Reasons for limited responses to HIV/AIDS in certain faith-based ministries:

A case study of Cloud and Fire Ministry, Kanye, Botswana

by

Joyce Wanjiru Pinto

Assignment presented in partial fulfilment of the requirements for the

degree Master of Philosophy (HIV/AIDS Management) at Stellenbosch

University

Supervisor: Prof. JCD Augustyn
Faculty of Economic and Management Sciences
Africa Centre for HIV/AIDS Management

March 2013

Abstract

The work of FBOs began to emerge as a specific area of study and discussion in global health, thirty years ago. Despite much work, repeated calls for more clarity, theoretical frameworks, data and empirical evidence, there are still major gaps in knowledge, that impede Africans, their Governments and the international community from making the best choices to improve public health in Africa, especially in this era of HIV/AIDS .In Botswana, the population is being ravaged daily, posing a serious developmental challenge .This study investigated the responses of certain faith based ministries in the Kanye village, Botswana, towards the disease. Cloud and Fire ministries was utilised as a case study. The study was prompted by the observation that the faith community seemed to build wall of silence around the disease with no sense of urgency to act, despite repeated calls by the government, for multi-sectoral interventions .

The study utilised an ARHAP research framework, which recognises the role of religion in health care, to argue that churches have intangible assets that can be useful in alleviating the suffering caused by HIV/AIDS. The Walt and Gilson's policy triangle framework was modified to replace actors with content in the middle, in order to explore how actors, process and context interact to shape the policy content of FBOs.The study adopted a qualitative and exploratory design. Data was collected through focus group discussions as well as in depth interviews with some key informants. Data analysis was corroborated by research questions that guided the study as well as the thematic areas that emerged .The literature review revealed a wealth of intangible religious assets that can be utilised to alleviate the suffering caused by HIV/AIDS, as well as how certain cultural elements and African health worlds can influence the health seeking strategies of most Africans. The study Results confirmed that Cloud and Fire ministry had not responded adequately to HIV/AIDS mainly due to stigma, and lack of a mission statement for HIV/AIDS .It is hoped that this study will contribute to a deeper understanding on how to engage effectively with FBOs, especially in scaling up care initiatives for PLWHA and their carers.

Opsomming

Die doel van hierdie navorsing was om die rol van die Kerk in die bestuur van die MIV/Vigs pandemie te ontleed en te ondersoek. Vir hierdie bepaalde ondersoek is die Cloud and Fire Ministries in die Kanya Vallei in Botswana gebruik.

'n Deeglike literatuurstudie oor die rol van die kerk in die pandemie word aangebied en sekere fundamentele vertrekpunte word geidentifiseer en bespreek. Die Walt en Gilson beleidsraamwerk word vir die bespreking ingespan en die bespreking van die kerklike rol in die pandemie word rondom hierdie beleidsraamwerk toegelig en bespreek.

Data is deur middel van fokusgroepe ingesamel en binne kategorieë ontleed en interpreteer. Die definiering van die rol van die kerk is uiteraard baie moeilik en geen definitiewe riglyne kan gegee word nie. As egter in ag geneem word dat mense op grootskaal kerkbyeenkomste op 'n weeklikse basis bywoon, kan geredelik aanvaar word dat die kerk 'n steeds groterwordende rol in die bekamping en bestuur van die pandemie behoort te vervul.

Abbreviations

AACC	All Africa Conference of Churches
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti Retroviral Treatment
BCC	Botswana Council of Churches
BTR	Botswana Traditional Religion
CHBC	Community Home Based Care giving
CSO	Central Statistics Office
CSIS	Centre for Strategic and International Studies
DMSAC	District Multisectoral AIDS Committee
FBO	Faith-based Organisations
HBC	Home Based Care
IHP	Interfaith Health Program
IRHAP	International Religious Health Assets Program
NGOs	Non-governmental organizations
NAB	Nurses Association of Botswana
NACA	National AIDS Coordination Agency
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	People Living With HIV and AIDS
RHA	Religious Health Assets
UNGASS	United Nations General Assembly
UNAIDS	Joint Universal Programme on HIV and AIDS
UNCF	United Nations Children's Fund
WHO	World Health Organization
WCC	World Council of Churches

Declaration

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

February 2013

Acknowledgements

I would like to thank the almighty God for enabling me to complete this study, at a time when it seemed humanly impossible. My heartfelt gratitude to the very able staff at the Africa Centre for HIV/AIDS management: Prof. Jan Du Toit, for his passionate commitment to the vision of the centre, my supervisor Prof. Johan Augustyn, for devotedly guiding me through this study; Arlene for her timely responses and cooperation all the way through, Burt Davis, your speed is indescribable, I appreciate you all

I also acknowledge with gratitude the kind assistance i received from the following people:

My sister/colleague Mrs Mberengo, for the emotional and immense support,

Mrs Esther Nthebolang, for her devotion in doing the English-Setswana translation;

My friend Felista Changwony for her timely support;

My niece Grace-Ann Maina for working so accurately behind the scenes;

My daughter Refilwe for taking over the household chores as i engaged in the study;

My son Ngoma for coming in promptly and efficiently with the computer skills.

Pastor Tshepho for his very valuable contributions

The pastoral team, leadership and the entire congregation at Cloud and Fire ministries who participated in the study

Dedication

I dedicate this study to my dear late mother, Mama Grace Mbugua, a God fearing woman, a peace advocate; my role model: May your legacy forever live

To my beloved dad, a man of great wisdom, I thank God for the days of your life,

To my dear husband Pastor Pinto, for believing in me, continually challenging me to aim higher and unceasingly praying with me and for me.

To my little boy Prince Jesse. May you grow into the depth of virtues that people of faith exemplify and may you be favoured to be part of the HIV-free generation that we envision today.

To all the dear ones all the world over, who have been emotionally, physically and psychologically challenged to despair by HIV/AIDS, may this study encourage you to continue fighting the good fight of faith, as the promises of God anchor you even in the fiercest of the storms.

To all those who support and continue to tirelessly work for the cause of humanity, especially in alleviating the suffering of those infected and affected by HIV/AIDS: your labour of love is not in vain, there is hope.

To the faith community, there is work out there for you

Table of Contents

Chapter 1: introduction

1.1 Chapter overview

This chapter will lay the groundwork for the study , state the motivation for the research and reflect on the Botswana religions and their involvement in HIV/AIDS responses. A description of the research domain follows, project motivation as well as the significance of the study. The research problem, research questions as well as the objectives of the study will conclude this chapter.

1.2 Background information

HIV is a sexually transmitted virus that causes the fatal disease AIDS, a virus that has claimed more than 25 million lives over the past three decades, making it one of the most rapidly growing epidemics (UNAIDS, 2010). The United Nations General Assembly termed epidemic a global emergency that poses one of the most formidable challenges to the development, progress and stability of our respective societies and the world at large, and requiring an exceptional and comprehensive global response, at all levels (UNGASS, 2011). Although breakthroughs in HIV treatment and prevention had indicated a hope for an AIDS free generation, many challenges still remain that call for a need to identify, mobilize and maximise all resources to make the hope of an AIDS free generation a reality (PEPFAR , 2012).

In June of 2001, the faith community made a statement to the United Nations (UN) special general assembly on HIV/AIDS, committing themselves to get involved in the global AIDS response (UNAIDS, 2010). They called upon the international community ,UNAIDS and other UN organizations to consider involving them in the planning, implementation and monitoring of HIV/AIDS programmes at local, national and international levels. They also called on religious leaders wherever possible to make use of their moral and spiritual influence in all communities to decrease the vulnerability of people responding to HIV/AIDS and to scale up their care and support initiatives.

The commitment by the faith sector was followed by another call by the World Council of Churches asking churches to be sensitive to the reality that HIV/AIDS brings the lives of many people into crisis, and that, it is a crisis which churches must face if they are to fulfil

their mission (WCC, 2002).This statement came in the wake of an increasing number of people worldwide falling sick, suffering physically, emotionally, spiritually, and in abandonment and desolation.

'FBOs are also known to be resilient and sustainable, continuing their work despite conflicts, natural disasters, oppression and disease, proving to endure for longer time when others tire, drop out or shift energies to other crises . At times of urgent need, these religious groups do already have an established presence in communities and they are able to start responding immediately. Most of them belong to extended denominational networks often covering wide geographic area, and therefore, for many under sourced African congregations, this translates into links to the resources of more wealthy communities.' (Foster, 2003, p.15).

FBOs have also demonstrated a long standing commitment to local community needs over time , over a century before the first HIV/AIDS cases were reported, FBOs were still active in the local communities (Ssewamala and Ismavilova, 2008), and still are. Foege, an internationally renowned leader in global health, re-affirms by saying …'in faith groups, we understand a tradition that goes backward and a responsibility that goes forward' (Foege,1996, p. 10). FBOs are therefore strategically positioned for HIV/AIDS responses as they have become an integral part of life and society in most parts of Africa, present within most communities. Over the years, they have built much credibility with people owing to their presence at the grassroots level, and for the many services they offer (Parry, 2003).

In sub-Sahara Africa, countless FBOs are working tirelessly to meet the needs of the people they serve. In Uganda religious organisations have used a faith-based approach to deliver HIV-prevention services based on five components; belief in Gods power and guidance, using relevant faith teachings and best practices based on the holy scriptures to complement prevention messages, use of religious /faith based structures and religious leaders to integrate prevention interventions into their pastoral work and promotion of application of self-control skills among the target audience (Liebowitz, 2002). One study from Masindi (in Uganda) reveals that, at least 66% of people reported changing their sexual behaviour because of AIDS; Senegal's and Uganda's success in reducing HIV prevalence was as a result of involving religious leaders directly . These humanitarian teachings that religion offers makes them effective partners in the fight against HIV/AIDS.

However, it's sad to note that despite these positive contributions by FBOs in HIV/AIDS interventions, many of them remain on the margins of national AIDS responses as their work remains undocumented (UNCF, 2004). FBOs have also met with hostility, they have been labelled as impossible to work with because they have so many agendas that are actively hostile to HIV prevention. (Paterson , 2002, p. 15).

A recent consultation on FBOs role in sustaining community and country leadership in response to HIV/AIDS emphasized the need to appreciate the unique qualities of the HIV/AIDS programs that FBOs offer that make them valuable assets in HIV prevention and treatment (PEPFAR, 2012)

It is in the light of this contradictory information on the, engagement of FBOs in HIV/AIDS programming that this study is carried out. Reasons for inadequate responses by certain FBOs in Kanye to HIV/AIDS will be explored, to ascertain the actual position of their engagement on the ground.

1.3 Research domain

The study was carried out in Kanye village, one of the biggest and oldest villages, situated south of Botswana's capital city, Gaborone, and with a population of 45,196 people as per the 2011 census. As a church operating at the community level, this study opines that the data that is availed, will act as a pointer to the patterns of FBOs in Kanye and Botswana as a whole. It will also be useful to the current initiatives they serve as well as the challenges they encounter.

The study took place in the premises of Cloud and Fire Ministry, an independent Pentecostal church founded in Botswana in 2008, by some faithful Batswana brethren in collaboration with the Voice of the Lord Evangelical Ministries in Ghana. The church is 100% self-supporting and managing all its financial obligations through members' contributions, and a membership of 250 people drawn from Botswana, Uganda, Zambia, Zimbabwe and Kenya.

1.4 Motivation for the study

Starting from the late 1990's, Botswana confronted the HIV/AIDS epidemic, acknowledging that more than 38% of its adults were HIV positive, and moved on to own the multi-actor response to HIV/AIDS , based on a comprehensive approach that includes prevention, treatment and care. In the year 2000, the seeming threat of losing a large percentage of Botswana citizens necessitated the then president of Botswana, His Excellency Festus Mogae , to declare the epidemic a national disaster . The National AIDS Coordinating Agency (NACA) was formed, to lead the multi-sectoral response in waging a decisive battle against the epidemic now considered a social-economic and health problem.

Although in the field of treatment Botswana's anti-retroviral treatment program ranks among the most advanced, people may not be able to just take the medication and live normal lives. There are many complex issues which can prevent people from moving forward (Turner, 2009). When living with an incurable stigmatizing disease, with increasing availability of drugs, Turner notes that research work will shift from the medical to the social needs of the people living long with the virus.

A study by the nurses association of Botswana indicated the wish for clients to be taken care of at home, especially during their last days, and meet their death in the presence of their loved ones (NAB, 2004). It is this situation that has inspired voluntary work for care giving, which is more evident in Community Home Based Care giving (CHBC) , a program that has been institutionalised and elevated to complement the mainstream health system (CSO, 2001). Care-giving has been long embraced in Botswana. The Batswana are known to be peace loving and very patriotic, having embraced the spirit of 'boithaopo' (Volunteerism), 'boineelo' (service to one another), and 'botho' (humanity), and the call for caring for one another in Botswana. These notions are all deeply enshrined in Botswana's vision 2016 (a call for people to value and inculcate the system of helping one another (Vision 2016, Botswana IYV newsletter).

Kanye CHBC program is one of those rated well by the Government. the Botswana second generation HIV/AIDS surveillance , however, reported a high death toll among the patients (NACA, 2005). The program was dominated by women and was also challenged by stigma, resulting in the neglect of the sick (Kangethe, 2004). More than 50% of these women caregivers were reported to be financially challenged, seriously influenced by aging and

unable to adequately understand the dynamism of the care process, especially the progression of the disease (Atta & Fidzani, quoted in Kangethe 2004).

The volunteerism of palliative primary caregivers in Kanye is culturally ordained in their Setswana culture and many other traditions. Caregivers have alluded to the power of religion as an important factor driving their volunteerism; a religious vocation that they have fully embraced (Kangethe, 2006). Faith-based organizations have been reputed as the principal places where people gain motivation to care for one another and learn the practical dimensions of care. If there is any hope of stemming the advance of HIV/AIDS, that hope relies in part on the work of FBOs. Sachs (2007) concur that 'religious motivation surfaces in characteristic forms of best practices in the fight against a deadly disease' (Sachs, 2007. p. 10).

1.5 The Botswana religions and their engagement in HIV/AIDS

Botswana is home to many religions, with over 80% of the population belonging to one religion or the other, covering and extending to all segments of the population. They are well placed to influence the mass of people at the grassroots and are being able to change their behaviour and adopt safer sex practices, culturally sensitive HIV prevention and care services (Togarasei et al, 2008, p. 51). Botswana Christian churches are divided into three categories: mainline churches, African Independent Churches and Pentecostal churches (Togarasei et al, 2011). Half of the Botswana population consider themselves Christians, while the majority of the other 50% practises traditional religious beliefs with two to three percent being Muslim. The level of atheism, which is very unpopular, remains unknown. The government policy and amicable relations among and between the country's religious communities, contribute to religious freedom and practice. The Government of Botswana has been able to maintain good relationships among religious groups, which greatly contributes to the country's stability

On 1st September, 2004, Church leaders in Botswana launched the September annual month of prayer for HIV/AIDS. This month of prayer was inaugurated in September 1996, by the then president Sir Ketumile Masire (Mmegi, 2004), as he also appealed to the churches in Botswana to help in the fight against HIV/AIDS. In the same year, the Christian churches initiated an ecumenical HIV/AIDS intervention under the umbrella of Botswana Christian AIDS Intervention Program (BOCAIP) (EHAIA, 2001). The mission of BOCAIP is to

develop and support a country wide network of church based responses to effect positive behaviour change and provide compassionate care and support to those infected and affected by HIV/AIDS.

