PERCEPTIONS OF THE ROLE OF CHURCH-BASED PROGRAMMES IN ADDRESSING HIV AND AIDS: A STUDY IN THE DURBAN INNER-CITY AREA

by

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DECLARATION

I declare that: ***PERCEPTIONS OF THE ROLE OF CHURCH-BASED PROGRAMMES IN ADDRESSING HIV AND AIDS: A STUDY IN THE DURBAN INNER-CITY AREA*** is my own work, and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references, and that this work has not been submitted before for any other degree at any other institution.

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Signature Date

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SUMMARY

A structured questionnaire was used to survey the perceptions of programme coordinators, fieldworkers and beneficiaries of the role of church-based programmes in addressing HIV and AIDS in the inner-city of Durban. One hundred and ninety two respondents were recruited from seventeen churches. Findings indicate that fear of HIV- and AIDS-related stigma and discrimination abound. The material and spiritual roles of church-based programmes in addressing the needs of people infected with HIV and affected by HIV and AIDS were stressed by the respondents. Whereas programme coordinators were well informed about HIV and AIDS, information that can dispel fears about stigma and correct myths about HIV-transmission should be tailored to reach ordinary men and women. It is recommended that further research be conducted on the preventive aspects of church-based programmes in the Durban inner-city.

Keywords: church-based programmes, Durban inner-city, HIV and AIDS, people living with HIV, perceptions, socio-economic impacts, mitigation, stigma and discrimination

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LIST OF ACRONYMS AND ABBREVIATIONS

ABC	ABSTAIN, BE FAITHFUL, CONDOMISE
AFM	APOSTOLIC FAITH MISSION
AIDS	ACQUIRED IMMUNE DEFICIENCY SYNDROME
ARVs	ANTIRETROVIRAL DRUGS
CBD	CENTRAL BUSINESS DISTRICT
DOH	DEPARTMENT OF HEALTH
ECAP	ESSA CHRISTIAN AIDS PROGRAMME
FBOs	FAITH-BASED ORGANISATIONS
HIV	HUMAN IMMUNODEFICIENCY VIRUS
ILO	INTERNATIONAL LABOUR ORGANISATION
IPPF	INTERNATIONAL PLANNED PARENTHOOD FEDERATION
NGOs	NON-GOVERNMENTAL ORGANISATIONS
NSP	NATIONAL STRATEGIC PLAN
PLWHIV	PEOPLE LIVING WITH HIV
SA	SOUTH AFRICA
SAHRC	SOUTH AFRICAN HUMAN RIGHTS COMMISSION
SPSS	STATISTICAL PROGRAMME FOR THE SOCIAL SCIENCES
STI	SEXUALLY TRANSMITTED INFECTION
UNAIDS	JOINT UNITED NATIONS PROGRAMMES ON HIV and AIDS
UNICEF	UNITED NATIONS CHILDREN'S (EMERGENCY) FUND
USAIDS	UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
VCT	VOLUNTARY COUNSELLING AND TESTING
WCC	WORLD COUNCIL OF CHURCHES
WHO	WORLD HEALTH ORGANISATION
WTO	WORLD TRADE ORGANISATION
YWCA	YOUNG WOMEN'S CHRISTIAN ASSOCIATION

CHAPTER 1:

ORIENTATION TO THE RESEARCH PROBLEM

1.1 INTRODUCTION

Globally the HIV and AIDS epidemic has presented great challenges to humanity since the first discovery of the Human Immunodeficiency Virus (HIV) and its connection to Acquired Immunodeficiency Syndrome (AIDS) during the early 1980s. In addressing the devastating and widespread impact of HIV and AIDS worldwide and especially in the African continent, the World Bank established a multisectoral AIDS Campaign in which church-based programmes play a key role (World Bank 2000: vi). This study sought to investigate perceptions of the role played by church-based programmes in addressing HIV and AIDS in the inner-city of Durban.

1.2 BACKGROUND TO THE STUDY

A study conducted by the Kaiser Family Foundation (2007a) suggests that by 2015 more than 60 million HIV infections will occur. In addition, the annual HIV-infection rate is expected to escalate by 20% in 2012. Three decades into the AIDS pandemic, no cure has yet been found for HIV-infection. In 2007, 33,2 million people were living with HIV globally, with annual deaths totalling 2,1 million that same year (Kaiser Family Foundation 2007b). Sub-Saharan Africa, where over two-thirds (68%) of the world's people are reported to be living with HIV, is the most severely affected region. In 2009, there were approximately 5,7 million people living with HIV in South Africa, with 1 000 AIDS deaths occurring every day (Avert 2009). The province of KwaZulu-Natal continues to have the highest prevalence at 39,1%, followed by Mpumalanga province at 34,8%.

Durban, where this study took place, is situated in KwaZulu-Natal, and is reported to be the most affected city (UNAIDS 2005a).

Whereas the World Bank has called for a multisectoral approach in curbing the number of new HIV-infections, the potential of church-based programmes to do so has not yet been fully exploited. A basic premise of this study is that the very nature of the Christian church as the ambassadors of God makes it imperative for churches to take an active role in HIV and AIDS intervention programmes.

It should be noted at the onset that the focus of this study was on perceptions of people of the role that the church can play in addressing HIV-infections and in assisting those infected with HIV and affected by HIV and AIDS. Thus, the researcher did not include all faith-based organisations (FBOs), but instead focuses on the church-based programmes of the Christian churches in the inner-city Durban area. Also, the study is not intended to be an exploration of what the role of the church should or could be. Instead, it is a survey of the ***perceptions*** of people involved in the church-based programmes of what that role entails.

1.3 THE IMPACT OF HIV AND AIDS IN SOUTH AFRICA

In the past 15 years, South Africa has moved from one dispensation to another. It has come from a past characterised by the unjust policies of apartheid and by the inequitable provision of services related to health care, education and housing. The legacy of these policies has seriously impacted the present, and manifests in how the country is dealing with HIV and AIDS. .

According to Williamson, (as cited in Karim & Karim 2008), there have been two patterns of infection in South Africa on two different time lines. The first cases of HIV and AIDS in South Africa were attributed to homosexual contact in the early 1980s. It is believed that at this time, HIV was still largely absent in the general population. Karim and Karim (2008) further claim that a second epidemic, driven

by heterosexual transmission, surfaced only in the late 1980s and early 1990s in South Africa. .

While at first HIV and AIDS was thought to be an exclusively medical problem, it soon became clear that it has a socioeconomic impact on human development. HIV and AIDS have been responsible for the breakdown of many families, creating and putting a burden on the most vulnerable sectors of society, especially women and children through loss, in many instances, of breadwinners. The rising prevalence of HIV and AIDS also reduces productivity, raises costs, and reduces individual savings and companies' costs (Whiteside, in Karim & Karim 2008).

The poem below by an anonymous grade-11 student (2000) reflects the basic Christian teaching that in the midst of pain, suffering and despair, God is able to change the hopeless situation into one of hope.

AIDS is so limited
It cannot cripple love
It cannot shatter hope
It cannot corrode faith
It cannot take away peace
It cannot kill friendship
It cannot shut out memories
It cannot silence courage
It cannot invade the soul
It cannot reduce eternal life
It cannot quench the spirit
Our greatest enemy is not disease
But despair

Anonymous Grade-11 Student (2000)

It is from this viewpoint that addressing the socioeconomic impacts of HIV and AIDS has been placed on the shoulders of civil society organisations, in particular faith-based organisations which are an important part of community to, inspired by their religious beliefs and faith, serve the community.

It is encouraging to note that, despite what Quiroga (2008) described as the church's *"once negative attitude and its inability to speak about sex, drugs and other taboo issues which made many HIV sufferers reluctant to turn to the church, in spite of their desire to reconcile with God"*, the church has eventually committed itself to helping people living with HIV in keeping with its biblical principles of *"Loving thy neighbour as thyself"* (Matthew 19:19).

Through this quantitative study, the researcher surveyed respondents' ***perceptions*** about the role of the church-based programmes in addressing HIV and AIDS. To achieve this, the researcher decided to focus on the Christian churches that have programmes to address the impacts of HIV and AIDS on the people and communities within the inner-city area of Durban.

Currently, the Durban inner-city is characterised by dense population and socioeconomic issues (such as unemployment and poverty) that have exacerbated the spread of HIV infections among the indigent. The researcher is a reverend whose interaction with programme coordinators, fieldworkers and beneficiaries in the church-based HIV and AIDS programmes has influenced the need to better understand people's perceptions and opinions about church-based HIV and AIDS programmes.

1.4 THE PROBLEM STATEMENT

The central research problem which the researcher set out to answer was:

What are the perceptions of the people involved in the church-based programmes of selected Christian churches in Durban of the role played by the church in addressing the problems of HIV and AIDS that beset their communities?

Tearfund (2010), one of the international stakeholders in the battle against HIV and AIDS, states that the church is ideally positioned to curb the pandemic. On July 9-14 2000, South Africa hosted an International AIDS Conference, themed *"Treatment for all now"*, which took several resolutions aimed at strengthening HIV prevention efforts by aligning the revised national policy on HIV counselling and testing with the National Strategic Plan (NSP) and World Health Organisation (WHO) guidelines 2000–2005. As a result of this conference, the religious leaders (using the Uganda model as an example), felt compelled to extend help to those other Southern African countries affected by HIV and AIDS. Consequently, in March 2005, the eThekwini Department of Health (DoH) district management committee responded to this call by organising a workshop at the Durban Beachfront Convention Centre themed *"Faith In Action Strengthening HIV and AIDS Responses"* for all FBOs. The researcher participated in this initiative that aimed to mobilise partnerships with government to address the socioeconomic impacts of HIV and AIDS. Furthermore, in response to this call, the Durban Diakonia Council of Churches, an ecumenical Christian body, through its "Faith and Action" programmes, mobilised different churches in the Greater Durban area to work together to address the socioeconomic impacts of HIV and AIDS in the city and its communities.

1.5 THE CHOSEN STUDY SITE

The organisations deemed central to this study were those churches that have undertaken the responsibility to minister spiritually and otherwise to those infected with HIV and those affected by HIV and AIDS. The leading organisation which serves and supports the people living with HIV in the Durban inner city

area is the Diakonia Council of Churches. The Diakonia Council of Churches assists churches to strategise and develop programmes for appropriate ministries related to HIV and AIDS.

The Durban Metropolitan Area has a population of about 2, 5 million people. Most of these people reside in the North Central (34,2%) and South Central (31%) areas, which are also the local council areas. According to the Durban Metropolitan Area (DMA) Spatial Development Plan. (Mavuso 2007), the demographic characteristics of the Durban are typical of cities in South Africa. Although the working age groups make up the bulk of the population (61,5%), there is a relatively large proportion of children under the age of 18 years (34,4%). Whereas the age profiles of the North and the North Central Local Council areas mirror that of the DMA as a whole, the South Central and Inner West areas have a higher proportional share of working age people (Mavuso 2007). This is because hostel-dwellers are found in these two areas – a fact that is reflected in the above-average presence of males in the Inner West (52,5%) and South Central (51,3%) areas. The Outer West has a substantially below-average proportion of working age people (55,3%), reflecting the fact that this area has an employment deficit and is consequently a net labour exporter. This is supported by the comparatively low ratio of males to females (46, 4: 53, 0). The DMA has a racially diverse population. The majority of residents are black (56%); there is a large Indian community (27%), and a minority white community (14%). Only 3% of Durban's population comprises Coloured people. Whereas in the past, different cultural groups were kept separate, there is now a mixing of different cultures and the city has become more 'Africanised' (Mavuso 2007).

A study conducted by Leggett (1999) of the School of Development Studies at the University of Kwa-Zulu Natal, Durban, uncovered that Durban was the second largest contributor of sex workers after the Johannesburg Central Business District (CBD), with nearly 20 per cent. Seventy per cent of sex workers

in the Durban CBD reside in residential hotels, while a similar percentage of black female sex workers reside in the surrounding informal settlements.

Due to the diverse population statistics and activities taking place in the Durban inner-city, it is obvious that more HIV infections and AIDS-related deaths can be expected to occur in the coming years. Also, overpopulation caused by the migration of people from the homelands and those residing in informal settlements surrounding the city has been cited as one of the causes of poverty, as people begin to compete for scarce resources. This state of affairs exposes unemployed women and girls to drugs and commercial sex as a means to earn a living and makes them vulnerable to HIV infection (Nattrass 2004).

1.6 THE PURPOSE OF THE STUDY

Research has shown that there has been much debate at a theoretical level about the development and implementation of programmes by churches to address the socioeconomic impacts of HIV and AIDS, but little empirical research has been conducted on the perceptions and opinions about the role of the church-based HIV and AIDS programmes in addressing the needs of people living with HIV.

Therefore, the main purpose of this study was to survey the respondents' perceptions and opinions about the role of the church-based HIV and AIDS programmes, and their perceptions on how these programmes should address the needs of people living with HIV in the Durban inner-city area.

1.7 THE OBJECTIVES OF THE STUDY

In order to fulfil the above-mentioned research purpose, the objectives were to:

1. Obtain information on the respondents' personal details, such as age, ethnicities, gender, knowledge of their own HIV status, possible fears of disclosing a positive status, and their understanding of the possible role of the church in addressing HIV- and AIDS-related issues;
2. Establish exactly what respondents do in the programmes, how long they have served in the programmes, entry requirements into the programmes, and the impact that the programmes have had on the respondents lives;
3. Unravel problems and challenges being encountered in the implementation of these programmes;
4. Find out what changes or improvements could be made to enhance the programmes.

The first objective dealt with gathering information on the participants' biographical data. The second objective underpinned data-generation about the respondents' programmatic perceptions and led to the formulation of the following questions:

- What is the involvement of the participants in these programmes?
- How long have they been involved in the programmes?
- What were the entry requirements into a programme?
- What was the impact of the programmes on their lives?
- Do the respondents know what services the church-based programmes provide in respect of HIV and AIDS?
- Which services do the participants benefit from?
- Are they familiar with the church-based HIV programmes?
- Have they attended HIV and AIDS workshops or awareness campaigns offered by the church-based programmes?
- How many of these sessions have they attended in the last 12 months?
- What were the reasons for non-attendance if they have not attended any?

The third and fourth objectives were aimed at discovering whether participants encountered any challenges when implementing a programme and which changes they would like to see. This underpinned questions such as:

- What changes or improvements can be made to reduce the stigma and discrimination against people living with HIV?
- Do the respondents have clarity on whether the church clearly outlines ways and strategies to reduce HIV-related stigma and discrimination?
- Do the respondents think the church discriminates against people living with HIV?
- Do the respondents think church leaders or ministers regard HIV and AIDS as part of their core business in the community?
- Do the respondents think that the church programmes are effective to reduce the spread of new HIV infections?
- Do the respondents think that the available church programme resources are sufficient to address the needs of people living with HIV?
- Do the respondents have any other ideas which could make a contribution to these church-based programmes?

1.8 THE RESEARCH DESIGN AND APPROACH

Since a quantitative approach favours structured data-gathering in which the researcher can ask the same question from a number of responses (De Vos 1998; Neuman 1997) it was deemed ideal for this study. Because there is no available data on the perceptions of people about the church-based HIV and AIDS programmes in Durban, a survey-type approach enabled the gathering of baseline data. Such baseline-data was needed to get an overview of the perceptions about the programme and to act as reference data for further studies.

Since this is a descriptive quantitative study intended to generate baseline-data, no hypotheses were stated prior to data-gathering. The full details of the

methodological decision taken for the study are given in Chapter 3 of this dissertation. Here, the general approach is outlined and substantiated in terms of the purpose and objectives of the study. Moreover, the research objectives, the question items and the sampling strategies were influenced by the literature reviewed by the researcher. In particular, Cunningham, Kerrigan, McNeeley and Ellen (2009) focused on the perceptions of church leaders and posed similar questions, although they opted for a grounded-theory approach. Francis and Liverpool (2008) reviewed several studies of church-based programmes and detailed similar methodologies as those chosen by the researcher. Finally, Lindley, Coleman, Gaddist and White (2010) followed a similar research strategy.

1.9 DEFINITION OF KEY TERMS

1.9.1 Beneficiaries

In this context, beneficiaries mean people who are receiving support from the churches-based programmes (Lindley *et al* 2010).

1.9.2 Church-based programmes

This term refers to social programmes and projects that are run by individual churches to address HIV and AIDS in the Durban inner-city (Cunningham *et al* 2009). When the notion faith-based organisations or faith-based programmes are used, it is done to include those Christian-orientated organisations that do not necessarily belong to a particular church but are ecumenical in nature. In this regard, the researcher is keenly aware of the fact that faith-based organisations are meant to include a broader array of religious organisations than churches.

1.9.3 Church

In this study this term denotes a Christian church, its leaders, members and teachings (Francis & Liverpool 2008).

1.9.4 Ecumenical body

This term refers to bodies such as the World Council of Churches, or the South African Council of Churches and Diakonia, which are responsible for bringing together members from various denominations to fulfil a common purpose.

1.9.5 HIV and AIDS Programmes

This is a reference to interventions which are aimed at mitigating the impacts of the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome.

1.9.6 Mitigation of impacts

In this context, mitigation refers to the ability to reduce the impact of HIV and AIDS.

1.9.7 Perceptions

In this study, “perception” refers to an impression or idea that is formed about something observed, or an ability to understand the true nature of something under observation.

1.10 ORGANISATION OF THE DISSERTATION

In this chapter, Chapter 1, the background information on HIV and AIDS in South Africa was given, followed by the statement of the research problem that led to undertaking this study. A description was given of Durban, where the research was undertaken, and this was followed by a discussion of the purpose and objectives of the study and the definition of the key terms.

Chapter 2 considers the literature on the debate over the perceptions of the role of the church-based programmes in addressing HIV and AIDS. Using the already available literature on HIV, it suggests a framework for analysis of the perceptions of respondents on the role of church-based programmes in addressing HIV and AIDS, and sets the background for the research questions.

In Chapter 3 the rationale behind the research is articulated. The instruments and techniques used for data gathering and data analysis are described, and the procedures undertaken in order to satisfy ethical requirements for a study of this nature, are detailed.

The findings are presented in Chapter 4 concerning the perceptions of respondents about the church-based programmes.

Chapter 5 offers the researcher's conclusions on the perceptions of the role of church-based programmes in addressing HIV and AIDS. Based on these conclusions certain recommendations are made.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter, literature pertinent to the study is reviewed. In this introduction, the researcher gives an overview of research that generated information about the roles of FBOs in HIV and AIDS interventions.

Research has found that in some countries, especially in Kenya and Uganda, governments and churches have excelled in developing strategies to fight HIV and AIDS (Cunningham *et al* 2009; Francis & Liverpool 2008; Lindley *et al* 2010). These strategies included addressing gender disparities, and creating awareness programmes which comprised among other things, education on methods of HIV-prevention and HIV-transmission, blood screening before transfusions and the use of disposable sterilised needles in hospitals, as well as the use of condoms. Communities were also encouraged to abandon risky cultural practices such as widow inheritance, unsafe circumcision and sexual cleansing (Oloo 2004). According to USAID (2007), between 30% and 50% of all formal health care in Africa is provided by church-based organisations. A survey conducted in Lesotho and Zambia reveals that two-thirds of all HIV and AIDS responses are provided by faith-based organisations (ARHAP 2006).

A study in Zambia found that 90% of all FBOs implement HIV and AIDS activities in the form of care and support, spiritual support, orphan support, home-based care, material support and prevention (Study of FBOs in Zambia 2006). A survey conducted in Namibia found that 90% of FBOs in that country implement HIV and AIDS activities in the form of awareness raising, spiritual support, counselling,

orphan support, home-based care, and pre-schools and support homes for orphaned and vulnerable children (Yates 2003).

A study, conducted by UNICEF (2003) in six countries in East Africa, found that FBOs support large numbers (that is, 150 000 or more) of vulnerable children, and some of these responses are faith-based and not necessarily faith-focused (Foster 2004). However, research also revealed that these strategies have not all been effectively implemented (Oloo 2004). Moreover, despite various responses to the impacts of the AIDS pandemic by different organisations including churches, little is known about people's perceptions and opinions about the role of the church-based programmes to address the needs of people living with HIV in their communities and society at large.

According to Mundy (2007), a pilot programme was conducted by Tearfund involving FBOs from the Democratic Republic of Congo, Ethiopia, Kenya, Malawi, Uganda and Zambia. The programme sought to strengthen the capacity of these FBOs to monitor and evaluate their responses to HIV and AIDS. It found that many of the contributions by FBOs could not easily be measured and were therefore difficult to monitor and evaluate. It further found that information on the development activities of FBOs was not easily accessible, as the FBOs were not trained in monitoring, evaluating and documenting their efforts (WCC 2003). This view is also supported by UNAIDS (2005b), who argues that the role of FBOs in responding to the HIV and AIDS pandemic has been considerable, but it is rarely examined in terms of the changing dynamics of the church as a social movement.

