this study.

Thank you

Malwela Nndondeni Edson
Researcher

© University of Venda

University of Venda
Creating Future Leaders

ANNEXURE 2 (B): Consent form

I (participant) ---------- hereby consent to participate in a research study entitled "Developing an adapted HIV/AIDS training programme for church leaders in Limpopo Province, South Africa". The conditions of the study have fully been explained to me and I fully understand the circumstances of my participation.

---------- Date----------

Signature of participant

---------- Date ----------

Signature of researcher

© University of Venda

ANNEXURE 2 (C): Consent form for voice recording

I (participant) ---------- hereby consent to be tape recorded during interviews in a research study entitled "Developing an adapted HIV/AIDS training programme for church leaders in Limpopo Province, South Africa". It was explained to me that the interviews will be recorded and that the digital voice data and notes will remain confidential and my identity will not be disclosed. Recordings and digital data of the interview will be listened to only by the researcher and the co-coder. The recordings and digital data files will be kept in a locked safe. The voice recordings and digital data will be destroyed immediately after the publication of the research findings.

The conditions of the study have been fully explained to me and I fully understand the circumstances of my participation.

---------- Date----------

Signature of participant

---------- Date ----------

Signature of researcher

© University of Venda

University of Venda
Creating Future Leaders

ANNEXURE 3 (A): Questionnaire

Instruction: Put a cross on the code next to the appropriate answer.

SECTION 1: DEMOGRAPHIC INFORMATION

1.1 Age	Below 20	1
	20-29	2
	30-39	3
	40-49	4
	50-59	5
	60-69	6
	70 and above	7
1.2 Gender	Male	1
	Female	2
1.3 Marital status	Married	1
	Single	2
	Divorced	3
	Widow(er)	4
1.4 Race	African	1
	White	2
	Colcured	3
	Indian	4
	Other specify	5

1.5 Nationality	South African	1
	Other specify	2

1.6 Home language	Tshivenda	1
	Sepedi	2
	Shangaan	3
	Other specify.....	4

© University of Venda

University of Venda
Creating Future Leaders

1.7 Your highest qualification	No schooling	1
	Grade 1-4	2
	Grade 5-7	3
	Grade 8-9	4
	Grade 10-12	5
	Post matric certificate	6
	Diploma	7
	Degree	8
	Honours degree	9
	Masters	10
	Doctorate	11
	Post doctorate	12
1.8 Your denomination	Pentecostal	1
	Charismatic	2
	Non-Pentecostal	3
	Evangelical	4
	Zion	5
	Other specify	6

1.9 Position in the church	Pastor	1
	Bishop	2
	Elder	3
	Other specify	4

© University of Venda

University of Venda
Creating Future Leaders

SECTION 2: KNOWLEDGE OF HIV/AIDS

2.1 AIDS is caused by HIV (Human Immunodeficiency Virus).

1. Yes
2. No

2.2 One can get HIV/AIDS because of witchcraft or other supernatural means.

1. Yes
2. No

2.3 HIV is commonly spread by having unprotected sexual intercourse with someone infected with the HIV virus.

1. Yes
2. No

2.4 HIV is commonly spread by sharing needles or syringes with someone who has the virus.

1. Yes
2. No

2.5 HIV is commonly spread by getting HIV-infected blood, semen, or vaginal secretions into open wounds.

1. Yes
2. No

2.6 HIV can also be passed from an infected pregnant woman to her unborn baby during pregnancy, birth and breast feeding.