In some parts of the country, FBOs are assisting vulnerable groups and they provide material support, grief therapy, counselling, pre-primary education, hospice care, healing, psychosocial support, grassroots moral education and social activism. The church has also incorporated training in counselling into the theological training of laity community based support to orphans and vulnerable children like Tshireletso. They also offer institutional care for orphans like SOS children's village, hospice services, home based care and Christian hospitals

In analysing the responses of FBOs in Kanye for purposes of meaningful engagement, this study therefore boasts of being one case of 'good practices 'in HIV/AIDS programming, that has Government backing.

1.6. Significance of the study

This study hopes to contribute to an emerging dimension of HIV/AIDS programming. It also hope to contribute to the intangible religious assets of the faith community, with the hope that health care providers, HIV/AIDS project managers /developers /lobbyists and advocates wishing to advance the cause of FBOs engagement in HIV/AIDS, will make optimal choices on health policy, practices and investments. To the faith community, the study hopes to provide strategic direction and also act as a valuable guide as to how they can respectfully engage with the public health system.

 It is also hoped that the insight provided in the study, will guide future FBO work, to develop appropriate strategies especially in areas where churches are not utilising fully their powerful advocacy tools.

1.7 Research Problem

In a country where the Government is so committed to tackle HIV/AIDS, and has recognised the critical role of FBOs (and even appealed for their help) the faith sector in Kanye seems not to have done enough to substantially increase their representation. Some scanty noble initiatives have been noted in some places, but the general feeling among many is that the

church has not adequately exerted its influence. Churches are not utilising their powerful advocacy tools to break the silence and the existing initiatives, though noble, are far too small.

A statement from one stakeholder describes the position of the Botswana church tas follows: 'HIV/AIDS is claiming lives daily and statistics are showing; to a large extent the church is putting on a great silent fight. We are faced with a big problem of denial in the church; as a result our clergy are not well equipped to deal with the affected. The sermons are not comforting, and the counselling is below par; openly talking about sex in the life of the church is taboo ' (Modiega & Moleko, BCC). The reasons for these limitations by the church are not known.

1.8 Research Question

This research seeked to answer the following question:
What are the reasons for limited responses to HIV/AIDS in Cloud and Fire Ministries, Kanye, Botswana.

1.9 Research Objectives

The objectives of this research paper were:
- to assess the characteristics of HIV/AIDS initiatives in Cloud and Fire ministry
- to assess the current scale of HIV/AIDS responses in Cloud and Fire Ministry
- to identify any challenges hampering HIV/AIDS initiatives in Cloud and Fire ministries
- to identify any overlooked HIV/AIDS initiatives in Cloud and Fire ministries
- to formulate strategies to increase involvement in HIV/AIDS initiatives in Cloud and Fire Ministries.

1.10 Limitations of the study

The study acknowledged the following as potential limitations to this study: the researcher was a foreigner and might not been able be able to explore and immerse fully in the study due to cultural and language constraints. The case that was studied may also not provide an adequate sample in terms of collating views on the responses of the churches in Kanye, and

Botswana as a whole. Case studies make clear that FBO health engagement in Africa varies far more than most appreciate, hence sweeping generalisations about them can obscure important realities (GHA report). The researcher also felt the study lacked some baseline information with which the responses of the Kanye churches would have been benchmarked. It later emerged that priorities of different places differ in scope as well as in factors influenced them.

1.11 Conclusion

This chapter gave a motivation for the study. It also highlighted the faith sector commitment to the global and national HIV/AIDS responses, as well as a brief overview of some of the diverse ways in which the sector has and can be used to respond to HIV/AIDS. The study has noted the social complexities of HIV/AIDS, and a brief mention of the church responses as well as the the CHBC programs that are currently offering primary care to the PLWHA courtesy of the compassionate and caring Botswana people motivated by religion and Botswana's vision 2016 . This research has been rendered significant as part of an emerging field of FBO engagement with the public health sector.

Chapter 2: Literature review

2.1: Introduction

This sector starts with an overview the incidence and intensity of HIV/AIDS in the world as well as in sub-Sahara Africa; the Botswana epidemic as well as its drivers; definition of key concepts that the study has utilised; the framework that guides the study; contribution of religion to healthcare; interaction of culture, religion and HIV/AIDS; Africa health worlds; limitations to FBOs work and the potential that exists to strengthen the work of FBOs

2.2 About HIV/AIDS

HIV weakens the immune system leaving people vulnerable to other infections that may prove fatal. There is currently no cure for HIV infection; however, effective treatment with antiretroviral drugs can be used to stop the progression of the disease, and may give an extra 15 years of life (Badri et al. 2006 as quoted in Turner , 2009). In 2011, approximately 34 million people were living with HIV globally. More than eight million people living with HIV were receiving Antiretroviral Therapy (ART) in low and middle income countries, while another seven million needed to be enrolled to meet the target of providing ART to 15 million people by 2015 (WHO,2011). Sub-Saharan Africa has the largest HIV epidemic, with nearly one in every 20 adults living with HIV, and is home to 69 % of People Living with HIV/AIDS (PLWHA), (WHO, 2011).

The advent of HIV/AIDS in Africa, a continent that has been in the midst of a plethora of problems (poverty, illiteracy, famine, political instability, natural disasters etc), over the past 50 years, was like adding insult to injury, ' The disease occurring in marginalized communities, in troubled and insecure times became a recipe for a new wave of prejudice, and a fertile breeding ground for moral and social-political complexities such as poverty-bred HIV; behaviour changes under conditions of deprivation and illiteracy; women's vulnerability and HIV/AIDS and the disenchantment of intimacy' (Van Niekerk, 2005. p. 67). A situation of this nature weighs down PLWHA in Africa as they expect to find deepening poverty, isolation, an inability to satisfy basic needs such as food and shelter, and a rejection in communities and formal services and fear for their children (Russel and Schneider as quoted in Turner 2009).

2.3 HIV/AIDS in Botswana

The HIV/AIDS epidemic presents a major threat to socio-economic development of Botswana. The country's rating in terms of HIV/AIDS prevalence is extremely high. In 2009, there were an estimated 300,000 adults living with HIV, or one quarter of the population aged 15 and over, with an adult HIV-prevalence among 15 - 49 year olds of 24.8%, the second highest in the world after Swaziland (UNAIDS, 2010) . The 300,000 figure for the infected may appear minimal in absolute terms but it is indeed a high one, considering the current Botswana population figure of two million people.

Although HIV and AIDS are affecting every region of the world, each country's epidemic is distinctive in terms of drivers, vulnerabilities, aggravating factors and the populations that are affected, and therefore the responses from the international community and the countries themselves must be uniquely tailored to each particular situation, taking into account the epidemiological and social context of each country concerned (UNGASS,).

Several factors are thought to have contributed to the rapid spread of HIV in Botswana. Lack of in-depth knowledge on HIV/AIDS such as the transmission routes of HIV infection has resulted in stigmatization and discrimination for PLWHA, since people fear contagion. The linkage of the disease to sexual immorality and the marginalised groups like sex workers causes the infected to be stigmatised and discrimination (CSO, 2005). HIV-related stigma and discrimination undermine prevention efforts by preventing people from seeking HIV testing (Wolfe et al, 2006) and from seeking and accessing healthcare services to protect them from infection. Fear of stigma and discrimination also impedes on adherence to treatment and disclosure of one's status to others such as family members or sexual partners (UNAIDS, 2005). The unfortunate thing is the inexistence of legislation to protect the human rights of PLWHA and the marginalised groups (OSI, 2008).

According to Campbell and Williams (quoted in Turner, 2009), the proliferation of the mining industry has also led to work migration patterns where many men from rural areas move to the major mining towns for employment. The young men involved in this migration often use prostitutes or have local girlfriends when away from their wives or girlfriends in their home towns, and this fuels HIV spread between men and later to their female partners when they return (Jochelson et al. quoted in Turner, 2009). Multiple partners and change of partners is accepted are accepted as the norm and are common in both urban and rural areas.

The exceptional mobility of the Botswana society is also a central driving factor in the HIV/AIDS epidemic, carrying the virus even to the remotest areas (CSIS , 2004). A typical Motswana moves among several homes, workplaces, home villages, cattle posts and arable farm. Government employees are commonly transferred every two years, while rapid construction of roads, hospitals and schools involves constant movement of construction teams. Botswana also straddles a major Southern African trucking route, which has given rise to a booming sex trade. CSIS further notes that the position of women in the society also contribute to the spread of HIV. Legally, a married Motswana woman is a minor, with no independent legal standing, have no right to refuse sex with her husband, and no authority over her finances or labour. There is little legal support available, except for shelter for battered women with only a bed capacity of 22. With limited economic resources, women are apt to fall into transactional sex for money.

Inmates in four prisons situated at the capital city of Botswana, Gaborone reported the presence of following risky behaviour that could lead to the spread of HIV. Sex between men; sex between women and the sharing of tattooing needles by both male and female inmates, among others , are common in the prisons. (Masetlhe , undated)

2.4 Definition of key concepts

Faith based organisations (FBOs)

According to the Centre for Faith and Service, developing definitions for a Faith-based organization has proven elusive; as such, organizations are encouraged to develop their own working definitions (CFS, 2001)

FBOs in this study will refer to the local church, the congregation, and individual; members' involvements in church and volunteer organisations in civil society (Smit (1996:119-129, 190-204).This definition brings into play following six statures of the church as an operational concept, as identified by Smit: the church as a worshipping community (referring to the Sunday worship service); the local church (also referred to as a congregation); a denomination (whereby a group of local churches in a specific areas cooperate to work together); an ecumenical body (whereby different churches and denominations meet to advocate important issues like HIV/AIDS) and also comprising of individual members who live according to Christian values in their everyday lives.

Initiatives

This term will be applied to mean the identifiable significant health work that is not yet formally organised, but may exist for some time through loose arrangements, often the early phase of formal organisation and not uncommon for religious leaders.

Religion

Religion in this study will refer to 'a wide variety of comprehensive systems of sacred beliefs and practices, usually issuing in religious institutions, groups or organizations, that range from fluid to codified, popular to formal, central to decentralised, communal to institutional. In Africa, they include African traditional religion. Christianity, Islam and generally a wide variety of other identifiable religions (ARHAP, 2007)

Faith community

This will refer to religious bodies at local levels such as churches, as well as local bodies of Christian order (PEPFAR, 2012)

Parameters of study

This study will focus mainly on the on the Pentecostals and African independent Christian churches/organisations, which account for the vast majority of FBOs, globally and in Africa; they are the newer, rapidly growing denominations in Africa, for which information is limited, and there are some concerns around their engagement in public health (GHA,).Their size and theological ties to health suggest they could be potentially powerful partners in health work in Africa. In 2008, there were 107 million Pentecostals, overtaking the AIC churches, that numbered 60 million; both movements put theological emphasis on spiritual, physical and mental health and embrace faith healing (www.pewforum.org).Pentecostal churches are the most vibrant and fastest growing group of churches in Botswana and are therefore poised to become the biggest group of churches in the near future (Togarasei et al, 2011).

Following terms will be used interchangeably:

'FBOs' and 'Churches';

'Spirituality' and 'Religion'.

2.5 The framework

This study is guided by the ARHAP research study report, 'Mapping, understanding, translating and engaging religious health assets'. ARHAP carried out the study in Lesotho and Zambia, as part of a World Health Organisation contract to try and identify, map, understand, translate and engage Africa Religious Health Assets, as well as explore how these religious entities work within their communities. It also explore religious entities within the religious and public health arenas in which they are engaged. The fundamental research question at the heart of this research was: 'what is the contribution of religion and religious entities to health and well being in the context of HIV/AIDS in Lesotho and Zambia'?

The ARHAP model theory builds on the assumption that human communities have assets, referred to as Religious Health Assets (RHA) of various kinds, located in or held by a religious entity. These assets can be leveraged for purposes of development or public health. The interface between religion and health can be understood in terms of both tangible and intangible assets. The study employed a holistic African perspective which considers health and religion as part of an indivisible 'health world', a term derived from the Sesotho word 'Bophelo', which has a range of meanings from biological life (of human, animals and plants), to the social life of individuals, families, villages and countries, hence religion and health are an intertwined part of the social aspect of Bophelo. The took the premise that religion, health and well-being are deeply influenced by the local culture and cannot be understood as a single simple cultural variable. The assumptions of the study were that this holistic perspective defines the health seeking strategy of many Africans and that failure of health policy makers to understand the influence of religion on African health worlds could seriously undermine efforts to scale up health services. The emphasis was placed on proper assessment, appreciation and enhancement of the potential of these assets for a better alignment between public health systems and religious structures with which they might partner.

This research study is an instrumental case study of ARHAP. It is conducted to provide insight into an issue, develop, refine or alter some theoretical explanation, and is undertaken to understand something more general than the particular case (Christensen et al, 2011). In

analysing the responses of Cloud and Fire Ministry, the study sought to further develop the ARHAP hypothesis.

Literature will be reviewed to understand what the intangible religious health assets are and how public structures can relate to them in a respectful way, the health worlds found in Africa as well as the impact that religious-cultural frameworks have upon the way in which people conceive of health and well being and undertake health seeking agency. Further literature will look into reasons why FBOs initiatives have been overlooked , limitations that stand in their way of effective involvement and what potential exists for strengthening them without undermining the very things they offer or destroying them through inappropriate interventions or engagements.

There are various theories and models at work that can also assist in analysing : why some issues are prioritised in the national and international health policy agenda while others are not ; support investigation why national health policies achieve less than expected, perform differently than expected, or worse off, fail in their goals (Morgan et al, 2009). FBOs involvement in HIV/AIDS will be both affected and directed by the way policies are externally and internally 'initiated, developed of formulated, negotiated, communicated, implemented and evaluated' (Buse, Mays & Walt, 2005). In order to adequately engage with them, there needs to be an understanding of what drives actors within the process. The Policy Triangle Framework of Walt and Gilson (1994) offers a way of conceptualising these influences, and focuses on the interaction between actors, content, and process within the policy making framework. This framework will therefore enable for an understanding of how religion is conceptualised and utilised within FBOs, highlight FBOs actions and motivation to work, and analyse how this has affected overall HIV/AIDS prevention/mitigation.

2.6 Religion in Africa

The role of religion in health

A number of conceptual and empirical studies have continued to document the relationship between spirituality and health, in the era of HIV/AIDS. With the changing face of the world, especially the quantum leaps in technology, many within the church and outside are questioning the role and importance of Christianity within the society; this item was given much attention at the 24th general council of the World Alliance of Reformed Churches,

Accra, Ghana, in 2004. A statement accepted by the general council states that 'the groaning of creation and the cries of the poor and the marginalised are calling us to conversion for and recommitment to mission'. (Henry, 2011. p. 25).

Sachs (2007) observes that, at the grassroots, in one context or the other, ordinary people give extra-ordinary care because of their religious foundation. He points out that the manner in which, religion permeates life in Africa, enables the creation of a framework of community, crossing lines that ordinarily divide, and linking individuals and family in social bonds. Since religion is rooted in local life, connecting with faith groups facilitates understanding of the broader context in which the disease proliferates, Sach observes.

