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**Catholic Pastoral care as a response to  
the HIV/AIDS pandemic in Southern Africa**

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Recent estimates suggest that more than 10% of Southern Africa is HIV+. This article is based on a research study of sixty four pastoral care projects focussing on the HIV/AIDS pandemic in Southern Africa. The projects, which fall under the auspices of the Southern African Catholic Bishops' Conference AIDS office, focus on both education for HIV prevention and the pastoral care of people living with HIV/AIDS (PLWHA). The article recounts the results achieved by these projects over the last two years discussing their strengths and weaknesses and proposes some recommendations for further action. Finally the author discusses the pastoral and theological dimensions of these pastoral services indicating the importance of socio-cultural mediation in

pastoral responses.

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Thembelihle Dlamini has just died of AIDS. Her first name means ‘beautiful hope’ but now she is one more victim of this major pandemic in Southern Africa. South African government figures recently reported that approximately 4,2 million South Africans are already infected<sup>1</sup>. This is more than ten percent of the population. The situation in the surrounding countries is somewhat similar. Thembelihle was a Catholic. However the Catholic Church was initially quite slow in its response to the crisis “influenced by socio-political realities, by ethical dilemmas, and by an inability on the part of church and community leadership to recognize signs of impending calamity”<sup>2</sup>. But now things are improving and in 2000, the Southern African Catholic Bishops’ Conference (SACBC) established an AIDS office to coordinate and oversee the various pastoral projects set up to respond to the pandemic.

In 2002 I was asked to provide a report on the impact of the Catholic Church’s response to HIV/AIDS in Southern Africa<sup>3</sup>. In collaboration with the SACBC AIDS office, a questionnaire was developed for use by a team of independent evaluators who were to visit the various projects. The questionnaire was designed to access both quantitative data on the various types of activity as well as qualitative responses to issues emerging. Many questions were kept open ended to achieve the latter. In this way the research tool had both positivist and phenomenological aspects<sup>4</sup>. The questionnaires were completed by the evaluator during an interview session with the project leader. For this reason evaluators had to be experienced in the work themselves and this was achieved by

choosing them from amongst experienced staff members of the larger and more established projects.

## **Results**

### *Penetration*

By 2002 there were eighty different HIV/AIDS pastoral care projects operating under the auspices of the SACBC AIDS office or receiving funding through it. These cover three Episcopal Conferences: The Namibian Catholic Bishops' Conference, the Lesotho Catholic Bishops' Conference and the Southern African Catholic Bishops' Conference (South Africa, Botswana and Swaziland). For various reasons only sixty four projects participated in the study. They are operating in South Africa, Lesotho, Swaziland and Botswana. South Africa has 91% of the total population of these four countries. The projects are relatively evenly spread throughout the region. Almost every diocese has at least one HIV/AIDS project. Thembelihle was a beneficiary of one of these projects before she died as we shall see later.

### *Capacity*

The vast majority of the projects are new. More than two thirds were established since 1998 and 15 since 2001. There are 475 full time workers. Five large projects employ more than twenty five workers each. Together they account for 236 of the full time staff. They are institutions providing hospice, orphanage and clinic facilities or a combination of these. Thirty nine medium level projects work with a small number of full time staff and volunteers providing a variety of community services. Twenty small scale projects are run by volunteers only.

### *Activities and services*

The evaluators were asked to determine the programmes and activities of each project. They found a great diversity of activities but four very common ones: Home based care, Orphan care, Counselling and Youth education. Two principal goals of these activities were identified: pastoral care of victims and the promotion of awareness and education about HIV/AIDS within the larger community especially youth. Projects render a large variety of services but there are six big ones. In numerical order these are: home based care services, counselling and guidance, work with orphans and abandoned children, hospice or clinic services, education and training, and, finally, projects which provide some material help for people. Other services include paralegal guidance to help people access benefits and state services, children's art projects, abuse prevention, and advocacy and lobbying for people living with HIV/AIDS (PLWHA) to government and society.