Foster (2004) argues that FBOs have certain strengths which can be utilised to contribute to efforts to address the impact of HIV and AIDS. They have well established structures capable of coordinating scalable responses and they are used to operating autonomously. FBOs are trusted in partnerships, are responsive to communities and are capable of mobilising large numbers of

volunteers, despite the fact that they receive no external HIV and AIDS funding. Some of the weaknesses of FBOs are that they often lack the necessary skills, may at times have limited networks and have poor relationships with the government sector (ARHAP 2006; Yates 2003).

Moreover, many FBOs have complicated governance structures and have no contact with other FBOs or development organisations (Yates 2003). The operating practices of most FBOs differ from development organisations in that they are self-resourced, are driven by compassion and individual needs and place little emphasis on monitoring and documentation (ARHAP 2006; Mundy 2007; Yates 2003).These research findings point to the fact that there are gaps that need to be filled to enable churches' HIV and AIDS programmes to be effective in mitigating the impact of HIV and AIDS. It is from this premise that the researcher has identified compelling reasons to examine people's perceptions about the role of church-based HIV and AIDS programmes in addressing the needs of people living with HIV within the Durban inner-city area.

Whereas there are a number of recent studies on the roles of FBOs, the researcher found very few studies that focussed specifically on perceptions of the role of the church and of church-driven programmes to mitigate the impacts of HIV and AIDS. One of the reasons for such lack of information may well be that in the beginning the churches' response to the impact of the AIDS pandemic has been slow. Initially, the church viewed HIV and AIDS as a punishment for irregular sexual behaviour, which might also have led to churches' fuelling the stigmatisation of people living with HIV rather than combating it (Fredericks 2008).

2.2 ORGANISATION OF THE LITERATURE REVIEW

This chapter is organised according to five major themes. Firstly, the roles of FBOs in South Africa are discussed. Secondly, the researcher discusses factors

that under gird the spread of HIV-infections and which falls within the ambit of church-based programmes to address. This is followed by a theoretical consideration of the potential roles of church-based programmes in making an impact on HIV and AIDS. Particular attention is paid to the material and the spiritual roles in this regard.

2.3 RESPONSES OF FAITH-BASED ORGANISATIONS TO HIV AND AIDS IN SOUTH AFRICA

The aim of the study was to assess the perceptions of the role of church-based programmes in addressing HIV and AIDS in the inner-city of Durban. To fulfil this aim, the researcher searched for background to the responses of FBOs in South Africa.

In November 2001, the World Council of Churches (WCC) and the All Africa Council of Churches organised a conference on the African churches' involvement in HIV and AIDS (Breetvelt sd:1). Subsequent to the call of the WCC was the consultative conference held by its member body in South Africa, namely the South African Council of Churches (SACC) also in 2001. At this three day consultation conference, the SACC crafted a "*Strategy to fight AIDS"* and a call was made to churches in South Africa to join hands with the government in the fight against HIV and AIDS (SACC 2001).

Over the past approximately fifteen years the government established the body called the National Council of Church Leaders (NACL). This council holds consultation sessions with the State President. Their major role is to advice the president on faith-related issues as well as on HIV and AIDS as a social issue.

Cunningham *et al* (2009) suggest that the church's involvement in the fight against HIV and AIDS has been characterised by the following:

- Care and support activities.

- Orphan support.
- HIV advocacy and rights.
- HIV and AIDS de-stigmatisation.
- HIV prevention

Maluleke (as cited by Haddad 2005:29) suggests that the motto of the church in the fight against HIV and AIDS is *"while we in the church might not all be infected, we all can be inf*ected and once one member of the body is infected, we are certainly all infected". This unique oneness that prevails in the church makes it an institution ideally placed to play a role in fight against HIV and AIDS. According to Centre for AIDS Development, Research and Evaluation (CADRE) there is 1 582 registered FBOs registered on the National AIDS Database (Haddad 2005:34). Out of this number, 96% of them are predominantly Christian FBOs.

2.4 FACTORS EXACERBATING HIV AND AIDS

In terms of those factors that drive HIV AND AIDS and which the church-based programmes can address, the researcher, following a review of literature, identified (1) gender inequality and male dominance; (2) lack of knowledge, myths and misconceptions about HIV and AIDS; (3) poverty; (4) cultural norms and practices and (5) stigma and discrimination. These are discussed in turn below.

2.4.1 HIV and AIDS, gender inequality and male dominance

Gender inequality continues to be a key driver of the HIV and AIDS epidemic in most African countries (WHO 2009). Gender inequality may be defined as the difference in the status, power, and prestige women and men have in groups, collectives and societies (Giddens 2004). Gender relations are shaped by the distribution of power and authority, while gender inequalities are underpinned by

cultural beliefs pertaining to the social status of men and women (UNAIDS 2005b).

According to Nattrass (2004), the social reality is that power relations are biased in favour of men. A similar view is shared by Giddens (2004), who believes that men's roles are generally more highly valued and rewarded than women's roles and that in nearly every culture women bear the primary responsibility for childcare and domestic work, while men have traditionally borne the responsibility of providing for the family's livelihood. According to the WHO and UNAIDS (2008), global estimates show that women comprise 50% of all people living with HIV. In sub-Saharan Africa, women constitute 60% of all people living with HIV.

In South Africa, women in particular, face a greater risk of HIV infection**.** Social, cultural and economic factors make it difficult for South African women to negotiate safe sex practices, and that refusing sexual advances often result in sexual abuse or violent confrontation (Ncube 2009). A study conducted by Pettifor, Measham, Rees & Padian (2004) found that the prevalence of HIV infection among South African women attending antenatal clinics was 26,5%. Among all 15- to 24-year-olds, 12% of women were infected, compared with 6% of men. These could be attributed to economic factors rooted in gender and power inequities, which exacerbate women's vulnerability to HIV infections. A study conducted by Haddad (2005) documents similar findings. The vulnerability of women to HIV infection could be attributed to biological conditions which render women more easily infected than men, and to the socioeconomic disadvantages experienced by women (Nattrass 2004). A lack of education and economic security affects millions of women and girls, whose literacy levels are generally lower than those of men and boys (WHO 2009). Many women are economically dependent on men and feel that they cannot risk losing the support from their partners by denying them sex or deciding to opt out from an abusive relationship.

Many women, particularly those living with HIV, lose their homes, inheritance, possessions, livelihood and even their children when their partners die. These circumstances force some women to adopt survival strategies that increase their chances of contracting and spreading HIV (WHO 2009). A study conducted in Zambia after the famine, revealed that women resort to '*survival sex'* out of desperation and choose to die of AIDS-related deaths rather than dying of hunger (Nattrass 2004).

Marx, (cited by Brym & Lie 2006:321), views the church as having been a contributing factor to gender inequality through its insistence that women should keep silent in the church and that, if there is anything they want to know, they should ask their husbands at home. This gender inequality imposed by the church subjects women to subordination and disempowerment as they cannot freely compete with their male counterparts even in church-related matters. For example, Brym and Lie (2006:321), argue that the continued resistance by some churches to recognise and ordain women as ministers has also contributed to the further subordination of women in the church, depriving them of an opportunity to a make a meaningful contribution as equal partners in matters relating to HIV and AIDS. However, the church's stance towards this has changed since the adoption of the Declaration and Plan of Action of Ecumenical Response (WCC 2001), where it has openly challenged the attitudes that seek to perpetuate gender inequality and the subordination of women in the church and community.

2.4.2 Lack of knowledge, myths and misconceptions about HIV and AIDS

Lack of knowledge about the disease has been cited as one of the key drivers of the HIV and AIDS pandemic. This view is supported by a study conducted in two communities in Pietermaritzburg in 1999, to draw up a strategy for the Essa Christian AIDS Programme (ECAP), which found that people lived in denial of the disease, both in the community and in the church (Okyere-Manu 2003). A study conducted by Geffen (2000) documents that many South Africans do not realise

that HIV and AIDS can be treated or that their health can be improved through lifestyle changes because they lack knowledge about treatment.

A survey conducted by MacPhail and Campbell (2001) into the social factors that hinder condom use amongst youth in the township of Khutsong, near Carletonville, documents that levels of knowledge about HIV were high, but that perceived vulnerability and reported condom use were low. Despite the fact that most South Africans already have a fairly good level of knowledge about HIV and AIDS, how the disease is transmitted and that condom use minimises the risk of infection, there are still many people, especially those with low levels of formal education, who lack proper access to accurate information on HIV and AIDS and sexuality (De Jong 2003).

A similar view is supported by Zulu (2007), who found that most men who sleep with young children are illiterate and can easily believe the myths and lies that if they slept with young children they would be cured of AIDS, which consequently exacerbates the spread of HIV and AIDS. HIV and AIDS have always been surrounded by myths and misconceptions, especially in Africa. A study conducted in Zambia documents that the number of children who were being sexually defiled has continued to increase because of the widespread belief that having sex with a virgin will cure HIV and AIDS – a misinformation which is mainly spread by local traditional healers (Zulu 2007). A study conducted by Earl-Taylor, as cited by Lowen (2007), indicates that this myth gained prominence in 19th century Victorian England, where the Christian legends of virgin martyrs used their purity as a form of protection against demons. This myth has been cited as one of the key drivers of HIV infection in South Africa.

According to Zulu (2007), as this problem continues to grow and to fuel the spread of infection in Zambia, it affects the raising of children – especially those who grow up without proper parental supervision. According to the statistics compiled by the Young Women's Christian Association (YWCA) of Zambia, one

child is defiled every week leading to the child being infected with a sexually transmitted disease (Zulu 2007). The same study revealed various misconceptions among traditional healers, who teach people that sleeping with young girls can make them rich. A study conducted in the Transkei documents that this myth is still prevalent in most communities. This study presents the case of a nine-year-old little girl who had been raped in the mistaken belief that having sex with a virgin will cure HIV, and the rapist was an HIV-positive uncle of the child (Meel 2003).

2.4.3 HIV and AIDS and poverty

Holden (2004) indicates that poverty causes higher susceptibility to HIV infection because poor people are less able to afford health care, and therefore they are less likely to be in good health, and less likely to get treatment for sexually transmitted infections (STIs).

HIV and AIDS impact economic development and growth in several ways. Becoming infected with HIV worsens all the issues surrounding poverty, and makes one vulnerable to full-blown AIDS. According to Nattrass (2004), in most households the socio-economic impacts of HIV and AIDS reduce the household security by decreasing the number of breadwinners, and thereby the household income, and increasing household expenditures because of AIDS-related medical costs.

People are said to be living in poverty when they lack the fundamental requirements for human existence such as sufficient food, clothing and shelter (Giddens 2004). Rose-Innes (2006) indicates that poverty caused by *inter alia* unemployment and an inadequate welfare system, is one of the contributing factors to people's vulnerability to contracting HIV. She goes on to mention that abject poverty and the daily struggle to survive may far outweigh any concerns about contracting HIV, and for single mothers, commercial sex work can become

a survival strategy that can expose them to HIV infection. This is confirmed by a study conducted by Cohen (2009), which found that poverty is associated with the vulnerability of humans to disease and a lack of financial resources; low levels of education are associated with low levels of literacy and a lack of marketable skills. This view is shared by Alsan (2006), who found that women are forced into unfavourable unions due to poverty.

Research conducted by the World Council of Churches (WCC 2003) documents that many poor women are driven by poverty to engage in high-risk sex or are sold into the sex work industry. By virtue of their inability to meet their basic needs due to poverty, women indulge in commercial sex, which exposes them to HIV infection, a view shared by Phiri (as cited by Fredericks 2008). Fredericks (2008 – in citing Phiri) argues that economic circumstances force women to resort to prostitution and sexual abuse, since sex, culturally, is a man's issue.

In response to the call by the WCC to alleviate poverty, FBOs have embarked on expanding their focus from their original long-term goal of implementing programmes to mitigate the impact of HIV, into short-term responses to meet the more pressing needs of food security (WCC 2003). For example, the Apostolic Faith Mission of South Africa (AFM), one of the Charismatic-Pentecostal churches, embarked on a national welfare programme that is driven by local congregations in their communities. These programmes are supported by their national office. The AFM established a national welfare council that promotes the vision of the ministry to the poor within various denominations. They have projects that address the needs of street children, maltreated and sexually abused children and AIDS orphans, to name but a few (Mathole 2005). Simmons, (cited by Tirrito 2003), concedes that it would be immoral for the church not to help those in need. According to Tirrito (2003), the church is the provider of services for the poor, the elderly, the orphaned and the needy.

A study conducted in Cuba found that the visit by Pope John-Paul to Cuba solidified the role of churches/faith-based organisations (Babun 2001). FBOs are viewed as independent social institutions and as places where people can go for help. To respond to the social needs, faith-based organisations in Cuba conduct neighbourhood humanitarian services, providing transportation, obtaining medical supplies and providing meals (Babun 2001). Therefore, in view of the lack of sufficient welfare support and the current high rate of unemployment, the need to address HIV and AIDS and poverty cannot be overstated.

2.4.4 HIV and AIDS, cultural norms and practices

Male dominance in South Africa aggravates negative attitudes towards the use of male condoms since it reinforces traditional beliefs regarding masculinity. Some of these attitudes place a lot of currency on unprotected, flesh-to-flesh sex with numerous partners (MacPhail & Campbell 2005). Nattrass (2004) indicates that the importance of fertility in most African communities may prevent the practice of safer sex, as some women may feel pressed to fall pregnant before marriage in order to prove their fertility. Under such circumstances, Nattrass (2004) continues, women usually do not use condoms or abstain from sex and thus expose themselves to the risk of HIV infection.

Research has found that the migration of people from other African countries in search of better wages and working conditions, as Nattrass (2004) indicates, often exposes them to HIV infection. Dube (2003) maintains that globalisation also increases job insecurity and mobility, and separates families for long periods of time. As a result, these factors destroy the long-held African values of abstinence and faithfulness to one partner, and expose them to HIV infection. A similar view is shared by Rose-Innes (2006), who believes that the movement of people from rural to urban areas in search of improved living and working conditions, exposes them to a diversity of cultural influences and lead to the

erosion of traditional values such as abstinence from sex before marriage, which could have served as protection against HIV infection.

Cohen (2009) argues that mobile populations, which often consist of large numbers of young men and women, are isolated from traditional cultural and social networks, and the new conditions expose them to and force them to engage in risky sexual behaviours, with obvious consequences in terms of HIV infection. Alsan (2006), in concurring with the preceding scholars, argues that the migrant labour system which separates husbands from wives, making normal family life impossible, exposes men to having sex with sex workers who may be infected with HIV. The disease is then passed on from husband to a presumably innocent wife back home. This situation results in the coexistence of traditional and modern values.

Some of these cultural norms and practices continue to expose people to HIV infection (Rose-Innes 2006). According to Rose-Innes (2006), polygamy, as practised in some parts of Southern Africa, has been cited as one of the key drivers of the AIDS pandemic. This, as Rose-Innes puts it, is condoned by the mistaken belief that men are biologically programmed to need sex with more than one woman.

African practices such as lobola (bride price) contribute to women's cultural vulnerability to HIV and AIDS. A study conducted with women indicate that their husbands often treat them as if they are "*owned"* because the man had paid lobola in order to marry her. This treatment of women by men as property extends to the couple's sexual relationship, with the husband expecting sex on demand, without giving a woman an option to refuse or to negotiate for safer sex (WCC 2003).

Men become angry and suspicious when women request the use of a condom, which results in women feeling unable to insist on its use during intercourse. This

practice significantly increases the risks to women contracting HIV (Haddad 2005). For instance, in KwaZulu-Natal, young girls are subjected to the cultural practice of virginity testing, whereby a young girl is inspected by an older woman to check whether her hymen is intact. This practice, according to Haddad (2005), has led to the practice of anal sex, which carries a far greater risk of contracting HIV than vaginal sex.

The Director of the Ugandan HIV and AIDS Programme, Ruteikara (as cited by Martin 2005), defended the so-called ABC approach (abstinence, being faithful and condom use) to HIV prevention. He asserts that abstinence is nothing new; instead, it is a traditional norm for many people in Africa, where especially females were encouraged to abstain from sexual activities until they were married. Virginity was a virtue held in high esteem by Africans and was a source of pride to the young woman and her parents (Martin 2005).

A study conducted by Luginaah, Yiridoe and Taabazuing (2005) to examine the efforts by some churches in Ghana to reduce the spread of HIV-infections, found that churches that had previously imposed mandatory HIV testing on members planning to marry, had then implemented voluntary testing programmes to help reduce the spread of HIV infection. Again, in response to the call to help mitigate the impacts of HIV and AIDS as opposed to promoting virginity testing, the church, through its biblical teachings, has continued to emphasise abstinence from sexual activity until the parties in love get married. The church has continued to condemn sex outside the bonds of marriage and to view it as going against the ordinances of God.

Loening (1992) states that to advocate sexual abstinence in the face of abject poverty in South African townships is hopeless. However he found that Christian youth camps appear to reduce levels of sexual activity. Preston-Whyte and Zondi (1992) establish that girls who attended churches with active youth groups

tended to be more abstinent, but that they also experienced pressure from boyfriends to engage in sexual activity.

2.4.5 Stigma and discrimination

Stigma, according to Chitando and Gunda (2007), has a close relationship with discrimination, for in most cases stigmatisation becomes the justification for discrimination. In the social context of HIV and AIDS, a stigma is a mark that is attached to certain objects, particularly human beings, which makes them feel less important in their communities because of the stigma attached to HIV and AIDS. Stigmatising means labelling someone as being unworthy of inclusion in the community and often leads to discrimination and ostracism. This is often the daily experience of people living with HIV (Chitando & Gunda 2007).

Hope and Cope (2008) suggest that HIV and AIDS are stigmatised due to the association with “immoral” or “sinful” sexual behaviour such as homosexuality, drug addiction, multiple sexual partners or commercial sex work. Religious or moral beliefs may also lead some people to believe that being infected with HIV is the result of moral transgressions (such as promiscuity or deviant sex).

The WCC (2003:3) suggests that the church has been accused of promoting stigmatising and discriminating attitudes based on fear and prejudice, and of pronouncing harsh moral judgements on those infected by HIV. In 1998 a young woman living with HIV, Gugu Myeni, was invited by the researcher to speak to the members of his church at a convention aiming to promote VCT uptake. Even before she completed her motivational speech, people interrupted her with loud prayers and attempts to cast out demons, because they believed she was under the influence of demonic forces. Some of the church members blamed the researcher for having brought to the conference such a “*sinful*” woman. The religious leaders have fuelled the stigma and discrimination by the way they talk

about HIV and AIDS – for example, saying that AIDS is a punishment from God and that infected people are sick through their own fault (Haddad 2005).

A global consultation on the ecumenical response to the challenge of HIV/AIDS held in Nairobi, Kenya on 25-28 November 2001 marked the beginning of a new era for the church's commitment to engage with the problem of HIV and AIDS. This consultation forum took a resolution that all churches had to take up their responsibility to overcome stigma and discrimination within their own structures, while continuing to be a voice of moral strength that demands that communities, nations and wider society respect the rights and dignity of people living with HIV (WCC 2001)

Maluleke (as cited by Haddad 2005) concedes that now is the time for theologians to establish the theological significance of this moment in the history of humanity in general and the history of Africans in particular, for our current context provides us with both a moment of truth in critical and dangerous times and a moment of grace and opportunity. Maluleke further argues that the church has been given a moment of grace and opportunity to rethink its mission and transform its structures in order to become a place of redemption, hope and healing (Haddad 2005).

2.5 THE POTENTIAL ROLE OF THE CHURCH IN RESPONDING TO HIV AND AIDS

According to Haddad (2005), churches and FBOs are key stakeholders in the response to HIV. The Church and FBOs provide two-thirds of the overall Africa response (ARHAP 2006). The church is viewed as having a moral authority to speak and influence change in people's lives (Haddad 2005). However, the church's response to the challenges posed by HIV and AIDS has been slow and in most cases coupled with judgemental pronouncements which labelled people

living with HIV as evildoers who are suffering the consequences of their sins (WCC 2003).

Worst of all, the church has been unwilling to embrace with a compassionate response those who are infected by HIV, because HIV is traditionally categorised as a sexual disease (Mageto 2005). This situation led to the church being accused of promoting stigmatising and discriminating attitudes towards people living with HIV.

The challenges posed by HIV and AIDS prompted the World Council of Churches to respond to the call for churches to get involved in this crisis, by issuing a Declaration Statement on behalf of the ecumenical churches that *"every person living with HIV should have access to treatments made available by medical science and that churches must advocate for this to happen*" (UNAIDS 2006). Churches and Christians were challenged to promote greater involvement of people living with HIV in churches' response to the pandemic and to adopt inclusive workplace policies for people living with HIV. In the Declaration Statement, the churches acknowledged that by their silence, words and deeds, they had contributed in stigmatising and marginalising people living with HIV (UNAIDS 2006).