The ARHAP study, in seeking answers to the question 'what does religion contribute to health? realised that, religion contribute to health through tangible and intangible health promoting factors of FBOs; with the 'intangible' factors ranking the most important than the more visible tangible factors; however, the researchers noted that the strength of religion lies in the integration of both; these assets therefore need to be understood and appropriately engaged in order to ensure maximum FBOs engagement in health care (ARHAP, 2006).

The Pew Research centre's forum on Religion and public life, a forum that delivers impartial timely information on religion, conducted a major public opinion research survey to assess how sub-Saharan Africans view the role of religion in their lives and societies (www.pewforum.org). The survey involved more than 25,000 face to face interviews, in more than 60 languages or dialects, and in 19 countries. Among the issues that the survey sought that bears relevance to this study were people's descriptions of their religious beliefs and practices , their degree of political and economic satisfaction, their position on issues such as polygamy.

The findings of the report were part of the larger effort (the Pew-Templeton Global Religious Futures Project) that aims to increase people's knowledge of religion around the world. The report hoped to contribute to a better understanding of the role of religion in the public and private lives of approximately 820 million residents of sub-Saharan Africa. This study found the report very crucial in analysing the contribution of understanding the crucial role of religion in the health seeking strategies especially in the context of HIV/AIDS.

The forum further revealed that the practice of religion in sub-Saharan Africa involve intense , personal encounters with God, spirits and miraculous events; in every country surveyed ,

three out of every 10 people say they have experienced or witnessed divine healing of an illness or injury, more than four in 10 people in nine countries have seen the devil or spirits being driven out of a person: the experiences are more common among Christians than muslims.The Pentecostal movement within the Christian community is credited for miraculous events and intense personal encounters with God. Divine revelations, interpretations of prophecy, exorcising of demons are commonly reported from the Pentecostals. More than half of Christians, in all but three countries, believe that good health and wealth will be availed by God to those who have faith. Across sub-Saharan Africa, people hold very conservative views on issues such as abortion, homosexuality, and prostitution, and detest western movies, music and television, which they claim have hurt morality in their nations. Majority of African Muslims and Christians support that believing in God enables moral uprightness. A substantial number view HIV/AIDS as a punishment from God for immorality. The majority of people in most countries oppose drinking alcohol.

Conceptualisation and utilisation of religion within FBOs
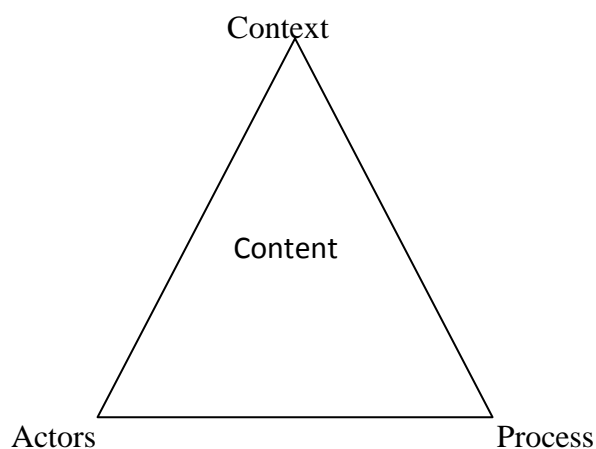

Figure 2. 1: Policy triangle (Adapted from Morgan et al (2007)

This policy triangle replaces 'actors 'by 'content 'in the middle, in order to explore how actors, process and context interact to shape the policy content of FBOs.

Content

Content in this study will refer any national and international policy and or resolution that have been put into place either by the faith community, the public health care system or both, that direct the work of FBOs in the African health care system. It will also be viewed as 'an agreement or consensus on the health issues, goals and objectives to be addressed, the priorities among those objectives, as well as the main directions for achieving them', both written and unwritten (WHO , quoted in Morgan et al, 2009).

The significant role of the spiritual dimension of health was recognised in May 1984, by the 37th World Health Assembly. They adopted resolution WHA 37.13, which made the 'spiritual dimension ' part and parcel of WHO Member states strategies for health, and of whose some vital parts read as follows: 'The spiritual dimension plays a great role in motivating people's achievements in all aspects of life; if the material component of the strategy can be provided to people, the non-material or spiritual one is something that has to arise within people and communities in keeping with the social and cultural patterns; the spiritual dimension is understood to imply a phenomenon that is not material in nature, but belongs to the realm of ideas,beliefs,values and ethics that have arisen in the minds and conscience of human beings ,particularly ennobling ideas' (WHO,1985).

In the early days of the HIV/AIDS epidemic, at the All Africa Conference of Churches 8th assembly on 22-27 November 2003, a total of 1000 church delegates, ecumenical movement, development agencies and the Africa Union president, adopted 'the covenant document on HIV/AIDS' (WCC,2003) . In it, the ecumenical family envisioned a transformed and life-giving church, embodying and thus proclaiming the abundant life to which they are called, and capable of meeting the many challenges posed by the epidemic. The covenant document was a re-affirmation of the potential that FBOs have to infiltrate the society and effect change in morals. Due to their engagement in civic behaviour, they have been proved to generate networks of trust and experience, which enables them to accomplish certain social goals (Putnam, quoted in Turner, 2009). Putnam labels these networks of trust and experience as 'social capital' affirming that it is this social capital that helps explain why religious institutions have out done the Government in combating HIV/AIDS.

In June 2011, the UNAIDS published a policy paper that laid a new framework for investment for the global HIV/AIDS response, based on existing evidence of what works in HIV treatment, care and support. Among the six programme activities they laid out that are

essential to an adequate HIV response are programs that focus on the reduction of risk to change people's behaviours and social norms, treatment, care and support for People Living with HIV/AIDS (PLWHA). These programs bear relevance since there is 'a lack of attention to care and support for HIV-infected people (Gruskin and Maluwa (2002, p. 646)

In Botswana, ever since the nation was confronted with HIV/AIDS in the late 80s, the Government has led in successfully creating an enabling environment to fight the disease; this environment includes good governance, guided by a comprehensive HIV/AIDS policy of prevention, care and support, supported by a long term multi-sectoral, multi-level strategy to combat the epidemic . Botswana has excelled in the field of treatment, with the country's anti-retroviral treatment program ranking the highest in the world. Mosarwe (2006), is of the opinion that greatest problem in the fight against HIV/AIDS is that 'we are misfiring', instead of shooting at the target. He is of the opinion that we are focusing at the wrong spot, yet there is contentment that at least the shot has been fired though it has hit the wrong spot. He was referring to the numerous efforts that have gone towards analysing the disease (AIDS), instead of focusing on the sort of people that are likely to die from it. He observes that such an approach only emphasizes what we should do rather than what we must become. He quoted some few instances of misfiring as follows *we are partial in our approach rather than holistic in our delivery, we have spoken much about the disease, and yet we have not lived and acted contrary to its diabolic effects. We are manufacturing more condoms than developing and empowering citizens to conduct affairs in the light of Gods provisions. We are scratching where it is not itching, assisted those that have gone public about their positive status yet barely enriching those that are still negative'.*Mosarwe's argument is that it's not a political revolution that people are waiting for, but a moral one, not as an option but as the only workable alternative.

Tangwa (2008), also shares useful insights as he challenges the current content of HIV/AIDS programmes. He is of the opinion that the African epidemic will not be easily solved by the present over-emphasis on study, statistical collection, data analysis or the knowledge of the epidemiological trends. The situation in Africa is rather that sick people crave for help, and don't want to be analysed. When they know there is no cure for their illness, they quietly accept their fate with courage and hope. 'An epidemic of the calibre of HIV/AIDS is not the ideal occasion for interminable wrangling, for scoring points or for opportunities of any sort; it is, first and foremost, the time to mobilise all available resources in the interest of those helplessly in need', laments Tangwa. At the the same time he emphasided the need to an

ethically approach to HIV/AIDS interventions. He plead for sympathising and empathising with fellow humans in need and urge fellow human being to treat those infected as ends in themselves and never as mere means to an end. He plead that, above all, we do them no harm.

In Christian circles, the Bible is considered the standard for Christian living, the inspired word of God. It is its own interpreter and means just what it says, there is no contradiction in it. It satisfies the criterions of beauty, morality, honesty and truth. It's an all time book that combines antiquity with modernity with precision, giving solutions to the current issues of man, as if it was written yesterday. One feels its content by its contextual application to man's life while contextualising its content; issues surrounding families, politics and economics are relevantly addressed by this incarnation book (Mosarwe,2006).

Intangible health assets of religion in health care

ARHAP (2006) identified the following RHAS inherent in FBOs that can be utilised to mitigate the effects of HIV/AIDS in PLWHA. Spiritual encouragement (the strength religion gives people in the midst of ill health, poverty and misfortune), compassionate care (the ability in religion to offer help in a caring and compassionate manner), contribution of religion in the areas of education, training and teaching, material support in form of food parcels to the sick and clothing for orphans as well as moral formation through its impact on the behaviour and lifestyle of people.

Spiritual encouragement

The Spiritual encouragement that religion advocates can be an important element in the way people face chronic illnesses like HIV/AIDS, the suffering and eventual loss. Spirituality helps patients find meaning in their suffering. According to Frankl (1984), 'Man is not destroyed by suffering; he is destroyed by meaning without purpose'. Medical ethicists hold that, religion and spirituality form the basis of meaning and purpose for many people (Foglio & Brody quoted in Frankl 1984).

It is commonly observed that, while patients struggle to cope with the physical aspects of their disease, they also suffer mentally and spiritually, as they attempt to understand the reasons for their suffering, and engage the deepest questions of life. People need to understand things like how their families will cope with their demise, why God would allow

them to suffer and a whole lot of issues. True healing requires answers to all these questions. However, some observational studies have suggested that people who have regular spiritual practices tended to live longer (Strawbridge et al.1997). Spiritual beliefs can help people cope with disease and face death, as they believe that their death would usher them into the loving presence of God, and that death was not the end but a passage, and that they would live on through their children and descendants (George H,1997). It emerges then therefore that, spiritual values help the sick understand their illness and are able to cope, and those who have lost dear ones are able to cope with the loss. (Puchalski, 2001)

FBOs health care facilities

Tens of thousands of FBOs in Africa deliver healthcare, 75-80% or more Christian and between 5-10% Muslim, the remaining be Baha'i, Hindu, Jewish and other faiths.

Compassion

Compassion is defined as the energy we need to right the wrongs that cause suffering; a revolutionary compassion must deal with the causes of suffering, not just the symptoms Purvis, quoted in WCC (2007). Compassion for the sick allows them to pour out their hopes, fears and beliefs, all of which can be incorporated into their therapeutic plan.

However, it is not only the PLWHA who needs healing, but also the church and the world Heath (quoted in WCC, 2007), therefore the church should look upon itself as a Church Living with HIV/AIDS and feel the pain, the rejection and the suffering as do PLWHA. According to Purvis, in the HIV and AIDS era, our revolutionary compassionate Christian leadership and faith should address the social causes of HIV/AIDS by: condemning corrupt and violent governments and encourage reconciliation; contest laws that do not protect the vulnerable like children and women; promote peace so that welfare funds are not diverted to war; address the social evils that encourage the disease such as poverty, gender inequality, unhelpful cultural practices and many more. Purvis however acknowledges that there will be situations that the church cannot change, and in such situations when the church cannot right the wrongs that cause suffering, it takes a compassionate church leadership to rise up to its prophetic role and condemn social evils, using the same word of God by which he created the earth.

Christians are called to be compassionate since Christ was the very embodiment of compassion, by identifying himself with our suffering regardless of his very nature of being

God himself . Christians are supposed to be Christ like and emulate Christ (Mathew 25:31-46). Jesus, in his earthly ministry went about doing good and healing all that were oppressed, not some. This means that even diseases like HIV/AIDS are not exempt; in Mark 1:40-42, the Bible says that Jesus was approached by a leper (leprosy in ancient biblical times was an infectious impurity (Lev.13:1-17), and lepers suffered emotionally and socially from the exclusion associated with the disease. The leper asked Jesus to make him clean if he chose to and Jesus, moved with compassion replied 'I do choose. Be made clean!', Our criteria to enter God's Kingdom , according to Mathew 25, will be based on whether we were able to suffer and stand with the sick, the poor, and the oppressed; whether we took responsibility to right the wrongs that caused suffering by giving water to the thirsty, food to the hungry. It is however unfortunate, that a lot of church efforts are being wasted on attempts to win more members to their different beliefs.

Care giving

The work carried out by FBOs in care giving draws from their biblical mandate to care.The church's commitment to caring for the sick in Africa has been unwavering, as evidenced by this statement from the All Africa Conference of Churches 'we shall do all that is necessary and within our power to encourage both men and women to love, care, support and heal all those who are infected and affected by HIV/AIDS in our communities, countries and continent (AACC, 2003).

FBO s represent a significant portion of a nation's infrastructure, and in some countries, are the dominant social service providers, managing hospitals, schools and social service facilities (Sachs, 2007). According to Sachs, FBOs, intent on serving the particular needs of their localities, offer a wide range of care giving , ministering to PLWHA as well as their caregivers. Work-related stress and burn-out are experienced by health care workers, who are particularly vulnerable to exposure to chronic stress.

Sachs makes the observation that one of the hallmarks of FBOs service delivery is that they usually pay attention to the personal dimensions of care giving, and are able to build trust and listen to the personal stories of those they visit.

Aspects of religion also include questions of what is considered right and wrong and what constitutes fair and unfair (Diouf , 1996). There is therefore evidence of a relationship

between spirituality and both positive and negative attitudes towards HIV/AIDS. The view that there would be a worldwide decline in religion as development produced more secularized states has therefore been deemed flawed and instead it has been acknowledged that religion and religious networks have gained increased prominence (Olivier et al, 2006), and therefore deserve to be incorporated in HIV/AIDS programming.

Actors

Actors in this study refer to those that may influence the policy process of FBOs in Africa and specifically Botswana. In Africa, there is a notable impact of different religious organisations influencing each others' health efforts. Christianity and Islamic religions predominate in Africa. Traditional African religious beliefs and practices have not disappeared in Africa, but co-exist with those of Muslims and Christians. A large number of Africans, who actively participate in Christianity and Islam, also believe in witchcraft, evil spirits, ancestor sacrifices and other elements of traditional African religions. In most countries, majority say this is their religious affiliation. Following traditional African religious beliefs and practices were also recorded in the research report. Beliefs that sacrifices to ancestors and spirits can protect them from harm, belief in the protective power of sacrificial offerings and sacred objects, believe in the evil eye or the ability of certain people to cast malevolent curses or spells and use of traditional healers are pretty common. In Botswana, an online article on countries and their cultures reveals religious practices of treating people. Batswana seek medical help from a number of sources including clinics and hospitals, traditional practitioners and Christian healers. Practitioners of the African Independent Churches (e.g Baporafota (prophets), or a Baruti (minister or teacher), also engage in healing.