Forty four of the sixty seven projects have a component concerned with home based care (HBC). A very large number of people suffer from numerous AIDS related sicknesses yet institutionalization of the sick is only possible for a few. Home based care projects focus on training families to look after the sick person at home. Volunteers are also taught how to visit the families on an ongoing basis in order to provide assistance and training in primary health care and nutrition, as well as to help with more serious health issues. Thirty one projects provided quantitative data giving a total of 7559 families reported as being visited on a regular, usually weekly, basis in home based care activities. Thembelihle was one of these. When she lost her source of income in the city she came back home to her ancestral village. As she began to get very sick, the family didn't know what to do. Luckily they had heard about the group of people who did home visiting of sick people and

contacted them. Home based care workers visited her, showed her family what to do to help her, and came periodically to check up on her during the last few months of her life.

When she died, Thembelihle left two small children behind: Musa, a five year old boy and his sister Lindiwe. These are just two more in the upsurge of orphans and other vulnerable children resulting from the continually increasing number of deaths from AIDS. Faced with this reality a number of the projects have tried to introduce some form of orphan care and by 2002 twenty six of the projects had set up some response to this need. Some have been able to develop institutions such as orphanages and care centres. But the principal thrust is in promoting the placement of children within a family environment. In some cases the extended family is happy to take the children as has happened with Musa and Lindiwe. If this is not possible they search for a foster family within the clan or, if necessary, look for foster care elsewhere. Only eight of the twenty six projects provided figures giving a total of 620 orphans or other vulnerable children being placed with families or in other forms of care.

A third major area of pastoral care of PLWHA is in the provision of counselling services. Twenty four of the projects are active in this area. Post test counselling is essential for those who receive confirmation of HIV positive status and ongoing counselling of both PLWHA and their families helps people to cope with their situation. A few projects, especially in schools, have begun training young people as peer counsellors. Youth discuss sexual matters with their peers and the presence of some young people with training helps in awareness of the relationship between HIV and AIDS as well as in providing some input about alternatives lifestyles to avoid the dangers of promiscuity.

Only three of the projects provided figures giving a total of 415 people having received some form of counselling.

In most Southern African cultures, issues of sex are taboo and not discussed in normal company. Thembelihle never heard about HIV and AIDS and its link to sexual practice until after she was HIV positive. Preventative care demands the education of youth around sexuality and sexual behaviour as well as promoting awareness regarding the HIV/AIDS pandemic. Thirty four of the projects are responding to this need in youth education or awareness programmes. Many focus on education and training for lifestyle change, promoting behaviour which is compatible with Catholic teaching and which will avoid infection. These programmes do not promote condom usage and stand in contradistinction to the government and a number of other religious organisations which support the “ABC” campaign which promotes **A**bstinence, **B**eing faithful to one partner and the use of **C**ondoms. The Catholic Church is promoting an “ABCD” campaign where A stands for **A**bstinence outside of marriage and B for **B**eing faithful within it. C, however, stands for **C**hange your lifestyle through correct moral choices which people should make in life and D for **D**anger of contracting HIV/AIDS. The campaign has reached most tertiary institutions of South Africa, all Catholic parishes and all Catholic schools. Many have criticised the anti-condom stance of the Catholic Bishops as being too idealistic<sup>5</sup>. But the message of condoms in a society of high sexual promiscuity may give a false sense of security to people and “permissive and irresponsible behaviour has to be addressed if any impact is to be made on the spread of HIV infection”<sup>6</sup>. Other initiatives in education and training include the provision of AIDS awareness programmes and skills training, especially of volunteers, in areas like home based care, primary health care, income generating

projects and counselling skills. Not all, the projects quantified their results. From the majority that did we know that 450 different courses were held during a twelve month period. 313 were skills training courses of which ten were ongoing and 114 AIDS workshops were held.

