THE ROLE OF CHURCHES IN RESPONSE TO HIV AND AIDS EPIDEMIC IN VHEMBE DISTRICT OF SOUTH AFRICA

By

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DECLARATION

"I Nndondeni Edson Malwela declare that **THE ROLE OF CHURCHES IN RESPONSE TO HIV AND AIDS EPIDEMIC IN VHEMBE DISTRICT** hereby submitted to the University of Venda for the degree of Magister Curationis has not previously been submitted by me for a degree at this or any other university; that it is my work in design and in execution, and that all reference material contained herein has been duly acknowledged".

SIGNATURE **DATE**

NEMalwela ..... 18/04/2013 .....

PRINT

N.E MALWELA

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DEDICATION

This study is dedicated to my two sons Nndondeni Goodness and Muphulusi Joshua together with Rock of the Living Hope Church, Makonde UAFC assembly.

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I would like to thank God for providing 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.

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The study design was qualitative in nature. Qualitative interviews allowed the investigator to obtain an in-depth understanding of what interventions churches have with regards to HIV and AIDS. The population of this study consisted of Christian churches in the Vhembe District of Limpopo province. Purposive sampling was used and data was collected through in depth interviews and analyzed using steps of open coding. Measures to ensure trustworthiness were observed and ethical issues were attended to.

The results of this study revealed that churches do play a role in the HIV and AIDS epidemic with regards to prevention of HIV infections, and by offering support and care to those people living with AIDS. Several challenges with regards to the implementation of intervention programmes were also identified. This study also revealed a lack of collaboration amongst churches themselves and primary health care organizations. Relevant recommendations are made to enhance the intervention programme in the district.

KEY WORDS: HIV/AIDS; Churches; Christianity

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LIST OF ACRONYMS USED

AIDS: Acquired Immune Deficiency Syndrome

ART: Anti Retroviral Therapy

CBO: Community –Based Organization

CHBC: Community Home-Based Care

DOTS: Directly Observed Treatment, short course

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

SACC: South African Council of Churches

UNAIDS: Joint United Nations program on HIV/AIDS

UNICEF: The United Nations Children's Fund

WCC: World Council of Churches

WHO: World Health Organization

PHC: Primary Health Care

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION, BACKGROUND AND RATIONALE

The number of acquired immune deficiency syndrome (AIDS) cases and associated deaths continues to rise and the provision of effective Community/home-based intervention has become not only a priority, but an absolute necessity in sub-Saharan Africa. The human immune virus (HIV) and AIDS epidemic has placed a large burden on public health facilities in developing countries, particularly in sub-Saharan Africa. This situation has stretched hospitals beyond their limits and has shifted the burden of care to families and communities. Community/home-based care (CHBC) has become a central concept in the provision of care in this era of HIV and AIDS (Ncama, 2005:33). HIV affects all people, regardless of their religion, race, age, ethnicity or geographic location.

A number of conceptual and empirical studies have continued to document the relationship between spirituality and health, particularly the role of spirituality in health and helping those with serious illnesses, especially where spirituality is viewed as a strong predictor of people's quality of life (Aldrige, 2000:55; Buck, 2006:289; Goodier & Eisenberg, 2006:51). This role of religion continues to receive attention with the emergence of chronic illnesses like HIV/AIDS. Buck (2006:289) argues that spirituality influences adaptation to chronic illness and mediates uncertainty. Spiritual meanings are linked to actions, and those actions have consequences that are performed as prayer, meditation, worship, and healing. In some instances, ecology of treatment at various physical, psychological, social, and spiritual levels all meet the needs of the sick, which includes prayer, laying-on of hands, and a celebration of their fait (Aldridge, 2000:55).

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In addition to prayer, Muturi (2008:115), in her study conducted in Jamaica, revealed that spiritual or faith healing is one of the Faith Based Organization (FBO) initiatives for Jamaica and practiced widely across the wider Caribbean. Literature from the U.S. has documented the importance of spirituality, defined broadly as prayer, meditation, having faith in God and drawing one's strength from ones beliefs, on the psychological health of HIV-positive individuals. Research has also shown that PLWHA who report greater engagement in spiritual activities report lower emotional distress, lower depression, greater optimism and better psychological adaptation (Muturi, 2008:115).

A study done in Jamaica revealed that FBO contributions range from offering prayers and other spiritual support. In all the focus group discussions, members indicated that they went to their religious leaders and asked for prayers, once diagnosed with any kind of illness. People living with HIV/AIDS (PLWHA) focus groups stressed the role of prayers in helping them cope, particularly in the early days post-diagnosis (Muturi, 2008:116).

According to Paterson (2005:2), the story of church responses to AIDS has been a gradual process of moving 'out of the box.' It mirrors movements that have taken place in missiological thinking over the past half century. We might take this in Africa, 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.'*

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Phase 3 was triggered by the current focus on the eradication of stigma. Statements like the Nairobi declaration (World Council of Churches (WCC), 2001:4) reveal a growing realisation that churches have contributed to the spread of the virus by their 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 believe, and what their churches think and teach (Joint United Nations Programme on HIV/AIDS (UNAIDS), 2005:6). 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. Landmark events have included the WCC-sponsored meeting of African church leaders, held in Nairobi in 2001; the UNAIDS-sponsored theologians' workshop on stigma, held in Namibia in 2003

Churches have the potential to play much larger role in health promotion, disease prevention and caring for people living with HIV/AIDS, as churches are to be found within every community and hold much credibility with the people. According to Parry (2002:13), churches have the widest network coverage in the continent, the largest constituency of people, and an enviable infrastructure, extending from the international community to the most marginalized. Nicolson (1995:211), in his study conducted in Pietermaritzburg South Africa, observes that churches have greater access to the general population than any other institution in South Africa. Churches can provide grounding in Christian values for children, teenagers and young adults; something that cannot be done in public schools or in the prevention materials provided by the Department of Health.

According to Casey (2003:276), there is no place on earth that has been spared from the onslaught of HIV and AIDS. At the end of 2007, about 33 million people were infected with HIV globally, and almost half (15.5 million) of these were women. In 2007, there were more than 15 million AIDS orphans and this figure was estimated to increase

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to 40 million by 2010. Since 1981, more than 25 million people have died of AIDS (Pembrey, 2008:10; UNAIDS, 2008:13).

HIV/AIDS marks a severe development crisis in Sub-Saharan Africa, where 70% of the world's 42 million infected people live. Seven countries in Southern Africa have adult infection levels exceeding 20%, and in Botswana, Zimbabwe, Swaziland and Lesotho, one in every 3 adults is infected. The estimated number of orphans in the region already exceeds 34 million, of whom more than 11 million have lost one or both parents to AIDS (Parry, 2002:1).

The prevalence of HIV/AIDS is still rising in countries such as Madagascar and Swaziland, although it is declining in Uganda and Zambia (UNAIDS, 2007:7). Sub-Saharan Africa is a home to just over 10% of the world's population, but 68% of adults and almost 90% of children infected with HIV worldwide live in this region. More than 1.5 million (76%) of AIDS deaths in 2007 took place in Sub-Saharan Africa (UNAIDS, 2007:7). At the end of 2007 there were 11.6 million AIDS orphans in Sub-Saharan Africa alone, while in South Africa, there were 5.7 million people infected with HIV and 1.4 million AIDS orphans (Pembrey, 2008:10; UNAIDS, 2008:13).

At the end of 2010 the UNAIDS world AIDS day report revealed that there was a drop of infection rate worldwide. Sub-Saharan Africa remains the region most heavily affected by HIV. In 2010, about 68% of all people living with HIV resided in sub-Saharan Africa, a region with only 12% of the global population. Sub-Saharan Africa also accounted for 70% of new HIV infections in 2010, although there was a notable decline in the regional rate of new infections. The epidemic continues to be most severe in southern Africa, with South Africa having more people living with HIV (an estimated 5.6 million) than any other country in the world. Almost half of the deaths from AIDS-related illnesses in 2010 occurred in southern Africa (UNAIDS, 2011:7). The Church in South Africa faces a new challenge - the HIV/AIDS pandemic, which claims the lives of people in its communities and congregations every day.

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On March 15, 2009, President Jacob Zuma in his address at the Rhema Church prayer meeting service in Randburg said:

"In the post-2009 election administration, we will work for a continued partnership with the faith-based sector to give practical meaning to the African National Congress's (ANC) moral vision, based on our country's constitution. Our moral value embodies the values of a just and caring society. We need the support of the church and all faith-based organizations, so that together, we can release our people from slavery and its manifestations. Government should open its doors to enable interaction with churches and faith-based organizations on policy and implementation. There are many programmes that require collaboration with churches and faith-based organizations. One is health which has been made a priority, especially HIV and AIDS. The social impact is massive. The 2001, national census found that the country had more than 248 000 child-headed households, mostly as a result of the pandemic. Children as young as 15 have taken over the role of parenthood and look after their siblings" (Http:/www.anc.za/unedocs/speeches/sp015.html accessed 26/04/2010).

It is clear that the president recognizes that churches have greater access to the general population than any other institution in South Africa; therefore, the Department of Health is tasked with the responsibility of coordinating HIV/AIDS strategies to churches and faith-based organizations. According to the Government Communication and Information system (2003:2), all sectors of government and other stakeholders in civil society should be involved in combating HIV/AIDS through intervention programmes.

According to Statistics South Africa (SA) (2003:2), South Africa covers a total area of 470,693 square miles with a population of approximately 50 million. The religious demography from the 2001 census shows that approximately 80% of the population identify themselves as belonging to the Christian faith; approximately 4% belong to other religions, which include Hinduism (1.3%), Islam (1.5%) and Judaism (0.2%). Only 15.1% do not belong to any particular religion or did not indicate their affiliation. From

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these findings, it is clear that the South African government cannot make it without the involvement of churches and faith-based organizations.

It has long been recognized that churches and faith-based organizations play a pivotal role in relation to HIV and the AIDS epidemic. Their involvement includes doctrinal position and religious teachings on the meaning of HIV infection; the degree of openness with which religious figures address HIV and AIDS; and HIV prevention as well as HIV and AIDS mitigation efforts in the communities and societies within which they work (Parker & Birdsall, 2005:11).

Observers are largely in agreement that earlier on churches constituted part of the problem rather than part of the solution. Churches 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. The association of HIV infection with immoral behaviour and the failure to openly discuss the root causes underpinning HIV transmission, particularly differentials of power, have contributed to stigmatization and discrimination of people living with HIV and AIDS within the church (Parker & Birdsall, 2005:12).

Although churches have been involved with AIDS-related activities for a decade or longer, attention to their contribution has increased in recent years as Faith Based Organizations (FBOs) and churches and other religious groups have come to be seen as key actors in many aspects of AIDS response. Currently many international donors are channeling HIV and AIDS funding to FBOs and churches in the belief that their proximity to affected communities and relative cost-effectiveness make them logical conduits for assistance (Parker & Birdsall, 2005:17). Ethiopia has formed 'The Organization for social Service for AIDS bringing in religious organizations and HIV and AIDS focused Non-Governmental Organizations (NGOs) to support the Ministry of Health.

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On the other hand, 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, Olivier, & De Gruchy, 2008:3). Similarly, a Kinshasa study in DRC on the role of religion in HIV-positive women's disclosure experiences and coping strategies, revealed that out of 40 women interviewed, 37 women mentioned their faith and /or the role of religious leaders in their disclosure and coping experiences (Maman, Catchcart, Burkhardt, Omba & Behets, 2009:3).

In Uganda, the church to its credit, stood side-by-side with the government health care services and put its full weight behind the campaigns as well. Whilst the secular response was condom promotion and responsible behaviour, the message from the church was abstinence and fidelity. Alongside the government education campaign entitled 'love carefully', the church developed its own 'love carefully' campaign. These two leading bodies agreed not to undermine the efforts of each other, or the messages, but to do what each could do best within their own spheres of influence. Through this efforts Uganda has experienced the most significant decline in HIV prevalence of any country in the world. National HIV infection rates for pregnant women declined from around 21% in 1991 to just over 6% in 2000, according to sentinel surveillance at some fifteen sites (Ham, 2004:25).

The South African council of Churches (SACC) 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. While many care and support activities happen locally and on a small scale, there are also examples of large scale interventions, such as the integrated care program run by the Catholic diocese of Ndola, in Zambia, which uses a network of 750 volunteers to

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serve a population of 350,000 - 400,000 people in 26 low- income townships (Aggleton, Wood, Malcom & Parker, 2005:34). South Africa is facing challenges on how to effectively address the impact of the HIV and AIDS pandemic.

Furthermore, the following statement by the *The Ecumenical Response to HIV/AIDS in Africa, World Council of Churches (2001:4)* captures the most crucial role of churches in HIV and AIDS interventions:

> *For the churches, the most powerful contribution we can make to combating HIV transmission is the eradication of stigma and discrimination…Given the extreme urgency of the situation, and the conviction that the churches do have a distinctive role to play in the response to the epidemic, what is needed is a rethinking of our mission, and the transformation of our structures and ways of working.*

The HIV/AIDS epidemic requires a multidisciplinary team approach which co-ordinates all sectors involved in health to identify strategies to reduce the infection. Health is the product of a person's positive interaction with his or her total environment, but the role of religion and faith with regards to HIV/AIDS seems to be neglected or unnoticed. If churches in the Vhembe District are active and organized, they can collaborate with clinics and other community-based programmes dealing with HIV/AIDS to form a strong primary health care network and reduce the impact of HIV/AIDS in the district.

1.2 PROBLEM STATEMENT

South Africa is facing a challenge on how to effectively address the impact of the HIV/AIDS pandemic, which claims the lives of people in its communities every day. The HIV/AIDS epidemic requires a multidisciplinary team approach which co-ordinates all sectors involved in health to identify strategies to reduce the infection. According to the Government Communication and Information system (2003:2), all sectors of government and other stake holders in civil society should be involved in combating

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HIV/AIDS through intervention programmes. Churches also like other organizations that are providing care to AIDS patients, have the potential to play much larger role in health promotion, disease prevention, caring for people living with HIV/AIDS and praying for the sick. Churches are found within every community and hold much credibility with the people because of their presence at grassroots, and their involvement with the people in every aspect of their lives. The researcher is a Christian involved in church leadership for more than fifteen years in the same church. Since his engagement in the leadership role, the researcher has observed that there is a lack of recognition of the churches role by the government's health facilities in response to HIV/AIDS in the Vhembe district of the Limpopo province in South Africa. There is also a lack of documentation and literature regarding the role of churches in response to HIV/AIDS within the district. The researcher also noted that churches work in silos in their intervention, as there is little or no collaboration. In addition, when determining the collaborative practices between the churches' work with Primary Health Care (PHC) services in the Vhembe district, seemingly there are no clear linkages between the churches and the Primary Health Care system. Literature shows that the spiritual health of individuals plays an important role in the client's positive response to HIV and AIDS. There is thus a need to investigate and document the role of churches in response to the HIV and AIDS epidemic in selected communities in the Vhembe district of Limpopo Province, South Africa and to determine the linkage and collaboration practices with Primary Health care systems.

