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**An Exploration of 'Pentecostal/Charismatic' Church Responses to the HIV and AIDS
Pandemic in the Western Cape: A Policy Learning Approach**

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University of Cape Town

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COMPULSORY DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

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ABSTRACT

HIV and AIDS continues to cause unprecedented global misery, predominantly affecting the world's poor. In South Africa, it is a Public Policy issue that has been handled sub-optimally by the state. Across Sub-Saharan Africa, Christian churches have responded to the pandemic in the void created by state policy failure. Pentecostal/Charismatic churches are particularly significant in South Africa, both in terms of growing attendance and members' apparent lower levels of extra-and-pre-marital sex (EPMS) than that displayed by mainline churches and secular society. This is important for public policy attempts to reduce HIV transmission. Most research on 'Pentecostal/Charismatic' Churches in South Africa, though, examines reasons for their growth and related socio-economic development potential. Not one examines their response to HIV and AIDS specifically. Therefore, this dissertation seeks to answer two important questions:

- (1): How are Pentecostal/Charismatic Churches in the Western Cape responding to the HIV and AIDS pandemic?**
- (2): What Policy Learning can be derived from the examination of these churches' responses to the HIV and AIDS pandemic in the Western Cape?**

Methodologically, the researcher combined a *literature review* and *internet-and-telephone-based desktop study* with a *single case study* to answer the research questions. The research is qualitative and the conclusions are tentative. Church responses are analysed in light of the literature on HIV and AIDS epidemiology, its impact on socio-economic development, and Policy Learning.

The researcher's findings – in relation to each question respectively - are as follows:

(1): Responses are nearly always rooted in (and sustained by) a phenomenon known as a 'calling'. While this means that responses are often 'reactive' rather than 'pro-active', they are driven by passion and competence.

(1): Responses are multivariate, holistic and strongly informed by the Gospel of Jesus Christ. HIV and AIDS is understood as both a behavioural and a socio-economic issue. Health interventions are often combined with efforts to educate, seek employment and care for the destitute. They tend to impart a sense of inner value and a set of moral values which are conjunctively likely to reduce the propensity to perpetrate (or succumb to) transactional, polygamous or promiscuous sex.

(2): Churches' HIV and AIDS ministries are achieving notable intervention success in the face of limited resources and a high proportion of volunteer staff; success is contingent both on institutional flexibility and the establishment of credibility within the communities in which ministries operate. The relative scale of their interventions is small. However, that these ministries exist at all is significant. The Policy Learning is that the state should be supporting their efforts either financially or with technical assistance.

(2): In light of contemporary Policy Learning debates, 'evidence' is only likely to be intelligible against presupposed 'appropriateness'. Building a policy on the grounds of 'evidence' in the absence of presupposed 'appropriateness' is likely to lead to oscillating responses to HIV. Therefore, these churches have imparted the important policy lesson of combining presupposed appropriateness with scientific evidence to inform their responses to HIV and AIDS.

These findings constitute a useful start in understanding the landscape of 'Pentecostal/Charismatic' Church responses to HIV and AIDS in South Africa.

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This is the only higher education institution I have known. After 7 years I should have a PhD! Perhaps it will still happen. Thank you to the Commerce and Humanities Faculties (the Political Studies Department and the School of Economics in particular); I have enjoyed my three degrees tremendously.

LIST OF ABBREVIATIONS

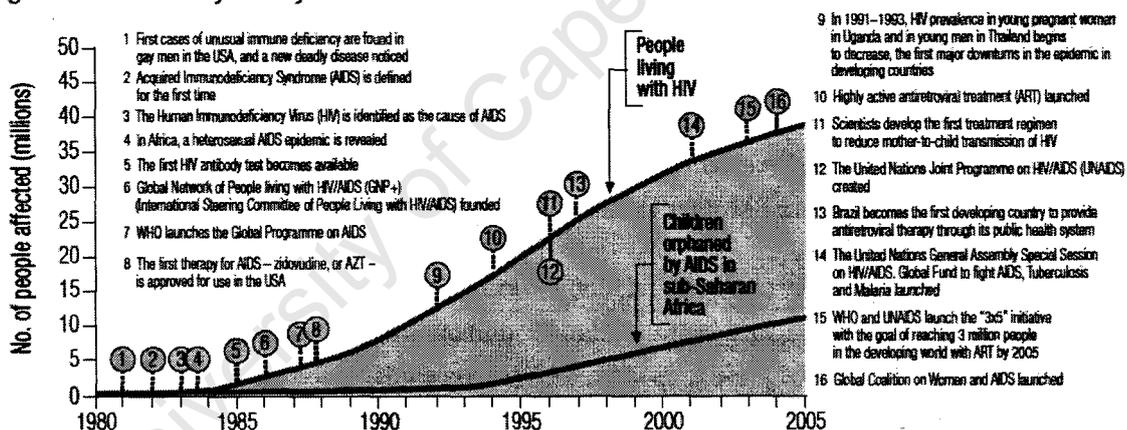
1. ABC: The South African Government's 'Prevention Campaign', advising citizens to 'Abstain, Be faithful, or use a Condom' when considering sexual activity.
2. AOG: Assemblies of God
3. ARHAP: African Religious Health Assets Programme
4. ARV: Anti-Retroviral
5. CBO: Community-Based Organisation
6. EPMS: Extra-and-pre-marital sex
7. FBO: Faith Based Organisation
8. FHBCT: Fish Hoek Baptist Church Trust
9. HIV; AIDS: Human Immuno Deficiency Virus ; Acquired Immuno Deficiency Syndrome
10. MSF: Medicins Sans Frontieres (Doctors Without Borders)
11. NCMI: New Covenant Ministries International
12. NGO: Non-Governmental Organisation
13. NPO: Non-Profit Organisation
14. PCM: 'Pentecostal/Charismatic' Movements
15. PEPFAR: The (US) President's Emergency Fund for AIDS Relief
16. PMTCT: Prevention of Mother to Child Transmission
17. RE: Religious Entity
18. SAP: Structural Adjustment Programme
19. StatsSA: Statistics South Africa
20. UCT: University of Cape Town
21. UN: United Nations
22. VCT: Voluntary Counselling and Testing (for HIV)
23. WHO: World Health Organisation
24. ZCC: Zionist Christian Church

1. Introduction and Rationale for study

1.1. HIV Timeline: Significant Events

The latest World Health Report (2007) charts the trajectory of HIV infection over time. Punctuating the inevitable upward curve are sixteen significant occurrences. These range from the first reported case in the United States of America (USA) in 1981 to the establishment of the Global Coalition on Women and Aids in 2005¹:

Figure 2.1 Twenty-five years of HIV/AIDS



Source: 2006 Report on the global AIDS epidemic. Geneva, Joint United Nations Programme on HIV/AIDS, 2006.

Not a single punctuation reflects action by Christian churches.² This in itself is no indictment on churches, but it is nonetheless interesting to note that their role in the HIV and AIDS arenas is either overlooked or viewed as insufficiently significant. Admittedly, the WHO is a western,

¹ The World Health Report 2007: Towards a Brighter Future. World Health Organisation (WHO). P. 18, Figure 2-1. Available at http://www.who.int/whr/2007/whr07_en.pdf, accessed June 19, 2008

² *ibid.* Nor does it reflect the actions of any other faith-based organisations (FBOs).

secular organisation that subscribes to the *scientific paradigm*³ of conceptualising, preventing and treating disease. Therefore, it is likely to be biased in terms of which contributions to prevention and treatment it includes as significant.

1.2. Different Frameworks Through Which Disease is Understood

The above point is made to illustrate that there are highly influential worldviews (particularly in Africa) - namely *religious and traditional*⁴ - through which disease is understood. Arguably, neither churches nor organisations such as the WHO have been sufficiently adept at framing their prevention and treatment efforts in a manner that resonates with people who hold a *religious* or *traditional* worldview. This is significant because the majority of people infected with (and affected by) HIV and AIDS are likely to see the world through either a religious and/or traditional framework⁵. Therefore, the question of how Christian churches' – as an important component of religion - perceive and apply their role in the battle against HIV and AIDS is considerable. This dissertation seeks to answer at least a part of that question.