The fourth main area of activity was in the provision of socio-economic services. Seven projects provide access to poverty relief through food distribution. Many families are provided with regular food parcels. Another popular approach to this problem was the establishment of income generating projects. These included initiatives such as community gardens, and small scale production of various artifacts like candles, textiles, and even coffins for low cost funerals. The project in Thembelihle's area has set up a small scale community based farming operation.

### **Strategies and approaches**

There are a number of different pastoral strategies adopted by the projects.

#### *Institutional*

Some have opted for the more traditional institutional approach. This involves setting up a resource within the community which provides medical expertise and caring skills for those who can make use of the service at the site of the institution. These hospices, orphanages, clinics and caring centres do vital work in a society where the State is not yet able to provide these services to all people. In some cases existing institutions have set up an HIV/AIDS caring component.

#### *Community based*

The large numbers of people infected and affected by the pandemic means that there will never be enough resources to provide institutional services to all people especially those in the more disadvantaged regions of Southern Africa. A community based pastoral response offers access to greater numbers especially in the more disadvantaged areas. It focusses on bringing the community on board in the planning and execution of the pastoral services. Twenty eight of the projects have gone this way. Some, including the one near Thembelihle's village, praise the enthusiasm of those communities which provided volunteers to help achieve the project's goals. Others established support groups for the project within the local community. Some have described how effective education of people in the community has helped reduce the stigma of HIV amongst people. This allows patients to be more open about their HIV status. Greater awareness helps to break the powerful silence and shame which surrounds HIV/AIDS in most Southern African communities. A community based approach to pastoral care also builds good relationships with local health authorities and clinics. But there are sometimes difficulties. The Sisters who set up the AIDS project near Thembelihle's village went there because it was in an area of high HIV prevalence according to figures supplied by the local clinic. When they first arrived they contacted the local leaders to explain what they wanted to do. They were surprised by the response of the elders of the area that HIV/AIDS was not a big problem there. The real concern was poverty and the provision of jobs. Initial community support for the project was only obtained when a poverty relief component was introduced into the services provided.

*Goal changes*

A question was asked about how goals had changed since the project began. Just under half the projects indicated that they are still working to achieve the goals they set themselves initially.

However, slightly more than half declared that they had modified their original goals as a response to pressing needs emerging in the course of their work. Two principal changes were reported. The first was the introduction of new goals responding to the reality of AIDS orphans and other vulnerable children. Fourteen projects had incorporated this kind of work as they found this need to be much greater than was initially envisaged even though it was one of the four principal services provided by the 65 projects in the original goals.

The second goal change was in response to the situation of abject poverty on the ground. A few projects initially envisaged a poverty relief component as an essential aspect of their work but the majority preferred to focus their efforts on providing care which directly responded to the HIV/AIDS crisis. But most, especially those working in rural areas, eventually found that their work was impossible without a poverty relief component. A common problem of AIDS patients, is the lack of adequate nutrition which rendered both medication and other aspects of care almost ineffective. The socio-economic level of the people being served by the projects was almost without exception low. Adjectives such as “poor”, “very poor”, of the “lowest level” and “very disadvantaged” were common. This level of poverty required strategies to change in order to incorporate a poverty relief component in the pastoral care services. Clearly these two goal shifts have meant additional work for the projects and will result in the need for additional resources.

#### *Use of volunteer help*

The projects would not succeed without the large numbers of volunteers who work for little or no

recompense in day to day care of people. They have succeeded in animating around 2500 volunteer workers and this can be seen as a major success in the work that they do. All of them have enlisted some volunteer work.

### **Strengths of the projects**

Those involved recognize many strengths in what they do and perceive their projects as fundamentally strong. There is a large amount of positive energy amongst those involved and a deep belief in what they are doing. The major strengths indicated were “people related strengths”, “organisational support”, “care based outcomes through education” and “management”.