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1.3 PURPOSE OF THE STUDY

The purpose of this study was to investigate the role of churches in response to the HIV and AIDS epidemic and to determine the link between the churches and primary health care services in the selected communities in the Vhembe District of the Limpopo Province. The goal of the research is to make recommendations to Christian churches on how they can collaborate with each other and with the PHC facilities towards HIV and AIDS interventions.

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1.4 RESEARCH QUESTIONS

The study addressed the following questions with regard to churches in the Vhembe district:

a) What role do churches play towards the fight against the HIV and AIDS epidemic in the Vhembe district?
b) How do churches collaborate with PHC services in terms of addressing the HIV and AIDS epidemic?
c) What are the challenges faced by church leaders in their attempts to address HIV and AIDS-related issues in collaboration with PHC services in their communities?
d) What can church leaders do to enhance community-based interventions for HIV and AIDS?

1.5 RESEARCH OBJECTIVES

The objectives of the study were to,

a) Explore and describe the role of churches towards the HIV and AIDS epidemic in the Vhembe district;
b) Determine the ways in which churches could collaborate with PHC on HIV and AIDS intervention programmes;
c) Identify challenges faced by church leaders in the implementation of the HIV and AIDS intervention programmes; and
d) Provide recommendations to the church leadership on how they can play an active role in contributing to community-based interventions of HIV and AIDS.

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1.6 SIGNIFICANCE OF THE STUDY

It is envisaged that data obtained through this study will bring awareness to church leaders on how they can intervene in the HIV and AIDS pandemic in the district, and how they could collaborate with each other and with the Primary Health Care system on issues of HIV and AIDS intervention. In addition, the study will hopefully rejuvenate the active role of churches towards HIV and AIDS intervention. The study will also provide data to policy makers and other community based organizations (CBOs) on the collaborative role of churches in HIV and AIDS interventions, the challenges churches face and the perceptions of their contributions to the HIV and AIDS pandemic.

1.7 DEFINITIONS OF CONCEPTS

- **Primary Health Care**

The Alma-Ata, defines Primary Health Care as:

"Essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at the cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care service" (WHO, 1988:15).

In this study primary health care refers to clinics and health centers which are situated in the community as close as possible to where people live and work, which constitute the first level of care.

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- **Church**

Clowney (1995:30), defines church as the actual gathering of Christians and not necessarily the building in which they use for public worship. The Biblical dictionary 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 spirituality shapes their identity.

- **Pastor**

Pastor is a Minister in charge of a church or a congregation, exercising spiritual guidance (Oxford Dictionary, 1990:870). Mahoney (2002:50) defines a pastor as a shepherd who cares for and feeds the flock of God. His ministry is similar to that of an elder. He has a loving, caring, nurturing personality and ministry.

In this study, 'pastor' refers to an ordained spiritual leader who is in charge of a church or congregation.

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- **Community/home-based HIV/AIDS care**

This can be defined as any form of care given to sick people in their homes, which includes physical, psychological, palliative, and spiritual activities (WHO, 2002:2). Russell and Schneider (2000:40) identified two community based models that include home-based care: home visiting programs and comprehensive home-based care.

- **Home visiting**

Volunteers visit patients in their homes and spend time talking and educating them and their family about basic care needs. Home visiting also provides support with cooking, cleaning and errands, including accompanying patients to health facilities. Home visitors may also arrange access to food parcels and other material support.

- **Comprehensive Home-based care**

Comprehensive home-based care programs provide in addition to those mentioned earlier, varying degrees of palliative care. These programs tend to be run by more established NGOS such as Red Cross societies, or Church linked groupings. Training of care givers includes supportive counselling, cleaning and dressing of wounds, oral hygiene, supervision of medication taking, and in certain instances, necrotic wound care, pain management, and diagnosis of opportunistic infections. The package of services also includes DOTS (Directly Observed Treatment, Short Course) for tuberculosis. All projects have invested considerable energy in creating partnerships and referral networks. Relationships are formed with the local welfare department, schools, businesses, hospitals, respite care facilities, and clinics. Some comprehensive home –based care programs have stretched further to incorporate orphan care, social support, and income generation activities.

In this study, community/home-based interventions refer to the prevention and care that can be provided to individuals affected and infected by HIV and AIDS within their own homes. It seeks to promote community participation and networking between all organizations within the community.

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- **Community-based organization.**

A community-based organization is a public or private nonprofit (including a church or religious entity, women's clubs, care groups etc.) that is representative of a community or a significant segment of a community, and is engaged in meeting human, educational, environmental, or public safety community needs at grassroots level (Swanepoel & De Beer, 2011:22).

A community-based organization is one that is driven by community residents in all aspects of its existence. By that I mean,

a) The governing body consists of a majority of residents;
b) The staff is drawn primarily from the pool of local residents;
c) The main operating offices are in the community; and
d) Priority issue areas are identified and defined by residents through open forums and surveys and solutions to address priority issues are developed with residents.

In this study, community-based organization refers to a non-profit local organization within a community that provides various services to people.

- **Christianity**

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,

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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. 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 Christian churches are classified according to three main locally understood classifications:

1) **Pentecostal churches**, referring to those churches which emphasize the centrality of the Holy Spirit in faith and in practice and are connected with overseas churches administratively.
2) **Charismatic churches** are of more recent origin. Most of these churches arose in the 1980s. They also 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.
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.

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- **Faith-based organization**

Dicklith and Rice (2004:662) define faith-based organisations (FBOs) as a non-state actors that have a central religious or faith core to their philosophy, membership, or programmatic approach, although they are not simply missionaries.

Faith-based organisations as defined by United States Agency for International Development (USAID), are groups of individuals who have come together voluntarily around a stated spiritual or belief system that informs and guides their work together. They range from small, grassroots organisations with simple structure and limited personnel to large, global institutions with highly sophisticated bureaucracies, wide networks, substantial financial resources, and significant human resources (Green, 2003:81).

Bradley (2009:103) defines a faith-based organisation as one where faith is embedded into the organizational structure, producing a diversity of approaches to development practice. In some cases, faith acts as a platform for close partnerships at the community level. Bradley further categorises faith-based organisations into three groups:

- **Grassroots organizations**, whose spirituality shapes their identity and desire to closely relate to the local community. These are entities involved in Church governance.
- **Denominational organizations** which use their religious affiliation to raise money. They have national networks.
- **Missionary driven FBOs**, whose concept and practice of development is less about being locally responsive and more concerned with achieving the goal of religious salvation for all. These are more complex as an interfaith or ecumenical coalition of congregation or clergy.

In this study an FBO is understood as a Christian based structure which functions as a non-profit organization which addresses the needs of community members in a variety of ways locally, nationally and internationally.

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1.8 RESEARCH DESIGN AND METHODS

The research design of this study was qualitative, explorative, descriptive and contextual in nature because it attempted to describe human experiences as provided by people involved (Brink, Van der Walt & Van Rensburg, 2011:113). Detailed information of the design and methods will be discussed in Chapter 3.

1.8.1 Qualitative research design

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 (Burns & Grove, 2003:356).

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., 2011:113; Polit & Hungler, 2004:15). This design was chosen because it studies people in terms of their own definitions of the world in this study the emic perspective of Christians: it focuses on the subjective experiences of individual Christians and is sensitive to the context in which people interact with each other.

1.8.2 Exploratory research design

Exploratory research begins with a phenomena of interest; but rather than simply observing and describing it, exploratory research investigate the full nature of the phenomenon and other factors to which it is related (Polit & Beck, 2008:20; Polit & Beck, 2006:21; McMillan & Schumacher, 2006:68). According to Burns and Grove (2005:482), explorative studies examine relatively unknown phenomena in order to gain

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new insights and to understand the phenomena with the aim to determine 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 role of churches towards the HIV and AIDS epidemic in the Vhembe district.

1.8.3 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 (Burns & Grove, 2005:232). According to Polit and Hungler (2004:716), descriptive research refers to studies that have information as their main accurate portrayal of the characteristics of reasons, situations or groups. While Pope and May (2006:80), 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 was able to collect information about the role of churches in response to HIV/AIDS epidemic, describing and classify the phenomena under study.

1.8.4 Contextual research design

The study is contextual when the phenomenon is studied for its intrinsic and immediate contextual significance (Mouton, 2001:133). Contextual studies focus on specific events in a 'naturalistic setting'(Lobiondo-Wood & Haber, 2002:128). 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, 2002:128). This study focuses on the role of Christian churches in the HIV and AIDS epidemic in their own context, without their situation having been manipulated.

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1.9 POPULATION AND SAMPLING

1.9.1 Population

The population of this study consists of all Christian churches in the Vhembe District of the Limpopo Province. Furthermore, a population is a group of potential participants to whom the researcher wants to generalise the results of the study. As such, a subset of the population that were used for the study is called a sample (Burns & Grove, 2005:447).

1.9.2 Sampling

Trochim (2006:61) defines sampling as a process of selecting units (e.g., people, organizations) from a population of interest so that by studying a sample we may fairly generalize our results back to the population from which they were chosen. Since it is generally impossible to study an entire population, sampling procedure is a step-by-step use of sampling methods to select a sample from within a general population. It is therefore important that the group selected be representative of the population, and not biased in a systematic manner.

A non-probability purposive sampling was chosen for this study because it involves conscious selection of certain participants to be included in the study. The researcher selected informative participants that best represent the population under study, based on personal judgment about which participant is the most representative (Polit & Beck, 2004:729; Burns & Grove, 2001:376; Munhall, 2007:230).

Sampling was done in two stages. The first stage was sampling of churches and second stage was sampling of individuals in the sampled churches. The size of the sample was considered satisfactory when data saturation occurred, that was when new data yielded the same information as that already collected, and a sense of closure is

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reached (Polit & Hungler, 2004:308). Predetermination of the number of participants was therefore impossible.

1.10 RESEARCH SETTING

A naturalistic setting is a real life situation where nature takes its course without any interference (Burns & Grove, 2009:359; Streubert, Speziale & Carpenter, 2003:331). For the purpose of this study, the naturalistic setting was in their churches, and their homes depending on where participants felt comfortable. No control or manipulation was imposed during this study.

1.11 DATA COLLECTION

Data was collected using the in-depth individual interviews to explore and obtain information on the role of churches in response to HIV and AIDS epidemic in the Vhembe district. The common ground in interviews is that, by their nature, the interviews put the researcher in the role of research instrument "through which data is collected" (Streubert, et al., 2003:150).

In this study the researcher was the main research tool or primary gathering instrument. 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 an environment where the participants felt safe and at ease. Permission was obtained from the participants to record the interviews with an audiotape. The researcher continued interviewing the participants until data saturation was reached. Interviewed participants included pastors, church board members and members.

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1.12 DATA ANALYSIS

Collected data included field notes and transcripts from interviews. Data was analysed qualitatively using Tech's steps of open coding as described by Creswell (2009:227). Open coding is the process of breaking down and conceptualising the data (Holloway and Wheeler, 2002:34). Detailed information on data analysis will be discussed in Chapter three.

1.13 TRUSTWORTHINESS

To ensure that the findings of this study are a true reflection of the role of churches, the model of Lincoln and Guba (De Vos, Strydom, Fouche & Delport, 2011:419-422) 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.

Table 1.13 Trustworthiness strategies

CRITERIA	STRATEGY	APPLICATION BY RESEARCHER
CREDIBILITY	Reflexivity	Bracketing and intuiting in each phase of the research process.
	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 colleague who have

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		experience and knowledge of the phenomenon being studied namely HIV and AIDS Care.
	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 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 in order to build a trusting relationship.
	Member checks	Analytical categories, interpretations and conclusions tested with members to ensure credibility.
TRANSFERABILITY	Purposeful sample	Sampling was purposive: suitable participants with knowledge and experience selected to represent group under study.
	Dense description	Data about participants, research context and setting were adequately provided

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DEPENDABILITY	Stepwise replication	The data and analyses were then checked for comparability and similarity, and discrepancies resolved through member checking with the participants.
	Inquiring audit	Supervisors of this study were responsible for examining the data, interpretations and recommendations in order to attest that they are supported by data.
	Audit trial	The researcher also has done peer debriefing with other research colleagues in the work place
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.

1.14 ETHICAL CONSIDERATIONS

The major guiding ethical principles were observed throughout the study. Permission to conduct the study was obtained from the University of Venda Ethical committee and leadership of churches in the Vhembe district. 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.

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Participants' names were not used in the interviews and their information was handled with dignity. The researcher protected participants from psychological, social harm and exploitation by carefully considering the phrasing of questions.

1.15 LIMITATION OF THE STUDY

The researcher recognizes the restrictions in the study that may limit the credibility of the findings and restrict the population to which the findings can be transferred. The study is limited to the Vhembe district Christians from Pentecostal, Charismatic and Zion churches only. The findings must be applied with caution to avoid generalization since they might not represent all Christian churches.

1.16 DISSEMINATION OF THE FINDINGS

Findings will be disseminated to the participants and churches where the study was conducted in the form of a research report. The participants were informed that a copy of the report will be handed to the University of Venda and the primary health care component in the district. Presentations of findings will also be offered at national and international conferences.

1.17 OUTLINE OF THE REMAINING STUDY CHAPTERS

Chapter 2: literature review - discusses literature on the role played by churches and faith-based organizations in response to HIV and AIDS worldwide, including South Africa.

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.

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Chapter 4: Data analysis and presentation of findings – the data and the findings are presented and discussed.

Chapter 5: Conclusions and recommendations - conclude with some recommendations made as a result of the findings, and consider limitations of the study and ideas for further research.

1.18 SUMMARY

This chapter outlined the overview of the study which included introduction and background, problem statement, objectives, research questions, and research design and methods. Relevant concepts were defined as used in the study.

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CHAPTER 2:

LITERATURE REVIEW

2.1 INTRODUCTION

The previous chapter addressed the background of the study, problem statement, purpose, research question, objectives, and significance of the study as well as limitations of the study. This chapter deals with existing body of knowledge in the field of Christian churches and HIV and AIDS. It covers a review of the literature that is related to the study research. It intends to indicate where the present study fits into the broader debates, thereby justifying the significance of the study. The researcher then reviewed the literature on how Christian churches and Christian faith-based organizations have responded to the HIV and AIDS epidemic in Africa. A number of studies have been done on the role of faith-based organizations in HIV and AIDS intervention some of them focused entirely on faith communities in general, others focused on leaders of churches while others focused on the activities faith communities are engaged in. Not all studies covered the roles played by specific faith-based organizations or churches. The studies reviewed in this study concerned Christian churches and Christian faith-based organizations, although others included faith-based organizations of other faiths. A few studies have looked at the issue of churches and AIDS from a socio-medical perspective.

2.2 PURPOSE OF LITERATURE REVIEW

A literature review is a process involving finding, reading, understanding and forming conclusions about the published research and theory as well as presenting it in an organized manner (Burns & Grove, 2005:93; Brink, et al., 2011:67). The purpose of the review is to convey to the reader what is currently known regarding the topic under study (Burns & Grove, 2009:91). It can also be done to acquire knowledge for use in practice or to provide a basis for conducting a study (Burns & Grove, 2003:55). The

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review provides information and background for understanding what has already been learned on a topic and illuminates the importance of the new study (Polit & Hungler, 2004:91). It also provides the identification of feasible research purpose and problems (Burns & Grove, 2003:117). The purpose of a literature review in a qualitative study is to place the findings in the context of what is already known about the topic (Streubert, et al., 2003:21).