1.3. Magnitude of Pandemic and Normative Imperative for Churches to Respond

³ Benn, Christoph. 2002. "The Influence of Cultural and Religious Frameworks on the Future Course of the HIV/AIDS Pandemic" in *Journal of Theology for Southern Africa*, Issue 113, pp. 6-7.

⁴ Ibid, p. 7-12

⁵ Magesa, Laurenti. 2000. "Taking Culture Seriously" in *Catholic Ethicists on HIV/AIDS Prevention*. (Wellington House: London), pp. 76-84.

Consider also that although Sub-Saharan Africa contains only 3.5% of the world's population, yet 37% of the world's HIV/AIDS population. See Sekgoma, B and Samuels, S. Report on Strategic Plan for Southern African Development Community – Parliamentary Forum on HIV/AIDS 2007–2011. SADC Parliamentary Forum, HIV and AIDS Programme. Windhoek, Namibia. www.sadcpf.org, last accessed August 20, 2009.

Given the magnitude of the pandemic, and the concurrent magnitude of churches' influence across vast social networks and physical infrastructure, the expectation is that they would contribute to the fight against HIV and AIDS. An estimated 1.8 million South Africans have died from AIDS-related disease since the epidemic began⁶. Total annual deaths (from all causes) increased by 87% from 1997 to 2005 (from 316 505 to 591 213)⁷, with at least 40% of those deaths estimated to have been AIDS-related⁸. South Africa also has the highest prevalence of HIV infections in the world (approximately 5.5 million)⁹. This is a higher absolute number than any other country in the world, regardless of relative population sizes. How are churches, as a substantial element of civil society, responding to this pandemic?

Much theological writing recognises that Christ's love is a meaningless concept until (or unless) it is accompanied by compassionate action¹⁰. With regard to HIV and AIDS, action may include a number of variables. Churches may promote efforts to reduce stigma¹¹, teach abstinence as a means of prevention, and provide various forms of compassionate 'outreaches'. There is, however, also the inevitable question of condom usage. While it would be convenient to sidestep

⁶ Dorrington, RE., Johnson, LF., Bradshaw, D. and T. Daniel. *The demographic impact of HIV/AIDS in South Africa: national and provincial indicators for 2006*. Cape Town, Centre for Actuarial Research, South African Medical Research Council and Actuarial Society of South Africa.

⁷ Ibid.

⁸ Anderson, B and H. Philips. 2007. *Adult Mortality Based on Death Notification Data in South Africa, All Causes and by Natural and Unnatural Causes: 1997-2004*. pp. 1-48, available at <http://uaps2007.princeton.edu/download.aspx?submissionId=70248>, last accessed August 27, 2009.

⁹ UN AIDS, Sub Saharan Africa: AIDS Epidemic Update Regional Summary, 2007. Available at www.unaids.org, last accessed June 19, 2008.

¹⁰ This is not to say that there is no such writing; many scholars argue that the love of Christ is ultimately displayed by His penal substitutionary death for mankind. The point is not to create a conundrum of theological debate, but rather to note that there is often a significant difference between what is penned by theologians and actually practiced by clergy. See Keenan, James and Cahill, Lisa. In *Catholic Ethicists on HIV/AIDS Prevention*. See also John Dubbey, *The Church Against AIDS*. See also James 1-3, Matthew 25, and 1 John 4.

¹¹ Paterson, G. 2001. *AIDS and the African Churches: Exploring the Challenges* (London: Christian Aid)

the issue, a study on churches and HIV would be incomplete if it overlooked this debate¹². The churches' call to action also involves a battle against exacerbating factors that contribute to the exponential spread of HIV, such as poverty and socio-economic injustice. By virtue of the sheer number of people affiliated to churches^{13, 14} they carry a mandate to contribute both to the moral order of society and the needs of the poor and oppressed.

Of final interest here is the purported success of Uganda's battle against HIV and AIDS. It appears from the literature that a large part of this 'success' was attributable to constructive collaboration between churches and the state in tackling HIV and AIDS with a unified front and significant resources¹⁵. However, Parkhurst and Lush caution against strong conclusions being drawn in light of difficulties related to comparability¹⁶ between these countries. Either way, the potential for churches and the state to collaborate in addressing HIV and AIDS is an important

¹² The researcher expects that a particular theological disposition would translate into a certain set of predictable actions regarding condom usage.

¹³ According to the 2001 census in South Africa, approximately 79% of the population categorise themselves as Christian. The statistic requires intentional critique, as the Zionist Christian Church (ZCC) is here included as 'Christian', whereas many of their core beliefs would be considered as antithetical to global mainstream Christianity. Nonetheless, as far as self-categorisation is a reliable indicator, the statistic is notable.

¹⁴ The dissertation refers to 'churches' rather than 'the church'. The distinction is designed to place churches in the realm of civil society and avoids conceptualising them as a uniform, unitary actor. In so doing, it avoids the somewhat exhausted argument over separation of church and state. Furthermore, there remain doctrinal and ethical conflicts over condom usage, perception of disease, means of treatment, etc. between and within different churches. Much like with the state, 'hands-on' practitioners (or 'street-level' bureaucrats) often employ a different working doctrine to that held by the official governing body (or state policy).

¹⁵ UN AIDS, *A measure of success in Uganda*. UNAIDS Case Study (Geneva: UNAIDS, 1998). Available at <http://www.unaids.org/publications/documents/epidemiology/determinants/una98e8.pdf>, last accessed August 27, 2009.

¹⁶ See Parkhurst, J & L. Lush. 2004. "The Political Environment of HIV: Lessons from a comparison of Uganda and South Africa," in *Social Science and Medicine*. Volume 59, Issue 9, pp. 1913-1924. While not discounting the value of a comparison, these authors caution that the AIDS epidemic is at significantly different levels of maturity in both countries and Uganda is much poorer than South Africa. Additionally, statistical reliability is less likely in Uganda than it is in South Africa.

Policy Learning to explore.

1.4. Why further and coordinated research in this field is necessary

On December 27th, 2008, UK columnist and author Matthew Parris, wrote an article in *The Times* entitled, "As an Atheist, I truly believe Africa needs God". The subtitle reads, "Missionaries, not aid money, are the solution to Africa's biggest problem – the crushing passivity of the people's mindset."¹⁷ Notwithstanding the paradoxical title, the author makes some telling observations about the impact of evangelical Christianity in Africa. He argues that there is strong evidence that Christianity has released people from the oppression of communal cultural mindsets that perpetuate poverty. He observes that it has liberated them to be innovative and fulfil their potential¹⁸. Parris's argument drew heated comment from various quarters, especially from 'secular humanists'¹⁹. Either way, the observation is of a high profile and not to be ignored.

This growing recognition of the churches' irreplaceable role in transforming civil society in itself illustrates the need for more robust research in the field, particularly relating to HIV and AIDS.

¹⁷ Parris, M. "As an Atheist, I Truly Believe Africa Needs God", Available at http://www.timesonline.co.uk/tol/comment/columnists/matthew_parris/article5400568.ece, last accessed June 23, 2009

¹⁸ *ibid*: "The Christians were always different. Far from having cowed or confined its converts, their faith appeared to have liberated and relaxed them. There was a liveliness, a curiosity, an engagement with the world - a directness in their dealings with others - that seemed to be missing in traditional African life. They stood tall."

¹⁹ See Allen, N, "Africa Needs More Human-Centred Thought and Activism", available at http://www.centerforinquiry.net/blog/africa_needs_more_human-centered_thought_and_activism/, accessed on February 9, 2009, for one example. Ironically, this criticism is religious in its manner of critique, disputing not the assertions of Parris's argument, but rather promoting a different worldview seemingly for its own sake.