125 responses point to the quality of “people support” for the projects expressed in high quality staff, committed volunteers and support from the local community. The largest number (45) saw the support of the local community as their greatest strength, a sign that people around them recognise the value of their work. This was closely followed by the “quality of the staff” involved in the projects (43). Almost as many responses (37) pointed to the volunteers involved in the project as a major strength. The quality of human resources involved in these services is also a tribute to the ability of project leaders to access dedicated, effective and committed people.

Sixty four responses point to a high level of organisational support from other institutions or stakeholders. Twenty two referred to the support from the Church whether through the Bishop or the local parish. Sixteen referred to the support of professional health care services such as hospitals, clinics and professional health workers. Twelve spoke of the support received through

government institutions like health, welfare and other departments. Eleven responses indicated that networking with other groups and organisations was a strength for their project. Some mentioned the essential support of funders.

Training for effective pastoral care was recognized as another strong area. Thirty five responses recognised how training and education had improved the quality of care given especially home based care. Twenty three responses indicated that training local people had empowered them to respond to the pandemic rather than be victims of it. Training had also been valuable in the setting up of income gathering projects and providing poverty relief. Twenty three responses referred to the location of the project as a major strength. For some this meant that the project was situated amongst the people giving them easy access to it. For others, especially hospices and caring institutes, the issue was about the tranquil surroundings in which one could recuperate or die with dignity. Finally, eighteen responses mentioned the quality of management which has allowed some projects to become sustainable if present resources are maintained. Others noted that a model has been developed which can be effectively replicated elsewhere.

### **Weaknesses**

When asked what were the weaknesses of the projects, project leaders referred either to failures experienced in trying to make the project effective or to difficulties being encountered. Failures are clearly more serious since they point to areas of difficulty that those involved feel they cannot overcome. Happily there were many more reports of difficulties (265) than failures (36).

### *Failures*

The greatest areas of failure were the lack of funds (7) and transport problems (6). Funding failures were often linked to the highly prescriptive approaches of some donor organisations which are only prepared to make funds available for certain tasks. Once in the situation, project managers find that the reality is somewhat different and priorities have to be rearranged to meet the needs discovered. When funds are not made available for these needs the whole project suffers. Transport failures occur when infrastructure is poor and vehicles are unavailable. Other failures resulted from the social context of people since local communities generate their own issues which can inhibit the work of a project. Village divisions and rivalry often exacerbated problems of caring for all people. Such rivalry has even led to the withdrawal of community support for the project. Another problem was the lack of male involvement. Males occupy leadership roles in rural culture and their support is often critical for effectiveness. Culture can also militate against the ability of young people to care for the elderly. It is culturally unacceptable for young people to have the kind of intimate contact required to care for terminally ill patients when the person is elderly. This problem is easily overcome in a caring institution like a clinic, hospital or hospice where the cultural environment is very different and where the sick person is cared for by strangers. But in rural areas where the people are known to one another, the taboo may become an insurmountable obstacle to the work.

### *Difficulties*

The 265 difficulties fell into twenty two different categories mainly influenced by the different kinds of contexts within which the projects operate. However half the responses (52%) were in five principal categories. These were “transport difficulties” (32), “volunteer difficulties” (27), “obstacles generated by government structures” (25), “obstacles generated by HIV/AIDS stigma”

(23) and “obstacles generated by lack of support of local communities” (21).

### *Transport*

The most serious weakness seems to be the lack of transport whether to reach patients, take patients to clinics or hospitals or get people to training events. Bad roads in some rural areas exacerbate this problem. Transport is a major obstacle holding back a lot of the work.

Workshopping the problem among stakeholders might lead to some creative solutions.

### *Volunteers*

The second most commonly reported difficulty results from problems generated by the attempt to work with volunteers. Whilst volunteer commitment was one of the greatest strengths of the programmes it is clear that the system also generates some problems. The work can be dangerous and is often stressful. After an initial enthusiasm volunteers may tire. Often they volunteer with the hope of possible future employment. Sometimes they suffer the taunts of their peers who ridicule them for working for nothing. The government does provide cash incentives for registered volunteers but there are many problems involved in registering people and often government bureaucracy makes any formalizing of projects difficult.