The churches were further encouraged to promote open discussions on issues related to sexuality, gender-based violence and drug use. Churches were cautioned to correct their flawed theology and practices that equate the disease with sin, and that put morality over compassion. Churches were implored to make an effort to reach out to their membership to make all churches places of safety for people living with HIV (UNAIDS 2006). Churches were encouraged to become "*competent*" in order to take into account pastoral, cultural and gender issues, and to use its resources and structures in the provision of care, counselling and support for those infected with HIV and affected by HIV and AIDS (UNAIDS 2006). The Roman Catholic Church, the church with the largest following around

the globe, responded to the AIDS pandemic by providing 25 per cent of the care and support which people living with HIV receive across most developing countries (Alsan 2006).

Ndungane, the former Anglican Archbishop of Cape Town, as cited by Pillay (2003:109), delivered a speech at the session of the Diocesan Synod in which he lamented that *"until and unless we begin to measure the pandemic in terms of broken hearts, orphans, fear, loneliness, pain and grief, we will not adequately respond to a disease which is impacting on all of humanity".* In 2007 the then Deputy President of South Africa, Phumzile Mlambo-Ngcuka, in addressing the Roman Catholic Church, appealed to all religious leaders to "*give guidance on issues of morality*" in order to fight the AIDS epidemic (*Mercury,* Monday, 29 January 2007).

Following a resolution adopted in 2004, pertaining to the challenges posed by HIV and AIDS, the United Methodists embarked on programmes providing awareness, support, education and care to those affected by HIV and AIDS. They have achieved this by mobilising their congregations worldwide to be places of openness, where people living with HIV can name their pain and reach out for compassion, understanding, and acceptance in the presence of persons who bear Christ's Name (United Methodists Communications 2008).

To further tease out the role of the church in assisting people infected with HIV and those affected by HIV and AIDS, three interrelated issues are discussed below. These are the role of the church in addressing vulnerability, its role in addressing issues of safety, morality and identity and its role in health care provision. These issues frame theoretical and empirical work on the role of the church and influenced the question items that formed the data-generation instrument for this study.

2.5.1 The role of the church in addressing vulnerability

A study conducted by Nguru (2003) in Kenya found that at times of social, political and spiritual crisis, people look up to the church for guidance. Coetzee, Graaff and Mouton (2001: 486) highlight the historically important role played by non-governmental organisations (NGOs) in organised post-war relief and development work, where a strong church presence was instrumental in uplifting people. Coetzee *et al* (2001:486), citing Boesak, remind us of the role played by NGOs in Latin-American countries and South Africa, where NGOs became important allies in the liberation struggles and in grassroots socioeconomic activities. Churches have shared with many NGOs a similar moral, social, and at times political commitment towards alleviating poverty and human suffering. In South Africa, the National Council of Churches has been at the forefront of confrontation with the apartheid state over issues of human rights (between 1948 and 1994), and the government's policy of segregation and stratification of groups (McGuire 1997:256).

It was the church in the mid-1960s in Birmingham, that played a major role in securing civil rights for all in the United States of America, and it was the church that opposed Apartheid in South Africa (Austin 2008; WCC 2003). Today, it is assumed that the church can still play a leading role in advocating for the rights of people living with HIV. To support this view, Sanita (as cited by Nizigiyimana 2002) concedes that the reason why the church should be actively involved in the battle against HIV and AIDS, is based on the fact that *"historically and traditionally, by its nature and mission, the church is community-centred and service-centred, preaching, teaching and practising love, compassion and care to the disadvantaged and underprivileged in society"*.

De Gruchy and De Gruchy (2004) also admits that the church is known to have pioneered development in most parts of Africa, by means of, among other things, schools, hospitals and skills training centres. The church's role in society as a

social institution must thus be understood in the light of its past involvement in addressing social issues and its partnership with civil society. The church has a capacity for teamwork and has access to group formation (Oloo 2004). According to Kisaalu (2007:10), the church should mobilise the available resources to ensure a holistic response to meet the future challenges of the AIDS pandemic. James (cited by Coetzee *et al* 2001), believes that churches and NGOs may still consider cooperation through the creation of cooperative ventures rather than competing with one another.

A study conducted by Duan, Fox, Derose, Carson and Stockdale (2005), found that churches have a broad, direct reach to people and provide social support, volunteers, communication channels and facilities. They have direct access to subpopulations through their church membership as well as indirectly, through their members' kinship and social networks in the community. Nicolson, (cited by Okyere-Manu 2003:176), found that churches are still widely trusted as reliable sources of education and that they also have infrastructure, e.g. church buildings, which could be used as centres for ministry related to HIV and AIDS. Liebouitz, (cited by Gathigia 2006), suggests that churches demonstrate more commitment to society as compared to other political, social and economic institutions.

2.5.2 The role of the church in addressing safety, identity and morality

Christian churches' area of influence includes directly guiding people on issues of morality, the spiritual bases of disease, Christian identity, rules of family life and sexual activity. In terms of vulnerability Van Dijk (2007:314) differentiates between *"morality*" and *"spiritual safety*" in which the former refers to moral guidance and the latter to ways of addressing vulnerability against stigma, suffering and social insecurity. Taken in conjunction, Van Dijk (2007:315) regards the role of the church in addressing safety, identity and morality as enhancing people's *"capacity to effectuate change in social situations."* A study conducted by Hlongwana and Mkhize (2007) found that some people who are living with HIV

get involved and participate in church activities as a strategy to cope with their HIV-positive status. Such religious activity helps people living with HIV to forge a positive identity as a person living with HIV.

Maluleke (cited by Dumezweni 2004:14), argues that HIV and AIDS are not only ethical issues or merely a pastoral ones, but deeply theological issues. This is because HIV and AIDS raises questions about life and its meaning, people's understanding of church, their concept of God, human interdependence, human frailty, human failure, human sinfulness and community. Maluleke (cited by Dumezweni 2004:14) strongly believes that the church should be at the cutting edge to make a difference in mitigating the socioeconomic impacts of HIV and AIDS.

De Gruchy and De Gruchy (2004), state that the church's role in social development is to proclaim the gospel of freedom and to provide the legitimisation and confidence to break the patterns of power. A study by Rhodes, Hergenrather, Wilkin and Jolly (2008) found that churches, though they have limited resources, offer participants spiritual support, a sense of belonging and of community, and provide physical shelter to the homeless and poverty-stricken.

As indicated by Okyere-Manu (2003:181) HIV and AIDS is *"one disease that has come to test the theology of the church".* HIV and AIDS are giving the church an opportunity to look at its own teachings on sexuality in order to deal effectively with the challenge posed by HIV and AIDS. Gathigia (2006) argues that the church as a transforming agent can help fight HIV and AIDS in various ways, which include among other things, sounding a prophetic voice, advocacy, pastoral care and counselling, capacity building, education and health-care provision that would enhance livelihood strategies which are already in operation. Maluleke, as cited by Dumezweni (2004), argues that the church should be at the cutting edge in mitigating the socio-economic impacts of HIV and AIDS.

2.5.3 The role of the church in health service rendering

Duan *et al* (2005) found that throughout history church organisations have played important roles in the health service delivery domain, developing church-based health programmes that addressed a broad range of health issues such as breast cancer, care-giving for seniors, cholesterol, alcoholism and other social issues such as HIV and AIDS.

According to Fredericks (2008:10), support and care for people living with HIV is a must since people living with HIV have similar experiences as people with other terminal and chronic illnesses. The main difference is that the stigma attached to HIV and AIDS is often characterised by social isolation of and discrimination against those who are infected with HIV (Fredericks 2008). There is a strong presumption that the church, driven by the love of God, can turn the tide and minister compassionately to people living with HIV. The church, through its counselling strategies and HIV and AIDS programmes, has the ability to restore hope to people living with HIV.

Dube, as cited by Fredericks (2008:11), states that if the church takes up the challenge to embody and represent Christ by caring for the sick, the naked, the thirsty, the strangers, it can enable even those who are infected with HIV to die with hope, love and dignity. Home-based care is another strategy that can be used to bring families, friends, the church, medical personnel and other relevant stakeholders together to form a network surrounding the patient. Magezi *et al,* as cited by Fredericks (2008), highlight the contribution that churches can make to ensure that this type of care is accessed by people living with HIV. Fredericks (2008), citing Magezi, calls this type of care a congregational home-based pastoral care which draws on the concepts of *“ubuntu”* and *“koinonia”* (fellowship), which according to the researcher, is a concept long and widely embraced by African people who have lived as communities throughout the ages.

Byansi, (as cited by Fredericks 2008), advocates a strategy of home-based care which mobilises existing structures of small Christian communities. These approaches put the patient and his/her family in the centre. This approach sees families rather than medical personnel as the primary care-givers in sub-Saharan Africa. It is from this vantage point that the church is seen as a caring community in responding to HIV and AIDS.

2.6 CONCLUSION

In this chapter, the roles of FBOs in South Africa were discussed. Those factors that drive the spread of HIV-infections and which fall within the ambit of church-based programmes to address were reviewed. In reviewing these factors, the researcher considered the role of Christian church-based programmes in playing a positive role in behaviour change to address at risk behaviour and to support those infected with HIV and affected by HIV and AIDS.

Also in this chapter, the potential roles of church-based programmes in making an impact on HIV and AIDS were discussed and the material and spiritual roles of such interventions were considered. These insights guided and influenced the study in terms of the methodological decisions taken, the data generated and the conclusions drawn. It was the researcher's contention that a fuller appreciation of the role of church-based HIV and AIDS programmes could be realised by examining this from the vantage point of the perceptions of the key role players (service providers and recipients) in these programmes. The methodological decisions taken to achieve this are discussed in the next chapter.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

In this chapter the researcher details the research method and the process of data collection followed. The aim of the study was to assess the perceptions of people of the role of church-based programmes in addressing HIV and AIDS in the inner-city of Durban.

3.2 DELIMITATION OF THE UNITS OF OBSERVATION

The units of observation for this study were confined to persons involved (as service deliverers, recipients or officials) in Christian church-based HIV and AIDS programmes in the Durban inner-city. Prior to embarking on data-generation, the researcher found that sixteen Christian churches in the inner city of Durban, all who have strong ties to the Diakonia Council of Churches, offered such programmes.

The researcher, as a minister of religion, works closely with the Diakonia Council of Churches and frequently attends various programmes including HIV and AIDS workshops organised by the Diakonia Council of Churches. This made access to the units of observation (programme coordinators, fieldworkers and beneficiaries) easy as the researcher already had a known and accepted role in the field.

The researcher made a conscious decision to gather data from programme coordinators, fieldworkers and beneficiaries rather than from the pastors or ministers of these churches. Four reasons informed this decision:

- Firstly, programme coordinators and fieldworkers interact directly with beneficiaries and therefore tend to know more about the needs of the

beneficiaries and the actual workings of the programme than the pastors/ministers.

- Secondly, due to their active involvement in the programme, these individuals have developed a strong working relationship and trust with people infected with HIV and affected by HIV and AIDS.
- Thirdly, programme coordinators, fieldworkers and beneficiaries are well placed to provide answers to the characteristics, problems and potential of church-driven HIV and AIDS programmes.
- Fourthly, the focus of the study was on how the people directly involved in the programme perceive the role of church-based HIV and AIDS programmes. A theoretical (or even theological) exposition of the possible, ideal or preferred role of such programmes thus fell outside the ambit of this study.

Because there is no available data on the perceptions of people about the church-based HIV and AIDS programmes in Durban, the researcher opted for a survey-type approach. The idea was to gather of baseline data that can provide an overview of the perceptions about the programme and that can be used as reference data for further studies.

3.3 THE RESEARCH DESIGN

To achieve the research objectives as stated in the first chapter, the researcher chose to implement a quantitative, survey-type research design. This was a baseline, descriptive, quantitative study and the intention **was not** to develop hypotheses, test them or test statistical strengths between variables. A survey design was chosen in preference to a qualitative study, because the researcher wanted an overview of the perceptions of various persons about various issues related to the programme at a given moment in time (Babbie & Mouton 2004). In addition, McNamara (1994) suggests that a survey, using a structured questionnaire, is a sound start in **programme evaluation** when the researcher

wants to find out what the people involved in the programme feel, think and know about it. The various subsections of the research design are discussed below.

3.3.1 The study site

The churches where respondents were sampled are situated in the inner-city area of Durban. Permission to conduct the study at 16 churches was sought and granted by the pastors, ministers and directors in charge of these churches.

3.3.2. The data gathering strategy

Developing a data-gathering strategy involved several steps. The first involved getting the names of 16 churches which had church-based HIV and AIDS programmes. The second comprised getting a documentary review of existing programmes within the churches. This information was obtained from programme coordinators who ran the church-based programmes. In addition, the researcher held exploratory discussions with office-bearers at the sixteen churches to secure their approval for the research. This was followed by seeking permission from the church leaders to conduct the study, developing a sampling framework, deciding on a method to gather the data, and planning and developing the data-gathering instrument.

3.3.3 The sampling framework and sampling procedures

In this study the sampling frame consisting of the names of the 16 churches in the Durban inner city with active HIV and AIDS programmes. This list was given to the researcher by the Diakonia Council of Churches which acts as the umbrella body. The initial sampling plan was as follows:

16 programme coordinators (thus 1 at each church),
16 fieldworkers/caregivers (1 at each church)
160 beneficiaries (thus 10 per church)

192 respondents in total

It should be noted that in terms of functions performed in the church-based programmes, there is no distinction between fieldworkers and caregivers. However these two names are used interchangeably by the different church-based programmes. As the study got underway, other ministers and pastors at neighbouring churches started expressing an interest to participate in the study. As a compromise, the researcher, in consultation with the Diakonia Council of Churches, added one more church-based programme to the study. This would have added to the initial sampling design 1 programme coordinator, 1 fieldworker/caregiver and 10 beneficiaries. However, in consultation with the Diakonia Council of Churches, this plan was abandoned as some church-based programmes had larger congregations.

The realised sample thus still included 192 respondents, but comprised:

17 programme coordinators from 17 churches (1 from each participating church)

24 fieldworkers (2 in 7 churches with larger congregations, and 1 from 10 churches with smaller congregations)

151 beneficiaries (10 from 12 churches; 8 from 2 churches and 5 from 3 churches).

3.3.3.1 Sampling the programme coordinators and the fieldworkers/caregivers

All programme coordinators and fieldworkers/caregivers were deliberately included in the sample - thus the actual office-bearers in each of the 17 churches were selected. As has been mentioned above, the permission to conduct research was granted by the pastors and ministers in charge of these churches.

Contact with programme coordinators and fieldworkers/caregivers were facilitated by the respective church ministers. This does not imply that the researcher used a non-probability strategy to include these two categories of respondents. Instead, it means that in terms of the 17 participating churches, the universe of actual office-bearers were included instead of a sample of respondents from these two categories. In terms of this strategy, because each of these two categories of respondents completed the questionnaire, no bias was introduced in the data due to sampling errors.

The researcher made telephone calls to these individuals, explaining the purpose of the study. Informed consent for the participation of the respondents was negotiated. The researcher delivered questionnaires to them during the month of June 2009, and collected the completed questionnaires towards the end of July 2009 (see the data-gathering strategies described below).

3.3.3.2 Sampling the programme beneficiaries

To recruit and sample beneficiaries as respondents in this study, the researcher relied on the help and cooperation of the programme coordinators and fieldworkers/caregivers. These office-bearers announced the study and its aims and scope to the programme recipients (beneficiaries), and asked them to attend a meeting in the church halls (the venues where they usually receive help or services from the church-based programmes) on two given times per week and in some instances, three times per week – depending on the churches' dates and times scheduled for the programmes. Getting the beneficiaries together in such venues on the scheduled dates and times, however, proved problematic due to heavy rainfalls over the period of data gathering and the distances which some of the beneficiaries had to walk to the church halls.

The sub-sample of beneficiaries was therefore recruited from a volunteer sample of beneficiaries who were willing and able to respond to the requests of the

programme coordinators and fieldworkers/caregivers to attend the meeting and be interviewed. The ideal would have been to generate a completely random sample of respondents. Volunteer samples are not necessarily representative of the universe of units from which they are recruited, but in the case of this study the following two considerations played a role:

- Firstly, the researcher did not have access to a list of names of all the beneficiaries of the programmes to use as a sampling frame to randomly select beneficiaries. Such lists are not open to outsiders as the names and addresses of beneficiaries are regarded by the churches as highly confidential, and the disclosure of such information as a serious breach of confidentiality that might damage the relationship of trust between the church and the beneficiaries.
- Secondly, the researcher did not have access to funding to try and visit the beneficiaries at their dwellings in order to recruit respondents. The **consequence** of these sampling decisions is that the results cannot be generalised to all the programmes in the Durban inner-city. **However, it was not the aim of this study to generalise or test hypotheses, but rather to generate a descriptive quantitative study of the perceptions and experiences of the people directly involved with the programmes.**

3.3.4. The data-gathering strategies

The researcher decided that structured questionnaires would be given to the programme coordinators, caregivers and fieldworkers to complete by themselves (self-administered questionnaires). However face-to-face interviews had to be conducted with the beneficiaries using trained and experienced interviewers. The reasons for this decision were two-fold:

- Firstly, programme coordinators and fieldworkers/caregivers tended to have relatively high levels of education and were able to understand and complete the questionnaire independently. By contrast, the levels of

education of the beneficiaries were lower and face-to-face interviews with trained interviewers were therefore more appropriate.

- Secondly, programme coordinators and fieldworkers/caregivers were relatively easy to locate in offices or church premises and were contactable in order to hand out and retrieve the questionnaires. By contrast, the beneficiaries were more mobile and less easy to locate.

3.3.4.1 Self-administered questionnaires for the programme coordinators and fieldworkers/caregivers

The use of self-administered questionnaires had several advantages:

- Firstly, it saved time in the field so that the researcher and his interviewers could carry on with the face-to-face interviews with the beneficiaries.
- Secondly, respondents could answer the questionnaires at their own pace and time without being intimidated by the presence of the researcher.
- Thirdly, the researcher could collect the questionnaires after completion, ensuring a good response rate (in this regard, a 100% return rate on the questionnaires was achieved for the programme coordinators and fieldworker/care-giver sub-samples.

3.3.4.2 Questionnaires completed in the presence of interviewers for the programme beneficiaries

The researcher recruited and trained 15 students from the neighbouring Universities who were on holiday between June and July 2009 as interviewers for the face-to-face interviews with the beneficiaries. Their training included how to obtain consent, how to conduct an interview using a structured questionnaire and how to translate question items from English into isiZulu for those beneficiaries who might have difficulty understanding English. The students rendered their services voluntarily; however, lunch, refreshments and travelling costs were provided by the researcher. The students conducted mock interviews with one

another after the training. In addition, the researcher checked the completed questionnaires with the interviewers after data-collection. In this way, the researcher tried to minimise the risk of inter-observer bias.

During the gathering of the volunteer sample of beneficiaries, the researcher introduced himself and his interviewers to the people, explained the objectives of the study and asked the interviewees to listen to a reading of the informed consent form. Then the interviewees were asked to sign informed consent forms and to sit with each of the interviewers in the hall to complete the questionnaire.

Face-to-face interviews, with one interviewer and one interviewee at a time, were preferred over focus group interviews, as some of the question items were of a personal nature. Due to the structure of the venues, it was possible to conduct a few face-to-face interviews simultaneously without the danger of third parties overhearing what was being said.

3.3.5 The questionnaire: construction and pre-test

Based on a review of the literature (see chapter 2), the researcher developed a structured questionnaire. The original questionnaire had to go through a number of revisions before it was finally accepted by the supervisors. The final version of the questionnaire was pre-tested with the assistance of an experienced senior researcher. The outcome of the pre-test and the discussion were written up as a report which was sent to the supervisors and minor changes were then made to the questionnaire.

The questionnaire comprised nine main questions, each of which dealt with a specific focus area related to the objectives of the study. The questionnaire included both fixed-choice and open-ended questions. The nine question areas culminated in the development of the following sections:

SECTION A: Biographical data of the respondents: In this section the researcher sought to obtain information on the background characteristics of the respondents, e.g. age, ethnicities and gender which may have relevance in this study. The researcher also sought to find out from the respondents whether they knew their HIV statuses, and to whom they would prefer to disclose their HIV statuses if they were diagnosed as positive. The researcher also wanted to find out about the respondents' perceptions of the role that the church can play in HIV and AIDS issues and what the respondents perceived to be the role of the church in HIV- and AIDS-related issues.