1. Yes
2. No

© University of Venda

University of Venda
Creating Future Leaders

2.7 HIV is not transmitted by simple casual contact such as kissing, sharing water glasses or hugging.

1. Yes
2. No

2.8 There is no cure for AIDS

1. Yes
2. No

2.9 One can avoid getting HIV.

1. Yes
2. No

2.10 Have you attended any HIV/AIDS training?

1. Yes
2. NO

2.11 Where do you get information regarding HIV/AIDS?

1. Radio
2. Television
3. Friends
4. Training
5. Other (specify): ----------

SECTION 3: ATTITUDE CONCERNING HIV/AIDS

3.1 Is HIV/AIDS desirable/ acceptable in the Church?

1. Yes
2. No

© University of Venda

University of Venda
Creating Future Leaders

3.2 Do you perceive yourself at risk of getting HIV/AIDS?

1. Yes
2. No

3.3 Are you willing to care for a relative/church member/ friend who is suffering from AIDS?

1. Yes
2. No

3.4 Will you accept a church member who is HIV positive to continue to lead a church music band or to lead a committee?

1. Yes
2. No

3.5 Do you associate people who have HIV/AIDS with sin?

1. Yes
2. No

SECTION 4: PRACTICES TOWARDS PEOPLE LIVING WITH HIV/AIDS

4.1 Are you involved in HIV/AIDS related activities in your church/ community?

1. Yes
2. No

4.2 For how many years have you been involved in HIV/AIDS related activities?

1. Less than a year
2. 1 to 5 years
3. More than 5 years.

4.3 Which of the following best describes the impact of your church's involvement in HIV/AIDS?

1. We are losing ground

© University of Venda

University of Venda
Creating Future Leaders

2. It is tiny compared to the need
3. It is starting to penetrate the community; our influence is growing
4. It is having widespread influence in the community; meeting a lot of need

4.4 What motivated you to become involved in the AIDS ministry in the first place?

1. Passion to help people
2. Recruited by a friend
3. Attended HIV/AIDS workshop/training
4. A church member/ relative who got AIDS

4.5 How is your involvement in HIV/AIDS perceived by community/church members?

1. Good
2. Bad
3. Don't know

UNIVERSITY OF VENDA
LIBRARY

© University of Venda

ANNEXURE 4: Validation checklist

Checklist questionnaire for validation of developed HIV/AIDS training programme

Validation questions	Yes	No
1. Are the training programme goals consistent with HIV/AIDS practice goals?		
2. Is the intended context of the training programme in line with the current HIV/AIDS practice situation?		
3. Is the content of the training programme appropriate for church leaders?		
4. Are the explanations of the content of the training programme sufficient to be used as a basis for HIV/AIDS response?		
5. Is the training programme addressing the needs of the church leaders based on the research evidence?		
6. Will the use of this training programme influence the response against HIV/AIDS epidemic in the Limpopo province		

COMMENTS

© University of Venda

University of Venda
Creating Future Leaders

ANNEXURE 5: Ethical clearance certificate

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Mr NE Malwela
Student No: 11607101

PROJECT TITLE: **Developing an Adapted HIV/AIDS Training Programme for Church Leaders in Limpopo Province, South Africa.**

PROJECT NO: SHS/16/PDC/08/2904

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof VO Netshandama	University of Venda	Supervisor
Prof ML Netshikweta	University of Venda	Co-Supervisor
Mr NE Malwela	University of Venda	Investigator - Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: April 2016
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: .....
Name of the Chairperson of the Committee: Prof. G.E. Ekosse

UNIVERSITY OF VENDA
DIRECTOR
RESEARCH AND INNOVATION
2016 -05- 03
Private Bag X5050
Thohoyandou 0950

University of Venda
PRIVATE BAG X5050, THOHOYANDOU, 0950, LIMPOPO PROVINCE, SOUTH AFRICA
TELEPHONE (015) 962 8504/8313 FAX (015) 962 9060
"A quality driven financially sustainable, rural-based Comprehensive University"

© University of Venda

University of Venda
Creating Future Leaders

ANNEXURE 6: Confirmation of language editing letter

Dr Catherine Hutchings

Freelance Editorial Services

51 Bathurst Road
Kenilworth
7708
Cape Town
Western Cape
South Africa

Telephone/Fax: + 27 21 7618522
Mobile: + 27 82 9702219
E-mail: catherinehutchings@gmail.com

To whom it may concern.

I hereby confirm that I edited **Nndondeni Edson Malwela's** PHDH thesis,

Developing an adapted HIV/AIDS training programme for church leaders in Limpopo Province, South Africa

in November 2018.

I wish this student well in their endeavours.

Catherine Hutchings

Catherine Hutchings

© University of Venda