### *Government*

Obstacles generated by government structures is the third most important weakness reported by the projects. Twenty five (almost half) report some difficulty here. These problems were only reported with regard to the South African government and not the other countries in the region. This matter is most discouraging when one reads about this government’s stated commitment to the struggle

against HIV/AIDS. The most serious problem seems to be bureaucratic obstacles. These prevent the registration of projects so that they can receive State incentives. Another obstacle created is in preventing victims from registering for welfare grants. Thembelihle was never able to get a welfare grant for her children because the official required the father's birth certificate. Now the father of Musa and Lindiwe was a miner who used to visit Thembelihle when she was staying in a squatter camp in Johannesburg. He made empty promises about marriage but nothing happened and when he found out about her condition he disappeared so she cannot get this certificate and cannot get the grant. Problems like this are the norm rather than the exception in many areas so most people who qualify don't get the grant.

Another problem is that some government welfare bodies such as clinics and social welfare offices are not supportive of collaboration with the Church and renege on promises made. Some of the projects staffed by white people spoke of an anti-white ethos in some government structures. Clearly there is a need for the SACBC AIDS office to liaise with relevant government structures to attempt to deal with these problems on a more formal level.

### *Stigma*

A fourth area of weakness is that generated by the stigma of HIV in communities and the attitudes of denial, disbelief and fear which surround it. This is an ongoing cultural problem which must be tackled by continuing education and HIV awareness campaigns. People like the elders in Thembelihle's village when the Sisters first arrived prefer to pretend that the problem doesn't exist

and the lack of community support for the projects in some areas may well be tied up with the question of HIV stigma. Sometimes a sense of demotivation may pervade impoverished communities which makes people unable to help themselves and leads them to wait in misery for someone to solve their problems.

### **The Church's response to HIV/AIDS**

Project staff were asked to evaluate how their programme has “enhanced the response of the Church in Southern Africa to the HIV/AIDS pandemic”. The responses to this question were very varied and so two different hermeneutic lenses were applied to interpret them. The first approach was to look at the responses from the perspective of “agency” whereas the second was in the nature of a “values analysis” of the response statements.

#### **A Church agency**

This is a praxis based analysis which looks at what kind of activity is perceived as “Church activity”. We might expect that an analysis of the responses made would reveal a number of different “visions” or “models” of what the Church is and what the Church does. And this turned out to be the case. Obviously these models could be reflective of the views of either the evaluator or those involved in the project or both. Nevertheless, it is useful to examine them as they reveal the kind of theologies which are operating at project level. We can then compare them to the Gospel and the teaching of the Catholic Church to discover what kind of evangelisation or catechesis may be needed in Catholic HIV/AIDS projects.

The most popular understanding was to see the Church as the agent of the project's response to HIV/AIDS. In other words the project represented the Church in action. There were forty such responses which reflect many verses of scripture as well as Vatican documents like *Gaudium et Spes* and *Apostolicam Actuositatem*<sup>7</sup>. They highlighted the compassion and care of the Church in the community through its service to people at grass roots level. A number of responses noted that the Church was the only body responding to this problem in their area whilst others said that the Church had initiated a greater community response to HIV/AIDS. The next highest group of responses concerned the role of the Church in promoting sexual morality amongst people and in responding to the simplistic "condomising" message of others through its ABCD programme. This is clearly in line with the Church's moral teaching and the 2001 SACBC statement on HIV/AIDS<sup>8</sup>. There were 22 responses highlighting this area of Church agency. Fourteen responses emphasised that the Church was not an NGO<sup>9</sup> providing a service for people but rather, that the Church was the people: those Christians involved in the project and ready to respond to the needs of those suffering in that place.