“The role of African faith-based organisations (FBOs) in combating HIV and AIDS is widely recognised as having growing significance but, at the same time, one which is not fully exploited, given the influence and reach of FBOs in African societies. Their impact at the community and household levels and their well-developed ‘on-the-ground’ networks make them uniquely positioned to influence values and behaviours and to mobilise communities.”²⁰

The UCT African Religious Health Assets Programme (ARHAP) has also emphasised the need for more research in this area, pointing to the trend of major international organisations to tap into networks already existing in local church communities.

“In their attempt to get ARV treatment to more people in developing countries, the WHO is also looking at the role that religious entities (REs) can play in the rollout of ARVs, and are embarking on an unprecedented research direction that will analyse where REs are located and how they can aid in the healthcare of AIDS patients... Other studies, largely published since 2003, indicate that African faith communities have begun to increase such efforts rapidly over the past five years - largely in response to the HIV and AIDS crisis, but in some cases also because of collapsing or compromised health systems, sometimes following on misplaced structural adjustment programmes (SAPs) that were introduced in many countries in the 1990s.”²¹

²⁰ *Tearfund Report*. 2004. “Faith Untapped: Why Churches can play a crucial role in tackling HIV/AIDS in Africa”, available at <http://www.tearfund.org/webdocs/Website/Campaigning/Policy%20and%20research/Faith%20untapped.pdf>, last accessed June 23, 2009

²¹ Olivier, J. Cochrane, J and Schmidt, B, with Graham, L. 2006. “Literature Survey: Working in a bounded field of unknowing” in *Africa Religious Health Assets Programme (ARHAP)*, (University of Cape Town: Cape Town)

Most tellingly, and congruent with Matthew Parris's observations, *Tearfund* writes the following: "There is an untold story about HIV and AIDS in Africa. Largely unrecognised, a [sizeable] and growing network of groups is toiling on the front line, tending the sick, caring for orphans, wrestling to halt the spread of infection. This network receives barely a mention in international and national strategies to tackle the pandemic, even though its volunteers' work is worth billions of pounds a year. This network is that of Africa's churches. Almost uniquely, their members are reaching the communities and people whom governments and NGOs cannot easily reach. International funding agencies and governments do not understand the nature of faith in local communities, nor do they appreciate how churches are working at village level."²²

It appears, then, that while there is significant work being done by churches on the HIV and AIDS front, it is not being particularly well documented, evaluated or coordinated (both by churches themselves and by research bodies). "Half the work in education and health in sub-Saharan Africa is done by the churches...but they don't talk to each other, and they don't talk to us."²³

In the context of religion making a marked re-introduction to public life toward the end of the first decade of the 21st Century²⁴, and the apparent nullification of the secularization

²² *Tearfund Report*. 2004. "Faith Untapped: Why Churches can play a crucial role in tackling HIV/AIDS in Africa", available at <http://www.tearfund.org/webdocs/Website/Campaigning/Policy%20and%20research/Faith%20untapped.pdf>, last accessed June 23, 2009

²³ World Bank President James Wolfensohn, speaking in 2002, quoted in Olivier, J. Cochrane, J and Schmidt, B, with Graham, L. 2006.

"Literature Survey: Working in a bounded field of unknowing" in *Africa Religious Health Assets Programme (ARHAP)*

²⁴ Special Report: "The Lesson from America: The superpower has mastered the politics of religion at home, but not abroad", November 1, 2007, in *The Economist*, available at http://www.economist.com/specialreports/displaystory.cfm?story_id=10015163, last accessed June 23, 2009

hypothesis²⁵, in addition to the potential that churches have to combat HIV and AIDS, it seems only appropriate that further research be undertaken in this area. “With this increased attention and urgency to religion comes the confounding realization that little is actually known about religious organizations or initiatives working in health. Some studies are emerging, and there is much anecdotal evidence that such bodies are present and busy intervening in health - but little is known about *how* they do their business, just what infrastructure they do or could command, and what effects are particular to REs as opposed to developmental NGOs. Furthermore, in basic terms, the general invisibility of REs to the public health infrastructure must mean that efforts are not being properly coordinated, that differing local and public health systems are not in alignment, and that resources are thus being misdirected.”²⁶

Finally, a survey of Pentecostal and Charismatic Churches from 2006 calls for further research in the area of church responses to HIV: “The Literature on Pentecostals and Charismatics in South Africa is strongest in the area of church growth and church numbers. Weak areas continue to be... the area of HIV and AIDS. This should be a priority in any future research initiative... as the present data suggests that PCM’s are more concerned about judgement than about reaching out to people living with HIV and AIDS.”²⁷

²⁵ Garner, R.C. 2000. “Religion as a Source of Social Change in the New South Africa” in *Journal of Religion in Africa*, Vol. 30, Fasc. 3, pp. 310-343

²⁶ ARHAP Literature Survey, 2006. Olivier, J. Cochrane, J and Schmidt, B. Emphasis added to highlight the importance of asking the ‘how’ question.

²⁷ Domeris, W. and P. Germond. 2006. “Pentecostal/Charismatic Christianity – A South African Survey”, commissioned by *Centre for Development and Enterprise*, (CDE: Johannesburg).

Additionally, Robert Garner's study provides persuasive reason for particular interest in Pentecostal/Charismatic churches in relation to HIV and AIDS: "Pentecostalism... accounts for between 8 and 10 percent of the national population...[but] I wanted to give the genre equal research time because of the powerful lifestyle effects - [Pentecostals had significantly lower rates of extra-and-pre-marital sex (EPMS) than mainline churches or secular society] - noted by other researchers, and because of its growing significance in South Africa and the rest of the continent..."²⁸

This thesis therefore seeks to make a useful start in understanding how 'Pentecostal/Charismatic' churches are responding to HIV and AIDS, and what Policy Learning can be derived from these responses.

1.5. Structure of Dissertation

Given the establishment of a rationale for this dissertation, the logic of the remaining structure is now delineated and reiterated in the methodology chapter.

First, the intended methodology is conveyed in order to explain how the topic question was derived and how it shall be answered.

The second component of the dissertation is the literature review. It is concerned with general church responses to the HIV and AIDS pandemic and Policy Learning as a sub-field of Public

²⁸ Garner, R. 2000. "Safe Sects? Dynamic Religion and AIDS in South Africa" in *The Journal of Modern African Studies*, Vol. 38, No. 1, pp. 41-

Policy. Its findings provide the grounds for the specific research questions.

The research questions thus constitute the third and crucial element of the study; a framework that maintains the dissertation's focus. They are answered by employing a combination of two methodological approaches:

First, a desktop study is used to establish a general overview of Pentecostal/Charismatic Church responses to HIV and AIDS in the Western Cape. It elucidates interesting cases that provoke potential policy learning and opportunities for future research. One such case stands out both in terms of size and interest, therefore lending itself to the methodology of a single case study.

Therefore, the second approach to answering the research questions is a logical progression from a desktop study to a single case. The single case study is the most instructive lens through which to better answer the exploratory question and contribute insightfully to Policy Learning; it is an appropriate supplement to the desktop study.

The dissertation concludes by answering the research questions.

2. Methodology and Research Design

2.1. Introduction

The researcher is interested in the contribution of Christian 'Pentecostal/Charismatic' faith to public life in South Africa, both for personal and academic reasons. He is also interested in HIV and AIDS, a policy area – in notable addition to South Africa's response to Zimbabwe's woes - that has invited ridicule and contempt from the rest of the globe²⁹. How then have Christian churches responded to the HIV and AIDS crisis in the face of state policy failure³⁰, and what Policy Learning can be derived from them?

To assert that the state has failed is viewed by some as unfair and premature³¹. However, it is not unfair to posit that current state policy - The National HIV and AIDS Strategic Plan: 2007-2011³² – is formulated in large part to mitigate the effects of recent policy failure.