SECTION B: Respondents' programmatic data: In this section the researcher wanted to establish what role the respondents played in the church-based programmes, how long the respondents have been involved in the church-based programmes, including the entry requirements into the programme, as well as the respondents' perceptions of the impact of the programme on their lives.

SECTION C: Respondents' level of exposure to the church-based HIV and AIDS programmes: The researcher wanted to obtain information on the respondents' familiarity with the programmes which the church provides, services they benefited from, whether the respondents had attended any workshops and the main reasons for non-attendance of HIV and AIDS awareness workshops if they had not attended them.

SECTION D: Respondents' level of knowledge and understanding of the programmes: The researcher sought to gain a better understanding of whether the respondents had sufficient knowledge and understanding of the myths and facts surrounding HIV and AIDS.

SECTION E: Respondents' perceptions and opinions about HIV-related stigma and discrimination: The researcher sought to obtain information of the respondents' perceptions and opinions on stigma and discrimination, whether

they felt stigma and discrimination hindered people from seeking treatment, and whether they thought resources were sufficient to address the needs of people infected with and/or affected by HIV and AIDS.

SECTION F: Respondents' perceptions and opinions of the role of stakeholders in the battle against HIV and AIDS: The researcher also wanted to find out whether stakeholders, e.g. business, political, and religious leaders, were playing any role in the battle to mitigate the socio-economic impacts of HIV and AIDS.

Section G: Respondents' perceptions and opinions about the challenges faced at the implementation phase of the HIV and AIDS programmes: The researcher wanted to find out whether the respondents had encountered any challenges as a result of the implementation of the programme.

Section H: Respondents' perceptions of the success stories of the programme: The researcher wanted to find out whether the respondents had any success stories which they could share with others as a result of the implementation of the programme, which could be used as a model for best practice.

Section I: Respondents' perceptions and opinions about the changes and improvements needed to enhance the programmes: The researcher wanted to obtain more information on what changes or improvements the respondents thought could be made to enhance the programmes, including any other ideas they might have which could be of benefit to churches that run the programmes or to policy makers.

3.3.6 Data analysis and interpretation

The completed questionnaires (both those completed independently by the programme coordinators and fieldworkers/caregivers and those completed by the interviewers) were checked by the researcher. No questionnaire was discarded as all of them were sufficiently completed to be included in the analysis. A coding list was developed for the open-ended questions. The completed questionnaires were coded, and the codes captured on the computer by the end of July 2009. The data was captured and analysed using the Statistical Programme for Social Scientists (SPSS, version 16), and tabulated by the researcher for report writing.

A system of univariate analysis as described by De Vos (1998) was used to reduce and sort the collected data. Univariate analysis is the examination of cases on only one variable at a time (Babbie & Mouton 2004).The results are displayed in the forms of tables and figures in Chapter 4 of this dissertation. Again, the researcher stresses that the **intent was not to test hypotheses** or the strengths between variables. The goal of the study was **a baseline description of the perceptions of persons of the role of the church-based programme** in addressing problems related to HIV and AIDS in the Durban inner-city. The sampling, data-generation and data-analysis strategies followed in this study, remained consistent with this goal. Whereas a baseline of perceptual data is deemed necessary for the further development of these programmes and as a reference for further research, the researcher is aware of the limitations in terms of generalisation of the findings. These limitations are due to the fact that (1) random sampling was not possible for all categories of respondents as explained above and (2) the data are based on perceptions and not verifiable fact.

3.4 ETHICAL CONSIDERATIONS

According to Smith (1988:283), the integrity of research, whether scientific of humanistic, refers to the extent to which researchers adhere to the standards or rules of scientific research. The standards for conducting research include appropriate methods of collecting and analysing data and generally agreed upon ethical guidelines for collecting, analysing and publicising research.

Ethical considerations for this study included gaining permission to conduct the research from the relevant University, church pastors and ministers, as well as gaining consent from the participants. The pastors and ministers of churches from which permission had been sought to conduct research, were assured that they would be given feedback on the findings of the research after completion. The research participants were also given telephone details to contact either Unisa or the researcher at any time, should they feel like doing so. Because HIV and AIDS are such a sensitive issue, the researcher took great pains to consider and implement the following ethical concerns:

3.4.1 Voluntary, informed consent to participate in the study

Voluntary, informed consent implies that individuals should comprehend what the research is about and what participation in it implies and, based on that knowledge be able to reach a voluntary, thoroughly reasoned decision about their possible participation. It also implies that respondents must be legally and psychologically competent to give consent and they must be aware that they are free to withdraw from the research at any time, should they wish to do so. The purpose of the study and what participation entailed were clearly explained in the consent forms that accompanied the self-administered questionnaires, and were read out to the interviewees prior to the face-to-face interviews. All of the programme coordinators and caregivers/beneficiaries were included in the sample. However, these individuals were not coerced in any way to participate.

Instead, each of them voluntarily participated because they felt that the information gained could benefit not only further programme developments, but also inform further research.

In order to guard against possible coercion, the beneficiaries were recruited as volunteer interviewees and clearly briefed that a decision to not participate in the study or to refuse to answer any question would in no way affect the usual services that they receive from their programmes.

3.4.2 Avoidance of harm

All necessary precautions were taken to ensure that participants did not suffer any spiritual, emotional or physical harm. In this regard, the programme coordinators and fieldworkers/caregivers could answer the questionnaire in their own time, and the interviews with the beneficiaries took place at the church venues where they usually met during business hours.

The question items were pre-tested for sensitivity. Babbie and Mouton (2004) concede that, because participants can be harmed psychologically in the course of an investigation, the researcher must look for the subtlest dangers and guard against them. Therefore, the emotional well-being of the participants took priority.

3.4.3 Confidentiality and anonymity

Confidentiality pertains to the treatment of information that an individual has disclosed in a relationship of trust, with the expectations that such information will not, without permission, be divulged to others in ways that are inconsistent with the understanding of the original disclosure (Babbie & Mouton 2004). The true identities of the programme coordinators and the fieldworkers/caregivers are known to the researcher, but their names and the names of their churches and programmes are not divulged in this dissertation. The signed informed consent

forms were personally collected from each respondent by the researcher and kept in a safe, secure and locked place. The names of the beneficiaries were unknown to the interviewers and not asked in the course of the interview. As anonymity means that the participant remains anonymous throughout the study, even to the researchers themselves, it can be argued that the respondents were not completely anonymous but that strict confidentiality was maintained. The completed questionnaires are kept locked up in the researcher's home. The interviewers were trained in the principles of research ethics by the researcher and asked to sign confidentiality agreements.

3.4.4 Provision of debriefing, counselling and additional information

In addition to constant feedback from participants as they hand in questionnaires, a debriefing session should be held once the fieldwork has been completed. This helps the participants to cope with any negative feelings arising out of their experiences during the survey, especially if they have been exposed to difficult situations of suffering abuse or deprivation (Babbie & Mouton 2001). Participants were provided with a brief background to the study in the accompanying letter of consent. The researcher made sure that the participants were debriefed at the end of each research exercise so that they did not go home in a distressed state. They were also given the contact details of the researcher in case they needed further information at a later stage.

3.5 RELIABILITY AND VALIDITY

In discussing the notions of reliability and validity for this study, cognisance should be taken of the fact that the goal of the study was to generate baseline information on the perceptions of people of the role played by church-based programmes in addressing the problems related to HIV and AIDS. The researcher **did not attempt to generate data that can be generalised** to all church-based programmes. No hypotheses were generated or tested. In addition,

the intent was not to develop composite measures of the role of the church or of church-based programmes via construct analysis. What the researcher set out to measure (and succeeded in measuring) were the **perceptions** of people of the role of church-based HIV and AIDS programmes.

However, the researcher still honoured the canons of scientific research by attending to the principles of rigour and fully documenting the methodological decisions made. Sampling and data-generation decisions were influenced in the field by pragmatic and ethical considerations. These decisions are fully declared and substantiated in this chapter of the dissertation. The researcher is aware of the fact that **sampling error cannot be calculated** in this study as the full population of units for the programme coordinators and the caregivers/fieldworkers was used and a volunteer sample was used for the beneficiaries. Ascertaining the sampling error was not deemed necessary as the researcher **did not attempt to do inferential statistical analysis or to generalise from the sample to the population**.

To generate reliable data, the researcher had to ascertain that the measurement of variables were consistent from respondent to respondent surveyed (Babbie & Mouton 2004). In this regard, the questionnaire was pre-tested, structured and standardised. Interviewers were trained in the application of the instrument and their knowledge tested via mock interviews. The importance of equivalence in the asking of questions and the conducting of the interviews was stressed during the training to minimise inter-observer bias. The researcher personally checked all completed questionnaires.

In terms of validity, the researcher had to adjudicate the extent to which the data-generating instrument measured constructs related to perceptions of the role of church-based HIV and AIDS programmes. In this regard, the question items were generated from a review of literature as reported in Chapter 2 of this dissertation (face validity) and led to the spread of question items as reported on in this chapter (see 3.3.5 above). Moreover, validity claims imply that the data

generated have to be sufficiently accurate and complete to support the conclusions. This issue is addressed in the last chapter of this dissertation.

3.6 CONCLUSION

This chapter is an account of the research design and methodology selected for the study. The reasons for taking certain decisions were given, followed by the description and explanation of the instrument and techniques for data gathering and the strategy for data analysis. Attention was also given as to how the requirements for correct ethical procedure were complied with. In the next chapter the researcher presents and discusses the findings of the study.

CHAPTER 4

PRESENTATION AND DISCUSSION OF THE FINDINGS

4.1 INTRODUCTION

In Chapter 3 the research methods used were outlined. In this chapter the findings based on the analysis derived from conducting the research, are presented and discussed. The aim of this study was to survey the perceptions and opinions of respondents in the Durban inner-city area regarding the role played by church-based HIV and AIDS programmes in addressing the needs of people infected with and affected by HIV and AIDS.

Chapter 4 is structured as follows: In the first section the biographical characteristics of the 192 respondents are discussed and described in the form of univariate percentage distribution tables; the ages, gender, ethnicities of research participants are discussed. This section also covers areas related to knowing one's HIV status, issues related to the fear of disclosure of one's status if diagnosed positive, including perceptions of the respondents about the role of the church in addressing HIV- and AIDS-related issues.

The second section discusses the programmatic data of respondents. These include among other things, designations of respondents in the programme, entry requirements, as well as the impact that the programmes have had on the respondents' lives. The third section discusses the respondents' level of exposure to church-based HIV and AIDS programmes. The fourth section discusses the respondents' level of knowledge and understanding of the programme, e.g. myths and facts about HIV and AIDS. The fifth section discusses the respondents' perceptions and the effects of stigma and discrimination. The sixth section discusses the respondents' perceptions and opinions about the stakeholders' participation in the battle against HIV and AIDS.

The seventh section looks at the respondents' views on the challenges experienced in the implementation stage of the church-based programme. The eighth section discusses the respondents' observations of the success stories as a result of the implementation of the programme. The ninth and final section discusses the respondents' views on the changes and improvements they thought could be made to the church programmes to address stigma and discrimination.

The reader should please note that the discussion of the findings and the tables or graphs that display the applicable data are presented in as close a proximity as possible to one another in this chapter. However, to avoid tables being broken over different pages the text might precede or follow the table or figure in some cases.

4.2 BACKGROUND CHARACTERISTICS OF THE RESPONDENTS

The items comprising the first section of the questionnaire were aimed at obtaining information on the background characteristics of the respondents. People engaged in programmes operating within the church institutions, as well as those who benefit from the programmes, are concentrated in the younger age groups, as 62,5% of the respondents were 34 years and younger (see Table 4.1 below).

According to Table 4.1, the majority of the respondents (79,5%) who benefited from the programmes were Africans. Just over two-fifths of programme coordinators (41,2%) were Africans, while Whites (24%) and Coloureds (23%) comprised almost a quarter each and Indians constituted just over a tenth (12%).

Table 4.1 shows that the majority of the fieldworkers were Africans (83%), followed by Whites (17%). Almost three-quarters of the respondents (63%) were female, and this overrepresentation of females also occurred in all subcategories

surveyed. What these findings translate into is that the most affected people in the Durban inner-city area are females, at the age of 34 years and younger.

TABLE 4.1: SELECTION BACKGROUND CHARACTERISTICS OF THE RESPONDENTS (N=192)

	All respondents	Programme coordinators	Fieldworkers / caregivers	Beneficiaries
Number of cases	**192**	**17**	**24**	**151**
	%	%	%	%
Age group				
20 – 24	35,4	11,7	29,2	37,7
25 – 29	14,6	5,9	12,5	15,9
30 – 34	12,5	17,6	8,3	12,6
35 – 39	9,4	11,8	12,5	8,6
40 – 44	12,0	29,4	12,5	9,9
45 – 49	3,6	5,9	0,0	4,0
50 – 54	5,2	11,8	12,5	3,3
55 – 59	3,6	0,0	4,2	4,0
60+	3,7	5,9	8,3	4,0
Total	100,0	100,0	100,0	100,0
Race				
African	76,6	41,2	83,3	79,5
White	7,3	23,5	16,7	4,0
Coloured	8,7	23,5	0,0	7,9
Indian	7,4	11,8	0,0	8,6
Total	100,0	100,0	100,0	100,0
Gender				
Female	63,0	82,4	87,5	57,0
Male	37,0	17,6	12,5	43,0
Total	100,0	100,0	100,0	100,0

4.3 RESPONDENTS' KNOWLEDGE OF THEIR OWN HIV STATUS AND PERCEPTIONS OF HIV-TESTING AND DISCLOSURE

The researcher sought to determine whether people attached to the church-based programme knew their own HIV status. Table 4.2 (below) shows that just more than half of all the respondents (57%) knew their own HIV status. Almost all of the programme coordinators (94%) knew their own HIV status; 75% of the

fieldworkers knew and half of the beneficiaries indicated that they had been tested for HIV and knew their test results.

TABLE 4.2: WHETHER THE RESPONDENTS KNOW THEIR HIV STATUS (N=192)

Do you know your status?	All respondents	Programme coordinators	Fieldworkers / caregivers	Beneficiaries
Number of cases	**192**	**17**	**24**	**151**
	%	**%**	**%**	**%**
Yes	56,8	94,1	75,0	49,7
No	43,2	5,9	25,0	50,3
Total	100,0	100,0	100,0	100,0

Respondents who had never been tested for HIV were asked to respond to a list of common fears about testing, and to indicate whether any of these items might influence them to fear a possibly positive HIV test result. The results are shown in Table 4.3 below.

The item that received the largest proportion of “do not know” responses was the one that asked whether those respondents who did not know their status feared that their families might disown them if they ever tested positive for HIV (see Table 4.3). Almost half of the respondents feared that their family would disown them (44,6%) or their partners would leave them (49,4%) if they tested HIV positive.

Table 4.3 (below) shows that the items that received the most positive answers were those related to stigma and discrimination, as 81% of the respondents who did not know their status felt that being the target of HIV-related stigma was something that they feared most. In addition, almost 80% of the respondents who had never been tested indicated that their friends might discriminate against them should they test positive for HIV. It thus seems clear that fear of stigma and discrimination is still a problem for many people in the Durban inner-city area, and that the church still has to work hard to address stigmatising attitudes and fears about testing and disclosure. The problem of stigma and discrimination and

the role of church-based programmes in this regard are discussed in the literature review under sub-heading 2.4.5.

TABLE 4.3: PERCEPTIONS OF POSSIBLE CONSEQUENCES OF A POSITIVE HIV-TEST RESULT AMONG RESPONDENTS WHO HAD NEVER BEEN TESTED (N =83)

My family will disown me (%)		
	Yes	44,6
	No	34,9
	Don't know	20,5
	Total	100,0
I would lose financial support from my partner/spouse (%)		
	Yes	31,3
	No	57,8
	Don't know	10,9
	Total	100,0
My partner/spouse will leave (%)		
	Yes	49,4
	No	39,8
	Don't know	10,8
	Total	100,0
I might lose my job (%)		
	Yes	41,0
	No	49,4
	Don't know	9,6
	Total	100,0
I would be stigmatised (%)		
	Yes	80,7
	No	13,3
	Don't know	6,0
	Total	100,0
My friends would discriminate against me (%)		
	Yes	79,6
	No	9,6
	Don't know	10,8
	Total	100,0
I would be blamed as the infective partner/cause of the infection (%)		
	Yes	56,6
	No	39,8
	Don't know	3,6
	Total	100,0

The item that received the largest proportion of "yes" responses in Table 4.3 (above) is the fear that individuals would be blamed for the infection by an intimate partner or spouse, and 57% of the respondents who did not know their status thought that this would happen if they ever tested positive for HIV. The item that received the largest proportion of "no" responses was the one that

asked whether those respondents who did not know their status, feared that they might lose financial support from a partner or spouse should they ever test positive for HIV.

TABLE 4.4: PEOPLE TO WHOM RESPONDENTS WOULD DISCLOSE THEIR HIV STATUS AMONG THOSE RESPONDENTS WHO HAD NOT YET BEEN TESTED (N=83)

		%
Priest (%)		
	Yes	44,6
	No	48,2
	Don't know	7,2
	Total	100,0
Spouse or partner (%)		
	Yes	31,3
	No	62,7
	Don't know	6,0
	Total	100,0
Parents or adult family members (%)		
	Yes	39,8
	No	54,2
	Don't know	6,0
	Total	100,0
Children (%)		
	Yes	21,7
	No	74,7
	Don't know	3,6
	Total	100,0
Friends (%)		
	Yes	15,7
	No	78,3
	Don't know	6,0
	Total	100,0
Health care workers, doctors, nurses (%)		
	Yes	48,2
	No	47,0
	Don't know	4,8
	Total	100,0
Traditional healer (%)		
	Yes	15,7
	No	67,5
	Don't know	16,8
	Total	100,0

Table 4.4 (above) shows the results of the question item which sought to find out from the respondents (who have not yet tested) who they would disclose their status to if they were to test positive. Priests (45%) and health care workers

(48%) were the groups that received the highest proportion of affirmative answers as people whom the respondents were likely to disclose their HIV status to. A shockingly large proportion of respondents (63%) who did not know their status, would not tell their partners or spouses, should they ever test HIV-positive. Such attitudes are dangerous as non-disclosure to a partner or spouse puts them at risk of infection. Large proportions of respondents who did not know their status also did not regard children (75%), friends (78%) or traditional healers (68%) as people whom they were likely to disclose an HIV-positive diagnosis to.

4.4 RESPONDENTS' PERCEPTIONS OF WHAT THE ROLE OF THE CHURCH IS IN ADDRESSING HIV AND AIDS

Three question items tested the views of the respondents regarding what they thought the role of the church was in addressing HIV and AIDS. The first was whether they thought that the church had a role to play in this regard whatsoever; the second item was to test among those who felt that the church had a role to play, what they thought the role should be; and the third item was to test among those who felt that the church had no role in this regard, why they felt that way. The responses to these questions are shown in Tables 4.5 and 4.6 below.

TABLE 4.5: RESPONDENTS' VIEWS ON WHETHER THE CHURCH HAS A ROLE TO PLAY IN HIV AND AIDS (N=192)

	All respondents	Programme coordinators	Field-workers / caregivers	Beneficiaries
Number of cases	**192**	**17**	**24**	**151**
	%	**%**	**%**	**%**
Yes	90,1	100,0	96,0	88,0
No	9,9	0,0	4,0	12,0
Total	100,0	100,0	100,0	100,0

As shown in Table 4.5 (above), the majority of the respondents (90%) felt that the church **had a role to play** in addressing HIV and AIDS issues. As can be expected, all of the programme coordinators also held this view. However, 12% of the beneficiaries felt that the church had no role to play in this regard. Possible

reasons for this might be that the beneficiaries felt that because the church did not provide direct medical help; the church cannot provide a cure for HIV. Also, there might be a possibility that beneficiaries did not have inside information on what the church did or could do around the issues of HIV and AIDS, or it may be that they viewed the church as a dispenser of alms only to the needy and not capacitated enough to go beyond their scope of ministry.