The process

This includes an assessment of how issues get into or do not get into the agenda setting, who is involved in the formulation, development and communication of policies; how policies are executed and operated and policy evaluation (Buse, Mays and Walt; Porter and Hicks, quoted in Morgan et al, 2009)

Unlike many countries, Botswana has 'National ownership' of the national response programme, funding more than 80% of the cost of the national HIV/AIDS prevention and

control programs; the multi-sector national response, as articulated in the National Strategic Framework, is in conformity with the UN principle of 'three ones', highlighting the importance of countries to have one agreed AIDS action framework that provides the basis for coordinating the work of all partners. It is also important the there is only one national AIDS coordinating body with a broad based multi-sector mandate (National AIDS Coordinating Agency), and only one agreed country-level monitoring and evaluation system in place in Botswana. NAC is the highest policy making body, and the National AIDS Coordinating body (NACA), is its secretariat that coordinates HIV/AIDS activities at national level (EHAIA, 2003)

In order to decentralise the multi-sector response, Government ministries and departments have their own programs. District Multi-sectoral AIDS committees (DMSAC) coordinate at district level, while District Development Committees (DDCs), support the DMSACs by coordinating Government and NGOs activities at the community level. The national strategic plan builds on the national policy on HIV/AIDS, with concerted action from all sectors, led by the ministry of Health and NACA. The Botswana Christian Council (BCC) is an ecumenical designed to bring about church unity and cooperation among different churches in Botswana. The BCC represents the Botswana churches in NACA, as well as in the Poverty Alleviation programme. Botswana government has also partnered with several international organisations to scale up responses. There is ACHAP (a model of comprehensive partnership approach to healthcare), WHO (supports surveillance, research, monitoring and evaluation); WHO (provides support to NACA in drafting national HIV/AIDS strategy); UNDP (supports teacher building capacity initiatives), UNFPA supports an alliance with Botswana youth).

The multi-sectoral response approach to HIV/AIDS has been noted to work best where partners and stakeholders combine their collective strengths to deliver effectively to the communities. It is in this regard that FBOs need to be engaged, rejuvenated and empowered to effectively play a much more meaningful and significant role in the national response.

The diagram below depicts the structure of the Botswana's multi-sectoral and multi-level national response. The church should therefore aspire to engage with these established structures in a process of mutual understanding to scale up responses.
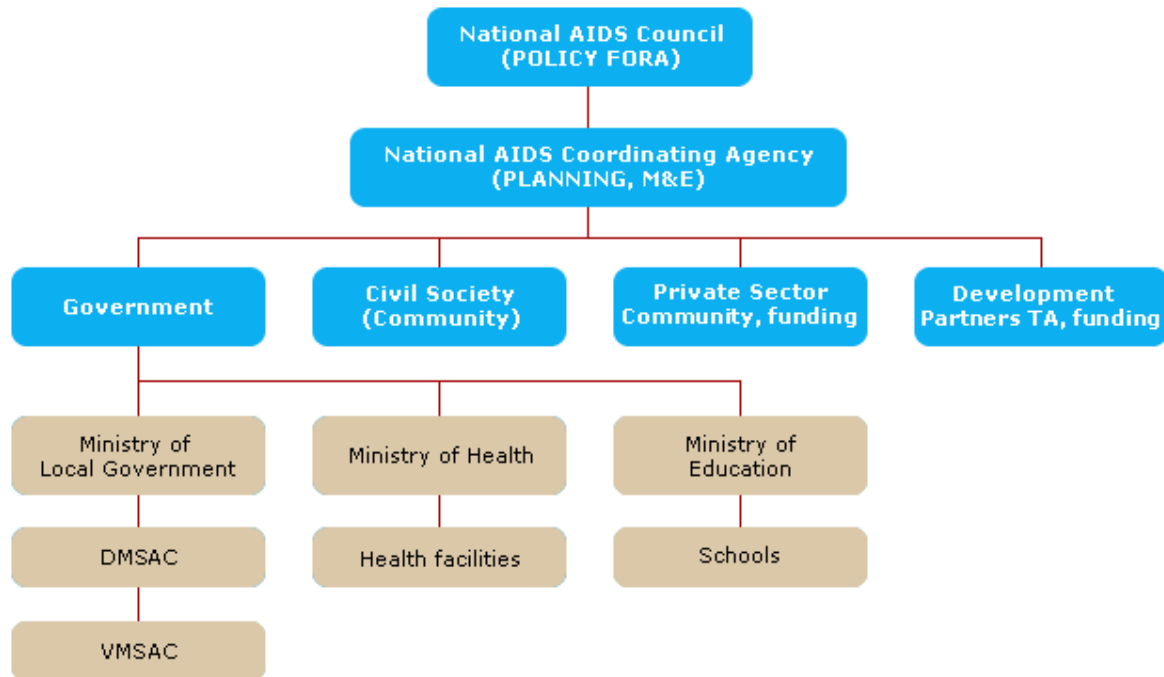
MULTI-SECTORAL & MULTI-LEVEL NATIONAL RESPONSE

Figure 2.2 Multi-sectorial and multi-level responses (Source: Department of HIV/AIDS prevention and http://www.hiv.gov.bw/content/national-response-and-partnerships)

Context

HIV/AIDS breeds in socio-cultural and religious beliefs and practices throughout the world, hence, the role of culture and religion in HIV/AIDS response need to be considered (Togarasei et al, 2011).

Context here will refer to political/structural, societal/cultural, and health/epidemiological factors that may affect how policy is made, changed or implemented. These holistic perspectives define the health seeking strategy of many Africans and need to be understood as part of efforts to scale up health services (ARHAP. 2006).

Van Niekerk (2005) cites poverty as social context for HIV/AIDS and women's vulnerability as some of the social complexities of AIDS in Africa. He observes that, for a viral disease to become an epidemic, a niche or social context is required; poverty is the main aspect of this niche or social context. Poor people engage in commercial sex while others in poor living conditions and deprived of education and health care are also vulnerable to HIV/AIDS.FBOs are challenged in their efforts to evangelise people for moral change in such contexts,

rendering futile their prevention efforts, especially abstinence. Women's devalued status renders them powerless over their sexuality especially in traditional African homesteads.

Political

In Botswana, the head of state together with his leadership, have demonstrated an unparalleled political and economic commitment to health issues especially HIV/AIDS. However ,leadership at the highest level does not by itself translate to leadership and action at every level. The dispersion of ideas, plans and strategies to the local level remains less swift and certain than it might be, and relations between local government and community also pose challenges (CSIS,2004).

Cultural practices

According to Pope Paul V1 it is enevitably to evangelise human individuals and communities means the evangelisation of culture (Wachege, 1983). HIV/AIDS flourishes most demonstrably in a society where women are particularly vulnerable and where certain cultural norms in the traditional African homestead tend to spark the devaluation of women leaving them with less control over the nature and frequency of their sexual encounters (van Niekerk, 2005:62). In Botswana, women's social position, coupled with the broad social conservatism have blocked efforts to empower women to combat and defend themselves from HIV/AIDS. This position of women points to long term real challenges requiring cultural change and women empowerment (CSIS, 2004).

Culture also impacts on patients' baseline clinical obligations. A research on ethnicity and attitudes towards patient autonomy revealed that Korean-Americans and Mexican-Americans prefer a family centred model of medical decision-making rather than the patient-autonomy model favoured by most of the African-Americans and European-Americans subjects (Blackhall et al ,1995). The study suggested that physicians should enquire from patients if they wished to receive information and make decisions, or if they prefer that their families handle such matters. Freedman (1997), also reflecting on how cultural beliefs in patients also affect baseline clinical obligations, observes ''the approach called here 'offering truth', represents a brief dance between patient and health care provider....When offering truth to the patient with cancer, rather than simply explaining all aspects of his/her condition and treatment,....i attempt to ascertain from the patient how much he/she wants to know'' (Freedman, 1997, p. 35).

Cultural medicines used by traditional healers in most African cultures also compete with western medicine. These traditional healers are believed to be endowed with spiritual powers, which they invoke in their services (Green, 2003); and have been included in primary health care in most countries since the late 1970's (UNAIDS (2000), quoted in Kangethe, 2009). The reasons advanced for this has been the inability of health ministries to cater for the health care services, as well as the fact that traditional medicine is deeply rooted in the beliefs, values, social organisation and customary behaviour patterns of each community. In Botswana, Ditlhare 'trees', (or melemo), are used for treating ailments in human and animals, protection etc. Traditional healers are often sought to address the causes of illness and misfortunes, whilst western medicine is mainly acknowledged for its ability to treat symptoms. From the focus group discussions, it emerged that in Botswana, these healers (referred to as sangomas) are mostly consulted by HIV/AIDS patients, who often believe that HIV is caused by withcraft.

However, certain cultural practices like male circumcision have been proved to reduce HIV transmission especially in western Africa where it is widely practised (Liebowitz, 2002). The prohibition of alcohol among Muslims and certain Christian denominations have also helped with reduction of vulnerabilities in Uganda.Liebowitz notes that alcohol prohibition cannot easily be adopted if it's not a prohibition of a particular religion.

The African Health worlds

According to Germond and Cochrane (2009), a health world is 'a conceptual innovation, an attempt to find a word that captures the complex manner in which people construct their understanding of health and illness in local contexts, and how these play themselves out in terms of multiple health seeking behaviours. They argue that this notion describes and provides a key analytical tool for the field of health in its social context; a tool that can explain the empirical complexity of health beliefs (importantly, including religion) and behaviours thereby illuminating possibilities for improving health practices and outcomes.

A person's health world expresses and guides his/her health seeking behaviour, choices and actions in respect of illness or dysfunction in health. The concepts' root in solid history enables an understanding of the relationship between health and religion as well as the health seeking choices that people make. People tactically alter their responses to health challenges

or crises through a strategic negotiation of the actualities that govern their situation and the possibilities they see in it, weighing up of the cultural-religious resources available to them in relation to any technical-scientific resources that may be in offer. In African, the health of the body is intrinsically understood as dependent upon the entire set of relationships; an unhealthy earth or society, an isolated village or one that lacks infrastructure, a lack of respect for what previous generations have built up, a disregard for the health of the homestead- all are regarded as having a direct, even if invisible impact upon the health of the body of the individual person.

It emerges then from this analysis of health worlds that, a sense of belonging to a community and humane living are virtues that are highly esteemed in the traditional African life. In traditional Africa, the individual does not and cannot exist alone but owes existence to other people, including those of past generations and his contemporaries. In Southern Africa, for example, the concepts of personhood have been dominated by a cultural orientation to the person as socio-centric; and are conceived primarily as dependent, rational, fluid and particular, existing as a member of a community, constantly subject to external influences (Germond & Molapo, 2006). Whatever happens to the individual is believed to happen to the whole group, and whatever happens to the whole group happens to the individual.....The individual can only say , ' I am because we are, and since we are, therefore I am. (J.S. Mbiti 1990; 106). In Botswana, the Batswana use the words 'Motho ke motho ka batho' while in Zimbambwe the Ndebele use 'Umuntu ngu muntu nga Bantu' to mean 'a person is made a person by people. This is in opposition to the western concepts of personhood that are dominated by a cultural orientation to the person as an individual. The person is understood primarily as rational and self-determining, existing as an indivisible whole, bounded from external influences, a single human being as contrasted with a social group and embedded in the concept of human rights

Figure 2.3: A conceptualisation of the person in the indigenous Setswana health world (Source: Adopted from, 'Understanding health- seeking strategies in Southern Africa Sesotho social ontology and cosmology.)

The Figure above shows the 'Moya' (the interior body) of a Motswana is conditioned by his/her exterior body , which is in turn controlled by the social body (Botho).The word

'Botho' or humanness is derived from Tswana, the national language of Botswana. The Botswana people use the word to describe a person who has a well-rounded character, well mannered, courteous and disciplined, and realises his/her full potential both as an individual and as part of the community to which he/she belongs. Botho is therefore an example of social contract of mutual respect, responsibility and accountability that members of the society have towards each other, and defines a process for earning respect by first giving it, and to gain empowerment by first empowering others. (Botho & Vision 2016).

The concept of 'Botho' has been utilised for effective HIV/AIDS education, preventing new infections, fighting HIV/AIDS related stigma and discrimination and promoting gender equity. A new approach system , utilising old values and early HIV interventions in Botswana , were designed for individual behaviour change independent of social context (APHA,2006). Safer sex and gender safety were presented in a way that seemingly discredited all traditional practices. This approach was found divisive, especially among age cohorts and nationally demoralising
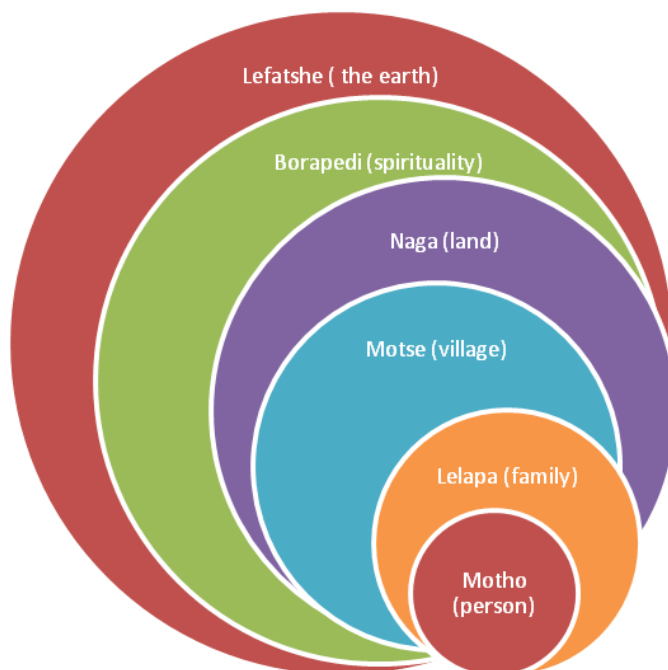

Figure 2.4 : Setswana social ontology and cosmology

Source: Adopted from, 'Understanding health- seeking strategies in Southern Africa Sesotho social ontology and cosmology. Available online.

The person (Motho) is surrounded by the family, the village, the land, the religion and the earth.He/she is at the very bottom as depicted in this figure.It is assumed that this 'motho' owes his survival to the rest in the hierarchy and he is controlled by the environment around him.If this 'motho' is living with HIV/AIDS,he cannot be described as a PLWHA,but rather a Society Living With HIV/AIDS (SLWHA).

Some African proverbs/sayings about compassion also go to show that by stigmatising PLWHA, we dehumanise the community as a whole: For the Dagara (a Ghanaian ethnic group), the saying 'BE be laar wie kye Innyei?' underlines that, 'we are not to be judgemental in responding to a request made of us in times of emergency, all that is required of us at those moments is to give the possible help we can give'; In Kenya, the Agikuyu tribe's proverb 'iri thaa ni iri iria' meaning 'the compassionate one has milk'. This tribe associates good things with things that can be eaten, therefore, compassion just like milk is edible and nurturing; 'Can you cry my cry?' a Liberian saying defines compassion as an emotional connection between people, you feel how I feel (WCC,2007)   ).

Engaging Religion, Culture and health

The literature above presents the struggle by African Christians to perceive and respond to Jesus, in ways that are meaningful to their own understanding and experience. However, it emerges that religion influences culture and culture influences religion. It's crucial to analyse how each religion is culturally conditioned. Although the infallibility of the Bible has been proved, yet, Christianity is different from one era to the next, one culture to the next.