²⁹ See <http://www.cbc.ca/canada/story/2006/08/17/aids-south-africa-resign.html> for an example of the contempt in which South Africa's public approach to HIV/AIDS has been held in recent years.

³⁰ For a deeper exploration of the question of state failure, see Brinkerhoff, D and Brinkerhoff, J. 2002. "Governance Reforms and Failed States: Challenges and Implications" in *International Review of Administrative Sciences*, Vol. 68, Issue 4, p. 511

³¹ The assertion of 'failure' is debatable. However, the dissertation is not concerned with evaluating whether or not the state has really failed, how failure should be defined, or whether failure is attributable to the state or merely to a stiff-necked people, colonial legacy, post-apartheid political economy structures, and so forth. The questions can become ridiculous and detract from the topic question. Therefore, state failure is assumed for the sake of simplicity; defined hereby as its inability to deal with HIV/AIDS as swiftly, competently, and urgently as could reasonably have been expected from a state with admittedly limited resources. See also footnote above.

³² Department of Health. 2007. "HIV and AIDS and STI Strategic Plan for South Africa, 2007-2011", available at <http://www.doh.gov.za/docs/misc/stratplan/2007-2011/part1.pdf>, last accessed August 31, 2009

The response of Pentecostal/Charismatic Churches³³ to the HIV and AIDS pandemic in South Africa is an understudied phenomenon. As such, the study thereof does not lend itself clearly to any one method. There are a number of plausible approaches, where plausibility is determined by the research question at hand. However, the type of question asked must also be mindful of data limitations. In other words, as much as the research question must not be defined by a fondness for one methodology, it must also be grounded in what can reasonably be discovered. In this way it may constitute a meaningful contribution to the academic literature, not only for the sake of contributing to knowledge, but more importantly to attain the end of contributing to the Policy Learning literature.

2.2. The Research Questions

As is clear from the introduction, the primary research question is exploratory in nature. It reads thus:

- **“How are Pentecostal/Charismatic churches in the Western Cape responding to the HIV and AIDS pandemic?”**

There is a subtle difference between asking *what* is being done and asking *how* it is being done. The latter is concerned with how resources are utilised and how relatively abstract vision translates into practical programmes (if at all). A distinction is drawn between examining potential causal mechanisms that produce particular programmes and simply describing those

³³ The mere mention of the phrase ‘Pentecostal/Charismatic’ evokes all manner of images in the mind of any given reader. For this reason, the researcher provides a detailed definition at the appropriate time (Introduction to Chapter 5) to avoid confusion.

programmes. However, information is not always available on *how* a church's ministries developed, nor is it often well understood by the institutions themselves – the chain of causal events is often not reliably identifiable or verifiable.

Finally, programmes are distinguished from outcomes (which are concerned predominantly with impact). This dissertation avoids formal examination of outcomes except by plausible inference (as these are important within a Policy Learning approach).

The secondary question is concerned with Policy Learning:

- **“What Policy Learning can be derived from the examination of these churches’ responses to the HIV and AIDS pandemic in the Western Cape?”**

The conventional wisdom is that Policy Learning is built on understanding past policy failures and incrementally ‘muddling through’³⁴ in response. However, there is increasing acknowledgement that new policy initiatives are often not premised on understanding past failures and attempting to rectify them. Rather, they are determined – amongst others - by political terms of office, partisan influence, personal agendas, single-issue lobbyists and what Anthony Downs termed ‘the issue-attention-cycle’³⁵. Therefore, it is reasonable to ask what Policy Learning the state can derive from the cases under examination without having formally evaluated whether they are ‘successful’ or not.

³⁴ See Lindblom, C. 1959. “The science of “muddling through”,” in *Public Administration Review*, Vol. 2, No. 19, pp. 72-88, and Lindblom, C. 1979. “Still Muddling, Not Yet Through” in *Public Administration Review*, Vol. 39, No. 6, pp. 517-526

³⁵ Downs, A. 1972. “Up and Down with Ecology: The Issue-Attention Cycle”, in *The Public Interest*, Vol. 28, pp. 38-50

The dissertation has therefore taken a threefold approach to answering these two questions. It begins with a *literature review* that examines the response of churches in general to HIV and AIDS and elucidates the interesting phenomena that is Pentecostal/Charismatic churches. Thereafter, owing to the necessity of narrowing geographical parameters, the *desktop study* moves to examine the response of Pentecostal/Charismatic churches in the Western Cape. The study is exploratory; findings are analysed against HIV and AIDS epidemiology literature, and one particularly successful intervention is uncovered. The final approach of the dissertation is therefore a *single case study*; findings are analysed in light of the Policy Learning literature.

2.3. Literature Review

The literature review serves as an overview of what has been written about church responses to (and understandings of) HIV and AIDS in Sub Saharan Africa. While the review tries to avoid a theological proclivity, it is to some extent unavoidable as the literature is dominated by theological discussions about how Christians should best understand and respond to the pandemic. The Public Policy researcher cannot become embroiled in these matters, yet must objectively present them to allow the literature to highlight potential areas of useful research.

The major methodological contribution of the literature review is to provide a broad overview of church responses to HIV and AIDS and to elucidate the interesting phenomenon that is 'Pentecostal/Charismatic' Churches in South Africa. Almost in the same breath, then, it serves as a rationale for the desktop study that follows.

2.4. Desktop Study of Cases

A way to conceptualise the desktop study is as a form of multiple-case study. "A multiple or collective case study will allow the researcher to analyse within each setting and across settings."³⁶ The exploratory methodological technique employed here was simply to extract all possible information from churches - which fall under the 'Pentecostal/Charismatic' umbrella³⁷ in the Western Cape - as to how they are responding to HIV and AIDS. This was undertaken through a combination of telephonic and internet-based information-mining exercises³⁸. A typical protocol - to ensure reliability of the research - should contain an overview of the project - objectives and issues being investigated; field procedures - data collection strategies that should be properly designed; case study questions - to be cognisant of during the research to ensure coherent flow. Because the investigator does not control the data collection environment, these procedures become all the more important.³⁹

In this study, data collection strategies have been followed and the research questions have been the guiding factor in these strategies. In this under-researched field, there is simply not sufficient comparable case research to undertake a rigorous large-N quantitative comparative exercise at

³⁶ Baxter, P and S. Jack. 2008. "Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers" in *The Qualitative Report* Vol. 13 No. 4, pp. 544-559

³⁷ A more comprehensive definition of this term is provided in the introduction to the desktop study.

³⁸ The researcher in this field works under the disclaimer that HIV/AIDS interventions are invariably difficult to disentangle from other interventions or ministries. For instance, there are some ministries that provide nutrition for children at school. It may not be marketed or referred to as a HIV/AIDS programme per se, but it affects a significant number of children who are HIV positive. This disclaimer, however, is no reason to abandon the task.

³⁹ Yin, R.K. 1994. "Discovering the Future of the Case Study Method in Evaluation Research" in *American Journal of Evaluation*, Vol. 15, No. 3, pp. 283-290

this stage. However, the hope remains that this study will provide Policy Learning and provoke both evaluative and explanatory questions upon which future research can be built.

Finally, the desktop study was adequately able to provide an idea of how Pentecostal/Charismatic churches in the Western Cape are responding to HIV and AIDS. It also uncovers a particularly significant and interesting contribution – which forms the object of a single case study - to the HIV and AIDS intervention landscape through which the research questions can be answered with greater depth.