However, another view saw the Church as an institution concerned just with spiritual things. Fourteen responses presented a view in which the Church and the project were two separate things. The project was providing a service in which either "the Church was involved" or "the Church was being helped" in some way. Here the Church appears to be equated to a purely "religious" entity: the priests and sisters at the mission where we go on Sunday. The Church in this model is seen as "them" as opposed to the "we" of the project. This view is also present in the eleven responses to the question about the role of the Church which focussed exclusively on the commitment, or lack of it, by priests, bishops and nuns. Such a view could perhaps be summarized as "the Church is the

bishops, priests and nuns”. This view is clearly not that of Vatican II and suggests that some work needs to be done to promote a more *Gaudium et Spes* vision of the Church and its praxis amongst certain stakeholders.

### *Catholic agency and Ecumenical agency*

Ten comments referred to the specific Catholic nature of the projects indicating how the Church is seen as supportive and caring amongst some communities they serve. However, more comments (13) focussed on the ecumenical dimension of the work and in particular how the projects have promoted interdenominational cooperation. This is a pleasing trend as merely sectarian approaches will be less effective than those emphasising collaboration.

### *Prayer and worship*

Finally a very disappointing number of comments focus on the importance of prayer and worship. It is difficult to detect from many of these projects whether this specifically Christian contribution is being pursued at all by these Christians. It appears to be a disappointing lacuna in this work of the Church. Recent scientific studies have shown that religious factors have a positive effect on healing. In the USA, the National Institute for Healthcare Research published a series of three volumes between 1993 and 1995 collecting together medical research on spiritual subjects<sup>10</sup>. It was shown that “most of these studies indicate a positive benefit for religious commitment”<sup>11</sup> including improved general health, reduced blood pressure, improved quality of life in cancer and heart disease patients, and most importantly, increased survival. Harvard Medical School’s conference on “Spirituality in Healing” provided studies showing the clinical benefit of religious practices like

prayer and worship<sup>12</sup>. These studies, and others like them, allow us to venture that medical science is also now beginning to recognize the operation of clinical factors in religious healing. It is thus disappointing to see an absence of such an approach to healing in Church based organisations which appear to run the risk of becoming too secular in their approach. In a deeply religious society like Southern Africa, people may come to Catholic pastoral services just for their material well-being and go to the “healing churches” such as African Indigenous Churches and Pentecostals for their spiritual needs.

Education is needed on the effectiveness of faith, worship and prayer on physiological curing and psychological well-being. Education is also required on the difference between curing and healing<sup>13</sup> so that programmes can be developed to enhance the promotion of effective Christian healing services and rituals for those who are chronically and terminally ill. Pastoral care programmes for those infected and affected by HIV/AIDS are required.

## **B Values analysis**

The values analysis of the Church’s response to HIV/AIDS showed a similar picture with regard to worship and prayer. It is in ninth place out of the twelve values identified with only four responses. The greatest number of responses focus on the value of “involvement in the struggle against HIV/AIDS”. Twenty five responses note that the Church is committed, in a “practical” and “vital” way, to respond to the suffering caused by HIV/AIDS. In this way, the Church is perceived as being an active participant in the transformation of society through involvement with people in especially difficult situations.

Twenty five responses support the value of “promoting sexual morality” and were actively affirming Church teaching in this regard. Their support was manifest in promoting the ABCD programme of the SACBC and in educating people in the values of abstinence and chastity. They noted the importance of countering the facile solution of condomising proposed by other players. Some noted that the Bishops’ stand on some of these matters had been challenging for them in their work with others who could not accept this position.

Fourteen responses refer to the value of “service” that the projects provide for the community. This is well in line with the pastoral plan of the SACBC which sees the Church in Southern Africa as a “community serving humanity”<sup>14</sup>. A similar number of responses affirmed the value of the “hierarchical structure” in the Church, noting in particular how the commitment of sisters, priests, bishops and diocesan structures manifests the presence of the Church in the world. Twelve responses substantiate the values of “care and compassion” in the work of the projects as key values the Church was manifesting. Ten referred to the value of “cooperation” and in particular to ecumenical cooperation in the work the projects carried out. The other values affirmed had fewer responses. Five noted the value of “support” saying that the Church was supportive of their endeavours. However, the same number of responses suggested that the Church still needs educating about the challenge posed by HIV/AIDS.