For Christianity to be embraced and grow in the African soil certain cultural values made it possible and it is these values that acted as the African worldview of life serving as a catalyst that made it possible for Christianity to grow (Shorter (1975), therefore, many parallels can be found between African culture and Christian salvation theology. The Christian transformation of a culture, according to Shorter, is a way of taking that culture seriously and not a take-over bid, but rather a way of enhancing its authentic meaning. In the process of inculturation, what matters is to remain faithful to the tradition concerning Jesus and to the authentic values of African tradition and culture. The sky is the limit as long as both faith and culture are respected, their demands met in a genuine inculturation.

Culture is most important when health communicators understand and acknowledge the strengths that reside in a particular community so that they can be able to identify cultural

strengths and examine cultural challenges. Airhihenbuwa also asserts that cultural identity links the past with the present to establish trails for the future, therefore. He laments that Failure to engage the historical and political trajectories of cultural identities and its relations to a range of positive and negative health behaviours has resulted in cultures being blamed for certain ill understood health practices or, exalting culture for imagined past glory. Airhihenbuwa (2007) recommends that, rather than focus exclusively on the negative aspects of culture as is often done in interventions, beginning with the positive aspects of culture is recommendable.

Cultural values can also be utilised to effect moral formation, and ultimately a healthy society. It would help to revisit some of these traditional values that helped shape our traditional African societies, and utilise the same to shape our societies .A good example is on the 'Agikuyu elderhood' is one elder hood that was deeply integrated in the Agikuyu religion bearing an intimate link to the Agikuyu religious social life (Wachege (1992) . 'While a tradition may wither and die, or worse become an albatross around our necks, it can also be retrieved as a source of empowerment in the present, providing the symbols not only for its revitalization and renewal, but also for the society at large.

The church workers involved in care giving (pastors, chaplains) operate in challenging clinical contexts such as inter-cultural and multi-faith environments and on the other hand need to form their identities if they are to be influential as pastoral caregivers (Townsend , 2002). Townsend is a pastoral theologian and his survey on pastoral care giving reveals that theological reflection is at the core of pastoral identity in maintaining integrity with care seekers' differences and proposes a liberation motif of theological reflection that does not objectify clients but invites them to full partnership in the reflective motion of meaning-making and transformation, which leads not only the oppressed towards their own empowerment, but also the counsellor towards a more challenging and renewed knowledge and awareness of God, and new direction for empowering others. Townsend therefore argues that pastoral identity is socially constructed between care partners (among them God in their midst), and between the human partners and cultural .Such constructions result in an embracing of multiple personal identities, including spiritual representatives, fellow humans, pastors and divine partakers.

According to Wachege (1983) in incarnating the gospel of Jesus Christ in African culture will depend on the extent to which a church's pastoral activities are accompanied by a serious

reflection of the values which are present in each community and which can be usefully introduced into the life of the church. Tlhagale observes that 'the not-so-easy process of discernment has begun. The belief in the power of the ancestors to inflict pain or to enhance life, the belief that they can control the destiny of human beings has been radically adjusted and their god-like status as superhuman beings has been reduced to the status of deceased human beings. Faith in God has progressively become the determining factor of religion-consciousness, and exposed African culture to self-cleansing. With Christianity and Islam making powerful inroads into Africa this century, the forces that precipitate and sustain radical change in the continent, including western culture and socio-political systems, Christianity and Islam, now largely provide new framework and elements for community living and harmony in most societies in Africa.

The gospel certainly is not identified with cultures and transcends them all, but the kingdom that the gospel proclaims is lived by men deeply tied to a culture (Hickey,1982:288 pg 1.

The liturgy and mystical sacredness of worship by mainstream traditional churches are giving way to free, flexible and open forms of worship (Daily Nation Newspaper, 13 Feb'13.

2.7 Limitations to FBO work

While there is sufficient evidence that FBOs provide a wide range of HIV-related services, including to populations that are undeserved by governments and other service providers, FBOs are unlikely to reach their full potential in supporting countries to achieve their universal access targets without support from Governments and development agencies (UNAIDS, 2009).This could be attributed to lack of understanding about the nature, scale and scope of their contributions and how they supplement and interface with more centralised responses. .

Conflict between FBOs and external agencies/ public health practitioners

ARHAP study noted that FBOs faith based discourse are value laden (ingrained with notions of right or wrong, sin and virtue, guilt and innocence)', an approach that many development and public health practitioners engaged in promoting safer sexual health behaviours struggle with , and that agencies wishing to work with FBO's end up developing their own personnel religious literacy since religions tended to entangle humanitarian work and promotion of religion. With external agencies aid to FBO's meant for strengthening the health or

educational components of their service delivery; they are constantly wary that their resources might assist promote religion'. The agencies are therefore faced with a predicament of weighing to what extent they should tolerate religious promotion conducted through the FBO's development activities they support, lest they be accused of supporting religious activities. This situation threatens the already forged partnerships between external agencies and FBO's; agencies expect FBO's to implement projects with clearly defined objectives, specified activities and measurable targets, the result being many time consuming application procedures, stringent reporting requirement and short time frame". This situation forces FBOs to sometimes compromise their values and faith in order to secure funding.

It emerged from the responses of some key informants that their religious beliefs hinder some churches from supporting some interventions endorsed by the broader public health community. Most pastors are not afraid to make certain statements in public as long as they believe they are in agreement with their religious beliefs. They cited the opposition of issues of condoms and family planning methods, and instead their advocate for pure abstinence. Such are the issues that seem to fuel tension between other organisations and FBOs, causing even their 'positives' to be overlooked.

Decreasing human and financing resources

FBOs that have encompassed public health activities are constrained by human and financial resources; there is a notable change from FBOs traditional reliance on Government to an increasing reliance on often-ambiguous contractual agreements; as facilities compensate financing gaps on their own or rely on the limited external sources. (Boulenger & Criel , 2012).Some experts warn that failure to resolve these accountability and financial issues may compromise some of the value added and intangible benefits that FBOs bring to Africa.

Stigma in FBOs

According to Futures group, Stigma is defined as that part of identity that has to do with prejudice; our sense of identity is intertwined with social and cultural ideas that allow us to understand ourselves in relation to others. Stigma therefore, is the setting up of individuals or groups, through the attachment of heightened negative perceptions and value. It involves the social expression of negative attitudes and beliefs that contribute to the process of rejection, isolation, marginalisation and harming of others (Link & Phelan , 2001).

FBOs have been viewed as part of the problem rather than part of the solution. They have been accused of 'being a sleeping giant, of promoting stigmatising and discriminating attitudes based on fear and prejudice; of pronouncing harsh moral judgements on those infected; of obstructing the efforts of the secular world in the area of prevention; and of reducing the issue of AIDS to simplistic moral pronouncements that have not made churches or mosques places of refuge and solace, but places of exclusion to those out there' who are 'but suffering the consequences of their own moral debauchery and sin' (Parry (2003). Stigma can manifest as perceived (when PLWHA fear how society will view and treat them), enacted stigma (denoting ways in which public reacts to individuals in certain groups for being HIV-positive or are thought to be so), (Brown et al,2003); and internalised stigma (that manifests in self blame and self deprecation) (Bond et al, 2002).

 FBOs are ideally placed to deal with the realities of HIV/AIDS, some have reportedly been involved in denouncing or rejecting PLWHA; HIV positive clergy and members have been forced1 out of churches, compelling them to confess the 'sins' that led to their infection, and leading congregations in special prayers for HIV-positive followers who may be 'punished' for their status (Paterson et al, 2005). Furthermore, since HIV is largely transmitted through sexual contact, those deemed to have transgressed morally are denounced , rejected and dismissed.

HIV stigma in churches have also been linked to fundamental misunderstandings about the nature of the epidemic like: HIV/AIDS as a biomedical rather than social issue; stereotypical beliefs about who is at risk of HIV infection; lack of knowledge and awareness of the modes of HIV transmission; lack of understanding of underlying factors that contribute to vulnerability to HIV (Cadre). In Botswana, stigma and discrimination create an environment that maintains the potential for increased infection as well as limiting the ability of people to live positively and responsibly with HIV/AIDS (NACA. 2003)

When we categorise people into groups and out groups, our perceptions and beliefs about them as individuals and groups are markedly influenced (Fishbein, 2002) However, consensus among social psychologists concerning bases of prejudice and discrimination is that there are multiple causes that can be construed as falling somewhere in a continuum, with individual and psychological causes at one pole, and cultural/historical on the other; the initial motivating force for the development of prejudice and discrimination is the attempt of dominant groups to continue holding onto the powers and privileges they have

Inadequate monitoring of FBO work

Although tangible and intangible health assets significantly and positively impact on health, it has not been consistently easy to link changes in health outcomes to these assets due to inadequate monitoring and evaluation systems especially for intangible assets (ARHAP, 2006). It becomes difficult therefore, for health systems to appreciate and incorporate these assets thus impeding the capacity among some other partners to engage effectively with FBOs.

Lack of partnerships and linkage with Government

ARHAP (2006) study reported that many FBO's function independently, with no network with other FBO-led HIV/AIDS initiatives, even within their own faith grouping. Out of 109 FBO's they surveyed in Namibia, 61% of respondents with HIV/AIDS programs did not belong to a network or affiliation that supported their response and another 19% belonged to a network but had not received any support. With some quarter of a million congregations alone in the AIDS belt of East and South Africa, ARHAP maintains that FBO networking needs are enormous. Hundreds of thousands of congregations and FBO support groups implement small HIV/AIDS responses, with most remaining unconnected to external sources of support .

2.8 Potential for engaging FBO s to strengthen African Health systems

PEPFAR (2012) commending the role played by FBOs in providing care in rural and hard to reach populations, providing tangible and intangible services,   recommends 'the need to capitalise on the trust that has developed between FBOs and the local communities to build stronger, more comprehensive integrated HIV-prevention efforts, built not on stigmatization but unconditional love , develop the capacity for FBOs to advocate for improved healthcare for all citizens and hold governments accountable' as well as 'to develop and make widely available mechanisms to support the organizational development of FBOs'

Partnerships with Government agencies

Although the Government of Botswana has tried to allocate resources to some FBOs, there is need for increased partnership especially in aligning RHAs and the public sector, as did Uganda; the parties (government and FBOs), sat at the dialogue table in policy formulation,

planning, distribution of resources, monitoring and evaluation, and in a partnership of shared vision, goals, objectives and outputs (Orach, 2009). Stressing that partnerships is the way to go, Orach (2009) insists on only partnerships that must work and not for convenience; cultivating interest in the others' work; appreciating one another for whom and what each is with mutual respect; partners that are in interested in the sustainability of the others system for mutual benefit; helping weaker partners overcome weaknesses and avoiding blame games, among others.

2.9 Criteria for effective FBO response to HIV/AIDS

Recognise the changing contexts

In the words of Henry (2011. p. 11), 'the church is indispensable; its mission is uncompromising; it's time to reflect theologically on our biblical text and specific context. He reiterates that its the time for acceptance of both continuity and discontinuity at local church level as well as denominational level, noting that change is inevitable and everything must change in order for us to see reformation and revival in the theology and praxis of the African church'.

This statement points to the need for the church to recognise the changing contexts in which it finds itself in, and the wider implications of the disease.The silence surrounding HIVAIDS debate in the church seems to stem from a lack of policy and framework to address the issue. Few churches in Botswana were reported to have a mission statement on HIV/AIDS, with the result that the pastors and priests are not sufficiently equipped with the necessary tools to cope with HIV/AIDS.The clergy need to understand the wider implications of the HIV/AIDS in order to plan for the future. Issues like the impact on the population pyramid, urbanisation of the population that causes the elderly and orphans to remain in the rural areas without traditional support systems. Armed with such knowledge, the church will be able to prepare its mission ground accordingly to cater for future interventions.

The church is the only institution Jesus instituted to 'go into the entire world and preach the gospel to every creature' (Mark 6; 15), as 'his witness 'in Jerusalem, Judea, Samaria and the uppermost parts of the earth (Acts 1:8) The purpose for which this credible institution of the church was ordained is to embark on a mission to be salt and light to the world (Mark 16:15).Salt is known for its ability to flavour as well as to preserve, therefore, if the church loses its saltiness, people will not taste godliness, as humanity will be tasteless and cannot be

preserved. The bible calls upon the world to accept him by putting on his nature. He was given to rescue those who escaped preservation so that they may be reinstated back to life (John 3:16). This can only be done through prayer . Even in this era of HIV/AIDS, God has made provision for healing our land and calls upon those who are called by his name to humble themselves, pray, seek his face and turn away from all their wicked ways; he promises that by so doing, he will hear from heaven, forgive them and heal their land (2 Chronicles 7:14).

According to Pastor Ray McCauley, the church of the 21st century is here to serve our generation. The original purpose of the church must be re-visited and it should be purpose-driven. He says that what is needed in this new millennium is a visitation of God and, as the lord pours his spirit on the ungodly, the church needs to reach the unchurched that are beyond our normal sphere of influence and this calls for an evangelical focus. Jesus ministered to people at the points of need; he healed the broken hearted, proclaimed liberty to the captives and recovery of sight to the blind, and the oppressed; the church of today can do likewise.

Communication between clients and caregivers

Literature has revealed the numerous efforts that have gone towards analysing how FBOs can contribute towards alleviating the suffering of PLWHA.This study however opines that the voice of community in need of help is lacking. It can prove very difficult trying to impose solutions to a people who are not responsive, or who may want to choose between what they may deem desirable for them or not. 'Studying giving without considering communication between the giver and recipient has the potential to overlook many valuable insights. Communication, especially the power of asking greatly influences feelings of empathy and pro-social behaviour. Selfishness typically predominates and the human capacities for altruism is activated through social cues . Humans have evolved the dual capacities to both be very compassionate and to put on blinders to protect us from our naturally altruistic tendencies. Communication from recipients, either real or inferred, is one way that our species triggers the empathy required to remove these protective blinders'. Community participation is therefore needed in identifying needs and design and implementation of programs to ensure community ownership.

2.10 Conclusion

This literature has set forth the context for the study. There is scope for more research on the role of religion in health care. The influence of culture and health worlds on religion provides yet another area for further exploration. The intangible assets of FBOs are undoubtedly worth further understanding; you cannot utilise what you don't understand and if it becomes inevitable that you have to do so, it will be for convenience and such a thing can easily be discarded, with emergence of better alternatives. If however you do understand something, you will crave to have it , you will appreciate the thing and treasure it.This study will engage on further examining reasons behind the seemingly limited responses of Cloud and Fire ministry, as a case study for the Botswana church. The ultimate aim is to discover what is there, appreciate and maximise its potential, in fighting the HIV/AIDS epidemic.

Chapter 3: Research Design and Methodology

3.1 Introduction

This chapter presents the paradigm and design of the research, population, sampling and data collection methods, ethical consideration and data analysis

Paradigm and design

The study was exploratory in nature, qualitative in design. A qualitative research is an interpretive research approach relying on multiple types of subjective data and investigation of people in particular situations in their natural environment (Christensen et al, 2011). In order to ensure accurate portrayal of participants' feelings, 'member checking ' process was used. This involved discussing the findings at the end of each session with the participants in order to ensure the findings represent their actual meanings of a phenomenon.

3.2 Population Sampling and data collection procedures

The population for the study was sampled from Cloud and Fire ministries, a multi-cultural, multiracial church. The church has a population of about (200) members from the nations of Botswana, Zimbambwe, Kenya, Zambia and Ghana. This is a good representative sample for this research study; considering that HIV/AIDS is most rampant in sub-Saharan Africa, the researcher will be able to gather evidence-informed data for this study.