2.4.1. Potential Concerns and Limitations

The first concern is that internet-and-telephone-based research may undermine representivity. Research should aim to be accurate and reliable in order to produce generalisable findings. It is unlikely to achieve this in the absence of representivity amongst cases. One expects that not all churches have websites, even if they do have internet access, and one might expect that not all churches have telephones either. However, the researcher found that most churches amenable to the study (by virtue of the definition of Pentecostal/Charismatic Churches given in chapter 5) did have telephones, and those that did not have websites were linked to organisations that do⁴⁰. Therefore, representivity is not heavily undermined by this methodology. However, the

⁴⁰ One of the many complicating features of HIV/AIDS is that it affects the poor more visibly than the rich. The related irony is that well-resourced churches are not highly overtly affected by HIV/AIDS. While HIV/AIDS infections are strongly correlated with poverty affliction, they are not absent in wealthy communities. Few wealthy people test for HIV, and those that do test positive often have confidential access to private care, thus never being compelled (except by conscience, perhaps, to make their positive status public knowledge. Churches that are highly affected, however, are often under-resourced to respond. In many of these under-resourced churches, though, significant interventions are occurring but remain undocumented. In well-resourced churches, there are generally few responses. This peculiar 'resource-paradox' presents possible questions for future research.

narrowing of the geographic parameters to study the Western Cape in isolation from the rest of South Africa may still undermine *national* representivity, but this drawback is neither devastating nor avoidable at minor dissertation level.

Another concern is that of selection bias, which is also essentially a representivity issue. Some Pentecostal/Charismatic churches – like the Rhema Church in George - do not have physical responses to HIV and AIDS; therefore, churches appearing in this study are ‘self-selected’.

The second concern is one of definition. What criteria are comparable and replicable with which to categorise a church as being ‘Pentecostal/Charismatic’? The researcher trusts that the criteria ultimately employed will be useful to other researchers in this field of study.

Neither of these concerns is devastating: Neither the representivity issues nor the definitional quandaries undermine the exploratory and Policy Learning objectives of the dissertation⁴¹. The findings from the Desktop Study are analysed in light of the literature on HIV and AIDS epidemiology.

2.5. Single Case Study

“The qualitative case study is an approach to research that facilitates exploration of a phenomenon within its context using a variety of data sources. This ensures that the issue is not explored through one lens, but rather a variety of lenses, which allows for multiple facets of the

⁴¹ It should be noted, however, that the study may not satisfy researchers who yearn for quantitative certainty – if such a thing exists in Public Policy - on which to build policy decisions.

phenomenon to be revealed and understood.”⁴²

Historically, the controversy between qualitative case study research and quantitative ‘large N’ comparisons has been typified by arguments about the relevance of case study research for a broad array of problems: “A frequent criticism of case study methodology is that its dependence on a single case renders it incapable of providing a generalizing conclusion.”⁴³ However, despite this general limitation, the case at hand is capable of providing specific Policy Learning in public health. Additionally, “Case study can be seen to satisfy the three tenets of the qualitative method: describing, understanding and explaining.”⁴⁴ Therefore, while the criticism of the case study method is valid, it does not undermine the Policy Learning potential embodied by the single case.

“A case study design should be considered when: a) the focus of the study is to answer “how” and “why” questions; b) you cannot manipulate the behaviour of those involved in the study; c) you want to cover contextual conditions because you believe they are relevant to the phenomenon under study; or d) the boundaries are not clear between the phenomenon and context.”⁴⁵

The focus of this dissertation is indeed to ask a ‘how’ question. Certainly, the study of

⁴² Baxter, P and S. Jack. 2008. “Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers” in *The Qualitative Report* Vol. 13 No. 4, pp. 544-559

⁴³ Tellis, W. 1997. “Introduction to Case Study” in *The Qualitative Report*, Vol. 3, No. 2, pp. 1-12

⁴⁴ *ibid*

⁴⁵ Baxter, P and S. Jack. 2008. “Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers” in *The Qualitative Report* Vol. 13 No. 4, pp. 544-559

developmental interventions by any complex organisation does not lend itself to manipulative experimentation. Moreover, there are important contextual conditions that are relevant to the phenomenon under study. However, the context is not entirely unique, and therefore Policy Learning from the case can be applied to similar contexts elsewhere.

While the above contribution to the case study methodology literature supports this dissertation's approach, there are other contributions that question its optimality.

"The case study occupies a vexed position in the discipline of political science...methodologists generally view the case study method with extreme circumspection... At the same time, the discipline continues to produce a vast number of case studies, many of which have entered the pantheon of classic works... Judging by recent scholarly output, the case study method retains considerable appeal... By the standard of praxis, therefore, it would appear that the method of the case study is solidly ensconced and... even thriving. Thus, a paradox: Although much of what we know about the empirical world is drawn from case studies...the case study *method* is held in low regard... Even among its defenders there is confusion over the virtues...of this ambiguous research design... The case study survives in curious methodological limbo."⁴⁶

Gerring goes on to provide a number of definitions that scholars might have in mind when using the term 'case study.' "To refer to a work as a case study might mean a) that its method is qualitative, small-N; b) that the research is ethnographic, clinical participant-observation, or otherwise "in the field"; c) that the research is characterised by process-tracing; d) that the

⁴⁶ Gerring, J. 2004. "What is a Case Study and What is it good for?" in *American Political Science Review* Vol. 98, No. 2, pp. 341-342

research investigates the properties of a single case; or e) that the research investigates a single phenomenon, instance, or example (the most common usage)."⁴⁷

Curiously, Gerring later writes that: "...for methodological purposes a case study is best defined as an in-depth study of a single unit (a relatively bounded phenomenon) where the scholar's aim is to elucidate features of a larger class of similar phenomena. It is demonstrated that case studies rely on the same sort of covariational evidence utilised in non-case study research. Thus, the case study method is correctly understood as a particular way of defining cases, not a way of analysing cases or a way of modelling causal relations."⁴⁸

This is difficult to understand, especially in light of Gerring's assertion elsewhere that "Case studies are good for building theory and developing insights. Case studies allow scholars to explore causal mechanisms, large-N comparisons allow them to identify causal effects."⁴⁹ In Przeworski's words, "we need to study the causes of effects as well as the effects of causes."⁵⁰

The unit of analysis for this dissertation's single case is Fish Hoek Baptist Church's HIV and AIDS Ministry, known as "Living Hope". The dissertation aims to describe, understand and explain this markedly successful intervention in a challenging developmental context.

⁴⁷ *ibid*

⁴⁸ *ibid*

⁴⁹ Gerring, J. 2007. "The Case Study: What it is and What it Does" in *The Oxford Handbook of Comparative Politics*, (eds) Boix, C and Stokes, Susan C. (Oxford University Press: New York), p. 93. It is not the place of this dissertation to try and understand how Gerring comes to view case study methodology so differently from what he argues case studies themselves are capable of doing.

⁵⁰ Przeworski, A. 2007. "Is the Science of Comparative Politics Possible?" in *The Oxford Handbook of Comparative Politics*, (eds) Boix, C and Stokes, Susan C. (Oxford University Press: New York), p. 148

Following Miles and Huberman's suggestion that a case is a phenomenon of some sort occurring in a bounded context, the next step is to delineate case parameters. To avoid the tendency of trying to achieve too many objectives for one study, the researcher must be clear about what is *not* going to be answered.⁵¹

In keeping with the subject question, the researcher looked only at Living Hope, and not at Living Grace or Living Way⁵², which are an integral part of Fish Hoek Baptist's social impact ministries. The case has thus been bound by the parameter of healthcare 'activities'⁵³, while working in full recognition that health cannot easily be detached from broader developmental objectives.

In attempting to understand how Living Hope came into existence and how it has proliferated into the significant entity it now is, a historical analysis is offered, utilising numerous sources such as a documentary video, personal visits to the main healthcare facility, personal communication with staff, the constitution of the Fish Hoek Baptist Church Trust (FHBCT - that governs Living Hope), letters, a written history and newspaper reports. The case has also been bound by certain necessary parameters:

⁵¹ Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded source book* (2nd ed.). (Thousand Oaks, CA: Sage)

⁵² Living Grace is a ministry intervention that caters for people without food or shelter, and Living Way is a developmental ministry dedicated to finding meaningful employment for those currently unemployed and capable of work. These ministries are integrally connected to Living Hope, especially administratively, but could not be included in the study at hand. They would, however, provide useful policy learning evaluations to future researchers. See http://www.livinghope.co.za/index.php?option=com_content&view=article&id=14&Itemid=15 and http://www.livinghope.co.za/index.php?option=com_content&view=article&id=13&Itemid=14, last accessed August 12, 2009.