TABLE 4.6: RESPONDENTS' VIEWS ON WHAT THE ROLE OF THE CHURCH IN HIV AND AIDS SHOULD BE (N =173)

		%
Pray for people to uplift their spirit		23,1
Put in place HIV and AIDS programmes for support		16,2
Raise awareness / advocacy		15,0
Embrace people living with HIV and people affected by HIV and AIDS with love		11,6
Provide psychological support		9,8
Give material support		6,4
Have support groups		5,2
Provide health education		3,5
Create job opportunities for the needy		2,6
Ensure adherence to medication		1,2
Encourage people to test for HIV		1,2
Ensure confidentiality		0,6
Work with doctors		0,6
Approach the government for help		0,6
Train lay health care workers		0,6
Provide intensive training to counsellors to equip them with required skills		0,6
Teach their followers not to discriminate		0,6
Provide equipment		0,6
	Total	100,0

As shown in Table 4.6 (above), among the 173 respondents who felt that the church had a role to play, the majority (23%) listed the spiritual responsibility of the church to pray for people. A smaller proportion of respondents (16%) said that churches had put together educational programmes for support to the vulnerable and needy. Spiritual support in the form of prayer (23%), putting in place HIV and AIDS programmes (16%), advocacy (15%), psychological support (10%), and material support (6%), were among the top priority areas expressed by respondents in which they believed the church could play a crucial role in dealing with HIV. This finding resonates with the arguments made by Maluleke (cited by Dumezweni 2004) and discussed under sub-heading 2.5.2 in Chapter 2

regarding the role of the church and church-based programmes in the spiritual upliftment of people.

4.5 TIME INVOLVED IN THE PROGRAMME AND KNOWLEDGE OF PROGRAMME FEATURES

Nine per cent of the respondents in this study were programme coordinators, 13% were fieldworkers or caregivers active in the church-based programme, and 79% were beneficiaries of the programme. According to Table 4.7 (below), more than four-fifths of the respondents (88,1%) had been engaged in the programmes for five years or less. A salient finding is that 40,2% of all respondents (192) spent up to one year in the programme.

TABLE 4.7: TIME SPENT IN THE PROGRAMME (N=192)

	All respondents	Programme co-ordinators	Field-workers / caregivers	Beneficiaries
Number of cases	**192**	**17**	**24**	**151**
	%	**%**	**%**	**%**
0 – 1 year	40,2	5,9	54,1	41,7
2 – 3 years	32,3	0,0	29,1	36,4
4 – 5 years	15,6	47,1	8,1	13,2
6 – 7 years	6,2	11,8	4,5	6,0
8 – 10 years	3,1	23,4	4,2	0,7
More than 10 years	2,6	11,8	0,0	2,0
Total	100,0	100,0	100,0	100,0

However, the majority of the programme coordinators (94,1%) appeared to have served in these programmes for more than four years, as opposed to caregivers (16,8%) and beneficiaries (21,9%). In some instances, programme coordinators are the core founders of the programmes and can appoint themselves as coordinators to minimise expenses and enjoy ownership of the programmes. In the case where coordinators are employed, their conditions of employment are accompanied by good remuneration and benefits which attract them and retain them to serve longer. Also, they are equipped with relevant skills and have better qualifications which put them in good standing, entrusted with such

responsibilities. Their conditions of employment differ widely from those of fieldworkers, and they are employed in long-term contracts if not permanent positions, as their long terms of service attest to.

In contrast, fieldworkers / caregivers are employed on a short-term basis and there are no guarantees that their jobs are secured; their contracts can be terminated with immediate effect, which denies them job security. As a result, they search for better jobs with better remuneration and better working conditions while engaged in current jobs. What this means for this study is that poverty and job insecurity encourage mobility as people keep on moving in search of better working conditions and better salaries.

Participants were asked to state the requirements for someone to be admitted to the church-based programmes. Results are presented in Figure 4.1 (below).

Figure 4.1 (below) shows that the majority of all the respondents (93%) stated that a person had to be impoverished or destitute to be admitted to the programmes. This view was also shared by the majority of the beneficiaries. This role of the church and church-based programmes is discussed under sub-heading 2.4.3 in Chapter 2 of this dissertation. Just over a quarter of all the respondents (27%) said that only terminally ill people could be enrolled in the programmes.

It is interesting to note that the fieldworkers stressed entrance requirements such as a passion for working with children (22%), good counselling skills (17%), and good communication skills (17%). Programme coordinators also mentioned a passion for working with people living with HIV or affected by HIV and AIDS (25%).

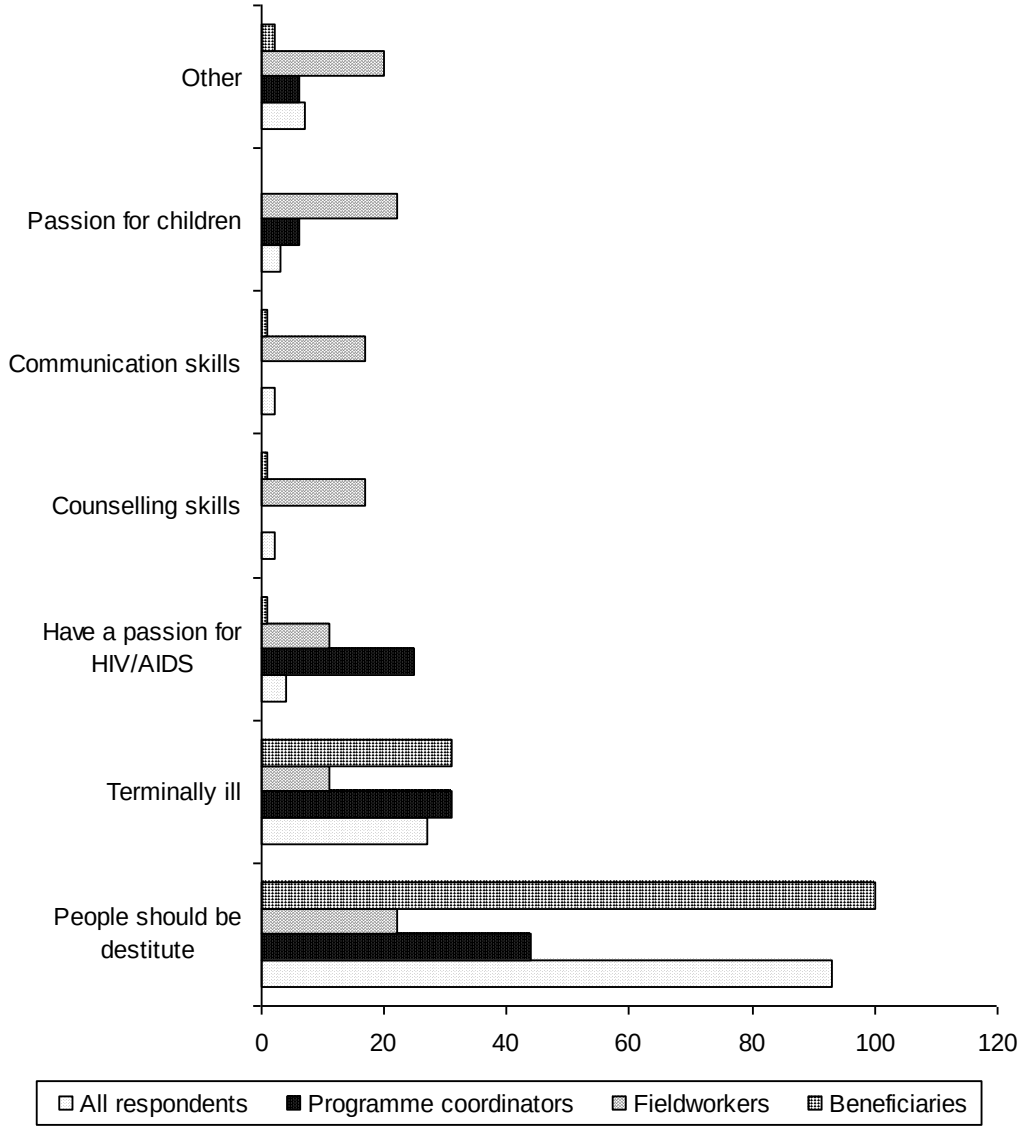

FIGURE 4.1: PERCEPTIONS OF THE REQUIREMENTS FOR ENTRANCE TO THE PROGRAMME (N=192)

4.6 RESPONDENTS' PERCEPTIONS OF THE IMPACT OF CHURCH-BASED PROGRAMMES ON THEIR LIVES

The respondents were asked to rate the impact that the programmes had on them. As shown in Figure 4.2 (below), the majority of the respondents (92%) indicated that the programmes had had a positive impact on their lives.

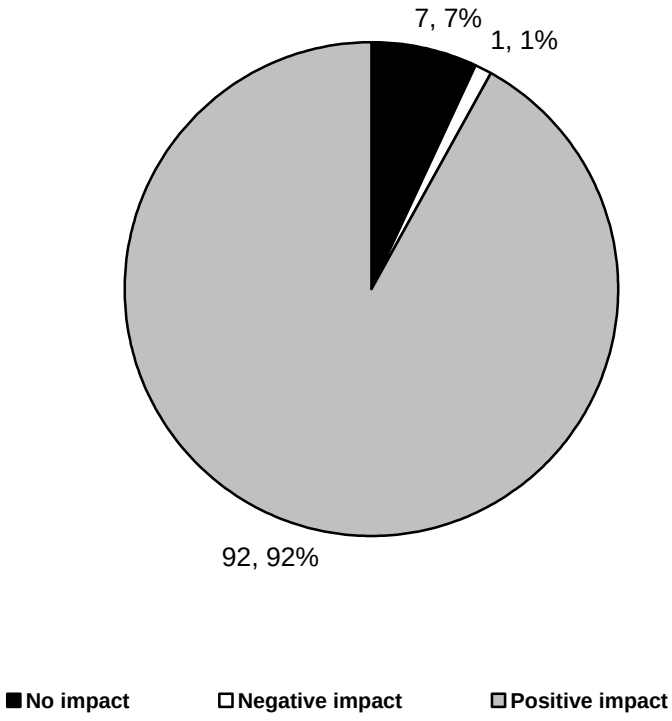

FIGURE 4.2: PERCEPTIONS OF THE IMPACT OF THE PROGRAMME ON THE RESPONDENTS' LIVES

Although that data is not displayed in a table or a graph here, the questionnaire elicited responses from respondents on the reasons for their perceptions of the impact of the church-based programmes on their lives. Because most of the

respondents indicated that the programme had a positive impact on their lives, the researcher will only comment on the reasons put forward by these respondents. These open-ended responses listed material support such as shelter, clothes or food as the chief reason why they felt positive about the programme's impact on their lives. Such a finding is in line with the findings by the Study of FBOs (2006) and Yates (2003) as reported earlier on in this dissertation. Many respondents also mentioned the role played by church-based programmes in skills gained, spiritual support and educational support.

The respondents were asked to indicate whether the church-based programme offered services such as shelters, food parcels, voluntary testing and counselling, antiretroviral therapy or bereavement counselling. The responses to these question items are shown in Table 4.8 (below). More than half of the respondents (52,6%) affirmed that church-based programmes provided shelter in respect of those living with HIV and AIDS. Fieldworkers (62,5%) and beneficiaries (51,7%) acknowledged that shelter was provided to the needy. Just over nine tenths of the respondents (92,2%) knew that people infected with HIV and made vulnerable by HIV and AIDS received food parcels from the church-based programmes.

As shown in Table 4.8 (below), slightly over half of the interviewees (52,1%) agreed that church-based programmes provided voluntary counselling and testing. Most programme coordinators (82,4%) appeared to be knowledgeable about voluntary counselling and testing as the service offered by the church-based programmes. More than half of the participants (53,1%) said that antiretroviral therapy was not offered by church-based programmes. More than half of all respondents (59,1%) knew that church-based programmes provide bereavement counselling.

TABLE 4.8: KNOWLEDGE OF THE TYPES OF SERVICES OFFERED BY THE CHURCH-BASED PROGRAMMES (N=192)

	All respondents	Programme coordinators	Fieldworkers / caregivers	Beneficiaries
Number of cases	**192**	**17**	**24**	**151**
	%	**%**	**%**	**%**
Provides shelter				
Yes	52,6	47,1	62,5	51,7
No	43,8	52,9	29,2	45,0
Don't know	3,6	0,0	8,3	3,3
Total	100,0	100,0	100,0	100,0
Hands out food parcels				
Yes	92,2	100,0	87,5	92,0
No	5,7	0,0	8,3	6,0
Don't know	2,1	0,0	4,2	2,0
Total	100,0	100,0	100,0	100,0
Voluntary counselling and testing (VCT)				
Yes	52,1	82,4	45,8	49,6
No	42,2	17,6	33,3	46,4
Don't know	5,7	0,0	20,9	4,0
Total	100,0	100,0	100,0	100,0
Antiretroviral therapy (ART)				
Yes	40,1	58,8	33,3	39,1
No	53,1	41,2	41,7	56,3
Don't know	6,8	0,0	25,0	4,6
Total	100,0	100,0	100,0	100,0
Bereavement counselling				
Yes	59,4	82,4	45,8	58,9
No	33,3	17,6	16,7	37,8
Don't know	7,3	0,0	37,5	3,3
Total	100,0	100,0	100,0	100,0

4.7 SERVICES WHICH RESPONDENTS BENEFITED FROM

This researcher wanted to find out which types of church-based programme services respondents felt that they benefited from. The responses to these questions are shown in Table 4.9 (below). Almost half of all the respondents (49,1%) agreed that they benefited from the shelter provided by the church, whereas 54,3 % of all beneficiaries said that they received shelter via the church-based programme. A high number of respondents benefit from food parcels

provided by the church, particularly beneficiaries (92,1%) and fieldworkers (66,6%).

TABLE 4.9: RESPONSES TO THE QUESTION "WHICH OF THE FOLLOWING SERVICES DO YOU BENEFIT FROM?"(N=192)

	All respondents	Programme coordinators	Fieldworkers / caregivers	Beneficiaries
Number of cases	**192**	**17**	**24**	**151**
	%	**%**	**%**	**%**
Shelter is provided				
Yes	49,6	17,6	41,5	54,3
No	49,8	82,4	54,0	45,7
Don't know	0,6	0,0	4,5	0,0
Total	100,0	100,0	100,0	100,0
Food parcels are distributed				
Yes	85,0	47,1	66,6	92,1
No	14,0	52,9	29,2	7,9
Don't know	1,0	0,0	4,2	0,0
Total	100,0	100,0	100,0	100,0
Voluntary counselling and testing (VCT) is offered				
Yes	33,1	23,5	29,2	35,8
No	66,2	76,5	66,6	64,2
Don't know	0,7	0,0	4,2	0,0
Total	100,0	100,0	100,0	100,0
Antiretroviral therapy (ART) is offered				
Yes	18,1	5,9	8,3	21,9
No	81,1	94,1	87,5	78,1
Don't know	0,8	0,0	4,2	0,0
Total	100,0	100,0	100,0	100,0
Bereavement counselling is offered				
Yes	51,4	17,6	33,3	57,7
No	45,3	82,4	62,5	39,7
Don't know	3,3	0,0	4,2	2,6
Total	100,0	100,0	100,0	100,0

The responses in Table 4.9 (above) show that smaller proportions of respondents indicated that they access VCT and ART via the church-based programmes. Only 23,5% and 5,9% of programme coordinators; 29,2% and 8.3% of the caregivers and 35,8% and 21,9% of the beneficiaries benefit from VCT and ART offered via church-based programmes respectively. However, the response in terms of bereavement counselling, show that 57,7% of the beneficiaries access this type of service from church-based programmes. In terms of the findings as shown in Table 4.9 (above), the material support (shelter and food parcels) and

spiritual support (bereavement counselling) offered by the church-based programmes were accessed by substantial proportions of the respondents.

4.8 RESPONDENTS' LEVEL OF EXPOSURE AND KNOWLEDGE OF HIV AND AIDS PROGRAMMES

Question 13 in the questionnaire sought to determine how much the respondents knew about church-driven HIV and AIDS programmes. Respondents were presented with a number of knowledge-based statements about church-based programmes, and asked to indicate whether they agreed or disagreed with each statement. Table 4.10 (below) reflects the responses to these statements.

TABLE 4.10: KNOWLEDGE ABOUT HIV/AIDS PROGRAMMES (N=192)

	All respondents	Programme coordinators	Fieldworkers / caregivers	Beneficiaries
Number of cases	**192**	**17**	**24**	**151**
	%	**%**	**%**	**%**
Statement: *I know the church-based HIV and AIDS programme very well*				
Strongly agree	26,6	82,4	33,3	19,2
Agree	28,6	17,6	12,5	32,5
Disagree	19,3	0,0	25,0	20,5
Strongly disagree	13,5	0,0	25,0	13,2
Don't know	12,0	0,0	4,2	14,6
Total	100,0	100,0	100,0	100,0
Statement: *I know some of the details of the church-based HIV and AIDS programme, but would like to know more about i*t				
Strongly agree	29,7	0,0	20,8	34,4
Agree	39,1	23,5	45,9	39,8
Disagree	12,0	47,1	8,3	8,6
Strongly disagree	10,9	29,4	20,8	7,3
Don't know	8,3	0,0	4,2	9,9
Total	100,0	100,0	100,0	100,0
Statement: *I'm not familiar with the church-based HIV and AIDS programme and do not wish to know more about it*				
Strongly agree	4,2	0,0	4,2	4,6
Agree	13,0	0,0	12,5	14,6
Disagree	42,7	52,9	33,3	43,0
Strongly disagree	31,3	47,1	45,8	27,2
Don't know	8,8	0,0	4,2	10,6
Total	100,0	100,0	100,0	100,0

As shown in Table 4.10 (above), slightly more than half (55,2%) of all respondents indicated that they knew the church-based HIV and AIDS programme well, particularly programme coordinators (100%) and beneficiaries (51,7%). More than half of the fieldworkers (54,2%) did not feel that they knew the church programme well. More than half (68,8%) of all respondents agreed and strongly agreed with the statement that they knew some of the details of the church-based HIV and AIDS programme, but wished to know more.

All of the respondents' attendance of HIV and AIDS awareness campaigns offered by the church-based programmes was tested. In this regard, the reader should keep in mind that even the programme directors and fieldworkers might not have attended these workshops, but rather HIV and AIDS awareness programmes offered elsewhere. This is the reason for the inclusion of all the respondents in the analysis of these variables pertaining to attendance of awareness campaigns. Again, such data is needed for a baseline survey of what is happening in terms of church-based programmes.

Table 4.11 (below) shows that only 44,4% of all the respondents attended such workshops. Moreover, only 39,1% of the beneficiaries attended workshops. However, more than four-fifths of the programme coordinators (82,4%) attended HIV and AIDS workshops offered by the church-based programme. This is a significant finding and warrants further investigation as the knowledge and perceptions of the role of the HIV and AIDS church-based programmes seem to be bifurcated in terms of material and spiritual support as emphasised by the beneficiaries and awareness creation, education, material and spiritual support as emphasised by the programme coordinators. Whereas the researcher views these findings with circumspection given the shortcomings in the sampling (see Chapter 3) and the fact that this is perceptual data, this seems to point to an avenue for further discussion and fact-finding. If the church-based programmes are to move beyond a reaction to HIV and AIDS (by offering support for those infected with HIV and affected by HIV and AIDS) to prevention work via

education, then a broadening of the role of these programmes so that all can benefit from awareness creation is needed.

TABLE 4.11: ATTENDANCE OF HIV AND AIDS AWARENESS WORKSHOPS

"Have you attended HIV and AIDS workshops or awareness campaigns offered by the church-based programme?"				
	All respondents	**Programme coordinators**	**Field-workers / caregivers**	**Beneficiaries**
Number of cases	**192**	**17**	**24**	**151**
	%	**%**	**%**	**%**
Yes	44,3	82,4	50,0	39,1
No	55,7	17,6	50,0	60,9
Total	100,0	100,0	100,0	100,0
"If yes, how many of these sessions (HIV and AIDS workshops or awareness campaigns) have you attended in the last 12 months?"				
Number of cases	**85**	**14**	**12**	**59**
	%	**%**	**%**	**%**
1 session	49,4	0,0	50,0	61,0
2 sessions	18,8	0,0	16,6	23,7
3 sessions	9,4	14,3	16,7	6,8
4 or more sessions	22,4	85,7	16,7	8,5
Total	100,0	100,0	100,0	100,0
"If NO, please tell the main reasons why you have not attended any HIV and AIDS workshops or awareness campaigns in the last 12 months?"				
Number of cases	**107**	**3***	**12**	**92**
	%	**%**	**%**	**%**
Don't know any of the programmes	47,7	*	50,0	47,8
I was never invited	16,8	*	8,3	17,4
Never avail myself	9,3	*	25,0	8,7
I'm scared to participate	6,5	*	8,3	6,5
Don't like workshops	12,1	*	0,0	14,1
Only interested in getting food	3,7	*	0,0	3,3
Other	13,2	*	8,4	2,2
Total	100,0	*	100,0	100,0

* *Number of cases too small to analyse.*

As shown in Table 4.11 (above), just more than half of all interviewees (50,6%) had attended more than one HIV and AIDS awareness session in a period of one year, with 85,7% of all programme coordinators attending 4 or more sessions per annum. Again, the relative benefit in the educational role of the church-based programmes for the coordinators can be seen in this finding.