In qualitative studies, the review of literature can follow the data analysis to achieve a pure description of the phenomenon under investigation (Streubert, et al., 2003:70). The fewer ideas or preconceived notions that researchers have about the topic, the less likely their biases are to influence the research. Once data analysis is complete, researchers review the literature to place the findings in context.

However, in the present study the researcher undertook the literature review first in order to sensitize himself to the phenomenon under study, to develop an inventory of vocabulary and to gain insight into the meaning of the topic (Streubert, et al., 2003:70). Doing this led to the awareness of the phenomenon under study, namely, the role of churches in response to HIV and AIDS epidemic, and to enhance bracketing.

2.3 THE PHENOMENON OF CHRISTIANITY

2.3.1 Definition of Christianity

Christianity refers to the religion of Christ (Stample, 2000:40). Luke (1:1-4) and John (20:30-31), in their Gospels revealed that Christianity is a historic religion and cannot exist from Christ of history. Barrett's World Christian Encyclopedia (1994 update), gives a figure of 1.9 billion Christians (or about 33% of the world population), and projected that by the year, 2000 there would be 2.1 billion Christians in the world, or 33% of the total population. Regardless of the degree of accuracy of this figure, Christianity, if taken as a whole, is unarguably the largest world religion. (It is important to remember that

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although Christianity is the world's largest religion, it is an umbrella term that comprises many different branches and denominations).

For statistical purposes, groups which self-identify as part of Christianity include, but are not limited to: 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. These groups exhibit varying degrees of similarity, co-operation, communion, etc. with other groups. None are known to consider all other Christian sub-groups to be equally valid. David Barrett, an Evangelical Christian who is the compiler of religion statistics for the *Encyclopaedia Britannica* and the *World Christian Encyclopaedia*, includes **all** of the groups listed above in the worldwide statistics for Christianity.

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, Fundamentalists..

According to Barrett and Johnson (2001:24-25), 26% of the world's Christians are Pentecostal/Charismatic, and this number will rise to 31% by 2025. An estimated three-quarter of Pentecostals are to be found in the third world. Anderson (1992:59) is of the opinion that one of the main reasons for the growth of the Pentecostals and

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Pentecostal-type (Charismatic) churches in Africa has been the remarkable ability of Pentecostalism to transplant itself. Sub-Saharan Africa is the most Christian of all continents after Latin America. Roman Catholic and many Protestant churches were founded there in the era of colonialism and missionary work (Tiendrebeogo & Buykx, 2004:18).

2.3.2 History of Christianity in caring for the sick

Christianity has its beginnings, from the subjective human side, in temporal history. Christianity values are inextricably linked with the person, life, and death of Christ (Cairns, 1996:49). Christ's character, work, teachings, and above all, His death and resurrection mark the beginning of Christianity.

The first Christian church was founded in Jerusalem in the 1st century by the followers of Jesus Christ the son of the living God. From A.D. 30 to approximately 44 the church in Jerusalem held a leading position in the early Christian community (Cairns, 1996:60). The Holy Spirit was given the position of prominence in the founding and continuation of the Christian church. After the coming of the Holy Spirit in Acts (2:2-41), Peter's message brought about three thousand souls to Christ, leading to the birth of the New Testament Christian church. Growth was rapid. The total number of those baptized soon reached five thousand (Acts 4:4). Since that time Christianity continued to spread to the neighboring countries and abroad. Christianity is now a global movement.

The early church had no benevolent welfare state to give aid to the poor and sick (Cairns, 1996:84). A church took responsibility on itself. The money collected from those able to give in the offering following the celebration of the communion was dispensed to meet such needs (Cairns, 1996:84). Paul also mentioned the practice of collecting money of the faithful each Sunday (1 Corinthians 16:1-2). The deacons would then use it to care for those who were in need. The needy people included orphans, widows, the poor and the sick people. The women of the churches also aided in this charitable work by making clothes for those who had a need of them (Acts 9:36-41).

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Jesus in his ministry demonstrated love and compassion to those who were suffering different types of sicknesses by praying for them for healing. His main purpose was to alleviate human sufferings (Luke 4:18-19). Jesus came to bring the good news to the deprived and excluded, to heal them and set them free, and to establish through them the new community. The gospel accounts of his practice of healing at different levels from simple fever, to leprosy, to demonic possession, to forgiveness of sins forms the basis for the Christian commitment to caring for the sick and those with disabilities. Dearmer, (in Kelsey, 1973:55-57), indicates that wherever Jesus Christ went, he played the role of a religious healer. The majority of the recorded healings of Jesus Christ were either psychological (mental illness) or physical. The New Testament church continued to carry out the same responsibility of praying for the sick.

The long Christian missionary tradition, although often faulted today for its complicity in colonialism, left a legacy of church involvement in social services in all regions, particularly in the areas of education and health (Ferris, 2005:316). Headley, of Catholic Relief Services asserts, "The principal agents of human development in the world have been or continue to be faith-based organizations". In the United States of America for example, the Catholic Church is the largest non-public provider of human services to poor families. One-third of all AIDS patients in the world are served through the auspices of the Catholic Church (Ferris, 2005:316). Ferris continues to argue that Christian nongovernmental organizations are active in virtually every country in the world.

Historically, Christian faith-based organizations have been very active in alleviating human ills and promoting the welfare of the people. In the immediate post-World War II period, there was a dramatic increase in the number of secular and Christian organizations that were created to respond to humanitarian need. Care International, Christian Aid and Church World Service all had their roots in the interwar period but grew rapidly in the years following World War II. The World Council of Churches was formed in 1948 as a fellowship of churches, but much of its programmatic work in its early years was concerned with responding to humanitarian needs, particularly the

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needs of Europe's displaced millions. Similarly, the Lutheran World Federation (LWF) was founded in 1947 and focused much of its early work on responding to the needs of Lutherans displaced by the war (Ferris, 2005:314-315).

During the 1950s and 1960s, NGOs, particularly faith-based organizations, continued to provide substantial relief and were essential to the functioning of the refugee-serving community. One 1953 analysis found that 90% of post-war relief was provided by religious agencies (Nichols, 1998:32-33). NGOs also took the lead in lobbying for resettlement opportunities and in providing the resources needed for resettlement of the hundreds of thousands of Hungarian refugees fleeing Soviet intervention in 1956. Over the years, Northern church-based organizations channelled millions of dollars to churches and related organizations in the South through what was known as 'inter-church aid' in support of local church work with the poor and with victims of wars and other disasters. In 1962, the International Council of Voluntary Agencies (ICVA) was formed, largely as a result of the initiative of faith-based organizations, and by 1965, as many as 65 agencies had become members of ICVA. The ICVA played, and continues to play, a unique role as a coalition of both Southern and Northern NGOs active in the fields of development and humanitarian relief (Ferris, 2005:515).

In developing countries, churches are major providers of care and support services for people living with HIV and AIDS. Churches are uniquely positioned to spread HIV and AIDS education and prevention messages through their extensive networks that reach even remote villages (Green, 2003:11). Religious organizations appear to have been effective in HIV prevention, especially in Africa and Latin America (Green, 2003:12).

There is substantial evidence of the important role that churches 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 same country are owned and managed by local churches, and the

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Roman Catholic alone provides 25% of all HIV and AIDS care, including home-based care and support of orphans (Haddad, et al., 2008:4).

2.3.3 Religious demography in South Africa

The South African constitution provides for freedom of religion, and this has been generally respected in practice (United States Department of State, 2007:1). The government at all levels has sought to protect this right in full and not to tolerate its abuse, either by government or private actors (United States Department of State, 2007:1). The country has an area of 470,693 square meters, and a population of 47.4 million. According to the 2001 national census, Christians accounted 79.7% of the population. This includes Zion Christians (11.1%), Pentecostal (charismatic) (8.2%), Roman Catholic (7.1%), Methodist (6.8%), Dutch Reformed (6.7%), Anglican (3.8%); members of other Christian churches accounted for another 36% of the population. Muslims accounted for 1.5% of the population, Hindus about 1.3%, and Jews 0.2%. 15.1% has no religious affiliation, 2.3% were classified as other and 1.4% were unspecified (Statistics SA, 2003:2). The statistics clearly indicated that Christianity is the most popular religion in South Africa.

African Indigenous Churches make up the largest of the Christian groups. Some believe that people claiming no affiliation with any organized religion adhered to traditional indigenous religions. Many people have syncretic religious practices combining Christian and indigenous influence (Statistics SA, 2003:2). A common feature of the traditional indigenous religions is the importance of ancestors. Ancestors are regarded as part of the community and as indispensable links with the spirit world and the power that control everyday affairs. Ancestors are not gods, but because they play part in bringing about either good or ill fortune, maintaining good relations with them is vital (Denis, 2006:315). Followers of indigenous religions believe that certain practitioners may manipulate the power of spirits using herbs, therapeutic techniques, or supernatural powers. Some practitioners are considered witches and may engender

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fear. Many healers, including some in independent African churches, combine Christian and traditional indigenous religious practices (Denis, 2006:315).

An estimated 86.8% of whites are Christians, 8.8% have no religion, 0.2% are Muslim, 1.4% are Jewish, 2.7% have other or undetermined beliefs. Nearly half of the Indian population is Hindu, and the remainder is either Muslim (23%) or Christian (20%). The majority of Muslims is Indian or belongs to the multi-ethnic community in the Western Cape. Almost 80% of coloureds are Christians, while 7 percent are Muslim. 79.9% of Black residents are Christian, 17.5% have no religion, 0.2% is Muslim, and 2.3% have other or undetermined beliefs (Statistics SA, 2003:3).

A number of Christian organizations in addition to the denominations already mentioned, operate in the country, doing missionary work, giving aid, and providing training, including The Salvation Army, Promise keepers, Operation Mobilization, Campus Crusade, and the church of Jesus Christ of latter-day Saints (Mormons). The Muslim World league also is active, as is the Zionist International Federation (Statistics SA, 2003:4).

2.4 ROLE OF CHRISTIAN CHURCHES IN RESPONSE TO THE HIV/ AIDS EPIDEMIC

Different churches react differently to AIDS. Dixon (2002:85), mentions that there are 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, churches constituted part of the problem rather than part of the solution. Churches 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. The association of HIV infection with immoral behaviour and the failure to openly discuss the root causes underpinning HIV transmission, particularly differentials of power, have contributed to

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stigmatization and discrimination of people living with HIV and AIDS within the church (Parker & Birdsall, 2005:12).

Without a doubt, churches 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, 2005:11).

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

2.4.1 Prevention

Churches have traditionally been less involved with HIV prevention work in comparison to care and support activities, although the picture is not uniform. Liebowitz (2004:6), 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 Christian churches 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, 2004:1-2). *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

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protective measure against HIV/AIDS provided the couples using them are married. They agreed that fidelity and abstinence remained the best protection against HIV (Advanced sexuality studies short course, 2009:2).

Churches play an integral part in the combat against HIV and AIDS. For example, studies conducted in Uganda have revealed that the involvement of churches in AIDS in Uganda contributed to the decline of HIV prevalence (Ham, 2004:25). 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 this efforts Uganda has experienced the most significant decline in HIV prevalence of any country in the world. National HIV infection rates for pregnant women declined from around 21% in 1991 to just over 6% in 2000 (Ham, 2004:25). In the 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, 2001:70).

Since churches made a significant contribution to Uganda success story in preventing and mitigating the impact of HIV and AIDS some researchers, like Liebowitz chose to make a comparative study between churches in Uganda and KwaZulu-Natal province which has the highest HIV prevalence rate in South Africa. Liebowitz (2002:26) 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. During his research Liebowitz found that churches were involved in activities that ranged from communication during sermons to workshops to crusades to peer education (Liebowitz, 2004:8-9). These activities are described under various labels, usually as awareness, education, or providing information in KwaZulu-Natal and as sensitization or education

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in Uganda (Liebowitz, 2004:8-9). 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, 2004:4).

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

1. 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.

2. Different responsibilities (posters 19- 24)

The national government should encourage people to board a boat whatsoever. 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.

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3. 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 has stayed on, at least in his early youth. And 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. And everyone may at a determined moment have to change from one boat to another unless he takes 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.

4. Psychological constraints (posters 37- 44)

The real problem lies with those who don't want to board a boat, for irrational convictions like "AIDS is punishment for sin" or "I am bewitched". And many people especially women, cannot board a boat, being too poor and too dependent on their partners to make free choices.

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 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 torpedos at other

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boats instead of saving lives (Tiendrebeogo & Buykx, 2004:4-5). The church and secular services do not operate in isolation.

With regard 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 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, 2002:8).

With regard to youth, peer education programs were pioneered by FBO in Africa, specifically Uganda and of note is Sr. Dr. Miriam Duggan's 'Youth Alive' programme on 'Education for Life.' This programme has been adopted by other countries and formed the bases for other similar programs. 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 is to give youth the information to empower themselves with value systems, respect and responsibility, teach them negotiation skills and to withstand negative social and peer pressure (Parry, 2002:10). Father Emilio Sumbelelo of the diocese of Benguela, Angola stresses the importance of church schools, where education and role models help young people in their choices (Sumbelelo, 2002:18).

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 anti retroviral therapy. Community/Home-based care (CHBC) programmes developed through the early 1990s providing nursing and palliative care, as well as general support for households affected by HIV (Catalado, Musheke, Kulman, Mburu & South, 2010:1).

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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, 2005:33). CHBCs were mainly initiated by non-governmental organizations, community-based organizations, church-based organizations and concerned individuals (Cullinan, 2000:2). 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, 2003:273). Many CHBC in South Africa were started by church organizations or concerned individuals, particularly retired nurses (Cullinan, 2000:3).

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, co-ordinated by Ndola Diocese, offer basic health care, home visits and friendship to people at home. This home-based care since its establishment in 1991, 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 neighbourhood. In a second stage, these volunteers '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, 2004:8).

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, 2000:567). This home care model aims to provide a continuum of care for PLWHA from diagnosis to

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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, 2003:274).

Liebowitz (2004:8-9), 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, emotional, and 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 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 can't 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 Project gateway houses. The project focuses on caring for, assisting and equipping care-givers and children, paying particular attention to widows and orphans. Community Care Project gives food parcels and toiletries to people living with AIDS through caregivers. However, this activity has proved unsustainable due to a lack of funds from Project Gateway and as such the giving of parcels is limited to people who are in great need. Home visiting and care

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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, 2004:9). One of the recommendations from the study conducted by Sapepa (1998:187), 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 intersectoral approach to management. Campbell and Foulis (2004:12), 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 the caregivers and the patients.

Very little has been written on the cost of home-based care. A study by Uys and Hensher (2002:627), attempted to calculate what it would cost to roll 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, but that studies are necessary to establish the extent to which CHBC can be a substitute for hospitalization.

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, 2004:9). Catholic AIDS Action in Namibia provides

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voluntary counselling and testing precisely because it recognizes the need and its trusted role and potential to influence in a positive way (Haendler, 2001:5). According to Parry (2002:8), several mission hospitals are already providing this service. FBO, 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 serostatus journey.

Liebowitz (2004:9), in his research in KwaZulu-Natal, 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 resources.