## **Discussion**

Elsewhere I have defined ministry and Christian pastoral action as “culturally mediated Christian

praxis responding to culturally mediated human needs”<sup>15</sup>. The socio-cultural component of HIV/AIDS ministry is particularly important. This is because of the many ways in which social matters impinge on the etiology of the syndrome. HIV is more easily contracted in contexts of poverty, ignorance and social disorganisation. This is one of the reasons why it is so prevalent on the African continent. Cultural factors also compound the suffering of those living with AIDS. It is highly stigmatised both in the Christian context where it is identified with sinful behaviour and in the African traditional context where it is linked to witchcraft<sup>16</sup>. Those working to respond to the pandemic have discovered how important it is to listen to the people they work with and those in their local social network. Listening helps the pastoral worker to understand, together with the people of the place, exactly how it is that needs are culturally crystallized. In the same way it is important to allow the Holy Spirit to come upon (cf Lk 1:35) each human context in order that Jesus may pastor to his people. Christian pastoral praxis defines the body of Christ in which the ministering Jesus lives. If pastoral praxis is to be God’s work it must be perceived as being of service to the people. Those who come from outside the culture have to be very careful not merely to impose the solutions that seem sensible to them. The diverse mix of projects that have emerged in the Catholic AIDS effort seems to reflect some cooperation with local views. Western institutional approaches can be very powerful in dealing with urgent medical, material and some psychological needs. But the community based projects, which may respond more directly to the cultural concerns of the people on the ground, are essential to respond to a situation as prevalent as HIV/AIDS is in Southern Africa.

This study has shown that the vast majority of the projects funded through the SACBC AIDS office

are doing wonderful work throughout Southern Africa. They are established in contexts of great need and are doing their best to respond to the need as they find it. Taken together the projects demonstrate a multi-pronged response to the various challenges posed by HIV/AIDS. Sterling work is being done in the area of HIV awareness and disease prevention. There is a good focus on youth and on promoting behaviour change amongst the youth within a coherent and practical lifestyle vision. Many projects are providing various levels of care for the infected and the affected with a pleasing emphasis on the development of home based care programmes which involve family and the local community in effective care of the sick and dying. Some resources are also employed in more traditional caring institutions so that those who have no one to look after them can find somewhere to be cared for or to die in dignity. There is also an increasing response to providing services for the increasing number of AIDS orphans and other vulnerable children. In undertaking this processes of evaluation, I have been most impressed by the commitment, ability and dedication of those involved in these projects.

Of course there are still weaknesses. Revealing them does not ground criticism, but rather challenges further development to make the projects stronger and more effective. Many are already doing a lot to deal with their own weaknesses and to improve the quantity and quality of their services. Many recommendations were made in the formal report. Just a few are given here. It seems that the greatest need is in the rural areas and more projects are needed here. Given the socio-economic situation of rural areas, it is clear that projects without a poverty relief component will not be as effective. Transport is a major obstacle holding back a lot of the work and there is need for some creative reflection probably on the Southern African regional level to try to workshop

some solutions for this problem. Some obstacles to the work of the projects seem to be generated by government structures. Liaison with the State is important here so that these problems can be resolved on a more formal level. Donor organisations are also a source of some difficulty. They need to be helped to see the importance of openness to the methods and strategies adopted on the ground in order to provide a more effective service. Some funders are highly prescriptive on how they wish their money to be spent. Whilst this may help them in being more accountable to their donors, it is not sufficiently accountable to the context of those attempting to solve the problem on the ground. A number of projects have complained about this problem.

The two principal personnel matters concern the care of those involved in the caring ministry and the question of volunteers. It is clear that some form of “care for carers” is needed. Caring work in this field is extremely stressful and draining. Programmes are needed to meet this need. Issues surrounding the recruitment, use, training and recompense of volunteers in the projects must be discussed by all stakeholders. Guidelines and resources must be set up to prevent this promising system collapsing through a failure to respond to the difficulties it generates.