As shown in Table 4.11 (above), just below half of all the respondents (47,7%) who did not attend any awareness campaigns quoted the lack of knowledge that such workshops are offered as the reason for their non-attendance. Others mentioned that they disliked workshops (14,1% of the beneficiaries) or that they have never been invited (fieldworkers 8,3% and beneficiaries 17,4%). Read in conjunction with the above-mentioned findings on workshop attendance, the researcher wishes to recommend to the churches that the recruitment of workshop attendees across the widest spectrum of role players in the church-based programmes be investigated. Also, alternative formats should be explored for those people who are intimidated by the workshop-format.

TABLE 4.12: LEVEL OF UNDERSTANDING OF MYTHS AND FACTS ABOUT THE DISEASE (N=192)

	All respondents	Programme coordinators	Fieldworkers / caregivers	Beneficiaries
Statement: People on antiretroviral treatment die sooner than those not taking them				
	192	**17**	**24**	**151**
	%	**%**	**%**	**%**
True	6,3	0,0	0,0	7,9
False	69,7	94,1	95,8	62,9
Don't know	24,0	5,9	4,2	29,2
Total	100,0	100,0	100,0	100,0
Statement: An HIV-infected person cannot transmit the virus when taking antiretroviral treatment				
True	12,0	5,9	4,2	13,9
False	66,1	88,2	87,5	60,3
Don't know	21,9	5,9	8,3	25,8
Total	100,0	100,0	100,0	100,0
Statement: Antiretroviral treatment reduces the quantity of the HIV virus in the person's body				
True	65,7	88,2	62,5	63,6
False	10,9	5,9	20,8	9,9
Don't know	23,4	5,9	16,7	26,5
Total	100,0	100,0	100,0	100,0
Statement: Having sex with a virgin can cure HIV and AIDS				
True	7,3	0,0	0,0	9,3
False	83,3	100,0	95,8	79,5
Don't know	9,4	0,0	4,2	11,2
Total	100,0	100,0	100,0	100,0
Statement: A person can be infected with HIV and still live a long and healthy and productive life				
True	67,2	94,1	75,0	62,9
False	11,5	0,0	8,3	13,3

Don't know	21,3	5,9	16,7	23,8
Total	100,0	100,0	100,0	100,0

Table 4.12 continued

	All respondents	Programme coordinators	Fieldworkers / caregivers	Beneficiaries
Statement: The church-based HIV and AIDS programme increased my knowledge of HIV and AIDS				
True	61,5	94,1	66,7	57,0
False	21,3	0,0	8,3	25,8
Don't know	17,2	5,9	25,0	17,2
Total	100,0	100,0	100,0	100,0

Question 15 in the questionnaire (see appendix B) asked respondents to consider statements about facts and myths about HIV and AIDS and to then indicate whether these are true or false. The results are shown in Table 4.12 above. Overall, the levels of knowledge were quite high over all categories of respondents with the programme coordinators demonstrating the best insights. Given that these coordinators attended so many HIV and AIDS awareness programmes, this finding was expected.

Also shown in Table 4.12 (above), 66,1% of the respondents knew that the statement that an HIV-infected person cannot transmit the virus when taking antiretroviral treatment was false. However, 21,9% of all the respondents did not know whether it was true or false and this should be of some concern for programme coordinators as people should have the correct information about the possibilities of HIV-infection to curb further new infections or re-infections with different strains of the virus. All people should be informed that antiretroviral drugs cannot keep an HIV-infected person from passing the virus to others. Whereas ART can keep the HI-viral load down to undetectable levels, HIV is still present in the infected person's body and can still be transmitted to others. This information should be shared and especially with serodiscordant couples. The reader is reminded that the data as reported in this chapter pointed to a trend in which the beneficiaries regarded the chief roles of the church-based programmes to be those related to material (shelter and food) and spiritual (bereavement counselling). Education and awareness was not emphasised by the beneficiaries,

yet they seem to be the group to demonstrate lower levels of clear, up-to-date knowledge of HIV and ART.

In Table 4.12 it is shown that 65,7% of all respondents knew that the statement claiming that antiretroviral treatment reduces the quality of the HI-virus in the person's body was true. However, more than a quarter of the beneficiaries (26.5%) were tentative about the question.

Table 4.12 (above) shows that whereas all of the programme coordinators knew that the statement that having sex with a virgin can cure HIV and AIDS was untrue, 4,2% of the caregivers and 11,2% of the beneficiaries were uncertain whether this was true whereas 9,3% of the beneficiaries though that this statement was true. Even if these percentages are small, it still points to a number of people who are not correctly informed about such issues. In section 2.4.2 of this dissertation, the researcher argued from the review of the literature that such myths and misconceptions present important barriers to the possible preventive role that the church-based programmes can play as far as HIV and AIDS are concerned.

In Table 4.12 (above) it can be seen that 67,2% of all respondents regarded the statement that a person can be infected with HIV and still live a long, healthy and productive life as true. Moreover, about three-fifths of the participants (61,5%) agreed with the statement that they had gained knowledge about the disease from HIV and AIDS programmes. However, the fact that just more than a quarter (25,8%) of the beneficiaries indicated that the disagreed with this statement warrants further investigation. Again, this seems to suggest that as far as the beneficiaries are concerned, the church-based programmes can play a bigger role in educating people about HIV and AIDS.

4.9 RESPONDENTS' PERCEPTIONS OF HIV DISCLOSURE, STIGMA AND DISCRIMINATION

Table 4.13 (below) shows that almost three-fifths of the respondents (55,7%) said that they knew people who had regretted their decisions to disclose their HIV status. This shows that the fear stigma and discrimination (that can intensify when a person discloses an HIV-positive status) is still a matter to contend with.

TABLE 4.13: KNOWLEDGE ABOUT A PERSON WHO HAS REGRETTED THEIR DECISION TO DISCLOSE THEIR HIV STATUS (N=192)

Number of cases	**192**
	%
Yes	55,7
No	44,3
Total	100,0

To further explore the theme of disclosure within the context of the church or church-based programmes, respondents were asked (in Question 17 of the questionnaire –see appendix B) to indicate what their opinions were about someone disclosing to a church leader. As shown in Table 4.14 (below), the responses seem to indicate that the research participants have faith in their church leaders as 65,6% felt that church members should inform their leaders about their status. Some of the main reasons mentioned by respondents who felt that such disclosure would be a positive step were that a church leader could spiritual (42%) and psychological (35,3%) support. Another positive consequence identified was that church leaders could introduce people to educational programmes (8,7% of all respondents and 20% of the programme coordinators).

Despite the fact that almost two thirds of the respondents were in favour of revealing an HIV-positive status to a church leader, one third of all respondents felt that it was not an ideal decision to take. As shown in Table 4.14 (below), those respondents who felt that way quoted a fear of disclosure to others (66,6%)

and a fear of discrimination (30,3%) as the main reasons for their reluctance to encourage disclosure to a church leader.

TABLE 4.14: WHETHER MEMBERS SHOULD TELL CHURCH LEADERS ABOUT THEIR STATUS (N=192)

Question: Should a church member tell his/her church leader about his/her HIV-positive status?	All respondents	Programme co-ordinators	Field-workers / care-givers	Beneficiaries
Number of cases	**192**	**17**	**24**	**151**
	%	**%**	**%**	**%**
Yes	65,6	88,2	62,5	63,6
No	34,4	11,8	37,5	36,4
Total	100,0	100,0	100,0	100,0
Question: If yes, what do you think will be the consequences for persons living with HIV when they disclosed their status to their church leader?				
Number of cases	**126**	**15**	**15**	**96**
The church leader will offer spiritual support	42,0	33,3	20,0	46,9
The leader will provide psychological support, e.g. counselling	35,3	33,3	40,1	30,2
The leader will ensure that they learn more about HIV and AIDS	8,7	20,0	2,2	8,3
Leaders are entrusted with confidentiality	6,9	6,7	2,2	3,1
The leader enables you to have access to medication	3,5	6,7	2,2	3,1
I feel obliged to disclose because partner will reveal my status	1,8	0.0	13,3	5,3
I have developed a positive attitude towards the disease	1,8	0,0	20,0	3,1
Total	100,0	100,0	100,0	100,0
Statement: If no, state the main reason why you feel that a church member should not tell his or her leader about the status				
Number of cases	66	2*	9*	55
Church leaders may disclose my status	66,6	*	*	67,3
Fear to be discriminated against	30,3	*	*	27,3
I have a right not to disclose my status	3,0	*	*	5,4
Total	100,0	*	*	100,0

** Number of cases too small to analyse.*

Question 18, 19, 20, 21 and 22 in the questionnaire (see Appendix B) sought to measure the respondents' perceptions of stigma and discrimination against

people living with HIV and AIDS. In Table 4.15 (below) it is shown that 78.1% of all respondents, all of the programme coordinators, all of the fieldworkers and 72,2% of the beneficiaries responded that they would look after a family member with AIDS.

TABLE 4.15: PERCEPTIONS OF STIGMA AND DISCRIMINATION ATTACHED TO HIV AND AIDS (N=192)

	All respondents	Programme coordinators	Fieldworkers / caregivers	Beneficiaries
Question: Would you be willing to care for a family member with AIDS?				
	192	**17**	**24**	**151**
	%	**%**	**%**	**%**
Yes	78,1	100,0	100,0	72,2
No	21,9	0,0	0,0	27,8
Total	100,0	100,0	100,0	100,0
Statement: Fear of stigma and discrimination in the church community prevents people from seeking treatment for HIV and AIDS				
Strongly agree	54,2	82,4	54,2	51,0
Agree	29,2	5,9	33,3	31,1
Disagree	4,7	11,7	0,0	4,6
Strongly disagree	2,1	0,0	4,2	2,0
Don't know	9,8	0,0	8,3	11,3
Total	100,0	100,0	100,0	100,0
Statement: Some people living with HIV are reluctant to join HIV and AIDS support groups because of the fear of stigma and discrimination				
Strongly agree	57,8	70,6	58,3	56,3
Agree	31,8	29,4	37,5	31,1
Disagree	3,1	0,0	4,2	3,4
Strongly disagree	1,0	0,0	0,0	1,3
Don't know	6,3	0,0	0,0	7,9
Total	100,0	100,0	100,0	100,0
Statement: Some people living with HIV are reluctant to join HIV and AIDS support groups based near or in their communities, because of the fear of stigma and discrimination				
Strongly agree	58,9	76,5	66,7	55,6
Agree	27,1	5,9	25,0	29,8
Disagree	6,8	0,0	8,3	7,3
Strongly disagree	3,6	11,7	0,0	3,3
Don't know	3,6	5,9	0,0	4,0
Total	100,0	100,0	100,0	100,0
Statement: It is a waste of resources for the church to develop programmes for people living with HIV				
Strongly agree	9,4	11,8	12,5	8,6
Agree	9,2	5,9	0,0	10,6
Disagree	41,1	29,4	45,8	41,7
Strongly disagree	34,0	52,9	37,5	31,8
Unsure	6,3	0,0	4,2	7,3
Total	100,0	100,0	100,0	100,0

As shown in Table 4.15 (above), more than four-fifths of the respondents (83,4%) agreed that fear of stigma and discrimination in the church community prevents people from seeking treatment for HIV and AIDS. Almost nine-tenths of the interviewees (89,6%) concurred with the statement that some people living with HIV are reluctant to join HIV and AIDS support groups, because of the fear of stigma and discrimination. Eighty six per cent of participants affirmed that some people living with HIV are reluctant to join HIV and AIDS support groups based **near or in their communities**, because of their fear of stigma and discrimination. Since these two question items yielded similar responses, it seems that there is a perception among the respondents in this study that the fear of stigma and discrimination prevents people from accessing the support that they need – whether that support is available in or near their own communities or elsewhere. Almost three-quarters (75,1%) of the respondents disagreed with the statement that it is a waste of resources for the church to develop programmes for people living with HIV.

TABLE 4.16: ACCEPTANCE OF PEOPLE LIVING WITH HIV (N=192)

Question: Is your living environment friendly to (that is accepting and embracing of) people living with HIV?	All respondents	Programme co-ordinators	Field-workers / caregivers	Beneficiaries
	192	**17**	**24**	**151**
	%	**%**	**%**	**%**
Definitely yes	20,5	29,4	25,0	19,9
Yes, under certain circumstances	35,2	58,8	25,0	34,4
Definitely no	31,1	5,9	45,8	31,1
Don't know / undecided	13,2	5,9	4,2	14,6
Total	100,0	100,0	100,0	100,0
Question: Do people openly talk about their HIV-status in your community?				
Definitely yes	11,3	29,4	4,2	11,0
Yes, under certain circumstances	32,8	64,7	33,1	29,0
Definitely no	46,4	5,9	58,2	49,0
Don't know / undecided	9,5	0,0	4,5	11,0
Total	100,0	100,0	100,0	100,0

Table 4.16 (above) shows that just more than half of all the respondents (55,7%) stated that people living with HIV are accepted and embraced. . Of interest is the finding that 45,8 of the caregivers and 31,1 of the beneficiaries emphatically denied that people living with HIV are accepted. Table 4.16 (above) also shows that 46,4% of all the respondents felt that people do not talk about their HIV-status openly in their communities. Section 2.4.5 of the literature review alluded to the problem of stigma and discrimination and the findings seem to suggest that the fear of stigma and discrimination still plays a role in people's perceptions of HIV and AIDS, disclosure and health-seeking behaviour.

Question 25 in the questionnaire (see Appendix B) asked the respondents whether they have personally observed an incident of stigmatisation or discrimination related to HIV in their church community in the 24 months prior to the study. Figure 4.3 (below) shows that 45% of the respondents confirmed that they have witnessed such behaviour.

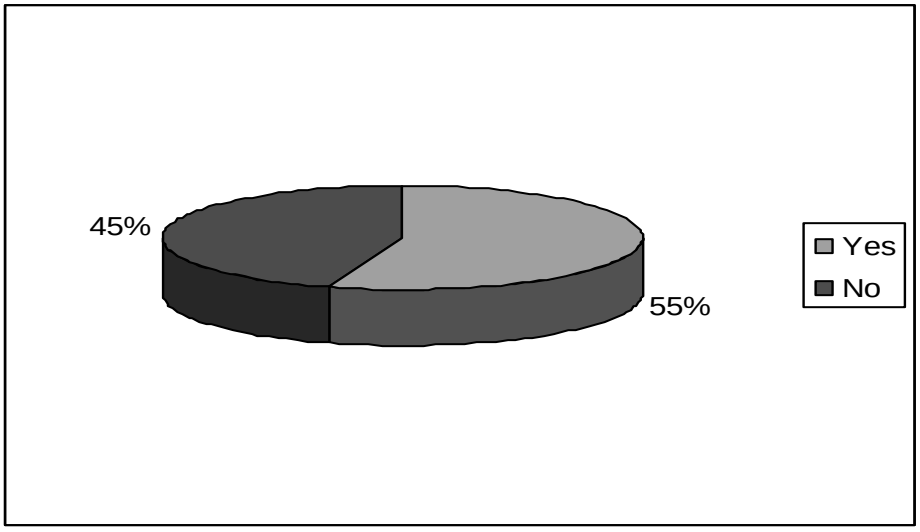

FIGURE 4.3: OBSERVED A PERSON BEING STIGMATISED OR DISCRIMINATED AGAINST IN THE CHURCH COMMUNITY BECAUSE OF AN HIV-POSITIVE STATUS (N=192)

To further explore perceptions of stigma and discrimination, Question 26 of the questionnaire (see Appendix B) asked respondents whether they agree or disagree with the statement that HIV and AIDS should be treated like any other chronic disease. Almost four-fifths of all of the respondents (78%) agreed that AIDS should be treated like any other chronic disease, as shown in Figure 4.4 (below). Thus, although the fear of stigma and discrimination seems to come to the fore in the respondents' answers, in terms of their own readiness to deal with AIDS as a chronic illness that afflicts some members of the community, positive responses were found in this study. Church-based programmes can build on such attitudes to address fears of stigma and discrimination.

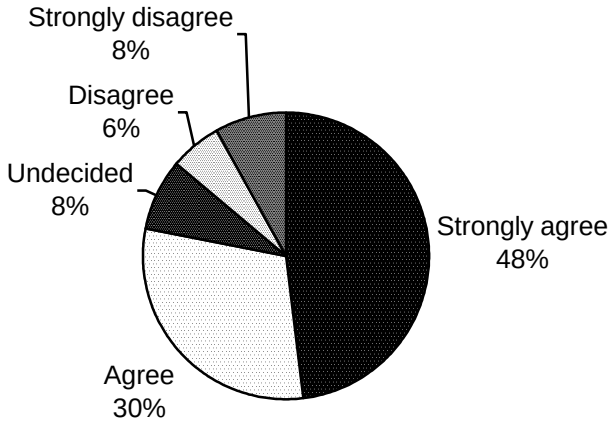

FIGURE 4.4: RESPONSES TO THE STATEMENT: AIDS SHOULD BE TREATED LIKE ANY OTHER CHRONIC DISEASE

To gauge how people might react to the services offered by church-based programmes when they are diagnosed as HIV-positive, Question 27 of the questionnaire (see Appendix B) asked them if they would enrol for the HIV programme which is offered at no extra cost by the church. As shown in Table

4.17 (below), the majority of respondents (76,5%) affirmed that they would enrol in the HIV and AIDS programme if they were diagnosed as HIV positive

.

TABLE 4.17: WHETHER RESPONDENTS WOULD ENROL IN THE HIV PROGRAMME OFFERED BY THE CHURCH (N=192)

	%
Yes	76,5
No	12,0
Do not know	11,5
Total	100,0

Question 28 of the questionnaire (see Appendix B) presented respondents with a number of statements about discrimination against people living with HIV and asked them to indicate their perceptions on whether such discrimination occurred often, sometimes, rarely or never. As shown in Table 4.18 (below), 83,9% of all the respondents felt that that people living with HIV are often or occasionally treated as outcasts. More than half of all respondents (62,5%), 70,6% of all programme coordinators, 70,9% of all caregivers and 60,3% of the beneficiaries felt that people living with HIV are often or occasionally discriminated against in the church. If one takes into account that only 45% of all respondents actually witnessed such discriminatory behaviour, it becomes evident that these perceptions are borne out of a fear of anticipated discrimination and not necessarily based on actual experience of discrimination in the church.

Table 4.18 (below) also shows that the majority of respondents (83,1%) feel that people living with HIV are often or occasionally rejected when other people learn of their HIV-positive status. Disclosing one's status to other people was also viewed as risky by most respondents (88% of all respondents; 94,1% of programme coordinators; 79,2% of caregivers and 82% of all beneficiaries).

TABLE 4.18: RESPONDENTS' VIEWS ABOUT THE WAY PEOPLE LIVING WITH HIV ARE TREATED (N=192)

	All respondents	Programme coordinators	Fieldworkers / caregivers	Beneficiaries
Statement: People living with HIV are treated as outcasts				
	192	**17**	**24**	**151**
	%	%	%	%
Often	41,7	41,2	50,0	40,4
Sometimes	42,2	47,1	41,6	41,7
Rarely	4,7	0,0	4,2	5,3
Never	3,6	11,7	0,0	3,3
Don't know	7,8	0,0	4,2	9,3
Total	100,0	100,0	100,0	100,0
Statement: People living with HIV are discriminated against in the church				
Often	19,3	17,7	33,3	17,3
Sometimes	43,2	52,9	37,6	43,0
Rarely	14,6	0,0	8,3	17,2
Never	14,6	29,4	8,3	13,9
Don't know	8,3	0,0	12,5	8,6
Total	100,0	100,0	100,0	100,0
Statement: Most people living with HIV are rejected when others learn about their status				
Often	41,7	47,1	41,7	41,2
Sometimes	41,4	41,2	33,3	43,1
Rarely	4,8	5,9	4,2	4,7
Never	5,3	0,0	12,5	4,4
Don't know	6,8	5,8	8,3	6,6
Total	100,0	100,0	100,0	100,0
Statement: People living with HIV sometimes regret having disclosed their status to others				
Often	37,0	23,4	50,0	36,4
Sometimes	51,0	70,7	37,5	51,0
Rarely	5,0	0,0	8,3	5,3
Never	3,0	0,0	0,0	2,7
Don't know	4,0	5,9	4,2	4,6
Total	100,0	100,0	100,0	100,0
Statement: It is risky for a person to tell others that he or she is HIV-positive				
Often	41,8	41,2	41,7	41,7
Sometimes	41,3	58,8	37,5	40,3
Rarely	4,4	0,0	4,4	4,6
Never	7,8	0,0	3,2	9,3
Don't know	4,7	0,0	13,2	4,1
Total	100,0	100,0	100,0	100,0

4.10 RESPONDENTS' PERCEPTIONS OF STAKEHOLDERS' PARTICIPATION IN THE BATTLE AGAINST HIV AND AIDS

Question 29 in the questionnaire (see Appendix B) was aimed at finding out more about the perceptions of respondents with regard to the level of participation by various stakeholders in the mitigation of the impacts of HIV and AIDS in the Durban inner-city area. Three types of stakeholders were included in the question, namely church leaders, business leaders and political leaders. As shown in Table 4.19 (below), more than half of all respondents (61,5%) agreed and strongly agreed that church leaders fully support of the church-based HIV and AIDS programmes. However, 18,5% of the beneficiaries were unsure of their church leaders' support and although this is a small proportion, church leaders should take cognisance of this and become visible in their support of such programmes.