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., 2008:3).

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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) for the country (Parry, 2002:12). 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, 2004:9).

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, 2002:10). 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 who 5,645 had received material assistance from the programme (Byamugisha, et al., 2002:24).

According to the findings in Liebowitz (2004:9)'s study of 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' 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

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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.

2.4 COLLABORATION BETWEEN CHRISTIAN CHURCHES AND GOVERNMENT HEALTH SECTORS IN ADRESSING THE HIV/AIDS EPIDEMIC

Studies conducted in different countries showed that where there was collaboration, effort was maximized. When government services fail, FBO are increasingly being asked to back up and support previously functioning systems. Ethiopia has formed 'The Organization for social Service for AIDS bringing in religious organizations and HIV and AIDS focused non-governmental organizations (NGOs) to support the Ministry of Health (Parry, 2002:13).

In Botswana, with the government providing everything, it took a long time for churches to take up the challenge of HIV/AIDS. However, when they did, they formed collaborative effort between denominations to fill the gaps, to supplement and complement Government efforts, and they established a counseling service and network that is second to none and has become a regional initiative stretching up to Liberia (Parry, 2002:13).

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On the other hand, 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 Joint United Nations Program on HIV/AIDS (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., 2008:3). 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) for the country (Parry, 2002:12).

Studies conducted in Uganda have revealed that early in the epidemic, the involvement of churches in AIDS in Uganda, which has received the most scholarly attention due to its regarded as a success story have contributed to the decline of HIV infection. In Uganda, the church to its credit, stood side-by-side with the government health care services and put its full weight behind the campaigns as well. Through this collaboration Uganda has experienced the most significant decline in HIV prevalence of any country in the world. National HIV infection rates for pregnant women declined from around 21% in 1991 to just over 6% in 2000, according to sentinel surveillance at some fifteen sites (Ham, 2004:25).

Faith Based Organizations operate parallel to governments providing virtually all the same major services as government but filling in the gaps where government fails to provide.

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2.5 CHALLENGES FACED BY CHRISTIAN CHURCHES WHEN IMPLEMENTING HIV/AIDS PROGRAMME

Although there are churches and FBOs that are involved in the fight against the spread of HIV and new infections, stigma and discrimination remains the major obstacles to HIV/AIDS prevention and care initiatives.

2.5.1 Stigma and discrimination

Stigma and discrimination threaten the effectiveness of HIV/AIDS prevention and care programmes. The association of HIV infection with immoral behaviour and the failure to openly discuss the root causes underpinning HIV transmission- particularly differentials of power, have contributed to stigmatization and discrimination of PLWHA within the church (Parker & Birdsall, 2005: 12).

According to Lindsey; Hirschfield; Tlou and Ncube (2003: 498), 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 also supported by Baker; Williams; Juma and Mahindra (2005:1), who explained 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.

Cochrane (2005:51), notes how religion feeds into the problem of stigma through the taboos, sanctions, and silences [about sexuality], much of it authorized by religious legitimations. This extends to the patriarchal aspects of religion, to prejudices about same sex relationships, and to racial and class differences. Similar 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, Atuyambe, Murphy, Ringheim & Woldehanna, 2007:56).

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The stigmatization of people with HIV/AIDS is connected with the mistaken link that Christians thinking has often made between sexuality and sin (Paterson, 2005:10). There are Christians and religious leaders who believe that AIDS is a punishment from God (Pillay, 2003:109), or that the sufferers contracted the disease because they had many sexual partners. Greyling (2001:70) mentions that Jerry Falwell speculated that AIDS could be God's judgment on homosexual persons and society. Weitz (1991:37) notes that those who consider AIDS a divine punishment for sin usually cite Deuteronomy 28:15-16. Hlongwana and Mkhize (2007:560), 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 (Hlongwana & Mkhize, 2007:560).

Adam (in Nicolson, 1996:58) mentions that the World Council of churches admitted that many churches continue to regard issues of sexuality as taboo. Many Christians feel that if they talk about sex-related issues it may pose questions about their moral or spiritual understanding, and this poses a problem when it comes to preventing the spread of HIV and AIDS.

A 2003 review of HIV/AIDS-related stigma in FBOs in South Africa, which included interviews and focus groups with both Christians 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 (2005:16) included:

- 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;

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- 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';
- Problem with confidentiality in relation to individuals' HIV status and lack of guidelines for clergy in how to deal with the disclosure; and
- Denial on the part of some religious leaders that AIDS is present within their faith or congregation.

Current literature makes reference to the challenges of eradicating HIV-related stigma and discrimination within churches and FBOs. The study conducted in Uganda by Otolok-Tanga, et al. (2007:58), revealed that through participation in HIV/AIDS trainings, FBOs have been armed with better information to fight discrimination and stigma within their institutions and congregations. Both international and local studies reveal that HIV/AIDS intervention programmes are aimed at changing the spread and the consequences of HIV/AIDS. Attitude of acceptance of people who are HIV positive improved due to participation in awareness programmes and HIV/AIDS training.

2.6 SUMMARY

From the literature studied above it appears that HIV and AIDS has taken a heavy toll on people's lives and health and that government agencies are struggling to cope with the pandemic. There is a major shortage of health care workers in Southern Africa. In this situation, churches and FBOs have emerged as auxiliary partners of the governments in preventing and mitigating the impact of the pandemic. Providing care within the household can overcome some of the barriers to accessing HIV care, including those that relate to the economic and opportunity costs incurred by patients if they have to travel to attend health facilities. While some churches and FBOs may struggle financially to run their programmes, others are making a contribution to the reduction of HIV and AIDS.

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CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The previous chapter reviewed and discussed literature on how the Christian churches and Christian faith-based organizations have responded to the HIV and AIDS epidemic. This chapter deals with the research methodology in detail which includes the research design, population, and sampling method, data collection, and analysis, ensuring trustworthiness as well as ethical considerations.

3.2 RESEARCH DESIGN

According to Mouton (2001:55), research design is a plan or blueprint of how you intend to conduct the study. It includes the methods and techniques used to collect, analyze and interpret data. A research design is a blue print for conducting the study that maximizes control over factors that could interfere with the validity of the findings; therefore research design guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal (Burns & Grove, 2005:211).

There are two broad categories of research design, qualitative and quantitative. Qualitative research rely more on language and the interpretation of its meaning, data collection methods involve human beings and a more creative process of theory development than testing.

3.2.1 Qualitative research design

In this study a qualitative, descriptive, exploratory and contextual design was used to explore and describe the role of churches in response to the HIV/AIDS epidemic in the Vhembe District. Quantitative techniques collect data that are based on numbers, which

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are open to hypothesis testing and critical methods such as statistical correlations (Burns & Grove, 2005:24-25; Polit & Beck, 2008:219). Qualitative research refers to the 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 (Burns & Grove, 2003:356; Morse & Field, 1996:199). Qualitative research is a way to gain insight through discovering meanings. This insight is obtained not through establishing causality but through improving our comprehension of the whole. Within a holistic frame-work qualitative research is a means of exploring the depth, richness and complexity inherent in phenomena (Burns & Grove, 2005:52). In qualitative research, the researcher eschews measurement and focuses on interpretative, non numerical narrative interpretation (Polit & Beck, 2008:219).

Researchers who use qualitative research adapt a person-centered and holistic perspective to understand the human experience, without focusing on specific concepts. The original context of the experience is unique, and rich knowledge and insight can be generated in depth to present a lively picture of the participants' reality and social context. These events and circumstances are important to the researcher (Holloway, 2005:4).

Regarding the generation of knowledge, qualitative research is characterized as developmental and dynamic, and does not use formal structured instruments (Holloway, 2005:4-6). It involves the systematic collection and analysis of subjective narrative data in an organized and intuitive fashion to identify the characteristics and significance of human experience (Holloway, 2005:47-51).

Qualitative researchers are concerned with the 'emic' perspective to explore the ideas and perception of the participants. The researcher tries to examine the role from the participant's point of view in order to interpret his/her words. 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

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gathered from the participants and to interpret and portray their experiences. However, immersion cannot be obtained without a researcher-participant trusting relationship. The relationship is built through basic interviewing and interpersonal skills.

General characteristics of qualitative research design as described by Polit and Beck (2008:219) 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;
- 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;
- Requires the researcher to become the research instrument; and
- Requires ongoing analysis of the data to formulate strategies and to determine when fieldwork is done.

The strengths of qualitative research are that, it studies people in terms of their own definitions of the world (emic perspective). According to Holloway and Wheeler (2002:11), the qualitative researcher attempts to examine the experiences, feelings and perceptions of the people they study, rather than imposing a framework of their own that might distort the ideas of the participants. Qualitative research is based on the premise that individuals are best placed to describe situations and feelings in their own words. It is also sensitive to the context in which people interact with each other. The researcher must be sensitive to the context of the research. The context of participants' lives or work affects their behavior, and therefore researcher has to realize that the participants are grounded in their history and temporality. Events and actions are studied as they occur in everyday, real life settings (Holloway & Wheeler, 2002:11). Another advantage is that it focuses on the subjective experiences of individuals. Researchers usually approach people with the aim of finding out about them. They go to the participant to

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collect the rich and in-depth data that may become the basis for theorizing (Holloway & Wheeler, 2002:10). Finally, the research design is flexible and unique, throughout the research process (Brink & Wood, 1998:246; Burns & Grove, 2003:374).

The research phases

There were four phases in the research process for this study as suggested by Brink, et al. (2011:51-56). These are described below.

Phase 1: **The conceptual phase**

Conceptualization refers to the process of developing and refining abstract ideas (Brink, et al., 2011:51). In this study, the conceptual phase was characterized by the identification of the problem, formulation of the research question, the objectives, purpose of the study, selection of research method and design of the study, as well as the selection of research subjects in a population (sampling). Then a literature review was done to become familiar with the content of the literature. In order to clear any preconceived ideas about the phenomenon, the researcher did bracketing by putting aside what is known about a study topic to allow the data to convey undistorted information.

Phase 2: **The empirical phase**

In this phase, the researcher implements all the plans that he/she made in phase 1 to collect the data (Brink, et al., 2011:54). In this study, the empirical phase involved the actual data collection. In-depth interviews were used to collect data from participants. The researcher was the data collection instrument.

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Phase 3: **The interpretive phase**

The data collected in the empirical phase are not reported in 'raw' form. The researcher must summarize them and subject them to various types of analysis and interpretation (Brink, et al., 2011:55). In this study, data analysis started as soon as the first interview had been obtained. The collected data was analyzed to determine conclusions and making sense of the results.

Phase 4: **The communication phase**

Without a scientific research report, the process is incomplete. Communication of findings involves the development and dissemination of a research report to appropriate audiences (Brink, et al., 2011:56). In this study, the researcher compiled a report at the end of the study with appropriate recommendations to be disseminated to various publications and stake holders.

3.2.2 Exploratory research design

Exploratory research begins with a phenomenon 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, 2008:20; Polit & Beck, 2006:21; McMillan & Schumacher, 2006:68). According to Burns and Grove (2005:482), explorative studies examine relatively unknown phenomena in order to gain new insights and to understand the phenomena with the aim to determine priorities for further research.

This study was concerned with exploring the role of churches in response to HIV and the AIDS epidemic in the Vhembe district. Exploratory studies are designed to increase the knowledge of the field of study but are not intended for generalization to larger populations (Burns & Grove, 2003:313). Through exploration the researcher gained new

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insights, discovered new ideas and or increase knowledge of the role of churches in response to HIV and AIDS epidemic in the Vhembe district.

3.2.3 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 (Burns & Grove, 2005:232). According to Polit and Hungler (2004:716), descriptive research refers to studies that have information as their main accurate portrayal of the characteristics of reasons, situations or groups. While Pope and May (2006:80), refer to descriptive research as non-experimental design that is used to observe and measure a variable when there is little conceptual background. The researcher was able to collect information about the role of churches in response to the HIV/AIDS epidemic, describing and classifying the phenomenon under study.

The researcher chose descriptive research because it summarizes the findings of the problem investigated as they exist without introducing changes (Burns & Grove, 2001:223; Polit & Beck, 2004:528). 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 (Cormack, 1996: 179). The use of a descriptive design in the study was justified on the basis of the flexibility in promoting in-depth descriptions of the role of churches in response to HIV and AIDS. According to Burns and Grove (2005:232), descriptive studies are designed to enable the researcher to gain more information about the characteristics within a particular field of study with purpose of providing a picture of the situation as it naturally occurs.

Descriptive research design, when compared to the formal measurement models used for qualitative studies, appears to lack rigor and objectivity. However, it would be erroneous to conclude that clinical research can 'do without' the flexible methods provided by qualitative research approach (Stommel & Wills, 2004:291). In this study

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the descriptive design provided a platform for participants to present their role on HIV and AIDS, to the point whereby they had nothing else to contribute to the research question.

Advantages of a descriptive approach for this study are that it gives the ability to collect accurate data on and provide a clear picture of the phenomenon under study (Mouton & Marais, 1996:43-44). In the present study, the descriptive approach was required of the role played by Christians from churches in the Vhembe district.

Streubert, et al. (2003:22) state that a descriptive method in data collection in qualitative research is central to open, unstructured qualitative research interview investigations. This means that the researcher facilitated pastors, church board members and individual Christian descriptions of their role and challenges in response to HIV and AIDS epidemic by applying and intuiting, so that the phenomena under study could unfold without unnecessary hindrances.

3.2.4 Contextual research design

The study is contextual when the phenomenon is studied for its intrinsic and immediate contextual significance (Mouton, 2001:133). Contextual studies focus on specific events in a 'naturalistic setting' (Lobiondo-Wood & Haber, 2002:128). Contexts can include physical settings such as homes or church or less concrete 'environments', such as the context cultural understandings and beliefs brought to an experience (Lobiondo-Wood & Haber, 2002:128).

The researcher aimed at understanding the phenomenon which was studied as described by the participants in their lived world (Brink, 2006:113; Babbie & Mouton, 2001:272). This study focuses on Christian Churches' involvement in HIV and AIDS epidemic without the situation having been manipulated. This study was done amongst Christian Churches; sampled individuals were interviewed using in-depth, unstructured, open, qualitative interviews.

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3.3 STUDY SETTING

Burns and Grove (2005:359), 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, 2009:359).

- Partial controlled setting is an environment that is manipulated or modified in some way by the researcher.
- Highly controlled setting is an artificially constructed environment developed for the sole purpose of conducting research, for example, laboratories
- A natural setting or field setting is uncontrolled, real life situation or environment.

The study was conducted amongst Christian churches in Vhembe district, which is one of the five districts of Limpopo Province in the Republic of South Africa. The Vhembe District is located in the most rural Northern part of the Limpopo Province. It shares borders with Botswana on the northwest side, Zimbabwe on the north and Mozambique on the eastern side. There are four municipalities in the district: Mutale, Musina, Makhado and Thulamela. According to Statistics South Africa (2010) by province and municipality, Vhembe District has a population of 119 9338 spread in 603 villages and townships; and has 3350 Christian churches spread in four different municipalities with about 850 000 Christians in total. This implies that majority of the population in the Vhembe district municipality are Christians.

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 to be interviewed.