The research utilised church members from three fellowship groupings in the church: the men, women and youth. Random sampling was used to select participants, utilising those who attended their weekly fellowships; it emerged that there was a group of more than nine people who were regular attendants in each of the fellowships, a number in the range of the 7-12 participants deemed fit for a focus group.

Focus groups, in-depth interviews and observations were used to collect data. Members of each fellowship were grouped together into a focus group of 9-12 members; this assured the researcher of having a group familiar with one another and exhibiting certain characteristics in common that relate to the topic of the focus group (Krueger, 1988). The total number of participants were 30.The researcher and the assistant, guided by an interview schedule as well as some observer instructions, guided each group in a focus group sessions of up 40 minutes.

Three key informants drawn from the elders and pastoral team were also engaged in a one on one interview.

3.3 Ethical consideration

Ethical principles were observed in this study, According to Christensen et. al, (2011), these principles are vital in research because they assist the scientist in preventing abuses that might otherwise occur and delineate the responsibilities of the investigator.

Ethics approval was obtained from the Research Ethics Committee (REC), Human Research, University of Stellenbosch. Key informants and the focus group participants were informed of the purpose and objectives of the study. A participant information sheet, detailing the intention of the study, was prepared and read. All the participants were asked to voluntarily consent in signing before the interviews /discussions started. To ensure confidentiality of the collected data, the researcher took due care to keep it anonymous and made sure that in the data analysis, no one was directly linked with any particular response.

3.4 Data analysis

Data was grouped into different thematic areas that emerged in the course of the discussions and interviews. A different research assistant was assigned to each of the focus group discussions. The different themes that emerged were noted down and revisited at the end of each session to check on the consistency of their recurrence; analysis was done under the identified themes

Chapter 4: Research findings and Reporting of results

4.1 Introduction:

In this chapter, key findings that emerged from the study will be discussed in the order of the research questions that were tackled within the focus group discussions and the in-depth interviews, and taking note of the actors involved, the content, context and process.
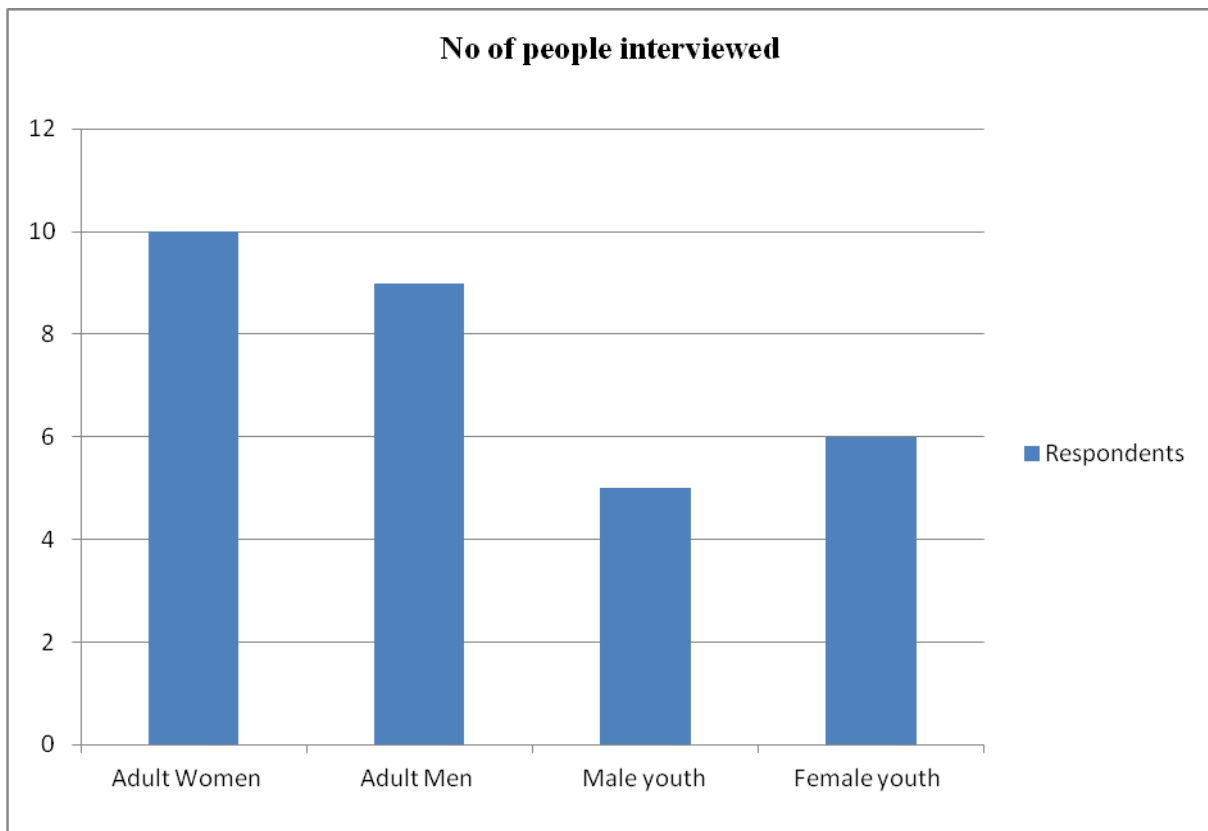

Figure 4.1. Composition of respondents

The female youths and adult women were the majority depicting the ratio of men to women in the church.
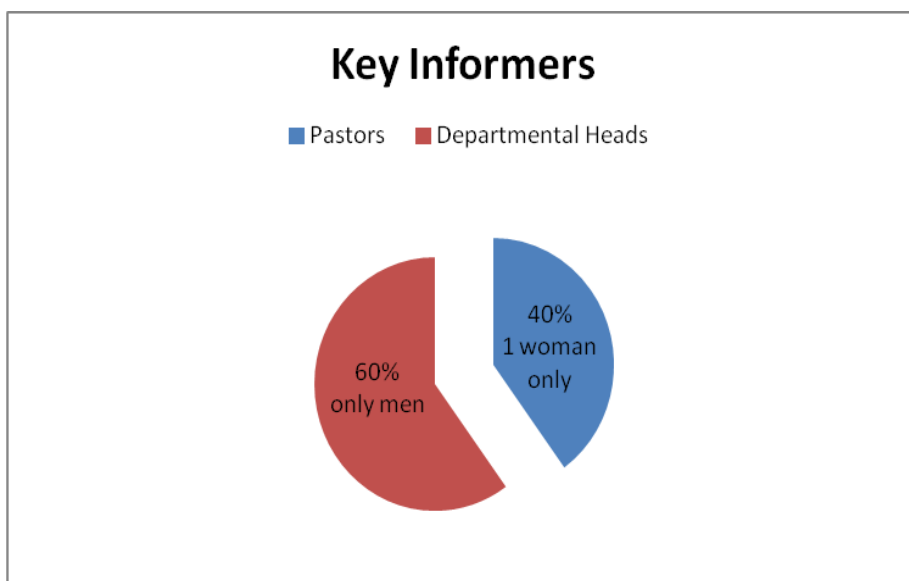
Figure 4.2 Gender distribution

The majority of the key informants were males, demonstrating the influence of men over women in decision making in the church.

4.2 Sources of HIV/AIDS information

The first question sought to establish the level of awareness of issues of HIV/AIDS in the church, specifically the sources from which they derived information on HIV/AIDS. The youth said that they heard about HIV/AIDS from their teachers and lecturers at school. The elderly respondents indicated that they learnt about the disease at the hospitals and VCT centers.There were also those to whom it was no stranger as they had experienced it first hand in their families. To these, the disease is a menace that has robbed them of their parents, children, aunts, uncles and even siblings. Television and the media as a whole were also cited as a source. It was clear that none of the youth had heard discussions about HIV/AIDS in the church.

4.3 The effects of HIV/AIDS in the church and community

Although HIV/AIDS debates hardly featured in the church, the question as to how the disease had been noted to affect lives received immense response. There were heart breaking stories on the devastating psycho-social and economic consequences of the disease that have depleted the family structure, leaving the nuclear and extended families incapacitated and with no resources to care for the infected ..Homes have been broken, children orphaned and

the society robbed of incredible people with great potential. There was consensus among the participants that women were more vulnerable than men due to the current economic situation that has led young girls to engage in sex for financial gain. One of the church members interviewed gave a moving case of a family where all the adults, save for one, died as a result of HIV/AIDS. It emerged that one HIV-infected rich man had taken pleasure in sexually engaging with all the female members of that family, for financial gain. He did it so tactfully that none of them knew the other was involved. The women got infected, from the mother to all the daughters, in turn infecting all their husbands. By the time he was exposed, all of them had succumbed to the disease. The orphaned children in the family looked at the only surviving adult and asked her if she was also going to die. The height of hopelessness in such a family is way beyond human comprehension. To the lady, the disease is a monster that should be rudely dealt with at any cost,

AIDS has also increased the poverty levels in the society. It has stolen bread winners from families leaving young children to fend for themselves. Such children end up in the streets, with no homes and those who are a bit lucky are left under the care of elderly grandparents. The lack of financial resources has led to increased immorality as orphaned young girls result to prostitution so as to earn a living. The rich men take advantage of such girls and lure them to sex for financial gain.
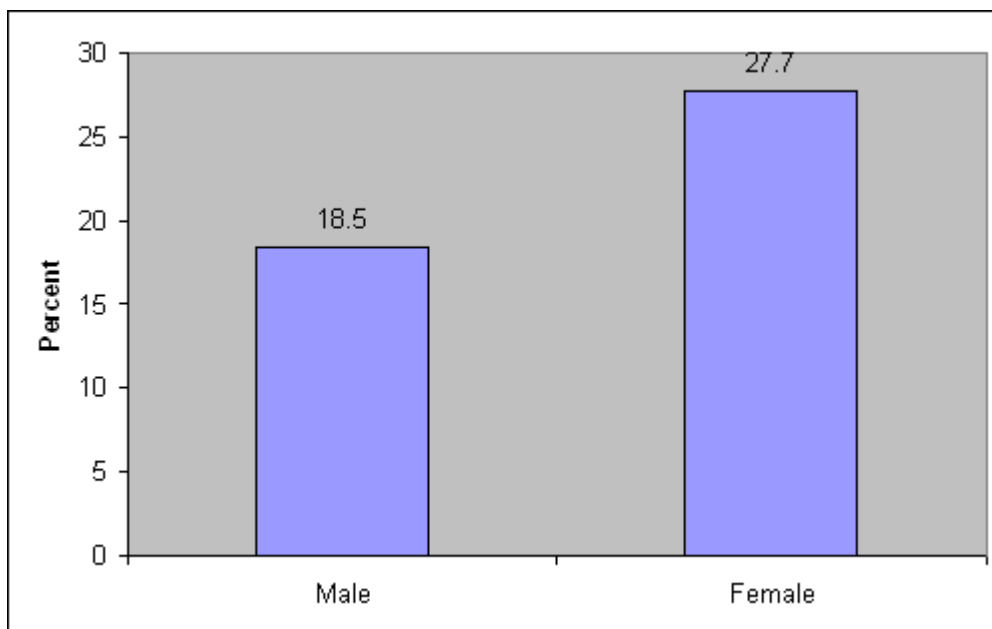

Figure 4.3: Previous sexual partners

Source: 2009 Botswana Second Generation HIV Antenatal Sentinel Surveillance Technical Report

Figure 4.3 shows that 18.5% of male and 27.7% of female had history of sexual partners who were ten or more years older, depicting how vulnerable women in Botswana can be.

4.4 Responses of Cloud and Fire ministry to HIV/AIDS

It was obvious the church has equated HIV/AIDS with sin and immorality. Sermons on immorality in the church have therefore been construed to be HIV messages, though they do not address the pandemic directly. Most of the initiatives were individual-driven, not corporate and were muted.

The spiritual encouragement that the church offered ranked high on the responses of the church. It was however noted that, by virtue of the stigma attached to the disease especially in the church, those infected would fear to ask for spiritual help as by so doing, '*one's status gets known and there is totally no secrets even within the church circles'.* It was however revealed that the pastors are always ready to offer help, especially counselling, to such people as and when they present themselves and ask for help.

It also emerged that pastors in the church are often called upon to attend to people who are unable to cope upon testing HIV positive, in their homes .They counsel those diagnosed HIV positive, together with their families,. According to Uys and Cameron, this is an act of debriefing (meaning a formal meeting done individually or in small groups, usually after stressful incidents, for the purpose of dealing with the emotional residuals of the event).The debriefing helps restore the strength and confidence in a caregiver, so that he /she can continue working in a stressful environment successfully.

Among the church documents availed to the researcher was a project proposal that was in which the church was soliciting for funds for a project aimed at establishing a rehabilitation centre to cater for the needs of inmates and ex-convicts. Counselling for the prisoners living with HIV/AIDS incorporation tops the list of the proposed projects. The church is currently involved in prisons ministry; every Sunday they conduct a spiritual encouragement session for the Kanye prisoners and moral lessons have formed most of the teachings. This brought the researcher to the conclusion that the church is not entirely silent on HIV/AIDS issues, but, such issues seems to be incorporated in other broader agendas of the church, making it difficult to point them out, especially if you are not a church member.

As the facilitator engaged the different groups in a member-checking process to agree on the responses identified, the respondents answer was a unanimous 'sepe' meaning 'nothing', they all felt there was no tangible response to boast of in the church.

One of the key informant gave very valuable insight, with supporting scriptures from the bible, to demonstrate how the church has failed to exercise its authority to impact the community *'the church has failed to come to the unity of the faith, and of the knowledge of the son of God (Ephesians 4:13), She has failed to migrate to God's character of taking off the old man and wearing the new man (Colossians 3:8-10); she has failed to bring back the spirit of supplication and grace to its community (Zechariah 12:10),the motive is wrong* as *churches do not have a heart to release the apostolic anointing to the earth and to those ready to receive, and are yet to impact regions, territories and nations.* He went on to decry the current state of church members as well as of those who come to church for help *'the church has made children of God to stay in prolonged periods of spiritual discontment and it's rather sad that people in the church as well as those who regularly visit, come to church to seek solutions and to be met at their points of need, only to leave worse than they came in, as no one in the leadership is able to discern their needs. The church doesn't hear God any more, and has forgotten that he is concerned with healing those infected with HIV/AIDS just as he is with our prosperity (3John 1:2) Members are experiencing spiritual brokenness; there are many of them with knowledge on HIV/AIDS issues but are never given the chance to minister to those who may need them, if you try to seek an opportunity to do so, leaders will calm you down saying you are rebellious , tell you to shut up, they are more anointed than you are.'*.

It also emerged that the church has neglected its foundation which is Jesus himself, and were now focusing on the apostles and the prophets (Ephesians 2:20), contrary to the biblical order. It was reported that many self-proclaimed apostles and prophets have mushroomed, and are trying to deceive people that they can work out healing for them, but with a foundation different from the bible one. *'An authentic church, built on the true foundation, brings lasting solutions, not temporary ones, people in need of solutions are 'window-shopping' from different churches; some get temporary solutions, others none at all; when they fail to get healing, they discredit the church, that is why many people have negative perceptions of the divine healing we as a church preach, what is the reason for all this mess? Foundation.'* one respondent lamented.