On the level of spiritual healing, more education is needed on the effectiveness of faith, worship and prayer in physiological curing and psychological well-being. Whilst the disease is not curable, pastoral care can mediate various forms of healing to these patients on the emotional, spiritual and psychological levels<sup>17</sup>. Programmes should be developed to show how to conduct effective Christian healing services and rituals for those who are chronically and terminally ill.

## **Conclusion**

After a slow start the Catholic Church is now making a powerful response to the prevention of HIV infection and the care of PLWHA throughout the Southern African region. Commitment is found on all levels, from bishops, many of whom have a hands on approach to ordinary Christians in rural areas who volunteer their services for the care of their neighbour. Eighty projects in a few short years is a good start but it merely scratches the surface of this enormous plague which infects so many and affects all of us. Thembelihle has died of AIDS and her children are orphans. The body of Christ is HIV positive. Jesus is with his people but more helpers are needed for the vineyard so that the beautiful hope may be realized.

(Footnotes)

1 South African Minister of Health, Dr Manto Tshabalala-Msimang, 18 April 2000. A figure closer to 5 million is given in “The Barcelona Report: The Report on the Global HIV/AIDS Epidemic” (Geneva: UNAIDS, July 2002).

2 Alison Munro, “Belated, but powerful: The response of the Catholic Church to HIV/AIDS in five southern African countries”. *Proceedings of the XIV International AIDS Conference*, (Barcelona, Spain, July 7-12, 2002. Monduzzi Editore, MEDIMOND Inc), p. 399.

3 Stuart C. Bate. “Independent Evaluation of HIV/AIDS projects funded through SACBC”. (Johannesburg, St Augustine College of South Africa 2002).

4 G. K. Huysamen, *Methodology for the Social and Behavioural sciences*. (Johannesburg: International Thomson Publishing, 1994).

5 *A Message of Hope from the Catholic Bishops to the People of God in South Africa, Botswana and Swaziland* (Pretoria, Southern African Catholic Bishops’ Conference, 2001)

6 Munro, *ibid.*

7 *Gaudium et Spes* is the Vatican II document on the Church in the modern world. In §43 it stresses the role of all Christians in Church activity. *Apostolicam Actuositatem* is the Vatican II document on the role of lay people in the Church and in § 10 it makes a similar point.

8 See note 4.

9 Non-Governmental Organization.

10 Dale Matthews, David B. Larson, and Constance Barry, *The Faith Factor: An Annotated Bibliography of Clinical Research on Spiritual Subjects Vols 1, 2, 3.* (Rockville, MD: National Institute for Healthcare Research 1998). The idea was to provide a collection of clinical abstracts of research carried out using the medical model and the scientific method showing the influence of religion on medicine and psychology.

11 Dale Matthews, *The Faith Factor* ( NY: Viking 1998).

12 The conference “Spirituality and Healing in medicine” was held in Denver, Colorado from March 19-21 2000. Details of the effect of prayer on healing are available at the templeton.org website.

13 For a distinction between curing disease and healing illness see Stuart C. Bate, *Inculturation of the Christian Mission to heal in the South African Context.* (NY: Edwin Mellen, 2000).

14 *Community Serving Humanity. Pastoral Plan of the Catholic Church in Southern Africa.* (Pretoria: SACBC, 1989).

15 Stuart C. Bate, “Culture in Christian Praxis”. *Journal of Theology for Southern Africa* ,2001, Vol 109 p.82.

16 Vitus S. Ncube, “Towards a theology of coping with *ukugula, ukufa nokuphumula ngoxolo* -sickness unto death and rest in peace- in times of HIV/AIDS with special reference to the Zulu

concepts of *ukubhula* -divination- and *ukuthakatha*- witchcraft.” (M. Th. Thesis, University of Natal 2003).

17 See Bate, *Inculturation...* 283-316.