Table 4.19 also shows that more than half of all respondents (51%), 35,3% of all programme coordinators, 58,5% of all caregivers and 49,1% of all beneficiaries felt that business leaders do not play a role in addressing the needs of people living with HIV. In addition, 53,1% of all respondents, 58,8% of all programme coordinators, 58,5% of all caregivers and 51,8% of all beneficiaries felt that political leaders do not play a role in the fight for the needs of people living with HIV. Thus, in terms of a comparison of the perceptions of the roles played by these three categories of stakeholders, the respondents in this study seemed to have placed greater confidence in the role played by church leaders than by business or political leaders in addressing the needs of people living with HIV.

TABLE 4.19: PERCEPTIONS OF THE ROLE PLAYED BY DIFFERENT STRUCTURES IN CHURCH-BASED PROGRAMMES (N=192)

	All respondents	Programme coordinators	Fieldworkers / caregivers	Beneficiaries
Statement: Church leaders are in full support of the HIV and AIDS church-based programme				
	192	**17**	**24**	**151**
	%	%	%	%
Strongly agree	17,2	29,4	16,7	15,9
Agree	44,3	64,7	25,0	45,0
Disagree	14,1	0,0	16,6	15,3
Strongly disagree	7,8	0,0	29,2	5,3
Unsure	16,6	5,9	12,5	18,5
Total	100,0	100,0	100,0	100,0
Statement: Business leaders play a crucial role in the fight for the needs of people living with HIV				
Strongly agree	7,3	11,8	8,3	6,6
Agree	17,7	23,5	8,3	18,5
Disagree	28,1	29,4	25,1	28,6
Strongly disagree	22,9	5,9	50,0	20,5
Unsure	24,0	29,4	8,3	25,8
Total	100,0	100,0	100,0	100,0
Statement: Political leaders play a crucial role in the fight for the needs of people living with HIV				
Strongly agree	6,3	0,0	12,4	6,0
Agree	19,8	23,6	25,0	18,4
Disagree	22,9	23,4	16,5	23,8
Strongly disagree	30,2	35,4	42,0	28,0
Unsure	20,8	17,6	4,1	23,8
Total	100,0	100,0	100,0	100,0

4.11 RESPONDENTS' PERCEPTIONS OF IMPLEMENTING A CHURCH-BASED HIV AND AIDS PROGRAMME

Question 30 in the questionnaire (see Appendix B) was aimed at establishing what challenges role players faced in the implementation of HIV and AIDS programmes. According to Table 4.20 (below) a quarter of the respondents (25%) did not know of any challenges in this regard. However, 20,3% of the respondents quoted financial constraints as the major obstacle faced by those implementing church-based HIV and AIDS programmes. This was followed by a failure to cope with the large numbers of people in need of help (quoted by 14,1% of the respondents) and a lack of resources – in particular food and medicine – to address the needs.

TABLE 4.20: CHALLENGES CHURCHES FACE IN THE IMPLEMENTATION OF AN HIV AND AIDS PROGRAMME (N=192)

	%
Don't know	25,0
Churches encounter financial constraints	20,3
Failure to cope with the large number of people seeking for help	14,1
There is not enough food and medication to offer people	13,0
There is a shortage of volunteers	7,8
Rejection of affected and infected people by other members	6,8
People lack knowledge about HIV and AIDS	6,3
Fear to lose status they have in the church	1,6
Fear to be killed	1,6
People don't speak up and cannot be identified easily	1,0
Difficulty to deal with diverse racial groups	1,0
There are unresolved internal conflicts in the church	1,0
There is a need for transport for patients and deliveries	0,5
Total	100,0

Table 4.21: SUCCESSES OBSERVED IN THE IMPLEMENTATION OF HIV AND AIDS PROGRAMMES (N=192)

	%
Don't know	50,5
People have benefited from the services rendered	26,0
Programmes are managed by knowledgeable people	1,6
People were enabled to talk freely about their HIV status	2,1
People's attitudes towards HIV and AIDS have changed for the better	3,6
People learnt about safer sex practices	1,7
It has helped people to get to know their HIV status	6,1
Church members became volunteers	2,1
People have donated money and resources to the programme	3,2
Provided VCT and ARVs to those who needed it	3,1
Total	100,0

Question 31 in the questionnaire (see Appendix B) sought to elicit examples of the successful implementation of church-based HIV and AIDS programmes. As shown in Table 4.21 (above), whereas less than half of the respondents (49,5%) were able to cite examples of successful practice, 26% mentioned that the success of such programmes was demonstrated in the services it rendered to people. Six per cent of the respondents quoted the success of programmes as related to helping people know their status. Changing attitudes towards HIV and AIDS for the better was mentioned by 3,6% of all the respondents.

4.12 PERCEPTIONS OF THE ROLE OF CHURCH-BASED PROGRAMMES TO REDUCE STIGMA AND DISCRIMINATION; CURB NEW INFECTIONS AND ADDRESS NEEDS

In the final section of the questionnaire, the researcher asked questions to establish respondents' perceptions of the role of church-based programmes in addressing stigma and discrimination. Issues of disclosure, stigma and discrimination were also explored and reported on under sub-heading 4.9 of this chapter. These last question items were added to the questionnaire as an additional test of perceptions as to whether there are formal guidelines for people related to the church-based programmes on how to deal with stigma and discrimination. In addition, the researcher wanted to gauge perceptions on whether the church per se discriminates against people living with HIV.

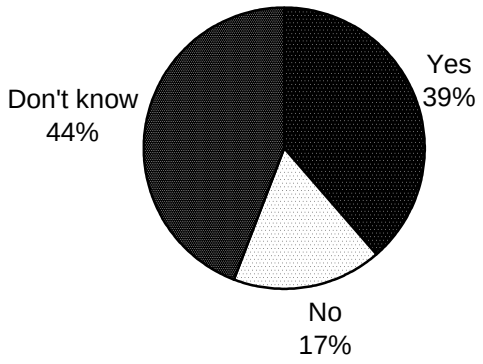

FIGURE 4.5: RESPONSES TO THE QUESTION: "DOES THE CHURCH'S HIV AND AIDS PROGRAMME CLEARLY OUTLINE WAYS TO REDUCE HIV- AND AIDS-RELATED STIGMA AND DISCRIMINATION?" (N=192)

Figure 4.5 (above) shows that 44% of the people interviewed were unsure whether the church's HIV and AIDS programmes clearly outline ways and strategies to reduce HIV and AIDS-related stigma and discrimination. However,

almost two-fifths of the respondents (39%) gave positive responses, while less than one-fifth (17%) disagreed.

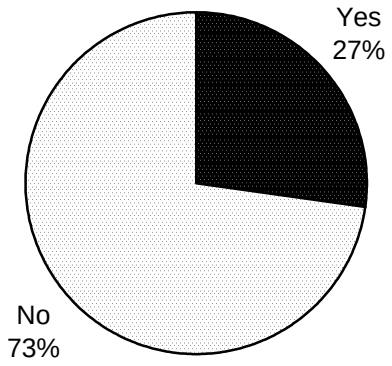

FIGURE 4.6: RESPONSES TO THE QUESTION: "DOES THE CHURCH DISCRIMINATE AGAINST PEOPLE LIVING WITH HIV?" (N=192)

Figure 4.6 (above) shows that the majority of respondents (73%) felt that churches do not discriminate against people living with HIV. Such a finding is important as it shows trust in the church's ability to negotiate the vulnerability of those infected with HIV and affected by HIV and AIDS. As an extension of this perception, Question 34 in the questionnaire (see Appendix B) asked respondents to what extent church leaders regard HIV and AIDS as part of the core business of the church community. As shown in Table 4.22 (below) more than half (57,3%) of the respondents stated that church leaders often and sometimes regard HIV and AIDS as their core of business in the church community, while 21,9% of the participants felt that this rarely occurs.

TABLE 4.22: WHETHER CHURCH LEADERS REGARD HIV AND AIDS AS PART OF THEIR CORE BUSINESS IN THE CHURCH COMMUNITY (N=192)

		%
Often		12,0
Sometimes		45,3
Rarely		21,9
Never		4,7
Don't know		16,1
	Total	100,0

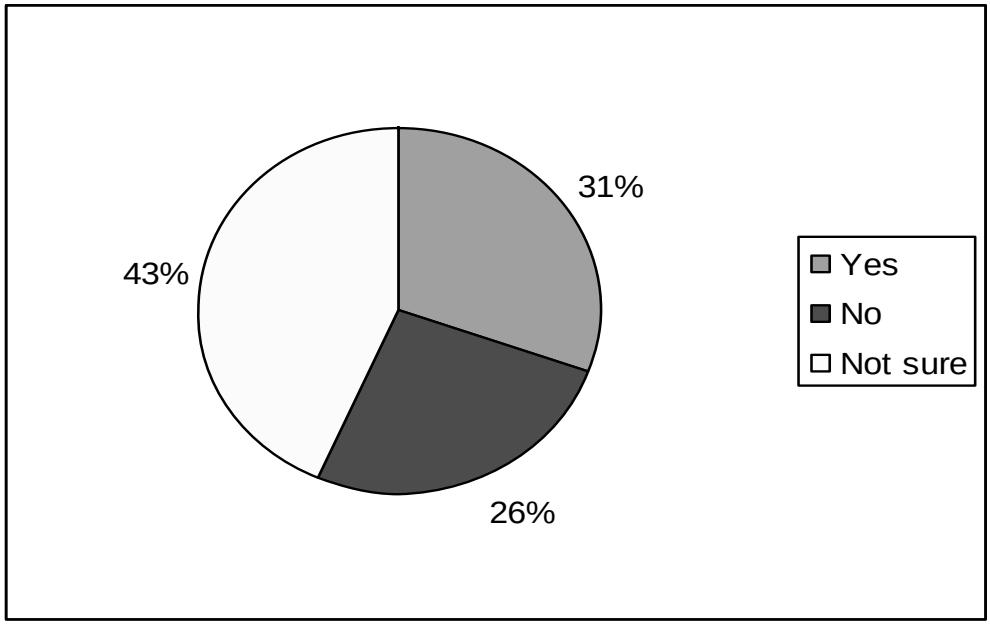

FIGURE 4.7: THE EXTENT TO WHICH CHURCH PROGRAMMES ARE EFFECTIVE IN PREVENTING THE SPREAD OF NEW HIV INFECTIONS AMONGST COMMUNITY MEMBERS (N=192)

Figure 4.7 (above) shows that as far as perceptions of the efficacy of church-programmes in preventing the spread of new HIV infections were concerned, 43% of the respondents were unable to give a definite answer, whereas 31% thought that the programmes was effective and 26% thought that the programmes were unable to achieve this.

In addition to the possible preventive role of HIV and AIDS church-based programmes, respondents were also asked whether these programmes are able

to address all the needs of people living with HIV. As shown in Figure 4.8, almost a third (32,8%) of the respondents were unsure about such achievements of these programmes, whereas less than half of all the respondents (46,4%) felt that the programmes were unable to comprehensively address all the needs of people living with HIV.

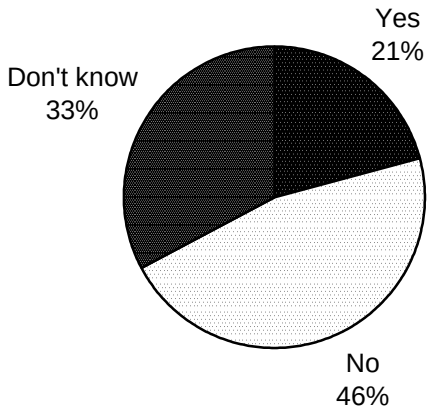

FIGURE 4.8: WHETHER THE CHURCH'S PROGRAMMES ADDRESS ALL THE NEEDS OF PEOPLE LIVING WITH HIV (N=192)

TABLE 4.23: RATING OF RESOURCES AVAILABLE TO THE CHURCH TO IMPLEMENT HIV AND AIDS PROGRAMMES (N=192)

		%
Poor		37,6
Good		35,9
Satisfactory		20,8
Very good		5,7
	Total	100,0

Question 37 in the questionnaire (see Appendix B) asked the respondents to rate the resources available to the church in order to implement HIV and AIDS programmes. Table 4.23 (above) shows that a larger proportion of respondents

(37,6%) rated available resources to implement HIV and AIDS programmes as poor, than the proportion that rated it as satisfactory (20,8%) or very good (5,7%).

TABLE 4.24: SUGGESTIONS ON HOW THE CHURCH'S HIV AND AIDS PROGRAMMES CAN BE IMPROVED (N=192)

	%
The government should provide financial support	15,6
Do not know	13,0
There should be more volunteers	12,0
All needy people should have access to food and shelter	11,5
Hold educational workshops with the infected and the affected	9,9
Church ceremonies should incorporate HIV and AIDS sessions	5,7
They should have life skills development programmes	5,2
The HIV and AIDS programmes are not effective to address the challenges faced by people	4,7
There should be no preferential treatment	4,2
Church leaders should be tasked with the provision of social, moral and spiritual support	4,2
Churches should work in collaboration with doctors for medical support	4,2
The victims should be offered a full meal instead of bread everyday	3,6
Frequent evaluation of workshops is essential	3,1
Provision of jobs will enable them to cater for themselves and their families	2,1
Encourage people to go for an HIV test	1,0
Total	100,0

The penultimate question in the questionnaire (see Appendix B) asked the respondents to suggest ways in which the church's HIV and AIDS programmes can be improved. As shown in Table 4.24 (above), 15,6% of the respondents suggested that state interventions in the form of financial support could improve the programmes. Whereas 13% of the respondents could not offer a solution, 12% felt that there should be more volunteers, 11,5% suggested that all those in need should have access to shelter and food and 9,9% emphasised educational interventions.

The final question in the questionnaire (see Appendix B) urged respondents to mention issues that they regard as pertinent to church-based interventions in HIV and AIDS that were not addressed during the interview. As shown in Table 4.25 (below), 63,5% of respondents did not add anything more. However, issues

mentioned by six or more respondents were access to grants and pensions (7.3%), skills development (6.7% and financial support to those in need (3,6%).

TABLE 4.25: ADDITIONAL COMMENTS (N=192)

	%
None	63,5
Access to grants and pension	7,3
Skills development / empowerment	6,7
Financial support to those in need	3,6
Working relationship between churches, social workers and counsellors	3,0
The financial constraints encountered by the church	3,0
Safe sex practices	3,0
Discrimination / rejection of the infected and the affected	3,1
The provision of shelter to those in need	2,1
The availability of resources required by the victims	2,2
The formation of support groups / awareness campaigns	1,5
The role of the government in providing financial support	1,0
Total	100,0

4.13 CONCLUSION

In this chapter the data generated in the study was presented and discussed. The broad range of issues covered represents base-line information on the perceptions of programme coordinators, caregivers and beneficiaries on the role of church-based programmes in HIV and AIDS. The next and final chapter of the dissertation summarises pertinent findings in relation to the stated research objectives.

CHAPTER 5:

SUMMARY AND CONCLUSIONS

5.1 INTRODUCTION

This study was a descriptive, baseline survey of respondents' perceptions of the role of church-based programmes in addressing HIV and AIDS. In this section the main findings are discussed in terms of the stated objectives. The respondents were people associated with inner-city churches in Durban which are involved in programmes aimed at addressing the impact of HIV and AIDS. They were programme coordinators, fieldworkers and beneficiaries of such programmes.

5.2 SUMMARY OF FINDINGS ACCORDING TO THE OBJECTIVES OF THE STUDY

The first objective was to obtain information on the respondents' personal details such as age, ethnicities, gender, knowledge of one's HIV status, possible fears of disclosing one's status if tested positive, and their understanding of the possible role of the church in addressing HIV and AIDS-related issues. The respondents to the study were mostly Africans (76,6%), females (63%). A large proportion of the respondents (43,2%) had never been tested for HIV and therefore did not know their status. These respondents indicated that their friends might discriminate against them, should they test positive for HIV. These findings complement the views shared by Nattrass (2004) and Chitando and Gunda (2007), who clearly indicate that the fear of stigma and discrimination are perceived to be one of the hindrances to prevention efforts and the reason why some people living with HIV are wary to seek care and support by disclosing their

status. With regard to the views whether the church has a role to play in the battle against HIV and AIDS, the majority of the respondents (90,1%) felt that the church had a role to play in addressing the HIV and AIDS issues – similar to the findings of UNAIDS (2005b). There is general consensus among different scholars that FBOs and churches are key stakeholders in the response to HIV, and that FBOs provide two-thirds of the overall African response (ARHAP 2006; Haddad 2005; Manda 2006).

The second objective was aimed at establishing what the respondents actually do in the programmes, how long they have served in the programmes, entry requirements into the programmes, and the impact that the programmes have had on the respondents' lives. Findings of this study revealed that many of the respondents benefited from the church-driven programmes. Ninety three per cent of the respondents indicated that to gain entry to the programme one had to be poor, destitute and homeless, while only 27% of the respondents explained that terminal illness was a requirement to gain entry into the programme. When questioned about the impact the programmes have had on their lives, the majority of the respondents (92,9%) indicated that the programme has had a positive impact on their lives. Material support such as shelter, clothes and food received by the respondents was stated by the majority of those who felt positive about the programme's impact on their lives, followed by skills gained, spiritual support and educational support. Food parcels figured prominently among the services rendered – a finding also supported by Babun (2001) Rose-Innes (2006) and Alsan (2006)

More than half of the respondents (52,6%) in this study affirmed that church-based programmes provided shelter in respect of those living with HIV. Most programme coordinators appeared to be knowledgeable about voluntary counselling and testing as the service offered by the church-based programmes. The study also found that respondents knew that the church-based programmes provide bereavement counselling.

The study found that slightly above four-fifths of the programme coordinators (82,4%) attended HIV and AIDS workshops, as opposed to fieldworkers and beneficiaries. The study also found that quite a substantial number of respondents, about 44,8%, were not sufficiently familiar with HIV and AIDS programmes offered by the church. This state of affairs highlights an urgent need to expose beneficiaries to more church-based programmes so that they can make informed decisions about their lives. Studies conducted by Okyere-Manu (2003), De Jong (2003), MacPhail and Campbell (2001) document that quite often the lack of knowledge about the disease is one of the key drivers of the AIDS pandemic, more especially among those with low levels of formal education and who lack proper access to accurate information on HIV and AIDS and sexuality.

More than half of the respondents (69,7%) in this study disagreed with the statement that people on antiretroviral treatment die sooner than those not taking them. About 66 per cent of the interviewees disagreed with the statement that an HIV-infected person cannot transmit the virus when taking antiretroviral treatment. However, 22 per cent of the respondents did not know whether it was true or false. Slightly over four-fifths of the respondents (83%) disagreed that having sex with a virgin can cure HIV and AIDS. This shows that most of the respondents in this study were aware about the disease, but that myths surrounding the disease were still prevalent. De Jong (2003) found that, although most South Africans already have a fairly good level of knowledge about HIV and AIDS, how the disease is transmitted and that condom use minimises risk of infections, there are still many who lack information about HIV and AIDS.

The study found that almost three-fifths of the respondents (56%) knew people who had regretted their decisions to disclose their HIV status in their community. On the question whether church leaders should be informed about the person's HIV-positive status, the study found that most respondents had faith in their

church leaders, as 66% felt that church members should inform their church leaders about their status in order to receive spiritual counselling. These findings complement Collins' (1998) research, in which he found that the church through its provision of help in times of crisis has the greatest potential for being a therapeutic healing community. Some of the main reasons mentioned by most respondents as to why people should reveal their status to their church leaders was that a priest would provide spiritual (48%) and psychological (36%) support.

Seventy eight per cent (78%) of respondents were willing to look after a family members living with HIV. A study conducted by Fredericks (2008) refers to the concept of *"ubuntu"* and *"koinonia*" fellowship, which are traditional notions embraced by African people as they care for one another.

As far as the challenges posed by stigma and discrimination among people living with HIV are concerned, the study found that an overwhelming majority of respondents (83%) felt that the fear of stigma and discrimination in the church community prevents people from seeking help or joining support groups. A large proportion of respondents (55,7%) felt that people living with HIV still faced discrimination in their environment. They agreed that fear of stigma and discrimination in the church community prevents people from seeking treatment for HIV and AIDS. These findings are similar to the literature review findings by Ndlovu, as cited by Chitando and Gunda (2007), who argue that stigma is one of the most powerful obstacles to the prevention of HIV transmission, to effective treatment and to the prevention of discrimination against people living with HIV.