One key respondent felt churches are only committed to faith activities, but they have no faith. The church services, choir practices, church sermons are without power therefore they do not have any impact. Pastors preach on divine healing, yet they cannot minister healing to even minor headaches, let alone HIV/AIDS, their faith is without works, and is therefore dead (James 2:14-26). Churches have become like human warehouses, completely devoid of the presence of God.

The nature of the messages preached on the pulpit also elicited concern. Respondents decried pastors who preached messages specifically targeted to certain people who they would have foreknowledge of their 'sins'. There were differing opinions on the matter as some felt that the true nature of the church is to preach the uncompromised word of God while others though consenting to this role of the church, still raised same concern.

4.5 Reasons for limited responses in Cloud and Fire ministry

Stigma and ignorance

When posed with the question as to why the church seemed silent on matters of HIV/AIDS, the respondents were quick to cite the highly stigmatised nature of the disease. It emerged that the stigma attached to the disease had brought prejudice, while ignorance has created fear. There is so much silence surrounding the issue of HIV/AIDS in the church. It is almost viewed as an untouchable subject and as such, cannot be openly addressed. Many stated that HIV is still viewed as a taboo and has yet to become a subject that can be discussed openly. They also said that no one can be trusted, even the pastors, because they have a tendency to engage in gossip and it would be just a matter of time before one's story is the talk of the town. This stigma, many agreed, has created a lack of trust within the church community. Other congregants were of the opinion that maybe the pastors may have been approached and addressed the issue privately, though that was just a speculation. An elderly respondent sadly narrated how church members are ashamed of exposing their families as they feel that the church will view them differently if they ever opened up about their status. She remarked sadly '*If i am infected with HIV, and openly confess in church, my children will be burning inside, by the time i step out of the church door, i will be insulted and assaulted, ga ke ake (am not telling lies)*. Considering the critical role attached to families as caregivers especially in Botswana, PLWHA would not like to differ with their families as they risk being stigmatised in their families as well and lose out on the support they receive from them.The

repeated mention of the terms '*that disease*' by many respondents, even with continued re-assurance from many respondents that the church aspires to treat HIV/AIDS just as it would treat a mere headache, is an indication of how stigmatised the pandemic has become.

Ethical issues

One key informant revealed that the issues of HIV/AIDS have challenged the church leadership. Pastors were not clear on what to focus on and how, especially with regard to programs implementation and complex HIV/AIDS issue. Some HIV infected members had self-stigma; others would pre-judge themselves before seeking help from pastors or other church members. The situation is made worse when you hear of accusations the church is confronted with from different quarters, questioning our motives and potential

Some respondents also indicated that the church is too spiritual and "holy ghostic", so spirit focused that anything that is not spiritual is quickly dismissed, and ministering to just the spiritual needs while shunning anything that is not spiritual. Sexuality and gender issues are not given attention, yet they are the contributory factors to HIV/AIDS. The church has a vibrant youth ministry, but no specific project especially to address sexuality,sex education and reproductive health. *To address these issues in the church, you really have to mince words,* lamented a respondent.

4.6 How the church can scale up responses

The church needs strategic direction on how to manage the disease. Most of the initiatives noted are driven by individuals based on their conviction and commitment. If such people happen to leave the church, they also leave with their visions. There is need, therefore, for a church policy on HIV/AIDS, to direct the church's initiatives.

The church, by virtue of its commitment to the truth, should emphasize the need for accurate information and open discussion of issues in the process of ethical decision-making. Secondly, the church's' emphasis on personal and communal responsibility should promote conditions which support persons in making ethical choices in line with the dictates of the bible; biblical truth brings freedom (John 8:32).

To deal with the disagreements in the church on how to approach certain ethical issues, the Christian ethics should derive from theological reflection on scripture and the churches' response to revelation; it is deontological in seeing obedience to God's living word as the

supreme rule for conscience and community, but its incarnational and eschatological orientation regards as God-given the human freedom to respond to the complexity and ambiguities of ordinary moral experience-an opportunity to grow through mutual forgiveness , in grace and understanding .

Cloud and Fire ministries can use relevant scriptures to induce hope in the lives of the affected as well as the infected. Scriptures such as Ezekiel 37, "let the dry bones live' would encourage the congregants by letting them know that HIV/AIDS is not a life sentence. Just like the dry bones came back to life, they can also overcome the stigma and rise above the disease.

The church can also use a non-judgemental approach in assisting the victims. As cited earlier, the church tends to think that AIDS is as a result of infidelity and as such has sometimes withheld the much-needed help from the needy This is a shallow misconception that denies them a chance to reach out to the members and preach hope as well as show love to those in need. The church needs to realize that it is not time to express anger or shock over the disease but to help the victims and share unconditional love. It is imperative for the church to become a place where such victims can find love, acceptance and the support they need to cope with the disease. This can be achieved by ensuring that AIDS is no longer a taboo, but a subject that can not only be discussed openly but also preached on the pulpit. This would definitely build trust within the church community.

Congregants at CFM had indicated that the church leadership's approach to the disclosure of one's HIV status was insensitive. The victim would be asked too many questions and based on the response; the leaders would address their issue accordingly. They seemed to show no compassion especially to those past immoral ways led to the disease. The lack of compassion pushes the victims away and as such, they end up looking for help from other places that may not be as well equipped to address their needs. The church should therefore show more compassion and just as they would not ask a cancer patient how they got the disease, they should treat the Aids victims in the same way.

The prison ministry that the church was currently engaged in should incorporate purely HIV/AIDS prevention programs. Prisons inmates live in confined and controlled environments that could predispose them to HIV infection. However, Botswana inmates have demonstrated overwhelming willingness and desire to participate in prisons HIV/AIDS prevention programs (Masetlhe, undated).

Observation is made that the church could be challenged on how to initialise HIV/AIDS initiatives. As a starting point, this study suggests the need to identify a best practice of a church HIV/AIDS initiative, for purposes of exchanging ideas and /or emulating the positives.

To deal with issues of fear manipulating messages the church was said to preach, be they true or not, this study suggests that the church should aspire to maintain its credibility, this will require a prayerful church that seeks divine direction by leaning on the the word of God and aspire to meet people at their points of need, as did Jesus to the Samaritan woman in the bible (John 4:1-42). Messages could be directed to morality whereas, at that moment in time, the urgent need of the people is food. The church should therefore aspire to emulate Christ; just as he declared that he had been anointed to preach good tidings to the meek, bind up the broken hearted, proclaim liberty to the captives and recovery of sight to the blind (Luke 4:18); the church can become motivational speakers and with the same declaration, preach the word of God without fear or favour, while delivering a timely holistic package of 'goodwill to the people to set them free from psychosocial impacts of HIV/AIDS.

Cloud and Fire should also liase with the District HIV/AIDS coordinator for more advice on how to get involved in HIV/AIDS programming. There are different skills in the church that can be utilised in the fight against the disease.

Chapter 5. Conclusion and recommendation for further studies

The complexity of the HIV/AIDS pandemic has caused this study to take a departure from previous studies on FBO engagement in the era of HIV/AIDS which have mainly dealt with the tangible religious assets of FBOs and explore in-depth, the field of the intangible religious health assets and their applicability in the emergent complex world of HIV/AIDS.

Amidst these challenges, the society should endeavour to adopt a biblical stance of managing the epidemic. It is time to choose Gods divine will for his people rather than his permissible will. The society can choose to limit God, as did the children of Israel in the wilderness (Exodus), and followed a path of missed blessings, one lacking in divine favour and watched by a God who was limited because his 'hands were tied' (Psalm 78:41, 'Yea, they turned back and tempted God, and limited the holy one of Israel).However, when the society yields to God as did Israel, he demonstrated what he would do for a chosen people, and res

This study is optimistic that as people of faith wake up to the reality of their purpose, God will becomes more real to the world and HIV/AIDS and its devastation will be a thing of the past. This study worked on the framework that sought to understand, map, appreciate and engage the religious health assets in Botswana. There is need for more study, involving diverse religions in Botswana, and utilising a bigger sample and local researchers, who can be able to immerse better in the culture of the local people. This recommendation draws from the limitations identified in this study and is of the view that more evidence-informed data can be realised from this approach. The study also reiterates the criticality of intangible religious health assets in HIV/AIDS responses, but, to deal with the urgent need of trying to establish how a new wave of responses can be designed to deal with such an issue requires more of problem consciousness to tackle a well as an application of Christian ethics that are guided by the bible.These are two areas in need of further exploration. Other question that continues to loom are: Are all stakeholders involved in HIV/AIDS programming in Botswana conscious of the complexity at hand and the availability of this cost effective asset of FBOs? Would they be ready to understand, map, appreciate and engage with them? How far can FBOs go in utilising these assets, given the chance? What complexities are bound to arise from such a move and from which quarter? These all point to areas of understanding, appreciating and complimenting one another, that need further research; it is important that the public health systems , and even the FBOs themselves, provid some baseline assessment guide that can be used in benchmarking the work of FBOs

References

African Religious Health Assets Programme (2006). Appreciating Assets: The Contribution of Religion to Universal Access in Africa. Report for the World Health Organization. Retrieved on Jan.10, 2013, from http://www.arhap.uct.ac.za/publications.php#reports

Badri, M., Cleary, S., Maartens, G., Pitt, J., Bekker, L., Orrell, C., Wood, R., 2006, When to initiate highly active antiretroviral therapy in sub-Saharan Africa? A South African cost-effectiveness study, *Antiviral Therapy*, *11,* pp63-72

Bond, V., Chase, E. & Aggleton, P. (2002) Stigma, *HIV/AIDS and prevention of mother-to-child transmission in Zambia*, Evaluation and program planning*,* vol. 25, no. 4, pp. 37-8,43.

Boulenger and Criel (2012).The difficult relationship between faith-based health care organisations and the public sector in sub-Saharan Africa . Retrieved on Feb2,2013,from http://www.anglicanhealth.org/Resources/PDF/AHN%20resources/Faith%20and%20health%20care/Medicus%20Mundi%20Africa%20faith%20based%20health%20care.pdf

Buti Tlhagale (undated). *Bringing the African Culture into the church*. Retrieved on Jan.5, 2013, from http://www.afrikaworld.net/afrel/tlhagale.htm

Blackhall L.J, Murphy S.T, Frank G,Michel V, Azen S, *Ethnicity and attitudes towards patient autonomy.* Retrieved on Feb2, 2013, from http//www.ncbi.nlm.nih.gov/pubmed/7650806

Brown, L., Macintyre, K. & Trujillo, L. (2003) Interventions to reduce HIV/AIDS stigma: What have we learned?, *AIDS Education and Prevention,* vol. 15, no. 1, pp. 49-69. Mosarwe L.G (2006).Beyond the AIDS pandemic

Campbell, C., 2000, Social capital and health: contextualising health promotion within local community networks, in Baron et al [eds]

Centre for Faith and Service (2001).Definitions of Faith based and Community based organization toolkit.Retrieved on October 2, 2012, from http://www.nationalserviceresources.org/files/legacy/filemanager/download/196/F_Definitions.pdf

Christensen, L.B, Johnson R.B, Turner L.A (2011). *Research Methods, Design and Analysis.* Pearson

Cochrane (2007).CCIH-NEWS, Intriguing concept of 'health world' seeks to tie religion and health together. Retrieved on Dec 8, 2012, from http://www.ccih.org/pipermail/news_ccih.org/2007-February/000093.html

CSO. (2005) Botswana AIDS Impact Survey 2 (BAIS 2): Popular Report, NACA in collaboration with CSO, March 2005. Retrieved on 13th Jan, 2013 from:http://www.unbotswana.org.bw/undp/documents/final_popular_report_feb06.pdf

CSO. *Central Statistics Office*, Gaborone: 2001.

CSIS.Botswana's Strategy to Combat HIV/AIDS: Lessons for Africa and President Bush's Emergency plan for AIDS Relief: Conference report, 2004. Retrieved on Nov 10, 2012, from http://csis.org/files/media/csis/pubs/0401_botswanahiv.pdf

Diouf, E. *AIDS* and religion: response of Christian churches. Conference conducted by the Senegalese Christian churches; January 1996; Dakar, Senegal.Retrieved on Sept.21,2012, from http://ftguonline.org/ftgu-232/index.php/ftgu/article/view/2038/4072

Freedman, Benjamin. Offering truth: one ethical approach to the uninformed cancer patient. Avaialable at http://www.romecriteria.org/global_perspective/program/slides/ThompsonGwee/Brodwin_CulturalBeliefs_HealthCare.pdf

Foglio JP, Brody H. Religion, faith, and family medicine. *J Fam Pract.* 1988;27:473–474. [PubMed]

Frankl VE. *Man's Search for Meaning*. New York: Simon and Schuster; 1984.

Green, E. (2003). *Faith Based organizations*: Contributions to HIV Prevention. Retrieved January 6, 2013, from www.popline.org/docs/1541/281643.html

Henry, D., 2011, 'A *vision for the sending of the Church in Botswana'*, Verbum et Ecclesia 32(1), 8 pages. http;//dx.doi.org/10.4102/ ve.v32il.432

Foege, W. (1996). Faith & health: A newsletter of the Interfaith Health Program of The Carter Center

Global Health and Africa. Assessing faith work and research priorities

Heald, S., 2005, Abstain or die: the development of HIV/AIDS policy in Botswana, *Journal of Biosocial Science*, *38*, pp29-41

Inter Religious Council of Uganda. Retrieved on Sept.21, 2012, from http://www.ircu.or.ug/programmes/ovc.html

Krueger, Richard A. Focus Groups*: A Practical Guide for Applied Research* . Sage Publications, 1988.

Kangethe S. Exploring states of panacea and perfidy of family and community volunteerism in palliative care giving in Kanye CHBC program, Botswana. *Indian J Palliat Care* 2010;16:16-22

Mbiti JS. *Introduction to African Religion.* 2nd ed. Portsmouth, NH: Heinemann Educational Books; 1991:34

NACA .(2003) National HIV/AIDS Strategic Framework (2003-2009), National AIDS Coordinating Agency. Available from: http://www.ub.bw/ip/documents/2003_Botswana%20National%20Strategic%20Framew ork%20for%20HIVAIDS.pdf [Accessed on 23 June 2009

Olson, K. K. and Sand F, G. (2005). From faith to action*;* strengthening family and community care for orphans and vulnerable children in sub-Saharan Africa.Retrieved on Jan.1, 2013, from http://www.firelightfoundation.org/publication-02.php

Parry, S. (2003). Responses of the faith-based organizations to HIV/AIDS in sub-Saharan Africa, World Council of churches, ecumenical HIV/AIDS Initiatives in Africa. Retrieved, January 23, 2013 from http://www.wcc.coe.org/wcc/what/mission/fba-hiv-aids-pdf

Puchalski(2001).The role of spirituality in health care.

Rosemary Morgan, Professor Andrew Green, Dr. Erica Gadsby (2009). Religion and HIV/AIDS Policy in Faith-Based Organizations.

Responses to HIV/AIDS in sub-Saharan Africa,World Council of Churches,ecumenical HIV/AIDS initiatives in Africa.Retrieved on May 14,2012,from http://www.wcc-coe.org/wcc/what/mission/fba-hiv-aids.pdf

World Council of Churches (2001). Plan of Action: The Ecumenical Response to HIV/AIDS in Africa. Global Consultation on the Ecumenical Response to the Challenge of HIV/AIDs in Africa.