⁵³ Stake, R. E. 1995. *The art of case study research*. (Thousand Oaks, CA: Sage), quoted in Baxter and Jack.

“The boundaries indicate what will and will not be studied in the scope of the research project. The establishment of boundaries in a qualitative case study design is similar to the development of inclusion and exclusion criteria for sample selection in a quantitative study. The difference is that these boundaries also indicate the breadth and depth of the study and not simply the sample to be included.”⁵⁴

The historical analysis begins in 1987 and ends in 2009, thus providing a time parameter. That Living Hope operates across six different geographic locations across the Western Cape is itself a parameter of place.⁵⁵ Finally, the case has been bound by its definition⁵⁶ as a Charismatic Christian intervention in the context of state policy failure.

An exploratory study should be “used to explore those situations in which the intervention being evaluated has no clear, single set of outcomes.”⁵⁷ Living Hope, however, does have a clear set of outcomes that they seek to achieve, although these are not necessarily measurable. Success is both assumed and demonstrated (as opposed to formally evaluated according to a pre-existing set of criteria). The study of Living Hope essentially offers a methodological complement to the desktop study.

⁵⁴ Baxter, P and S. Jack. 2008. “Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers” in *The Qualitative Report* Vol. 13 No. 4, pp. 544-559

⁵⁵ Creswell, J. 1998. *Research design: Qualitative, quantitative, and mixed methods approaches* (2nd ed.). (Thousand Oaks, CA: Sage), quoted in Baxter and Jack.

⁵⁶ Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded source book* (2nd ed.). (Thousand Oaks, CA: Sage)

⁵⁷ Yin, R. 1989. *Case study research: Design and methods* (Rev. ed.). (Beverly Hills, CA: Sage Publishing.), quoted in Tellis

2.6. Concluding Remarks

How Pentecostal/Charismatic churches have responded to the HIV and AIDS pandemic in the Western Cape is not an easily answerable question. Very few academically peer-reviewed, reliable studies have been conducted. The literature review highlights this fact, and makes the repeated call for more research on what is an increasingly interesting subject. Pentecostal/Charismatic churches are the fastest growing in South Africa, and HIV and AIDS are constantly presenting new challenges and complications for health policy practitioners. These churches' responses will therefore become increasingly important as a source of Policy Learning and potential collaboration between the state and civil society. They constitute a resource that could be a more optimal complement to the state than is currently the case.

Given the new terrain being chartered by this thesis, no single methodological approach was obviously conducive to the task. A single case study or a survey of cases may each have been valid on their own merits. That would, however, have been problematic: Organisations – like churches - that are thin on human and financial resources, are not amenable to answering researchers' questionnaires (which would have been the most robust methodological option for conducting a desktop study). Moreover, without the benefit of previous studies, there is little in the way of guidance as to which are the most elucidating questions to ask; a survey of cases built on questionnaires was thus implausible. Therefore, extrapolating information from what was already written on websites, spoken in documentaries and recorded in newspaper articles, proved a better and less time consuming route than either interviews or questionnaires. The multiple case study serves a useful purpose then in terms of answering the research questions, although it would in itself have been insufficient.

Given the desktop study's shortfall in terms of methodological rigour, then, more substance was required to provide a robust dissertation. On the other hand, a single case in itself would also have been insufficient, as the researcher would have remained uncertain about whether its activities were anomalous or consistent with other church ministries. The respective problems associated with each method – and that they were not easily overcome in a pioneering work – led to the adoption of a hybrid approach.

The desktop study was able to indicate that Charismatic church responses were similar in nature, and that Policy Learning in the arena of public health would be best served by the exploration of a single, interesting, successful case. The combination of desktop study and single case methodology achieves the objective of making an adequate start to answering the research questions.

3. Literature Review

The literature review serves both to illustrate why the topic question is a meaningful one and to provide a general overview of churches' responses to the HIV and AIDS pandemic. It is not a theological treatise on how churches should respond to HIV and AIDS; it is a review of what has already been written and accomplished by way of action. The review then moves to examine the Policy Learning literature as a means of framing the dissertation, particularly the single case study.

3.1. Overview: The HIV and AIDS Pandemic in South Africa

There are an estimated 5.5 million people living with HIV or AIDS in South Africa, making it the country with the highest number of infections in the world⁵⁸. In 2006, approximately 18.3% of adults (age 15-49) were living with HIV or AIDS; over half of those infected reside in KwaZulu-Natal⁵⁹. Young women face greater risks of contraction than males of the same age (15-24 years.) In this age group, "women account for about 90% of new infections."⁶⁰ Among 20-29 year old women, HIV incidence was six times higher than in men of the same age in 2005.⁶¹

⁵⁸WHO Library Cataloguing-in-Publication Data. "Sub-Saharan Africa AIDS epidemic update regional summary." "UNAIDS/08.08E / JC1526E".

⁵⁹ Dorrington RE, Johnson LF, Bradshaw and T Daniel. *The demographic impact of HIV/AIDS in South Africa: national and provincial indicators for 2006*. Cape Town, Centre for Actuarial Research, South African Medical Research Council and Actuarial Society of South Africa.

⁶⁰ Rehle ,T., Shisana, O., Pillay, V., Zuma, K., Puren, A., and W. Parker. 2007. "National HIV incidence measures – new insights into the South African epidemic" in *South African Medical Journal*, Vol. 97, No. 3, pp.194–199

⁶¹ *ibid.*

The trajectory of South Africa's political economy, in addition to a prevailing cultural view of women as inferior and subordinate to men, exacerbates their already significant susceptibility. Therefore, an optimal response to the HIV and AIDS pandemic has to consider more than mere statistics. It is what lies behind the statistics that requires analysis to aid more effective policy-making.

3.2. Can churches play a role in changing sexual behaviour?

"Despite limited resources, Uganda has shown a 70% decline in HIV prevalence since the early 1990s, linked to a 60% reduction in casual sex."⁶² Related work by the same authors finds that "In Uganda, HIV prevalence declined from 21% to 9.8% from 1991-1998, there was a reduction in non-regular sexual partners by 65% and greater levels of communication about AIDS and people with AIDS through social networks, unlike the comparison countries."⁶³

Some concern has been expressed at the validity of a South Africa/Uganda comparison. Nonetheless, given that the South African government had a window of opportunity in which to address HIV (infection rates were 7% in 1994⁶⁴) and had more resources with which to do so, the

⁶² Rand L. Stoneburner and Daniel Low-Beer. "Population-level HIV Declines and Behavioural Risk Avoidance in Uganda" in *Science*, 30 April 2004, Vol. 304, no. 5671, p. 714.

⁶³ Rand L. Stoneburner and Daniel Low-Beer. "Behaviour and Communication Change in Reducing HIV: Is Uganda Unique?" in *African Journal of AIDS Research*, 1 May 2003, Vol. 2, No. 1. Pp. 9-21

⁶⁴ Dorrington RE, Johnson LF, Bradshaw and T. Daniel. *The demographic impact of HIV/AIDS in South Africa: national and provincial indicators for 2006*. (Cape Town, Centre for Actuarial Research, South African Medical Research Council and Actuarial Society of South Africa.), p. 26. See Figure 5.

mechanisms of Uganda's different approach offer at least some cause for reflection.