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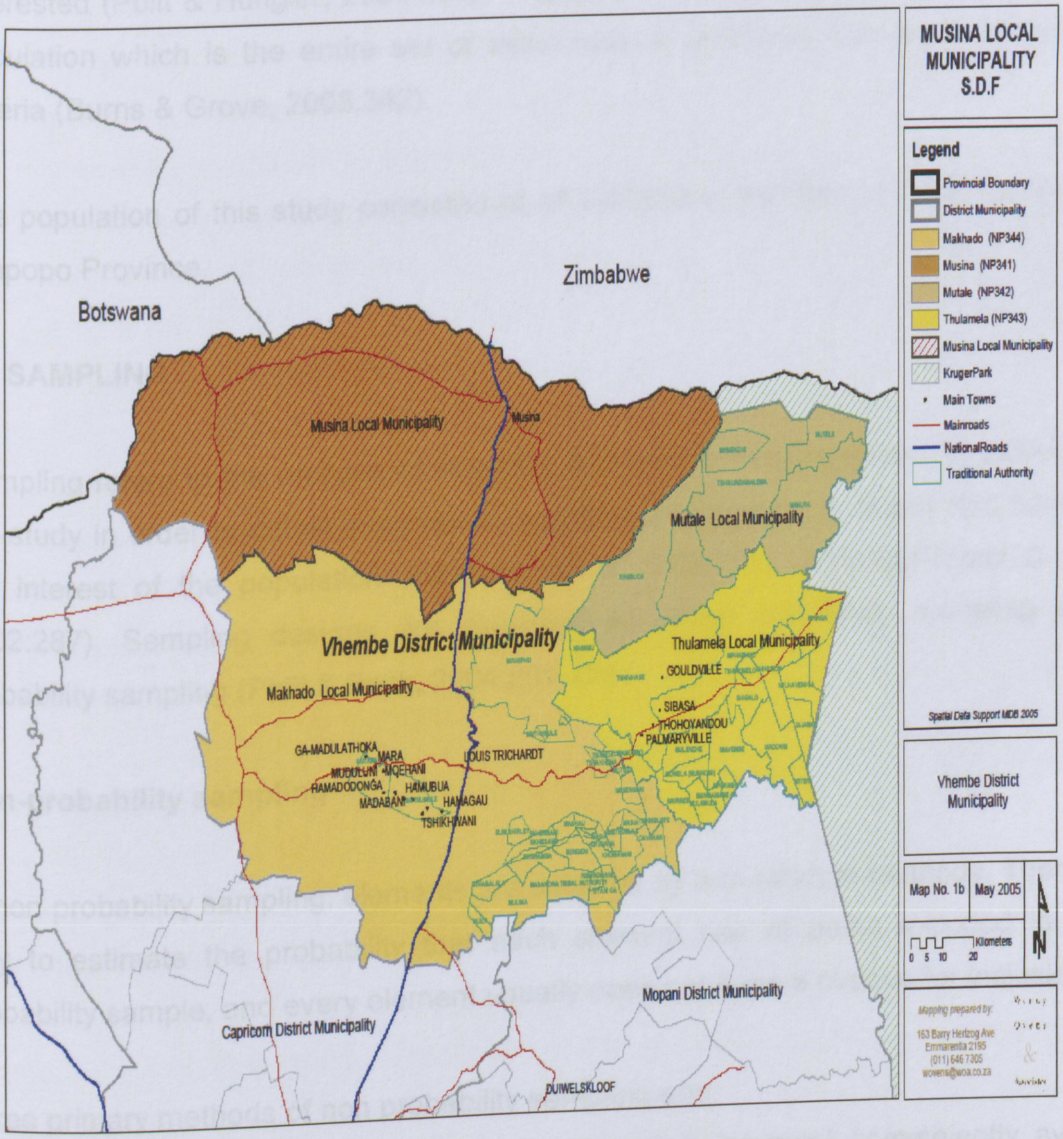
Figure1. Map of the Vhembe district municipalities showing the four district municipalities.



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3.4 RESEARCH POPULATION

Research population refers to the entire aggregation of cases in which the researcher is interested (Polit & Hungler, 2004:534). Population sometimes referred to as the target population which is the entire set of individuals or elements that meet the sampling criteria (Burns & Grove, 2005:342).

The population of this study consisted of all Christians churches in Vhembe district of Limpopo Province.

3.5 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 (Henning, et al., 2004:71; Lobiondo-Wood & Haber, 2002:287). Sampling designs are classified as either probability sampling or non probability sampling (Polit & Beck, 2004:291-294).

Non-probability sampling

In non-probability sampling, elements are selected by non-random methods. There is no way to estimate the probability that each element has of being included in a non probability sample, and every element usually does not have a chance for inclusion.

Three primary methods of non probability sampling are:

- **Convenience sampling**, which entails using the most conveniently available people as study participants. Burns and Grove (2005:350), concur with Polit and Beck (2004:291) that subjects are included in the study because they happen to be in the right place at the right time. Convenience sampling is also called accidental sampling. Convenience sampling is the weakest form of sampling, but most commonly used in many disciplines.

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- **Quota sampling,** is the one in which the researcher identifies population strata and determines how many participants are needed from each stratum. Quota sampling offers an improvement over convenience sampling and tends to decrease potential biases (Burns & Grove, 2005:351).
- **Purposive sampling**, sometimes referred to as judgmental or selective sampling, involves the conscious selection by the researcher of certain subjects, elements, events or incidents to include in the study based on the belief that researchers knowledge about population can be used to hand-pick sample members. 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 (Burns & Grove, 2005:352; Polit & Beck, 2004:294).

Four purposeful sampling techniques were used in this study—typical case, convenience, criterion, and maximum variation sampling for small cases as defined by Patton (2002:234-236). Purposeful sampling allows the most to be learned from the sample selected about the issues that are central to the research. These individuals were closest to the process and identified issues central to the research.

3.5.1 Sampling method and procedure

In this study, non-probability sampling was chosen, because elements are selected by non-random methods. There is no way to estimate the probability that each element has of being included in a non probability sample, and every element usually does not have a chance for inclusion (Polit & Beck, 2004:291). A non-probability purposive sampling was chosen in this study because it involves conscious selection of certain participants to be included in the study by the researcher. The study did not focus on all Christians since the participants were purposively sampled. Sampling in this study was done in two stages. The first stage was sampling of churches and the second stage was sampling of Christians from the participating churches.

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Stage 1: Sampling of churches

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 (2002:234) for small samples.

The researcher used his judgment, with assistance from supervisors and stakeholders regarding who should form part of the sample. In summary, the aim was to make the study as representative as possible by including maximum variation. The researcher effects were avoided by bracketing, explaining the interview process and the use of information collected and by triangulating the data.

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:

- Pentecostal
- Charismatic
- Zion

The reasons for selecting these Christian churches are: that they constitute the majority of churches in the Vhembe district, that they are found in almost every village in the district, including remote areas where there are no clinics, that they believe in faith as well as healing, and one of the activities during church services is praying for the sick, and that their membership is constituted of different age groups: children, teenagers, young adults and elderly people.

The number of participants interviewed depended on data saturation. The total number of churches included in the sample was eleven, four Pentecostals, four Charismatic and three Zion churches.

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Stage 2: Sampling of individuals in the church

Criterion sampling was used in selecting stakeholders because it involves selecting predetermined criteria that are of importance to the study. The sampling method considered the following criteria:

- Christian stakeholders (pastors in charge)
- Leadership of the church (church board members)
- Those who have been church members for at least a period of a year.

According to Patton (2002:236), key informants or knowledgeable participants can identify what is typical.

The researcher made a request from each church to interview one pastor in charge, one church board member and one church member who have been in the church for a period of more than a year in order to get a variation of the sample.

3.5.2 Sample size

Sample size refers to the number of participants needed in the study (Polit & Beck, 2004:308). 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 (Polit & Beck, 2004:308). The researcher has to be satisfied that sufficient evidence is collected to confirm the relevance of a particular concept derived from the data, or 'category' (Glaser & Strauss, 1967:61). Having saturated a particular area of interest, the researcher is then able to move on to others prompted by the findings. *"Saturation thus means that no additional data are being found whereby the sociologist can develop properties of the category. As he/she sees similar instances over and over again, the researcher becomes empirically confident that a category is saturated. He goes out of his way to look for groups that stretch diversity of data as far as possible, just to make certain that saturation is based on the widest possible range of data on the category"* (Glaser & Strauss, 1967:61).

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Participants included twelve [12] pastors' in-charge, eleven [11] church board members/ leadership and nine [9] church members. Out of 32 participants, 4 were nurses who were also members of the church board.

The size of the sample was considered satisfactory when data saturation was reached as demonstrated by repetition of themes. Predetermination of the number of participants was therefore impossible (Streubert, et al., 2003:25).

3.6 RECRUITMENT OF STUDY PARTICIPANTS

According to Polit and Beck (2008:352-353), recruiting subjects to participate in a study involves two major tasks, identifying eligible candidates and pursuing them to participate.

Factors over which researchers have control that can influence the rate of cooperation as described by Polit and Beck include the following recruitment methods:

- **Face to face method**: face to face method recruitment is usually more effective than a telephone call or a letter.
- **Courtesy**: depends upon using recruiters who are pleasant, courteous, nonthreatening, and enthusiastic about the study. Cooperation can also be enhanced if characteristics of recruiters are similar to those of prospective subjects.
- **Research benefits**: benefits of participating in the study should be carefully explained without exaggeration or misleading information.
- **Sharing results**: refers to offering to send participants' feedback after the study is concluded. Participants of this study were told that they will get feedback when the study is concluded.
- **Convenience**: every effort should be made to collect data at a time and location that is convenient for the participants.
- **Endorsement**: it may be valuable to have the study endorsed or acknowledged by a person or organisation that have prospective subjects' confidence and to communicate this to them

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- **Assurances**: prospective subjects should be told who will see the data, what use will be made of the data, and how confidentiality will be maintained.

To recruit the participants of this study, the researcher conducted an initial visit to churches to establish contact with the leadership concerned and to explain to them using an information letter to participants, the nature of the study, the purpose of the study and how churches can benefit from the results of the study. The researcher is a pastor of Pentecostal church who was not a stranger or threatening to most church leaders. Participants cooperated well with the researcher as they share similar characteristics with the researcher. Participants were told from the beginning that their contribution will be treated confidentially and names will not be used only codes, and that only the study supervisors will have access to the data for verification and analysis. Church members were communicated to through their pastors. Venues, dates and times for interviews were flexible to suit participant's preferences.

3.7 DATA COLLECTION

Data collection is the process of collecting information from the participants which is needed to address the research problem (Ulin, et al., 2005:178; Creswell, 2009:224). According to Burns and Grove (2003:373), data collection is the precise, systematic gathering of information relevant to the research sub-problems, using methods such as interviews, participant observation, focus group discussion, narratives and case histories. The empirical phase, which involves the actual collection of data, is followed by preparation for data analysis (Polit & Hungler, 2004:51). Data collection begins with the researcher deciding from where and from whom data will be collected (Talbot, 1995:472). The researcher was the main research tool or primary instrument (Streubert, et al., 2003:18).

The in-depth individual unstructured interview was the method used in this study to explore and obtain information on the role of churches in response to HIV and the AIDS epidemic. The purpose of interviewing was to allow the researcher to get more in-depth

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information on beliefs, practices and attitudes that could not be obtained through any other data gathering procedure (Brink, 2006:120).

The unstructured 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.

According to Mayan (2001:15), the purpose of an unstructured interview is to elicit in-depth responses from participants. The process of an unstructured 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 participant as they tell about their experience. Unstructured interviewing is near the heart of qualitative inquiry because it allows the participant to use their own language to fully describe their experiences.

An unstructured interview is designed in such a way that the researcher ideally asks just one question to encourage participants to share their perspectives without interruption. The researcher's responsibility is to keep the interview on track (on topic), and test emerging hypothesis, in a gentle manner so that the participant does not feel dominated or disturbed by the researcher (Mayan, 2001:15).

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 and secondly is its potential to provide a rich, highly specific perspective of participants' experiences, perceptions and or attitudes (Stommel & Wills, 2004:445).

Limitations of unstructured interviews as corroborated by Stommel and Wills (2004:284) include:

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- Possibilities that some of the participants might be reluctant to reveal their truth, particularly if rapport was not well established.
- Individual interviews and interactions might produce undesirable effects, such as continuous crying by interviewee which may make it difficult to continue or to spend almost too much time with one participant. As with all narrative transcripts of unstructured interviews, the data generated in unstructured interviews might be extensive and challenging to interpret, classify, or code into distinct themes, or key issues.

The findings typically cannot be generalized to a larger target population, because of the small size of individuals interviewed, and the nature of participants' selection.

Advantages of using unstructured interviews

The advantages of unstructured interviews, as indicated by Stommel and Wills (2004:284); Burns and Grove (2003:285); De Vos, Strydom, Fouche and Delport (2002:302), are as follows:

- Unstructured interview is an efficient tool for exploring a topic. Thus participants in this study were encouraged to voice their involvement towards HIV/AIDS epidemic to the point where there was no further new information coming up.
- Although the interviewer determined the focus, the unstructured interview allowed the participants to bring out their involvement in HIV/AIDS epidemic and to express their feelings and attitudes towards people living with AIDS.
- Participants could enhance their own thinking about HIV and AIDS. Thus, some key themes and ideas could have been generated from the interactions with the interviewees.
- Researchers could support their interpretations of the unstructured interview data with ancillary observations such as video/audio-tapes of the interview sessions. This would reduce forgetfulness, misrepresentations or selective memories on the part of the researcher.

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- Unstructured interviews provide rich data which can provide food for thought for future research.
- Interviewing is a flexible technique that allows the researcher to explore greater depth of meaning than cannot be obtained with other techniques.
- Interpersonal skills can be used to facilitate co-operation and elicit more information.
- There is a higher response rate to interviews than questionnaires, leading to a complete description of the phenomenon under study by the participants.
- Interviews allow collection of data from participants who are unable or unlikely to complete questionnaires, such as those whose reading, writing and ability to express themselves is marginal.

The leading question for the participants during data collection was **"what is the role of your church with regard to fighting HIV and AIDS?** 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 and they took about 45 minutes to an hour per participant. Pastors and board member were more vocal than members.

The researcher used the following communication techniques throughout the interview to encourage the participants to continue talking:

Paraphrasing

This involves a verbal response in which the researcher will enhance meaning by stating the participant's words in another form with the same meaning (De Vos, et al., 2011:345). The researcher paraphrased clearly and concisely what has been said with the 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.

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Reflective Summary

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., 2011:345).The researcher then summarized the responses to condense and crystallize the essence of the participants' statements.

Probing

According to De Vos (2006:293), 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, 2005:164).

Clarifying

This embraces a technique that will be used to get clarity on unclear statements. During the interview process with the participants, the researcher asked the participants to clarify some concepts to get the meaning of some statements in relation to their attitudes towards people living with AIDS. The researcher furthermore asked some participants to elaborate some statements in order to get clarity and avoid misunderstandings (Henning, et al., 2004:7).