World Council of Churches (2007). Theology in the HIV/AIDS era series.The HIV&AIDS curriculum for Tee Programmes and institutions in Africa.Module 7

World Council of Churches. (2002). Facing AIDS*:* The challenge, the churches' response. Geneva: Retrieved on Jan.10, from .http://www.oikoumene.org/en/resources/documents/wcc-

programmes/justice-diakonia-and-responsibility-for-creation/ehaia/world-council-of-churches-statements-and-studies/1997-facing-aids-the-challenge-the-churches-response/chapter-4-ethical-perspectives.html

World Council of Churches (2003).The covenant document on HIV/AIDS.Retrieved on Jan.10,2013, from http://www.oikoumene.org/en/resources/documents/other-ecumenical-bodies/church-statements-on-hivaids/aacc-covenant-on-hiv-and-aids.html

Link, B. & Phelan, J. (2001). Conceptualising stigma. *Annual Review of Sociology*, 27. 363-385.

Louis Dumont Essays on Individualism: Modern Ideology in Anthropological Perspective Chicago: University of Chicago Press, 1986. Retrieved on Dec 20,2012, from ht tp://www.arhap.uct.ac.za/downloads/Tues_Germond_prez.pdf

Leibowitz, J. (2002). The impact of faith-based organizations on HIV/AIDS prevention and mitigation in Africa. Durban: Health Economics and HIV/AIDS Research Division (HEARD), University of KwaZulu-Natal .Available at www.heard.org.za/downloads/the-impact-of-faith-based-organisations

Marshall K. Development and religion: a different lens on development debates. Peabody Journal of Education. 2001;76(3):339-375. Retrieved on 14th May,2012,from http://ftguonline.org/ftgu-232/index.php/ftgu/article/view/2052/4100

Muturi, N. (2007), Faith Based Initiatives in responses to HIV/AIDS in Jamaica International

University of Botswana,Botho & Vision 2016.Retrieved on February 1,2013, from http://www.ubotho.net/Botho-Vision2016

Mbiti JS. *Introduction to African Religion.* 2nd ed. Portsmouth, NH: Heinemann Educational Books; 1991:34

OSI (2008) Rights Not Rescue: A Report on Female, Trans, and Male Sex Workers' HumaRights in Botswana, Namibia, and South Africa, June 2009. Retrieved on Nov.25,2012,fromhttp://www.soros.org/initiatives/health/focus/sharp/articles_publications/publications/rights_20081114/summary_20081114.pdf

Parker, W., & Birdsall, K. (2005). HIV/AIDS, stigma and faith-based organisations: A review. Johannesburg, South Africa: Centre for AIDS Development, Research and Evaluation (CADRE). Available online at http://www.cadre.org.za/files/CADRE-Stigma-FBO.pdf

Paul Germond and James Cochrane (2009) "Health worlds: Conceptualizing landscapes of health and healing" Sociology Forthcoming. Retrieved on Dec 20, 2012, from http://www.arhap.uct.ac.za/downloads/Tues_Germond_prez.pdf

Paterson, G. (n.d.); Aggleton, P., Wood, K., Malcolm, A. & Parker, R. (2005). HIV-related stigma, discrimination andhuman rights violations: case studies of successful programmes. Geneva: UNAIDS.

Paterson G. The role of the church in combating HIV/AIDS. Retrieved on 14th May,2012,from   http://ftguonline.org/ftgu-232/index.php/ftgu/article/view/2052/4100

Ssewamala, F., & Ismayilova, L. (2008). Faith-based Institutions as project implementers: An innovative economic empowerment intervention for care and support of AIDS-orphaned and vulnerable children in rural Uganda.

Turner (2009)Formal and informal care and support for people living with HIV/AIDS in two sites in Botswana.

WHO(1985), in M.H.Khyat, Spirituality in the definition of health.Retrieved on Jan.15,2013, from http://www.medizin-ethik.ch/publik/spirituality_definition_health.htm

World Health Organization/UNAIDS/UNICEF. (2011). Global HIV/AIDS Response: Epidemic update and health sector progress towards Universal Access: Progress Report 2011. Retrieved on Jan 3, 2013, from http://www.who.int/hiv/pub/progress_report2011/en/index.html

PEPFAR Consultation on the Role of Faith-Based Organizations in Sustaining Community and Country Leadership in the Response to HIV/AIDS.Retrieved on Dec 15,2012, from http://www.pepfar.gov/documents/organization/195614.pdf

Ritchie, J. & Spencer, L. (2002). "Qualitative data analysis for applied research". In Huber man, A.M.& Miles, B. M. (Eds.). The qualitative research companion. London: Sage, (Chapter 12).

William L.Sachs (2007).Empowered by faith: Collaborating with Faith Based Organizations to confront HIV/AIDS.

Samuel Park,dissertation:Pastoral identity as social construction: An exploration of pastoral identity in postmodern, intercultural and multifaith contexts.Retrieved on Feb.1,2013,from http://udini.proquest.com/view/pastoral-identity-as-social-goid:288329453/

Togarasei et al (2008): The faith sector and HIV/AIDS in Botswana, Responses and challenges, Edited by Lovemore Togarasei,Sana K.Molai and Fidelis Nkomazana(2008:51)

Togarasei, L. (2011). Introduction. In L. Togarasei, S. K.Mmolai & F. Nkomazana (Eds.). *The Faith Sector and HIV/AIDS in Botswana: Responses and Challenges.* Newcastle upon Tyne: Cambridge Scholars Publishing, (Preface)

United Nations Children's Fund. (2004). Study of the response by faith-based organizations to orphans and vulnerable children. World Conferences of Religions for Peace

UNAIDS. (2010). Global report: UNAIDS report on the global AIDS epidemic. Retrieved on January 3, 2012, from http://www.unaids.org/globalreport/Global_report.html

United Nations General Assembly. Political Declaration on HIV/AIDS: Intensifying Our Efforts to Eliminate HIV/AIDS – United Nations General Assembly Resolution 65/277. New York, United Nations, 2011.

K Masetlhe Institution, Gaborone, Botswana. HIV/AIDS prevention in <u>Botswana</u> prisons: what could be done? The prisoner's perspectives and policy recommendations.Retrieved on Oct.1,2012,from http://www.iasociety.org/Default.aspx?pageId=11&abstractId=2169806

Marlink, R. (2006) Effects of HIV-related stigma among an early sample of patients receiving antiretroviral therapy in Botswana, *AIDS Care,* vol. 18, no. 8, pp. 931-933.

Mosarwe (2006).Igniting thespark for a moral revolution in Africa.Beyond the AIDS pandemic

McCauley (2000).Making your world different.Rhema publishing.

Parry, S. (2003). Responses of the faith-based organizations to HIV/AIDS in sub-Saharan Africa, World Council of churches, ecumenical HIV/AIDS Initiatives in Africa. Retrieved, November 23, 2010 from http://www.wcc.coe.org/wcc/what/mission/fba-hiv-aids-pdf

Tangwa , G (2005), The HIV/AIDS pandemic, African traditional values and the search for a vaccine in Africa in Van Niekerk, A.A, and Kopelman, L.M, (2008). Ethics &AIDS IN AFRICA: The Challenge to Our Thinking. David Philip Publishers, South Africa

Wachege, P. N., 1992. Jesus Christ Our Muthamaki (Ideal Elder): An African Christological Study Based on the Agikuyu Understanding of Elder

Wolfe, W., Weiser, S., Bangsberg, D., Thior, I., Makhema, J., Dickinson, D., Mompati, K. &

Wolfe, W R et al (2008) 'The impact of universal access to anti retroviral therapy on HIV stigma in Botswana.

World Council of Churches (1996), the impact of HIV/AIDS and the church's response. Retrieved on Jan.10, 2013, from http://www.oikoumene.org/resources/documents/central-committee/geneva-1996/the-impact-of-hivaids-and-the-churches-response.html

Addendum A

AFRICA CENTRE FOR HIV/AIDS MANAGEMENT

7 June 2012
To the Chairperson
Cloud and Fire Ministries
Kanye
Botswana

Dear Madam,

Consent to carry out a Research Study in Cloud and Fire Ministries (Botswana)

Mrs. Joyce W. Pinto is undertaking a Masters of Philosophy degree in HIV/AIDS management with Stellenbosch University, South Africa (Student no 14712997). She intends to carry out a research study on 'Reasons for limited responses to HIV/AIDS in Cloud and Fire Ministry'.

The study will target 4 key informants from the church leadership comprising of one Pastor as well as 1 leader from each of the different activity groups in the church; making use one on one in-depth interviews (unstructured), with open ended questions with discussions. Also another sample size of 30 will be randomly selected from the different church groupings, and will be engaged in 3 different focus group discussions of 10 people each, making use of the same questionnaires used on the leadership. A standard information letter, detailing the intention of the study will be prepared by the researcher and read to the participants, to voluntarily consent, before starting the interviews and focus group discussions. The researcher will take due care to ensure confidentiality of the collected data, and to ensure that no one will be linked directly to any particular response. The research is for academic purposes and the results will be availed to the Africa Centre for HIV/AIDS management at Stellenbosch University, South Africa.

We would appreciate if you would kindly grant Mrs. Pinto permission to carry out the research within your church establishment. For any clarifications and /or questions, do not hesitate to contact us.

Kind Regards,
Burt Davis
Lecturer
Africa Centre for HIV/AIDS Management
STELLENBOSCH UNIVERSITY | Private Bag X1 | Matieland 7602 | RSA
T: +27 21 808 3006 | F: +27 21 808 3015
E: burt@sun.ac.za | W: www.aidscentre.sun.ac.za

Industrial Psychology Building Private Bag X1, Matieland, 7602 South Africa Tel: (+27) 21 808 3002 Fax: (+27) 21 808 3015 e-mail: pdm@sun.ac.za www.aidscentre.sun.ac.

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot • your knowledge partner

**STELLENBOSCH UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH**

REASONS FOR LIMITED RESPONSES TO HIV/AIDS IN CLOUD AND FIRE MINISTRIES

You are asked to participate in a research study conducted by Mrs. Joyce W.Pinto, BA Economics (Hons), PGD HIV/AIDS from the Africa Centre for HIV/AIDS Management, Faculty of Economic and Management Sciences at Stellenbosch University. The results of this study will be contributed to an Academic Research Thesis. You were selected as a possible participant in this study because you are an active member of this church.

1. PURPOSE OF THE STUDY

This study is designed to establish reasons for low participation by Cloud and Fire Ministries in HIV/AIDS.

2. PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

a. Consent to participate in research

You will be included as a participant in this study which will involve six leaders of Cloud and Fire Ministries as key informants as well as focus groups of equal males and females drawn from the men, women and youth ministries. A sheet detailing the aims and objectives of the study will be read to you before the interviews/discussions start, after which you will be asked to voluntarily give your consent to participate in the research.

Once you have consented to participate in the study, you will then be asked to participate either in an   interview (for key informants) or in focus group discussion (for the youth, men and women fellowship participants).

b. Participate in interviews

A one on one interview will be scheduled, whereby the researcher will engage the key informants in a discussion, guided by 5-8 questions. The researcher will seek to establish why there have been limited responses to HIV/AIDS in Cloud and Fire Ministries, how the church has responded to HIV/AIDS challenge as well as any challenges and /or limitations to their responses. The session will last between 30-40 minutes and for your convenience, they will be held in the church premises, on dates agreed upon between yourself and the researcher. All due care will be taken to maintain confidentiality, by ensuring no one will be directly linked with any particular response

c. Participate in focus group discussions

Focus group discussion will comprise of 8 to 10 people. The participants will be drawn from the men, women and youth fellowships. The researcher, guided by an interview schedule of about 5-6 questionnaires will engage the group in discussions. The questions will seek to establish why there have been limited responses to HIV/AIDS in Cloud and Fire Ministries, how the church has responded to HIV/AIDS challenge as well as any challenges and /or limitations to their responses. The session will last between 30-40 minutes and for your convenience, they will be held in the church premises, on the respective weekly meeting dates of the different fellowships. All due care will be taken to maintain confidentiality, by ensuring no one will be directly linked with any particular response.

3. POTENTIAL RISKS AND DISCOMFORTS

There are no foreseeable risks for taking part in the study because none of the questions are of personal nature.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

There are no financial rewards or any other benefits for taking part in this study. Information collected will be used solely for academic purposes. Upon completion of the study, the findings will be availed to the church leadership, but the final results will be forwarded to Africa Center for HIV/AIDS management, at Stellenbosch University, South Africa.

5. PAYMENT FOR PARTICIPATION

You will not receive any payment for participating in the study.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of the researcher compiling an anonymous report in which no participant will be identified with any particular response.

The report so compiled will be stored in password-protected computer and network drives, only accessible by Mrs. Joyce W.Pinto.Hard copies of the report will be stored in locked cupboards at the researcher's office when not in use for data entry or analysis. This data will be destroyed after three (3) years.

No other person/s will have access to the document. However, the data can be availed to the institution supervising this research, the Africa Centre for HIV/AIDS management, upon request, or if there is any legal demand for the same.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact Mrs. Joyce W.Pinto, at phone numbers +267-75168247 (mobile) or +267-5442852 (landline) or Prof.Augustyn Johan, cell 836263081, email - jcda@sun.ac.za

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

The information above was described to [*me/the subject/the participant*] by [*name of relevant person*] in [*Afrikaans/English/Xhosa/other*] and [*I am/the subject is/the participant is*] in command of this language or it was satisfactorily translated to [*me/him/her*]. [*I/the participant/the subject*] was given the opportunity to ask questions and these questions were answered to *[my/his/her]* satisfaction.

[I hereby consent voluntarily to participate in this study/I hereby consent that the subject/participant may participate in this study.] I have been given a copy of this form.

_____

Name of Subject/Participant

_____

Name of Legal Representative (if applicable)

_____   _____

Signature of Subject/Participant or Legal Representative   Date

I declare that I explained the information given in this document to _____ [*name of the subject/participant*] and/or [his/her] representative _____ [*name of the representative*]. [*H*e/she] was encouraged and given ample time to ask me any questions. This conversation was conducted in [*English /Setswana*] **and *this conversation was translated into***

Setswana by ***Mrs Esther Nthebolang***

_____   _____

Signature of Investigator   **D**

CLOUD AND FIRE MINISTRIES

P.O BOX 11835,
Kanye.
Tel 71210061.

20th June, 2012

Joyce W.Pinto

P.o Box 2845,

Gaborone.

Dear Madam,

REF: PERMISSION TO CONDUCT RESEARCH IN CLOUD AND FIRE MINISTRIES

In response to your application to conduct research in our church, channeled through the Africa Centre for HIV/AIDS management; I am pleased to inform you that permission to conduct the study has been granted you, but under the following conditions:

- That your research will be confined only to the field you have stated in your application letter
- That you make a copy of your research findings available to the church
- That you don't publish any report on the study anywhere except to the authority stated in your application letter, any deviation from the same should be done only with our written consent.

We wish you good success

Thank you

Mr. Abel Matare

Church Chairman

CLOUD & FIRE MINISTRIES
P. O. BOX 11835 KANYE
BOTSWANA
71210061 / 5443888