The *Science* article attributes Ugandan success to "communication about AIDS through social networks."⁶⁵ Most notably, though, it acknowledges that other African countries, which have followed "substantial condom use and promotion of biomedical approaches...have shown neither similar behavioural responses nor HIV prevalence declines of the same scale."⁶⁶

However, if "communication about AIDS through social networks" is to be credited with Uganda's success, then this concept requires further substantiation. Interesting work from Physician/Theologian Christoph Benn provides a complementary perspective. Drawing on the UN AIDS Case Study of Uganda⁶⁷, he argues that a significant component of these "social networks" are churches and faith-based organisations. He illustrates that because they are rooted in local structures and command considerable trust and credibility, they are in an excellent position to mobilise communities in responding to HIV and AIDS. "Churches and other faith-based organisations can provide a balanced message of prevention and contribute greatly to effective HIV and AIDS programmes."⁶⁸

Benn further argues that Uganda's 'success' is attributable to "the joint effort of government and

⁶⁵ Rand L. Stoneburner and Daniel Low-Beer. "Behaviour and Communication Change in Reducing HIV: Is Uganda Unique?" in *African Journal of AIDS Research*, 1 May 2003, Vol. 2, No. 1. Pp. 9-21

⁶⁶ Rand L. Stoneburner and Daniel Low-Beer. "Population-level HIV Declines and Behavioural Risk Avoidance in Uganda" in *Science*, 30 April 2004, Vol. 304, no. 5671 pp. 714-718.

⁶⁷ UN AIDS, *A measure of success in Uganda*. UNAIDS Case Study (Geneva: UNAIDS, 1998). Available at <http://www.unaids.org/publications/documents/epidemiology/determinants/una98e8.pdf>, last accessed August 27, 2009

⁶⁸ Benn, C. 2002. "The Influence of Cultural and Religious Frameworks on the Future Course of the HIV/AIDS Pandemic" in *Journal of Theology for Southern Africa*, No. 113. P. 16

faith communities...as they have not confused people with conflicting messages as happened in other countries".⁶⁹ It is unclear whether he is referring to South Africa, but there is plausible argument that the South African government has sown obfuscation⁷⁰ around the question of HIV transmission: "Senior politicians...remain unwilling to attack the stigmatization that AIDS brings, while transmitting opaque messages about how HIV is transmitted..."⁷¹ However, Butler also lays blame for continued stigma and social attitudes at the door of religious leaders: "Religious values and traditions, rather than political leaders, obstruct condom distribution and inhibit learning about how HIV is spread... While churches have been at the forefront of palliative care for those living with AIDS, religious leaders have...balked at the attempt to change their followers' behaviour."⁷²

Pentecostal churches, however, display significantly lower rates of extra-and-premarital sex (EPMS) than their mainline denomination counterparts, which display no difference to secular society. "The global efflorescence of Pentecostalism has produced a great deal of ethnographic research, and many of these studies comment on the change in sexual attitudes (and, allegedly, behaviour) that follow on the heels of the 'born-again' experience."⁷³

⁶⁹ *ibid*

⁷⁰ There is extensive debate about whether this obfuscation has been purposeful, ie. a purportedly rational response emanating from deeply held ANC exile suspicions of anything 'western', or simply a deplorable faux poise on the part of some incompetent government officials. For an authoritative explanation of South Africa's HIV/AIDS Policy, see Anthony Butler (referenced below).

⁷¹ Butler, A. 2005. "South Africa's HIV/AIDS Policy, 1994-2004: How can it be explained?" in *Oxford Journal of African Affairs*, vol. 104, no. 417, p. 591-614.

⁷² *ibid*, p. 595

⁷³ Garner, R. 2000. "Safe Sects? Dynamic Religion and AIDS in South Africa" in *The Journal of Modern African Studies*, Vol. 38, No. 1, pp. 41-69

In research conducted in Edendale - a KwaZulu-Natal township - Garner shows that lower rates of EPMS amongst Pentecostals are reflected through four dimensions: "Across a range of social and economic factors, the research...found that different church types had markedly varying power to affect the sexual behaviour patterns of their members... Four aspects of any ideological group - in this case Christian churches, but more widely also - will determine its power to affect the behaviour of members, especially when the ideology promotes behaviour which runs counter to perceived self-interest or cultural norms. These four categories are: (a) *Indoctrination*⁷⁴, (b) *Religious/Subjective Experience*⁷⁵, (c) *Exclusion*⁷⁶, and (d) *Socialisation*.⁷⁷

Pentecostal churches score highly on each dimension: "Membership of such churches is by profession of faith and adult baptism, and the costs - both social and economic - of membership

⁷⁴ See Garner, R. 2000. "Safe Sects? Dynamic Religion and AIDS in South Africa" in *The Journal of Modern African Studies*, Vol. 38, No. 1, pp. 48-49: "This term is used...to describe the methods and depth of the group's educational programme. In the context of churches, this is usually dominated by its approach to Biblical teaching and the extent of Bible use among members. This variable is probably the most powerful of the four. The level of indoctrination may vary from issue to issue - tithing may be systematically taught, sexual norms virtually ignored, for example."

⁷⁵ Ibid, P. 49: "This category concerns the strength of subjective experience of the group member, as manifested by the level of participation in meetings, opportunities for self-expression, and emotional involvement. In churches, this is manifested in personal prayer; lay activity and spontaneity in public worship; and the prominence given to the hallmarks of dynamic religion, 'gifts of the spirit' (charismata), such as healing and speaking in tongues."

⁷⁶ Ibid, P. 49: "This measure concerns the discontinuity or boundary the group perceives between its members and society at large. This can be discerned from a church's articulation of cosmological and social dualism; conversion, salvation and judgement; spiritual conflict; restricted access to communion; adult versus infant baptism. Churches which emphasise exclusion in this sense are by no means closed to non-members; they usually devote considerable energy and resources to persuading outsiders to join. The point is: they believe that non-adherents are outsiders, and are legitimate targets for proselytism."

⁷⁷ Ibid, Pp. 49-50: "How does the group create and maintain this discontinuity, these boundaries? This is gauged from the involvement of the group or church in the lives of members; the amount of time that membership entails; the social activities which the church organises and promotes; the level of surveillance and control of social activities (especially use of time and money, and the functions of sex and marriage) that is exercised; and the implementation of church discipline."

are high. Meetings are frequent, long and energetic, with plenty of lay participation. The romantic and financial aspects of members' lives are monitored - if not exactly controlled - by church leaders. The powerful subjective experience of charismatic faith is coupled with an almost inexhaustible appetite for Bible study, prayer and choir meetings; biblical literacy is often prodigious. Pentecostals' emphasis on the need to be 'born-again'⁷⁸, with its adjuncts of exclusion and proselytism, provokes gentle mocking in society at large, with the use of the slightly derogatory Zulu phrase "*abasindiswa*", the 'saved'.⁷⁹

The author then proceeds – importantly for this dissertation - to provide extensive evidence for why EPMS is an important HIV prevention variable to study. In a context marred by gender inequality, related economic dependence on men, cultural reluctance for men to use condoms and their proclivity to have concurrent partners, reduced rates of EPMS are likely to reduce HIV transmission. The discerning reader will find their suspicions aroused at the concept of measuring a variable as evasive as levels of EPMS within churches. The author recognises these methodological barriers⁸⁰ and uses the following table as a guideline after having controlled for

⁷⁸ There is some debate as to the regularity of employment of this term. Certainly it has deep historical roots. Jesus tells Nicodemus – in John 3 – that he cannot be saved unless he is born again. However, mainline denominations have tended in recent years to shy away from the term for a number of theological reasons which cannot here be expounded and eschew it as a 'Charismatic phrase'.