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Minimal verbal responses

Refers to a verbal response that correlate with occasional nodding, for example 'mm-mm, yes, I see', will show the participant that the researcher is listening (De Vos, et al., 2011:345). The researcher encouraged the participants to freely describe their role in response to HIV and AIDS epidemic by listening without interrupting them. The researcher demonstrated respect and sincere interest throughout the interviews (Streubert , et al., 2003:58).

Reflecting

This is a process whereby the interviewer reflects back on something important that the person has just said in order to get him or her to expand on the idea (De Vos, et al., 2011:345). The researcher repeated some statements that were said by participants to allow for clarity and expansion on some issues regarding their role on HIV and AIDS.

Comments

The researcher injected his own ideas or feelings to stimulate the participant into saying more.

All of these techniques are used on daily bases in nursing when helping patients and clients so the researcher has practice with them. Throughout this research, the 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 (Kvale, 1996:89). A Tape-recorder was used to record narrative information which was transcribed verbatim.

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Field notes

These are written in the field 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: 353). 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., 2011:359).

3.8 DATA ANALYSIS

Data analysis is the process of bringing order, structure and meaning to the mass of collected data (De Vos, 2006:333). It is not a linear process, nor do all qualitative forms of inquiry take the same approach to data analysis (Holloway & Wheeler, 2002:335). Data analysis in qualitative research actually begins when data collection begins (Streubert, et al., 2003:36). Brink, et al. (2011:184), 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.

3.8.1 Data analysis process

In this study, data was analyzed using Tech's steps of open coding (Creswell, 2003:192; Creswell, 2009:227). Open coding is the process of breaking down and conceptualizing the data (Holloway & Wheeler, 2002:158). Data was broken down into discrete parts, closely examined, compared for similarities and differences reflected in the data. Themes and sub-themes were developed. The following steps as described by Creswell (2003:192) were followed during data analysis:

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Step 1: Getting a sense of the whole

The researcher read through all of the transcriptions several times carefully in order to understand the information provided by participants. The researcher immersed 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 (Creswell, 2003:192).

Step 2: Picking one document

The researcher picked up the most interesting, shortest interview and read through analyzing its underlying meaning. Thoughts coming to the mind were written on the margin (Creswell, 2003:192).

Step 3: Making a list of all topics

This involves organizing the text data or pictures gathered during data collection into categories which are 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, formed in columns that were arranged as major topics, unique topics and left-overs (Creswell, 2003:192).

Step 4: Involves the coding process

The researcher took a list of the topics, went back to the data, abbreviate topics as codes and 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.

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Step 5: Turn topics into categories

Topics derived from the interview reports that relate to each other were grouped together then the researcher classifies the qualitative information by looking for categories, themes or dimensions of information. General themes and sub themes were then identified. The researcher drew columns between categories to show how they are interrelated.

Step 6: Making a final decision

The researcher made a final decision on the abbreviation of each category and the codes were arranged alphabetically and themes were made by assembling data material belonging to each category.

Step 7: Preliminary analysis

The data material belonging to each category 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.

3.9 MEASURES TO ENSURE TRUSTWORTHINESS

Trustworthiness refers to establishing validity and reliability of qualitative research. Qualitative research is trustworthy when it accurately represents the experiences of study participants (Streubert, et al., 2003:364). According to Lincoln and Guba (1985:219), trustworthiness endeavors to establish confidence in the truth of the

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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 context. Streubert, et al. (2003:364); De Vos, et al. (2011:419), adopted the four criteria developed by Lincoln and Cuba to measure trustworthiness of data as follows:

3.9.1 Credibility/authenticity

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., 2011:419). Credibility is demonstrated when participants recognize the reported research findings as their own experiences (Streubert, et al., 2003:38). It is the truth of how the participants know and experience the phenomenon (Talbot, 1995:529). To ensure credibility the researcher must make sure that those participants are identified and described accurately (Holloway, 2005:8). Activities increasing the probability that credible findings will be produced are: prolonged engagement and persistent observation in the field; triangulation; peer debriefing; and member checks.

In this study credibility was established through prolonged engagement with participants; 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 (Streubert, et al., 2003:38).

Prolonged engagement

This 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 (Lincoln & Guba, 1985:302). Prolonged engagement also requires that the investigator must be involved

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with a site long enough to detect and take into account distortions that might otherwise creep into the data. 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 (Lincoln & Guba, 1985:302).

The researcher of this study 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 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 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 (Lincoln & Guba, 1985:304).

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 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,

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2003:380). The analysis of the researchers 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, 2005:430). Peer debriefing exposes a researcher to the searching questions of others who are experienced in the methods of enquiry, the phenomenon or both (Polit & Hungler, 2004:432). In this study, the research work was reviewed by experts and colleague who have experience and knowledge of the phenomenon being studied namely HIV and AIDS Care. 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.

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 & Hungler, 2004:433). 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.

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3.9.2 Transferability

Lincoln and Guba 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 (De Vos, et al., 2011:420). Transferability refers to the degree to which the results of qualitative research can be generalized or transferred to other contexts or settings (Burns & Grove, 2005:432). Generality and applicability is irrelevant in qualitative research because the researcher want to describe the particular phenomenon.

The researcher had a 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, 2004:433). In this study, 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.

3.9.3 Dependability

This is the alternative to reliability. Dependability is met through securing credibility of the findings (Lincoln & Guba, 1985:316; Streubert, et al., 2003:38). This is where the researcher attempts to account for changing conditions in the phenomenon chosen for the study and changes in the design created by increasingly refined understanding of the setting (De Vos, et al., 2011:420). The dependability of qualitative data will always tell the stability of data over time and over conditions. There can be no credibility in the absence of dependability (Polit & Hungler, 2004:443). Dependability determines whether findings would be consistent if the inquiry were to be replicated with the same participants in a similar context (Polit & Beck, 2004:433). In this study, the findings of the research were checked and audited by external checks in order to be dependable.

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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. The inquiry audit is based metaphorically on the fiscal audit. The inquiry auditor examines the product (i.e. 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. This process establishes the confirmability of the inquiry. Thus a single audit can be used to determine dependability and confirmability simultaneously (Lincoln & Guba, 1985:332).

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 data and analyses were then checked for comparability and similarity, and discrepancies resolved through member checking with the participant. In this study, these activities were establishing the dependability of the study.

3.9.4 Confirmability

Confirmability refers to the degree to which the results could be confirmed or corroborated by others (Polit & Beck, 2004:336). 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 (Lincoln & Guba, 1985:331; Streubert, et al., 2003:38). 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 (2002:168) suggested that the following auditing criteria be utilised for examining the information of the study:

- The raw data, namely, tape recording and field notes

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- 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
- 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, 2002:169)

In this study, reflexivity assisted the researcher to be free of bias in processing the data. 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, 2004:435).

3.10 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 protecting their rights, balancing the benefits and risks in the study by obtaining informed consent and submitting a research proposal for institutional review (Burns & Grove, 2003:65; Polit & Beck, 2004:84). The following major guiding ethical principles were observed when conducting this study:

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3.10.1 Permission to conduct the study

Permission to conduct this study was sought from the Higher Degree Committee and Ethics committee of the University of Venda, from the leadership of churches in the Vhembe District of the Limpopo Province and from participants through an informed consent form.

3.10.2 Informed consent

Participants were given full information about the study procedures using the language that they understand and informed consent forms were provided to those who were willing to participate for signing. The researcher considered the participants' comprehension when explaining (Polit & Beck, 2006:93). [See annexure 2].

3.10.3 Voluntary participation

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, 2002:272).

3.10.4 Right to anonymity and confidentiality

Participants 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 supervisors only for the purpose of analysis and report writing (Burns & Grove, 2003:66). Participants were informed that raw data will be destroyed immediately after the completion of the report. The use of a tape-recorder was also agreed by participants and that the cassettes and field notes will be kept safe untill completion of the report.

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3.10.5 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.

3.10.6 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, 2002:273). 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.

3.11 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. Provision of detailed data analysis of study findings and literature control will be in the third chapter.

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CHAPTER 4

DATA ANALYSIS AND PRESENTATION OF FINDINGS

4.1 INTRODUCTION

In the previous chapter, the research design and methods were discussed. The analysis of research data and the findings of this study are presented and discussed in this chapter. It presents the findings of the study derived from the following research questions:

- What role do churches play towards the fight against the HIV and AIDS epidemic in the Vhembe district?
- How do churches collaborate with PHC services in addressing the HIV and AIDS epidemic?
- What are the challenges faced by church leaders in their attempt to address HIV and AIDS-related issues in collaboration with PHC services in their communities?
- What can church leaders do to enhance community-based interventions for HIV and AIDS?

The researcher utilized data collection techniques carefully in order to promote quality of the process of obtaining data from participants which has produced credible results. Themes are derived from the in-depth-interviews conducted with thirty two participants from eleven different churches. Amongst the eleven, four were Pentecostals, four Charismatic and three Zionists. Furthermore, twelve (12) participants were interviewed from Pentecostal churches, twelve from charismatic churches and eight from Zion churches.

The findings are presented following the themes and categories that emerged during data analysis. Firstly, the researcher coded the data from three categories of sample

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separately, namely church leaders, board members and church members respectively. The broad categories of churches discussed in chapter one was maintained throughout the analysis process namely Pentecostal, Charismatic, and Zion Christian churches. The findings were thereafter compared through constant comparison method. The supervisors served as independent coders and consensus discussions were held with the supervisors. Eventually, it was noted that there was no significant variation in the way the different categories of participants responded.

Four major themes emerged from the interviews; these are: support offered to people affected and infected by HIV and AIDS, Churches' role towards prevention of HIV infection, lack of collaboration and challenges regarding implementation of HIV/AIDS intervention program.

Literature control is done simultaneously with the presentation of findings.

4.2 PRESENTATION OF FINDINGS

The following table presents the themes and subthemes that emerged.

THEMES	SUB-THEMES
Support offered to people affected and infected by HIV and AIDS	Spiritual support Financial support Home visit
Churches' role towards prevention of HIV infection	Awareness and education Voluntary counselling and testing
Lack of collaboration	Collaboration amongst churches Collaboration between churches and PHC
Challenges regarding implementation of HIV/AIDS intervention program	Lack of capacity building Misconceptions and stigma Beliefs regarding evil spirits (demons) and witchcraft

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4.2.1 Support offered to people affected and infected by HIV and AIDS

During the interview with participants, it became apparent that there were variety interventions that churches are involved in regarding HIV and AIDS although not in a particular structural form. This varies according to circumstances and the situation of the client. The most identifiable forms of support were spiritual and financial. Support interventions included home visits.

4.2.1.1 Spiritual support

Spiritual support here refers to giving strength and encouragement to those infected and affected with HIV and AIDS. Health is the product of a person's positive interaction with his or her total environment. Spiritual health of an individual plays an important role in the client's positive response towards HIV/AIDS (Chile & Simpson, 2004:323). It is in the church where spirituality finds expression, as the Bible provides answers to life's external and ultimate questions and problems.

Participants in the study, who were church leaders, indicated that they use common identified ways for spiritual support namely: counselling based on lessons from the Bible, Church leaders use the Bible as the basic guide for dealing with life's problems. It is used to induce faith and hope so that they can trust in God for healing and to cope with difficult life situations knowing that God is in control of everything.

Mr C, a pastor who participated in the study indicated that they use the Christian faith to encourage people living with HIV and AIDS to deal with their illness as follows:, *"We also encourage them with the word of God to cope with illness and give them hope that they can still live longer despite the disease if they continue to have faith towards God and being positive about their situation."* Furthermore, Mr X, another pastor from a different church commented, *"Besides encouraging them to take medication, we also show them that God is above all life situations, encouraging them to have faith in God and believe in supernatural healing."*

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The encouragement based on the Bible is done simultaneously with prayer. Prayers that are offered to those who are sick depend on individual churches. The Pentecostal churches and Charismatic churches believe in laying on of hands to the sick while Zion believe in giving prayer packages (ndaela) in the form of church tea bags or water from designated places as directed by the pastor to use at home.

Mr R a board member at one of Zion churches who participated in the study confirmed this by saying, *"Our involvement as a church is that we help those with HIV and AIDS with prayers that are offered in the church".*

Another church member, Ms J from a different Zion church when asked about the involvement of their church in helping those living with HIV/AIDS said. *"It is the responsibility of the pastor to pray for the sick and give them prayer package (ndaela)".*

Even those churches without an HIV/AIDS response program in place believe in praying for those who are sick with different diseases, including HIV and AIDS because they believe their leaders are anointed with the Holy Spirit to heal different kinds of diseases.

The inputs from the participants revealed that both Pentecostals, Charismatic and Zion churches believe in faith as well as healing. Almost all participants confirmed that one of the activities during their church gatherings is praying for the sick to get healed. Practising faith healing side by side with modern medicine is a common practice among Pentecostals and Charismatic churches.

Pastor D, from Charismatic church confirmed this by indicating that, *"besides encouraging those people who have disclosed their HIV status to take medication, we also encourage them to have faith in God and believe in supernatural healing".*

Mr Y, another pastor from Pentecostal church said, *"We do believe as a church that God heals but a person should not discontinue medication until tested negative".*

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The majority of participants indicated that when they are offering spiritual help they do not discourage their members who are on treatment to stop taking it and trust God only, although there are rare cases where individuals living with HIV/AIDS are said to have refused going for treatment, believing in the power of prayer and faith in God for healing, regardless of the nature of the disease.

Paradoxically, there were one or two churches that seemed to emphasize prayers to an extent that they felt that prayers they offer are sufficient to heal a person without the use of medical treatment and do not encourage people to go for medical treatment.

Pastor S, a participant from a Zion church confirmed this by saying "*We do not refer those who are sick to seek medical help but we pray for them in the church for healing*".

This is supported by the study conducted by Ntsimane that revealed that the Nazareth Baptist (Shembe) minister believed that the leader of his church could cure all diseases, including AIDS (Ntsimane, 2000:23). In addition to prayer, Muturi (2008:115), in her study in Jamaica revealed that spiritual or faith healing is one of the FBO initiatives for Jamaica and practiced widely across the wider Caribbean.

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4.2.1.2 Financial support

Interviews with participants revealed that most church leaders do realize the importance of taking care of their members beyond attending to spiritual needs. They indicated that where possible they offer food parcels and money depending on the need. The individual needs are mostly identified when the leaders visit the family for spiritual counselling or by other church members during house visitation.

In addition, some churches have arranged welfare collections from their members on top of the usual free-will offering to help those in need. The churches indicated that they saw the need to facilitate this because often the people who are living with HIV and AIDS do not have other support structure as this person may not be able to continue to

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work and provide for his family if this person is a breadwinner. Churches do realize the impact of the disease upon other family members; hence they help those who are infected as well as the family members affected by the situation of illness.

Mr B, one of the interviewed pastor said, "*If the infected person is a breadwinner and cannot work, his or her children can also become affected, so I help the family to get financial assistance and organize whatever type of help needed.*"

This finding is supported by Uys and Hensher (2002:625), that when the bread winner is infected and is terminally ill, the family income will be affected and this will lead to degradation of the household's economic status. Ruden (2000:568) also indicated unglamorous charity work that many churches undertake 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.

4.2.1.3 Home visits

Home visits are mostly done by pastors and home-based care volunteers. The study revealed home-based care systems initiated by the church members and other systems initiated by the community. Some participants indicated that churches without home-based care programmes in place do encourage their members to be part of the home-based care structures in the community and some of the pastors sit on the board of directors for these home-based care initiatives.