The third objective was to gauge respondents' perception of problems and challenges encountered in the implementation of programmes. The study found positive perceptions about church leaders' support to HIV and AIDS programmes. These findings concur with the findings of Gathigia (2006) who indicate that churches demonstrate a greater commitment to society, as compared to other political, social and economic institutions. The study found that

the challenges encountered by churches in the process of programme implementation are financial constraints. Foster (2004), documents that FBOs are capable of mobilising large numbers of volunteers, despite the fact that they receive limited external funding. The study also found that the inability of churches to cope with large numbers of people seeking support (14%) from them present numerous complexities as they cannot easily be managed and catered for. As a result, church-based programmes struggle with food shortages as well as insufficient medication to offer to those in need.

The final objective of the study was to find out what changes or improvements could be made to enhance the programmes. The study found that, despite the challenges faced by the church in the implementation of their programmes, the respondents had to a certain extent benefited from the programmes offered by the church. The church has enabled people to know their HIV status and church members have volunteered to the programme. The review of literature as reported in Chapter 2 stated that churches, despite their limited resources, offer participants spiritual support, a sense of belonging and of community, and provide physical shelter to the homeless and poverty stricken (Rhodes *et al* 2008:163). The study found that state intervention in the form of financial support is an important consideration for respondents to enhance the programme.

5.3 LIMITATIONS OF THE STUDY

The first limitation of the study was that it utilised a small, non-probability sample to generate data in terms of the beneficiaries. The total population of the programme coordinators of the 17 participating churches in the inner-city of Durban were included. As explained in Chapter 3, these pragmatic methodological decisions were taken due to ethical considerations, the non-availability of a sampling frame of beneficiaries and to establish good relations with key persons in the field of church-based programmes. The researcher did not have access to funding for the study as the University of South Africa does

not award bursaries to students enrolled in coursework Master's degrees. Additional funding would have enabled the researcher to include a qualitative component to the study to explore perceptions of the church-based programmes in greater depth with key informants. However, in terms of the goal to generate baseline information about the perceptions of the programme coordinators, caregivers and beneficiaries of the role of church-based programmes in addressing HIV and AIDS, the study was successful.

To save time in the field, the researcher opted for self-administered questionnaires to be used for data-generation from the programme coordinators and fieldworkers. In hindsight, textured information could have been gained from in-depth, qualitative, face-to-face interviews. However, such an approach can be used in a follow-up study and would benefit from the insights gained from the current study. The researcher is cognisant of the fact that his data was perceptual information and that the use of self-administered questionnaire may have increased the probability of acquiescence responding from the fieldworkers and programme directors in an attempt to protect the image of their organisations.

The researcher was careful not to allow his personal values, beliefs and bias such as gender, age, education and own socio-cultural background to influence the process of data collection.

5.4 SUGGESTION FOR FURTHER RESEARCH

As indicated earlier on, this study was conducted using a small, non-probability sample of people related to church-based HIV and AIDS programmes. The researcher strongly suggests that a survey of similar nature be carried out in a much broader scope in towns and townships in the outskirts of Durban so as such as to ascertain a broader view of the impact of HIV and AIDS.

In view of the number of people who do not know their HIV status and the apparent fear of disclosing a positive status, further studies would assist in gauging greater understanding of how exactly church-based programmes can address such matters in innovative ways.

5.5 RECOMMENDATIONS TO POLICY MAKERS

Whereas the researcher is cognisant of the fact that this baseline survey yielded tentative data that was not intended and should not be generalised to refer to other or all church-based programmes, it is a recommendation for this degree programme that students link their research (their reviews of literature and their own findings) to recommendations for policy and practice.

First, the study's findings should be regarded in the current context of South Africa where the government faces financial challenges in addressing the health care needs of its population. This has become evident following a statement issued by the South African Human Rights Commission (SAHRC) at the launch of its report entitled "Public Inquiry: Access to Health Care Services" on 16 April 2009 in Johannesburg, in which it stated: "*Access to health care services, especially for the poor, is still severely constrained by expensive, inadequate or non-existent transport, by serious shortages with regard to medicines, emergency transport and long waiting times at clinics and other health care service facilities (http://www.ngopulse.org/article/sa-healthcare-system-failing)*."

Furthermore, the Provincial HIV and AIDS Unit needs to be reminded of the importance of paying attention to what churches are doing, since the battle against HIV and AIDS is the responsibility of all stakeholders including the church as a social institution. If serious considerations are not taken into account in an attempt to address the spread of HIV and AIDS, the situation can be exacerbated by the rapid transmission of HIV and AIDS and the demise of people will take its toll. In addressing the problem the following is recommended:

5.5.1 Capacity Building and Awareness Campaigns

Since most of the churches' development work is not properly documented, training on monitoring and evaluation cannot be overstated. Studies conducted by Yates (2003), ARHAP (2006) and Rose-Innes (2006) revealed this. Proper training should also be offered to people managing programmes and they should be empowered with the relevant skills such as project management, monitoring and evaluation in order to manage programmes effectively. The findings of this study clearly show that there is a need for sex education and dissemination of information to dispel myths about transmission and cures for infection. The awareness campaigns must be extended to be suitable for all people – not only the programme coordinators.

5.5.2 Stakeholder collaboration and participation

Collaboration between priests and other health practitioners such as doctors, psychologist, social workers et cetera, needs to be encouraged. All these parties could share information and enrich one another. Respondents regarded church leaders as key in the efforts to address the issue of HIV and AIDS as a social problem, but felt that business leaders and political leaders should do more.

5.5.3 Creation of non-medical VCT sites in churches

Since the findings of this study show that people have confidence in the church leaders, health practitioners need to be encouraged to entrust priests with medication (e.g. ARVs) to avoid delays in the distribution of medical treatment. Also, the Department of Health needs to be encouraged to establish non-medical voluntary counselling and testing sites in churches to ease the burden of the influx of patients into hospitals on a daily basis for HIV and AIDS services, including HIV testing.

5.6 CONCLUSION

The respondents demonstrated a sound knowledge of church-based programmes and the role that such programmes play in addressing HIV and AIDS, with the exception of beneficiaries who lacked some understanding, particularly with regard to voluntary counselling, testing and antiretroviral therapy. This implies that the programmes have only penetrated to individuals (programme coordinators and fieldworkers) who participate in the programmes in terms of dissemination of the requisite knowledge. Some respondents proved to have benefited from the programmes by demonstrating that they could differentiate between certain myths and facts about HIV and AIDS. Judging from the responses given when respondents were asked to state the requirements for people to enrol for the programmes, it became apparent that some respondents were concerned mainly with receiving food and shelter, as opposed to seeking medical help.

In conclusion, the policy makers need to be made aware of the urgency of addressing the limited knowledge of HIV and AIDS, reducing the stigma and discrimination attached to the disease among the general population, and in particular among the churches or faith-based organisations, through more aggressive prevention efforts and a wider dissemination of information, education and communication materials.

Churches and FBOs are abundant throughout Africa and, driven by their moral obligation, are well positioned to provide HIV and AIDS services to people infected with HIV and affected by HIV and AIDS. In this regard, church-based programmes can play a pivotal role in expanding people’s capacity to effectuate changes to address the vagaries of hardship created by HIV and AIDS.

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APPENDIX A: LETTER OF ENDORSEMENT OF THE STUDY

Department of Sociology
26 May 2009

Title of the study: PERCEPTIONS OF THE ROLE OF CHURCH-BASED PROGRAMMES IN ADDRESSING HIV AND AIDS: A STUDY IN THE DURBAN INNER-CITY AREA

Principal investigator: Rev Sylvester Cele

The proposal and questionnaire for this study have been extensively reviewed in the Department. I consider the methodological, technical and ethical aspects of the proposal and the questionnaire to be appropriate to the tasks proposed. Approval is hereby granted to the principal investigator to proceed with the study in strict accordance with the approved proposal and the ethics policy of the University of South Africa.

In addition, the principal investigator should heed the following guidelines:

- To only start this research study after obtaining informed consent
- To carry out the research according to good research practice and in an ethical manner
- To maintain the confidentiality of all data collected from or about research participants, and maintain security procedures for the protection of privacy
- To record the way in which the ethical guidelines as suggested in the proposal have been implemented in the research
- To work in close collaboration with his supervisor
- To immediately notify his supervisor in writing if any adverse event occurs.

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APPENDIX B: THE QUESTIONNAIRE

PERCEPTIONS OF THE ROLE OF CHURCH-BASED PROGRAMMES IN ADDRESSING HIV AND AIDS: A STUDY IN THE DURBAN INNER-CITY AREA

Dear research participant

The Rev. Sylvester Cele is carrying out a study on the perceptions of the role of church-based programmes in addressing HIV and AIDS in the Durban inner-city area as part of his Masters degree studies at the University of South Africa. The purpose of this research is to examine the perceptions of people/respondents on the role of church-based programmes in addressing the needs of people infected with HIV and affected by HIV and AIDS in the inner-city area of Durban.

The envisaged outcome of this study is to identify gaps in the programme, and thus assist its implementers to consider addressing required improvements in order to enhance the programme so that it can achieve its goals. For this purpose, your kind cooperation is needed. You have been sampled for participation in this study. Your knowledge and views are crucially important in this study. The researcher and UNISA undertake that all information provided by you will be treated as strictly confidential. Please do not write your name anywhere on this questionnaire.

SECTION A: BIOGRAPHICAL DATA

PLEASE TICK IN THE RELEVANT BOX

1. What is your age group?

20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+
1	2	3	4	5	6	7	8	9

2. What is your race?

African	White	Coloured	Indian	Other
1	2	3	4	5

3. What is your gender?

Female	Male
1	2

4. Do you know your HIV status?

Yes	No
1	2
Go to Question 7	Go to Questions 5 & 6

5. If '**NO**' to Question 4, if you were to test HIV-positive, which of the following would you fear? (Please mark all possible options). If "YES" to Question 4, skip to Question 7.

	Yes	No	Don't know
Being disowned by family	1	2	3
Losing means of financial support from partner	1	2	3
Being left by my partner	1	2	3
Being blamed for infection by partner	1	2	3
Losing my job	1	2	3
Being the target of HIV-related stigma	1	2	3
Being discriminated against by friends	1	2	3
Other (please specify):			

6. If you were HIV-positive, who among the following people would you disclose your status to?

	Yes	No	Don't know
Priest	1	2	3
Spouse or partner	1	2	3
Parents or adult family members	1	2	3
Children	1	2	3
Friend(s)	1	2	3
Health care worker (nurse, doctor, etc.)	1	2	3
Traditional healer	1	2	3
Other (please specify): _____ _____			

7. Do you think that the Church has a role to play in HIV and AIDS issues?

Yes	No
1	2
⇧ GO TO QUESTION 7.1	⇧ GO TO QUESTION 7.2

7.1 If **YES** to Question 7, please tell me what you think the role of the church should be in addressing issues of HIV and AIDS.

_____

_____

_____

7.2 If **NO** to Question 7, please give a reason for your answer.

_____

_____

_____

SECTION B: PROGRAMMATIC DATA

8. What is your designation /position in the church-based programme?

Programme coordinator	Fieldworker/caregiver	Beneficiary
1	2	3

9. How long have you been in this programme?

0-1 year	2-3 years	4-5 years	6-7 years	8-10 years	More than 10 years
1	2	3	4	5	6

10. What are the requirements for one to be enrolled or admitted to this church-based programme?

_____

_____

_____

_____

11. Please rate the impact that this programme has had on your life by ticking the most suitable option below:

It had a negative (detrimental) impact on me	It had no impact on my life	It had a positive (beneficial) impact on me
1	2	3

11.1. Please give me the main reasons for your answer to Question 11:

_____

_____

_____

SECTION C: LEVEL OF EXPOSURE TO THE CHURCH-BASED PROGRAMME

I AM NOW GOING TO ASK YOU QUESTIONS ABOUT YOUR EXPOSURE TO CHURCH-BASED HIV/AIDS PROGRAMMES. PLEASE TICK THE BOX AT EACH STATEMENT THAT BEST DESCRIBES YOUR VIEW.

12. What services does the church-based programme provide in respect of HIV/AIDS?

	Yes	**No**	**Don't know**
Shelter	1	2	3
Food parcels	1	2	3
Voluntary counselling and testing (VCT)	1	2	3
Antiretroviral therapy (ART)	1	2	3
Bereavement counselling	1	2	3
Other (please specify): _____			

12.1. Which services do you benefit from?

	Yes	**No**	**Don't know**
Shelter	1	2	3
Food parcels	1	2	3
Voluntary counselling and testing (VCT)	1	2	3
Antiretroviral therapy (ART)	1	2	3
Bereavement counselling	1	2	3
Other (please specify): _____			

13. Think about your familiarity with the church-based HIV/AIDS programme, and then indicate whether you agree or disagree with the following statements:

	Strongly agree	**Agree**	**Disagree**	**Strongly disagree**	**Don't know**
I know the church-based HIV/AIDS programme very well	1	2	3	4	5
I know some of the details of the church-based HIV/AIDS programme, but would like to know more about it	1	2	3	4	5
I am not familiar with the church-based HIV/AIDS programme and do not wish to know more about it	1	2	3	4	5

14. Have you attended HIV/AIDS workshops or awareness campaigns offered by the church-based programme?

Yes	No
1	2
⇧ GO TO QUESTION 14.1	⇧ GO TO QUESTION 14.2

14.1 If "**YES**" to Question 14, how many of these sessions, HIV/AIDS workshops or awareness campaigns have you attended in the last 12 months?

_____ Sessions attended in the last 12 months

14.2. If "**NO**" to Question 14, please tell me the **main** reasons why you have not attended any HIV/AIDS workshops or awareness campaigns in the last 12 months.

Main reasons for not attending:

_____

SECTION D: LEVELS OF KNOWLEDGE AND UNDERSTANDING OF PROGRAMME

15. IN THIS SECTION I AM GOING TO ASK YOU A FEW QUESTIONS ABOUT YOUR KNOWLEDGE OF HIV/AIDS; PLEASE TICK EITHER TRUE OR FALSE.

	True	False	Don't know
People on antiretroviral treatment die sooner than those not taking them.	1	2	3
An HIV-infected person cannot transmit the virus when taking antiretroviral treatment	1	2	3
Antiretroviral treatment reduces the quantity of the HI virus in the person's body	1	2	3
Having sex with a virgin can cure HIV/AIDS	1	2	3
A person can be infected with HIV and still live a long and healthy and productive life	1	2	3
The church-based HIV/AIDS programme increased my knowledge of HIV/AIDS	1	2	3

SECTION E: STIGMA AND DISCRIMINATION

I AM NOW GOING TO ASK YOU QUESTIONS ON STIGMA AND DISCRIMINATION. PLEASE TICK IN THE BOX WHICH INDICATES YOUR OPINION, FEELING OR EXPERIENCE.

16. Do you know someone who has regretted their decision to disclose his/her HIV status?

YES	NO
1	2

17. Should a church member tell his/her church leader about his/her HIV-positive status?

YES	NO
1	2
⇧ GO TO QUESTION 17.1	⇧ GO TO QUESTION 17.2

17.1. If "**YES**" to Question 17, what do you think will be the consequences for the person living with HIV when he or she discloses their status to his or her church leader?

_____

_____

_____

17.2. If "**NO**" to Question 17, please state the MAIN reason why you feel that a church member should not tell his/her church leader about his/her HIV-positive status.

_____

_____

_____

18. Would you be willing to care for a family member with AIDS?

YES	NO
1	2

19. Do you agree or disagree with the following statement: ***Fear of stigma and discrimination in the church community prevents people from seeking treatment for HIV and AIDS.***

Strongly agree	Agree	Disagree	Strongly disagree	Unsure/Don't know
1	2	3	4	5

20. Do you agree or disagree with the following statement: ***Some people living with HIV are reluctant to join HIV/AIDS support groups because of their fear of stigma and discrimination.***

Strongly agree	Agree	Disagree	Strongly disagree	Unsure/Don't know
1	2	3	4	5

21. Do you agree or disagree with the following statement: ***Some people living with HIV are reluctant to join HIV/AIDS support groups*** **based near or in their communities** ***because of their fear of stigma and discrimination.***

Strongly agree	Agree	Disagree	Strongly disagree	Unsure/Don't know
1	2	3	4	5

22. Do you agree or disagree with the following statement: ***It is a waste of resources for the church to develop programmes for people living with HIV.***

Strongly agree	Agree	Disagree	Strongly disagree	Unsure/Don't know
1	2	3	4	5

23. Is your living environment friendly to (that is accepting and embracing of) people living with HIV?

Definitely yes	Yes, under certain circumstances	Definitely no	Don't know/ Undecided
1	2	3	4

24. Do people openly talk about their HIV status in your community?

Definitely yes	Yes, under certain circumstances	Definitely no	Don't know/ Undecided
1	2	3	4

25. In the last 2 years (24 months), have you personally observed an incident where a person was stigmatised or discriminated against in your church community because of being infected with HIV?

Yes	No
1	2

26. Tell me whether you agree or disagree with the following statement: ***AIDS should be treated like any other chronic disease.***

Strongly agree	Agree	Undecided	Disagree	Strongly disagree
1	2	3	4	5

27. If you were diagnosed as HIV-positive, would you enrol for the HIV programme which is offered at no extra cost by the church?

Yes	No	Don't know
1	2	3

28. What is your view about the following statements?

	Often	**Sometimes**	**Rarely**	**Never**	**Don't know**
People living with HIV are treated as outcasts	1	2	3	4	5
People living with HIV are discriminated against in the church	1	2	3	4	5
Most people living with HIV are rejected when others learn about their status	1	2	3	4	5
People living with HIV sometimes regret having disclosed their status to others	1	2	3	4	5
It is risky for a person to tell others that he or she is HIV-positive	1	2	3	4	5

SECTION F: PARTICIPATION BY STAKEHOLDERS IN THE BATTLE AGAINST HIV/AIDS

29. THE FOLLOWING SECTION FOCUSES ON THE INVOLVEMENT OF ALL ROLE-PLAYERS IN THE BATTLE AGAINST HIV/AIDS. PLEASE TICK IN THE BOX NEXT TO THE MOST APPROPRIATE ANSWER. What is your view about the following statements?

	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
Church leaders are in full support of the HIV/AIDS church-based programme	1	2	3	4	5
Business leaders play a crucial role in the fight for the needs of people living with HIV	1	2	3	4	5
Political leaders play a crucial role in the fight for the needs of people living with HIV	1	2	3	4	5

SECTION G: CHALLENGES IN THE IMPLEMENTATION OF THE CHURCH-BASED PR0OGRAMME

30. What are some of the challenges have you observed that this church has faced in the implementation of an HIV/AIDS programme?

_____

_____

_____

SECTION H: SUCCESS STORIES IN THE IMPLEMENTATION OF THE PROGRAMME

31. What successes have you observed that this church has had in the implementation of an HIV/AIDS programme?

_____

_____

SECTION I: CHANGES OR IMPROVEMENTS TO CHURCH PROGRAMMES IN ORDER TO ADDRESS STIGMA AND DISCRIMINATION

I AM NOW GOING TO ASK YOU A FEW QUESTIONS ABOUT THE IMPLEMENTATION OF THE HIV/AIDS CHURCH PROGRAMME TO REDUCE STIGMA AND DISCRIMINATION. PLEASE TICK THE STATEMENT THAT EXPRESSES YOUR OPINION THE BEST.

32. Does the church's HIV/AIDS programme clearly outline ways and strategies to reduce HIV-related stigma and discrimination?

Yes	No	Not sure
1	2	3

33. Does the church discriminate against people living with HIV?

Yes	No
1	2

34. In your opinion, do church leaders/Ministers regard HIV/AIDS as part of the core business in the church community?

Often	Sometimes	Rarely	Never	Don't know
1	2	3	4	5

35. Do you think that church programmes are effective in ***preventing*** the spread of new HIV infections amongst community members?

Yes	No	Not sure
1	2	3

36. Do you think that the church's programme addresses all the needs of people living with HIV?

Yes	No	Not sure
1	2	3

37**.** How would you rate the resources available to the Church to implement an HIV/AIDS programme?

Poor	Good	Satisfactory	Very Good
1	2	3	4

38. How can the church's HIV/AIDS programmes be improved?

_____

_____

_____

39. Is there anything which you think we have left out during our discussion? Please state.

_____

_____

_____

THANK YOU VERY MUCH FOR AGREEING TO PARTICIPATE AND ASSIST IN THIS IMPORTANT RESEARCH PROJECT