Ms E, a board member from a Pentecostal church claimed, "*We have a home-based care which was started by church members who were trained by centre for positive care organization.*"

Another pastor, Mr A, from a different church said, "*There are two home-based cares in our community; some of our members are part of these home-based cares as we encouraged them to join those groups to avoid duplication of the same program by the church.*"

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When asked about other structures they work with within the community, Mr M, one of the church leaders said, *"There is a home-based care in the community in which I am also a member of the board of directors."*

The service responsibility of the church to do home visits is gradually shifting to home-based care volunteers as the majority of people are working and those who are not working are mostly part of home-based care volunteers. Church house visitations are still done to certain extent, to visit those who are facing major challenges in their life and need support of some kind from the church.

Home-based care volunteers are mostly women who are not working and have an interest in serving the community. The study identified the main role of home-based care volunteers to be that of home visits, where they provide basic care at people's homes and supervise taking of treatment, under supervision of professional nurses from nearby clinics.

Mr T, a pastor whose church has a home-based care programme, said,
"Home-based care volunteers provide basic care to those who are sick at their home environment, supervise treatment and remind those who are sick to follow their check up appointments dates".

Most participants involved in home-based cares indicated that home-based care relieves the public health sector from the burden of caring people living with AIDS.

Ruden (2000:568) also indicated that 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. Cullinan (2000:3) confirms that many home-based cares in South Africa were started by church organizations. Similarly the study conducted by Liebowitz (2004:8-9), in Kwazulu-Natal found that home-based care and visitation were the common activities of many FBOs in KwaZulu-Natal. During church

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visits, those involved provide care, moral, emotional, and support, food, and treatment. In some cases congregation members initiated such programs and often are entirely responsible for carrying them out.

4.2.2 Churches' role regarding prevention of HIV infection

The findings indicated two areas in which churches play a role regarding the prevention on HIV infection: awareness and education, and voluntary counselling and testing.

4.2.2.1 Awareness and education

Participants from Pentecostal and Charismatic churches indicated their involvement in HIV and AIDS education and awareness formally and informally. Communication approaches adopted by churches to address HIV/AIDS epidemic in the Vhembe include organized time on Sundays and during other church gatherings like conferences and workshops. The Bible is the first port of call, particularly on issues to do with moral values and social responsibilities.

Participant B who is a pastor from Pentecostal church when describing their involvement said, "*We spread the message as part of our church services, on Sundays we do have time to speak about HIV/AIDS and there are times when we invite other experts to speak on HIV and AIDS.*"

Mr D another participant, who is a church board member from charismatic church, explained, "*Besides Sundays we use our different conferences especially youth conferences and women's conferences where in we arrange a person to give health education on HIV/AIDS in detail*".

Some of the Pentecostal churches that have participated in the study, when explaining how they conduct their awareness and education campaign indicated that they also use questionnaires which they distribute amongst those who can read and write especially

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young people followed by discussions. Pastor K, a participant from one of the Pentecostal churches who was bringing awareness through discussions, said:

"I started addressing HIV and AIDS on Sundays during our church meetings, wherein I distributed questionnaires amongst youth followed by discussions".

The findings further revealed that though churches are involved in awareness and education, their approaches are different. Each individual church has its own way of handling these campaigns.

These findings are in line with the study done by Liebowitz (2004:8-9), amongst FBOs in Uganda and KwaZulu- Natal, where he found that FBOs were involved in activities that ranged from communication during sermons to workshops to crusades and to Peer education.

The inputs from participants showed that there are churches with programs in place especially Pentecostals and Charismatic churches. The majority of those churches have support structures in place and majority of their leadership are young and well educated, unlike Zion churches that generally do not have support structures and are not involved in HIV/AIDS activities because majority of their leadership are elderly people who are not well educated.

Mr S a church board member from a Zion church when asked about his church's involvement in HIV and AIDS awareness and education responded by saying,
"*In our church we do not speak about HIV/AIDS.*"

By saying this he was indicating that his church does not have formal nor informal programme related to HIV and AIDS.

This concurs with the study conducted by Ntsimane (2000:22-25), amongst African initiated churches where in it was found that Zionist ministers knew that AIDS was a

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deadly sexually transmitted disease, neither knew anybody in their congregations with AIDS and neither spoke to their congregations about AIDS. Dixon (2002:175), also mentioned that there are 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.

Those churches with awareness and education programmes in place, some make use of the available health care professionals who are church members to assist in running those programmes, others use their pastors who have attended some form of training, while others can organize experts on the subject to come and address the church. The health professionals who are mostly doctors and nurses work together with the pastor in-charge to plan and implement the program.

Participant F, a church board member from a Pentecostal church said, "*We have a team that deals with health in our church composed of nurses who knows better about diseases; members who are living with HIV/AIDS are linked with this team for assistance.*"

Mr P, another church leader from one of the Charismatic churches confirmed this by saying, *"As a church we have members who are nurses and doctors whom we are using to address health issues including HIV/AIDS."*

The study revealed that though majority of the Pentecostal churches and Charismatic churches that participated in the study indicated having a program in place, there are several with no HIV/AIDS response program while others have inadequate responses. Those churches that are not involved in the fight against AIDS appear to have a different opinion about the HIV and AIDS epidemic. This observation is confirmed by one participant, Mr A, a pastor from a Pentecostal church who said:

"We use to have planned time to teach people about HIV/AIDS during our conferences but not so often these days because people reacted differently towards this program as the disease is largely a human sexuality issue and speaking about sex topic in public

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sounded unchristian. We then decided to have it less often until such time when people become more comfortable speaking about HIV/AIDS."

There are some Church members who feel that topics about HIV/AIDS cannot be addressed by the church as this disease is perceived to be caused by sinful way of life. Participants agreed to have misunderstandings among church members and some leaders about the nature of the epidemic accompanied by lack of knowledge upon which to act.

A similar problem was experienced by the Full Gospel Church of God in Gugulethu. Byamugisha, et al. (2002:75), report that Rev. Gideon Nqiwa introduced the idea of an AIDS programme in 2000 in his church. A lot of people felt very uncomfortable because they felt that AIDS and sex were not issues to be discussed in the church.

Adam in Nicolson (1996:52) mentions that the World Council of churches admitted that many churches continue to regard issues of sexuality as taboo. Many Christians feel that if they talk about sex-related issues it may pose questions about their moral or spiritual understanding, and this poses a problem when it comes to preventing the spread of HIV and AIDS (Bury, 1992:105).

Inputs from participants indicated that some of the churches have special programmes to address youth separately on HIV/AIDS. The majority of leaders interviewed, spoke about having time to encourage youth to abstain and live according to Biblical principles as a means of prevention of HIV/AIDS, and indicated that condoms are not encouraged amongst the youth.

Ms L, pastor from a Pentecostal church said, *"We discourage young people to engage in sexual intercourse before marriage using the bible as we do not talk about condoms as an alternative way to prevent HIV/AIDS"*.

Participants presented different views on the use of condoms as a means of prevention. Some participants reject it, claiming that people must be faithful to one partner

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according to Biblical principles. Those who reject condoms completely argued that condom use opened the door for immoral lifestyle; hence youth should be encouraged to abstain. Others believe that condoms can be used as a last resort if a person fails to be faithful.

Mr H, another pastor from a different Pentecostal church indicated his view on condom based on the information from the workshop he has attended, said, *"In one of the workshops I have attended, they were encouraging the use of condom if people fail to be faithful, as a church we believe condoms to be the last resort as we teach faithfulness amongst adults and abstinence with regard to youth".*

Another participant K, from the same church confirmed this by saying, "*We warn our people about HIV/AIDS and encourage them to abstain & to be faithful, for those who cannot then condom can be used".*

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 (Advanced sexuality studies short course, 2009:2).

Participants described the type of information given during awareness and education which includes the following: the modes of transmission, laying aside fear of knowing one's HIV status, what people can do if they find out that they are positive, dealing with wrong perceptions about HIV/AIDS, and how to handle and look after those who are infected or living with AIDS. The information provided is aimed at promoting life style that could reduce chances of being exposed to HIV infection as well as trying to eliminate stigma associated with the disease.

Participant K, a pastor from charismatic church claimed, "*Our discussions on HIV and AIDS included following topics: how HIV can be spread, laying aside fears of knowing*

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your status, dealing with wrong perceptions about HIV/AIDS, how to handle those who are infected or living with AIDS and help people to understand the nature of HIV and AIDS".

Anderson (1992:117), shows that when people have been provided with information, and are helped to develop new skills, this very often enables them to make changes in their lives, changes which could eliminate or reduce their chance of being exposed to HIV infection. Both international and local studies reveal that HIV/AIDS intervention programmes are aimed at changing the spread and the consequences of HIV/AIDS. Results from Swanepoel (2005:151), indicated that individuals who have received HIV/AIDS prevention information are more likely to use protections during sexual intercourse, ask their partners about their HIV status, be tested for HIV themselves, and know where to go for help regarding HIV issues.

4.2.2.2 Voluntary counselling and testing

Participants from churches in the Vhembe district that are involved in the fight against HIV/AIDS epidemic verbalized that church leaders encourage their members to know their status by advising them to go to the facilities where they do voluntary counselling and testing so that if negative they have an incentive to stay that way, if positive they should accept and seek medical help early. HIV testing is also encouraged during awareness and education so that people can be sure of their status.

Participant C, a pastor of a Pentecostal church reported what they do in their church, "*We encourage people to go for HIV test and to accept even if results may be positive so that they can seek medical help, if negative they should take precautions not to get the disease."* The study findings indicated that voluntary counselling and testing is an essential service for both prevention and treatment.

Another participant Ms S, a church board member confirmed, "*We do encourage people to go for HIV test so that they should be sure of their status so that if positive they*

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should seek medical help, young people who are on courtship are encouraged to go for test before marriage some do go and come back to report the results".

The study further revealed that youth are also encouraged to go for voluntary counselling and testing during their pre-marital counselling sessions. The decision to go for testing is entirely voluntary and the person must be assured that the process will be confidential.

Some participants indicated that there are Christians who still think it is better to live without knowing because of the fear of the disease. Mr G, a church board member from Charismatic church said,

"*I used to hear people commenting saying it is better to live without knowing rather than going for test and know that one is positive. They think if they know their status especially if positive it is like a death sentence".*

Mr V, another participant who is a pastor from one of the Pentecostal churches said, *"We have members whom we are sure that the partner died with HIV/AIDS related conditions. When we advice them to go for HIV test they are reluctant to go for test despite the fact that HIV/AIDS is killing people."*

Although the HIV test is free of charge in the public health centres of South Africa, some people are still reluctant to be tested. Inputs from the participants clearly indicated that fear of being tested is related to the stigma attached to the disease; therefore to some individuals it appears through their comments that to live without knowing one's status is better that having the stigma of the disease.

Literature shows that fear of stigma amongst people living with HIV/AIDS, or people who believe they are HIV positive, has been found to be a barrier to accessing Voluntary Counselling and testing and other HIV/AIDS- related support services (Bond, 2002:50). According to Lindsey, et al. (2003: 498), 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

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support is delayed. This finding is also supported by Baker; Williams; Juma and Mahindra (2005:1), who explained 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.

4.2.3 Lack of collaboration

Two subthemes have emerged here; the lack of collaboration amongst churches and that between churches and the PHC department.

4.2.3.1 Collaboration amongst churches

Although the majority of churches are involved in the HIV/AIDS epidemic, there are several with no HIV/AIDS response programmes, while others having inadequate response. Amongst those churches with programmes in place, their programmes are not co-ordinated. Each individual church has its own programme and only focuses on its own church and not its neighbouring ones. In one area, one church is involved, but the other is not involved at all. Response is not a collective effort but an individual church effort. Churches involved do not have any policy to guide their activities.

4.2.3.2 Collaboration between churches and the PHC department

Usually there is no link with the PHC department. Inputs from participants indicated that link that exists is with home-based care, which is also limited. Home based care organizations are facilitated and supervised by the near-by clinics, as most of their funds are coming through the department of health.

Churches in Vhembe district who are involved in HIV/AIDS do refer people to Primary Health Care facilities (clinics & health centers) in the community for HIV testing, treatment and medical advice. Churches do recognize the role of PHC facilities but those facilities do not recognize the contributions made by churches towards the

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HIV/AIDS epidemic. One pastor when asked about their relationship with the nearby clinic said,

"I used to go to the nearby health centers for preaching and prayer programme but with regard to HIV/AIDS we from the church side refer people to go there for HIV test, medications and any other problem which we think it may need medical help. I don't remember any other HIV/AIDS activities which churches were involved by the health centre".

From the responses of the participants, the only link that exists between churches and PHC is regarding spiritual matters. PHC component in the district seemed not to understand the role that churches are playing with regard to HIV and AIDS in the community.

4.2.4 Challenges faced by church leaders when implementing HIV and AIDS intervention program.

Among those churches with HIV/AIDS response programmes, several challenges that hamper their efforts were indicated by the participants. These include lack of capacity building, misconception and stigma, and beliefs regarding evil spirits and witchcraft.

4.2.4.1 Lack of capacity building

The findings of this study shows that there are pastors who have attended some form of training and are using that knowledge to care and support those living with HIV/AIDS, but there are many also who did not attend any form of training who are reluctant to engage themselves in the fight against HIV/AIDS. There are leaders amongst Charismatic and Pentecostal churches who are not involved because they do not know what to do or how to address it. Church leaders who have attended training on HIV/AIDS have better knowledge and are willing to engage themselves in response to the epidemic.

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Two pastors, Mr N from a Pentecostal church and Mr M from Charismatic church respectively highlighted this challenge by saying, *"Our challenge as Pastors is that sometimes we lack enough information to help people because of our lack of knowledge regarding HIV/AIDS."*

The results from Ntsimane's study show that there are still some people, even religious leaders, who are not well informed about HIV/AIDS. This underscores the need for churches to get involved in activities to increase knowledge about HIV and AIDS within their churches and the community (Ntsimane, 2000:22-25).

4.2.4.2 Misconceptions and stigma in churches

The findings of this study confirmed that churches in Vhembe have been involved in HIV/AIDS activities for a long time, but the progress has been slow because of misconceptions about HIV/AIDS. Ms R, a church board member from charismatic church when asked about the role played by her church with regard to HIV and AIDS, participant said,

"*Our progress has been slow due to the nature of the disease that requires confidentiality and not many people could be involved to help those infected."*

Participants agreed that there were misunderstandings among church members and some leaders about the nature of the epidemic accompanied by lack of knowledge on which to act.

Participant K, a pastor who participated in the study said, *"The commonest mistake that people do is to begin judging people who are positive before finding out what might have happened or contributory factors, hence stigma."*

The association of HIV infection with immoral behaviour and the failure to openly discuss the root causes underpinning HIV transmission have contributed to stigmatization and discrimination of PLWHA within the church.

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In this study participants showed different perceptions as far as HIV/AIDS is concerned. There are those who consider HIV/AIDS to be a disease like any other chronic diseases hence those who are suffering are accepted and supported. There are others who think HIV/AIDS is caused by sinful life. Participant Z, a pastor from Zion church when asked about his perception towards somebody having HIV/AIDS *said,*

"We take this person as somebody who committed sin and need to repent and be restored back to God."

Those churches that associate HIV/AIDS with sinful life have contributed to stigmatization and discrimination of people living with HIV/AIDS within their churches.

Cochrane (2005:51), notes how religion feeds into the problem of stigma through the taboos, sanctions, and silences [about sexuality], much of it authorized by religious legitimations. This extends to the patriarchal aspects of religion, to prejudices about same sex relationships, and to racial and class differences.

One participant who is in leadership raised his concern about unwillingness of people to become open about their status by saying, *"As a church we are also facing challenge on how to help those infected as it is not easy for people to disclose their status because of fear of stigma and rejection".*

The majority of church leaders involved in HIV/AIDS activities reported that the more people are getting information, their attitudes are changing and they are free to reveal their status. Another participant who is in leadership confirmed that people do disclose to them; *"We do have people who have disclosed their status, and as a church we know how to handle them rather than offending them. The interesting thing is that those members we know are HIV positive we do not discriminate them, we encourage them to play different roles they were playing before their status were known. When this people recognize that they are being accepted they cope well with the disease."*

In the study conducted in Kinshasa, DRC on the role of religion in HIV-positive women's disclosure experiences and coping strategies, the results revealed that out of 40 women

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interviewed 37 women mentioned their faith and /or the role of religious leaders in their disclosure and coping experiences (Maman, et al., 2009:968).

4.2.4.3 Churches' beliefs regarding evil spirits (demons) and witchcraft associated with HIV and AIDS

According to Gifford (1998:97), *"Pentecostals believe that demons are former angels, disembodied beings, who when they come to earth find themselves rivers, mountains, rocks, trees, and humans to dwell in. Activities of demons prevent humans from enjoying the abundant life that Jesus came to give. Some effects of their activities are phobias, allergies, chronic diseases, repeated hospitalization, repeated miscarriages, emotional excesses and striking odd behavior. Demons enter human beings through 'doorways' or openings such as ancestral gods, curses, involvement in wrong churches, and eastern cults. Satan has agents around seeking to deposit demons in people".* Some of those agents are those who practice witchcraft.

Churches in the Vhembe district, like many other African people, believe that when something goes wrong, there should be a cause. In most cases someone is suspected of having used evil magic, witchcraft against the victim or his household.

Participant G ,who is a pastor said, *"The problem is that our people think HIV/AIDS is related to witchcraft and some churches also believe that HIV/AIDS is from the devil and the cure is by means of prayer only hence they continue to die meanwhile those taking treatment continue to live."*

Another pastor from a different church who came across one of these cases claimed, "*Another challenging experience we had was one family where both husband and wife were positive, the husband was already on treatment but the wife did not believe in taking treatment thinking that the virus will not kill her as she beliefs in God".*

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These beliefs led most Pentecostal churches to develop deliverance ministries in their churches and further influence type of treatment option. Those people who hold similar beliefs, treatment option will be visiting faith healers for prayer to cast out the evil spirit and traditional healers for solution. These beliefs again hinder the victims of HIV/AIDS from seeking medical treatment, the antiretroviral treatments.

Pastor G further explained that besides the individual beliefs in witchcraft and activities of the devil, relatives do play a part in influencing the sick individual to default ARVs to can go and consult traditional healers or faith healers. Pastor G said,
"*There are people I know that are HIV positive who died because they stopped taking ARV and tried to look for help from traditional healers and some prophets having recruited by their relatives believing they will be cured".*

These findings concur with Edwards (1983:177-198), that the Zionists' belief that there are illnesses which are brought by witchcraft and sorcery, and that those illnesses are not treatable by western medicine, but can be treated through faith or traditional healing. That is why there are people who are stopping to take ARVs with the belief that AIDS is one of those illnesses which cannot be treated by western medicine.

4.3 SUMMARY

This chapter focused on data analysis, discussion of findings and literature control. Findings of this study were discussed and grouped according to identified relationships. The grouped information was categorized and contextualized against the background of the literature control.

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CHAPTER 5

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

5.1 INTRODUCTION

Chapter 4 dealt with the presentation and analysis of findings. This chapter deals with conclusions, recommendations and limitations of the study as well as brief overview of the study.

5.2 STUDY OVERVIEW

The study sought to investigate the role of churches in response to the HIV and AIDS epidemic and to determine the collaboration between the churches and Primary Health Care services in selected communities in the Vhembe district of the Limpopo province. The objectives of this study as set in chapter one were also evaluated.

Objectives of the study were to:

- Explore and describe the role of churches towards HIV and AIDS epidemic in the Vhembe district;
- Determine the ways in which churches could collaborate with PHC on HIV and AIDS intervention programmes;
- Identify challenges faced by church leaders in the implementation of the HIV and AIDS intervention programmes; and
- Provide recommendations to church leadership on how they can play an active role in contributing to community-based interventions of HIV and AIDS.

5.3 CONCLUSIONS

The results of the study revealed that there are various contributions from different churches with regard to the HIV/AIDS epidemic in the Vhembe district. Contributions

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were explored from participants through in-depth interviews. The objectives of the study are now evaluated to establish whether they were achieved.

Objective 1: Explore and describe the role of churches towards HIV and AIDS epidemic in the Vhembe district. Theme one and two revealed and described the role of churches which include various forms of support and prevention strategies. Most identified forms of support were spiritual and financial support as well as home visit. Prevention strategies employed by churches include awareness and education on HIV and AIDS during different church gatherings, as well as encouraging people to go for HIV testing in order to know their status. The findings confirm that there is a role that churches are playing towards the HIV and AIDS epidemic in the Vhembe district.

Objective 2: Determine the ways in which churches could collaborate with PHC on HIV and AIDS intervention programmes. The collaboration was addressed by theme three which is lack of collaboration. Information from the participants clearly showed that there is no collaboration the only link that exists is with the home-based care. Home based care organizations are facilitated and supervised by the near-by clinic, as most of the home based care funds are coming through the department of health.

Objective 3: Identify challenges faced by church leaders in the implementation of the HIV and AIDS intervention programmes. Several challenges were identified and discussed under theme four. Challenges indicated by participants included: lack of capacity building which result in some of the churches not willing to speak about HIV and AIDS because they are not well informed, misconception and stigma resulting from the association of HIV infection with immoral behaviour and finally the belief regarding evil spirit and witchcraft practices delayed people from seeking medical help to an extent that many people lost their lives believing in supernatural healing.

Objective 4: Provide recommendations to church leadership on how they can play an active role in contributing to community-based interventions of HIV and AIDS. Based on the research findings, recommendations can be made because objectives and the

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purpose of the study have been achieved. Objective number four will be addressed in this chapter where in recommendations will be drawn.

5.4 RECOMMENDATIONS

The following are the recommendations emanating from the findings:

5.4.1 Establishment of Training programmes

The findings revealed that some church leaders were trained whilst others were not. In addition, the training programmes are mainly ad hoc and uncoordinated. There is no evidence that church leaders are supported and trained to contribute to HIV and AIDS intervention. This compromises the understanding and knowledge of pastors regarding how they can maximize their contributions to HIV and AIDS intervention. In this regard, it is recommended that those leaders who have attended some training programmes should be in-serviced to renew and update their knowledge. In addition, that the training programmes be standardized so that all churches could receive similar information. Training could bridge the gap between the churches, overcome the different perspectives with good information and training, and help towards overcoming prejudices and stigma related to HIV/AIDS.

5.4.2 Recommendation to churches

Churches are best placed to provide accurate, unbiased information, ways should be identified to ensure frequency and regular provision of HIV and AIDS related information to dispel misconception, myths and issues of stigma and discrimination. Churches need to develop a set of guidelines for stigma- mitigation interventions. Church members who are living with HIV/AIDS should be empowered and involved in church activities without discrimination. Sensitivity is needed to overcome the different perspectives with good information and training

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Churches should include an HIV/AIDS module in their theological training institutions so as to enable those trained to be pastors to fight HIV and AIDS and assist in the mitigation.

Pastors alone cannot manage, there is a need for other members to be trained, as some pastors are not doing church work full time, so the church can also organize non-working interested women to be trained to care for those living with HIV/AIDS in the church and surrounding community to reduce the burden of caring PLWHA in the community which Primary Health Care facilities and other structures in the community are unable to cope with.

5.4.3 Collaboration

Churches collaboration and co-ordination on HIV/AIDS is lacking, although there are so many churches involved in HIV/AIDS activities, each individual church focuses on what is best for their members as there is no structure to manage and co-ordinate churches activities in the Vhembe district. Studies conducted in different countries showed that where there is collaboration, effort was maximized (see Parry, 2002). Collaboration is needed to maximize efforts, coverage, and quality of service delivery and better utilization of resources, both human and financial. It is on the strength of the above that the researcher recommends establishment of organised structure to network churches activities in the district. If churches work together, it may also become easier to secure funding for their activities.

5.4.4 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 organisations on how HIV and AIDS interventions can be enhanced in the district.

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5.4.5 Recommendation to Primary Health Care

The HIV/AIDS epidemic requires a multidisciplinary team approach which co-ordinates all sectors involved in health to identify strategies to reduce the infection. According to the government communication system (2003:2), all sectors of government and other stake holders in the community should be involved in combating HIV/AIDS through intervention programmes. The findings of this study showed that there are no collaborative practices between the church's work with Primary Health care services on issues of HIV and AIDS although the findings showed the complementarily between the two interventions. There is a need for Primary Health Care services to acknowledge the churches' contributions towards HIV and AIDS in the district and collaborate with them in the community, because health is the product of a person's positive interaction with his or her total environment. Greater collaboration is needed to maximize efforts, coverage, and quality of service delivery. If churches are involved they can also ask their members to contribute financially to help those infected and in need as they compose the majority of members. According to Statistic South Africa (2010), Vhembe has 3350 Christian churches spread in four different municipalities in 603 villages and townships. This number is far more than all clinics, health centers and home-based care groups in the district. Churches can also mobilize community structures like schools, civic and headmen as churches are respected in the community.

5.4.6 Ideas for Further Research

Further research is needed, to include other Christian churches and religions, using a larger sample size, and to develop a co-ordinated programme on HIV/AIDS amongst the churches in the Vhembe district.

5.5 LIMITATION OF THE STUDY

The study was limited to Christian churches in the Vhembe district of Limpopo Province and individuals within selected churches were included. Like most qualitative studies,

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the issue of limited sample size has several limitations to the study because it might be difficult to generalize the results based on the responses from few participants. However, an effort was made to ensure data saturation.

5.6 SUMMARY OF FINDINGS

The results showed that there is a role that churches are playing with regard to the HIV and AIDS epidemic in the Vhembe district, although it is not without challenges. Responsibilities identified were as follows:

- **Prevention of HIV infections through**:
  - awareness and education

Awareness and education campaigns are done during different church gatherings on Sundays as well as during different church conferences. Approaches vary from health education to group discussions depending on individual churches.

  - Voluntary counselling and testing.

The study findings indicated that voluntary counselling and testing is an essential service for both prevention and treatment. Church leaders encourage their members including youth to go for HIV test.

- **Support offered to people affected and infected by HIV/AIDS**

The study revealed variety of interventions which varies according to circumstances and situations of the client. Most identifiable forms of support from the participants' inputs were spiritual, financial as well as home visit.

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- **Several challenges regarding HIV/AIDS intervention programmes were identified:**

  - A Lack of capacity building.

The findings of this study showed that there are pastors who have attended some form of training and are using that knowledge to care and support those living with HIV/AIDS but there are many also who did not attend any form of training who are reluctant to engage themselves in the fight against HIV/AIDS.

  - Misconception and stigma

In this study participants showed different perceptions as far as HIV/AIDS is concerned. There are those who consider HIV/AIDS to be a disease like any other chronic diseases hence those who are suffering are accepted and supported. There are others who think HIV/AIDS is caused by sinful life. Those churches that associate HIV/AIDS with sinful life have contributed to stigmatization and discrimination of people living with HIV/AIDS within their churches.

  - Beliefs associated with witchcraft and demons

The study revealed that there are churches which believe that HIV/AIDS is caused by the involvement of the devil hence associate the disease with witchcraft and demons.

The findings of the study further reveal the lack of recognition of the churches' efforts in response to HIV/AIDS epidemic by primary health care component. Finally the study reveals that churches having response programmes lack collaboration, there is no structure to manage and co-ordinate churches activity with regard to HIV/AIDS in the district.

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7. ANNEXURES

Annexure1 Permission letter to churches

P.O Box 3179
Sibasa
0970

To the leadership in charge

Dear Sir/ Madam

REQUEST FOR PERMISION TO CONDUCT A RESEARCH

I am a Masters degree student at the University of Venda in the school of Health Sciences. The title of my dissertation is 'The role of churches in response to HIV and AIDS epidemic in Vhembe district of Limpopo Province'. I am requesting permission to conduct a study in your church. The study will be conducted amongst Christian churches in the Vhembe district. The purpose of the study is to investigate the role of churches in response to the HIV and AIDS epidemic and to determine the link between the churches and primary health care services in the Vhembe district.

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 and AIDS interventions and will provide data to policy makers and other community based organizations on how HIV and AIDS interventions can be enhanced in the district.

Thanking you in anticipation.

Yours sincerely

Mr Malwela N.E.

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Annexure 2(a)

INFORMED CONSENT

Dear participant

I am a Masters' student at the University of Venda. I am presently engaged in a research study entitled 'The role of churches in response to the HIV and AIDS epidemic in the Vhembe district of the Limpopo province in South Africa'. The purpose of this study is to investigate the role of churches in response to the HIV and AIDS epidemic and to determine the link between the churches and primary health care services in the Vhembe district.

I would like to conduct interviews of within 30-45 minutes, and which will be audio-taped for verification of the findings by my supervisors and an independent coder. However, if you agree to participate but are not comfortable with being recorded, you are free to say so and I will make notes during the interview to be used for data analysis and verification of the findings by my supervisors and the independent coder.

Please understand that the name and dignity of each participant will be preserved by observing the following ethical standards throughout the research process:

- Voluntary participation and freedom to withdraw without a penalty;
- Informed consent;
- Names of the participants and their church will not be mentioned during discussions;
- Raw material will be kept under lock and key to ensure confidentiality;
- Information related to the interviews will only be accessible to my supervisors and the independent coder;
- Field notes will be destroyed and audio tapes will be erased after completion of report;
- The summary of the research will be made available to the participants if they wish.

There will be no finances or reward for participating in this study, however I would appreciate it if you do share your thoughts with me.

Thank you

MALWELA NNDONDENI EDSON
Researcher

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I (participant) ---------- hereby consent to participate in a research study. 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

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Annexure 2(b)

CONSENT FORM FOR TAPE RECORDING

I (participant) ---------- hereby consent to be tape-recorded during interviews in a research study entitled 'The role of churches in response to the HIV and AIDS epidemic in the Vhembe district of the Limpopo province in South Africa'. It was explained to me that the interview will be recorded and that the answers that I will provide will not be linked with my name or used against me and that the information provided by me will remain confidential; only supervisors will have access to the information. Once the information has been analyzed it will be destroyed. 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

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