⁷⁹ Garner, R. 2000. "Safe Sects? Dynamic Religion and AIDS in South Africa" in *The Journal of Modern African Studies*, Vol. 38, No. 1, p. 53

⁸⁰ See Garner, R. 2000. "Safe Sects? Dynamic Religion and AIDS in South Africa" in *The Journal of Modern African Studies*, Vol. 38, No. 1, pp. 53-54: "The evidence produced here is drawn primarily from the seventy-eight in-depth interviews with respondents from the four church types, and from a control group of non-churchgoers; these five groups were stratified by gender and socioeconomic class, to control for those influences. The discussion also draws on various informal conversations, and group discussions, held with the youth groups of church 1 and church 2... How would it be possible to assess sexual behaviour in Edendale? It is not hard to identify the methodological and epistemological barriers to obtaining reliable data on sexual behaviour. It did not seem likely that answers to direct questions could be trusted. In trying to find proxies for direct measures of EPMS, the first obvious and verifiable measure was whether the respondent had a child or children born illegitimately. As it stands, however, this measure may be misleading when applied to church type: people, especially women, may leave their

factors such as gender and socioeconomic class:

Measures of EPMS

Higher EPMS	Lower EPMS
1. Higher incidence of illegitimacy	1. Lower incidence of illegitimacy
2. Higher incidence of membership at time of illegitimate conception	2. Lower incidence of membership at time of illegitimate conception
3. Lower age at first birth	3. Higher age at first birth
4. Lower estimate of abstention from EPMS	4. Higher estimate of abstention from EPMS
5. Higher number of co-parents	5. Lower number of co-parents
6. Higher approval of condom use	6. Lower approval of condom use

Source: Garner, R. 2000.

The findings are indeed astonishing:

church if they conceive a child while unmarried, and join another church after the birth. So a high figure for Measure 1 may simply indicate that a church is particularly welcoming to single mothers, a low figure that the church makes life difficult and uncomfortable for them. To get around this problem, a derivative measure was calculated: which church types did parents belong to at the time they conceived illegitimately? This number was then expressed as a percentage of all the people in the sample who had illegitimate children, as Measure 2. As the sample contained almost exactly equal numbers of the theological types, a type with a score of higher than 25 per cent probably has a higher level of EPMS, a type with a score of less than 25 per cent a lower level of such activity. Third, in the case of all the respondents who had children, the age at which they gave birth to their first child is recorded: a low figure probably implies that sexual activity began at an earlier age. This is not necessarily an indication of EPMS - women may be married very young - but some correlation between the two would be expected. Measure 4 asked each respondent to estimate what percentage of members of their church abstained from all EPMS; it seemed probable that respondents' answers would reflect both their own experience, and their knowledge of other church members. An average of these estimates was obtained for each theological type. Measure 5 was the number of partners with whom members of each group had co-parented children. Measure 6 asked respondents about their support for the use of condoms."

“By almost every measure⁸¹, [Pentecostalism] emerges as the theological [church] type with the lowest implied level of EPMS... Although this evidence is circumstantial, its cumulative effect is persuasive, and is corroborated by the discussion with members... all the measures employed indicate that EPMS is rare (but not absent). This is achieved by attention to each of the four variables discussed above: *indoctrination* characterises EPMS uncompromisingly as displeasing to God, a view reinforced by high levels of teaching and Bible reading. To stray from this code is to imperil salvation, and to risk *exclusion* from the community of the saved. The young members’ primary *social* network, the youth group, offers the reciprocal support of other group members, who also monitor each other’s behaviour. And the spiritual resources of a charismatic *experience* assist the maintenance of this counter-cultural behaviour.”⁸²

This research provides evidence of irrefutably counter-cultural trends, despite common assertions that “to advocate celibacy, in the absence of a change in socioeconomic circumstances in the townships, is hopeless”⁸³. There is indeed substance to the argument that sexual norms may be partially determined by a society’s political economy.⁸⁴ Therefore, a social influence that reverses high rates of EPMS is to be viewed with more than passing interest.

⁸¹ See Garner, R. 2000. “Safe Sects? Dynamic Religion and AIDS in South Africa” in *The Journal of Modern African Studies*, Vol. 38, No. 1, p. 61: “Pentecostals were the least likely to have an illegitimate child, and waited the longest to have their first child. People who did have illegitimate children were less likely to have belonged to a Pentecostal church [at the time of conception] than to any of the other types. Pentecostals were by far the most optimistic about the absence of EPMS among members of their church (or, more precisely, among ‘born-again’ Christians). And Pentecostals with children had the fewest co-parents.”

⁸² Garner, R. 2000. “Safe Sects? Dynamic Religion and AIDS in South Africa” in *The Journal of Modern African Studies*, Vol. 38, No. 1, pp. 60-61

⁸³ Loening, W. 1992. ‘Adolescent pregnancy: a medical perspective’, in S. Burman & E. Preston- Whyte, eds., *Questionable Issue: illegitimacy in South Africa*. (Cape Town: Oxford University Press.

⁸⁴ See Steinberg, J. *Three Letter Plague*, for a discussion on sexual promiscuity as a ‘cultural norm’ as opposed to a development that is a response to a changing political economy (brought on in large part by the family-rupturing effect of migrant labour).

It is important here to acknowledge that concurrence (having multiple sexual partners at the same time)⁸⁵ is a stronger contributing factor to the epidemiology of HIV than is promiscuity (defined as serial monogamy)⁸⁶. Combined with a strong cultural reluctance to use condoms⁸⁷, concurrence is especially discouraging in the face of rapid HIV transmission. Changing 'sexual behavioural', however, is often associated with trying to prevent promiscuity and encouraging condom usage, rather than promoting faithful, monogamous marriage. EPMS – *any* sex outside of or prior to faithful, monogamous marriage – therefore, is an especially constructive measure of the type of sexual behaviour that should be rescinded to reduce HIV transmission.

That Pentecostal churches are making significant inroads into changing the levels of EPMS amongst their congregants is highly relevant because of the notable global growth of this 'brand' of Christianity, and is therefore of particular importance for this study.

3.3. In the World, not of the World: Churches and their relation to civil society

⁸⁵ Formal polygamy or the 'dual-family' system are both elements of this phenomenon.

⁸⁶ See Rosling, H. at a February 2009 TED Conference - available at <http://dotsub.com/view/36cdf4a6-ed3a-4834-8d77-10fb16cf8ae7/viewTranscript/eng> and <http://www.youtube.com:80/watch?v=3qRtDnsnSwk>, last accessed August 13, 2009 – for a convincing demonstration of concurrence and age-disparate sex as highly influential contributors to HIV transmission, as opposed to 'serial monogamy'.

⁸⁷ See Garner, R. 2000. "Safe Sects? Dynamic Religion and AIDS in South Africa" in *The Journal of Modern African Studies*, Vol. 38, No. 1, p. 56: "It is reasonable to assume that many of those who practise EPMS do so with multiple partners; research in a number of locations in sub-Saharan Africa has found wide support for the idea that African males are entitled to have multiple partners concurrently. The use of condoms is rare among black South Africans, for many reasons. To begin with, AIDS is dismissed by many blacks as a fictitious scare story, a white plot to limit population growth or stop them from having fun; deaths from AIDS are, at present, obscured sufficiently for this illusion to persist. Even where people are aware of the dangers of AIDS and the way in which it is transmitted, a number of cultural factors militate against the use of condoms. Men maintain that sex with a condom is less pleasurable, and are unlikely to initiate condom use."

Some Christian authors argue, however, that EPMS is not as significant a contributor to HIV as the studies would have us believe: "AIDS is a justice issue, not primarily a sex issue. AIDS as a justice issue concerns the social relationships that help spread HIV and fail to alleviate AIDS, relationships of power and vulnerability that are in violation of Catholic norms of justice and the common good."⁸⁸ Cahill draws connections between poverty and the spread of HIV, arguing that indeed the primary responsibility of churches lies in eradicating the "*unjust ultimate social causes*."⁸⁹ She makes the controversial point that political and ecclesial controversies over AIDS have sidetracked churches' efforts by focusing 'myopically' on more volatile proximate causes and deterrents – sex outside marriage and condoms.⁹⁰

In respect of the above, Attanasi suggests two broad categories into which South African Pentecostals fall. Institutionally speaking, one category understands the church's mission in the world to be primarily concerned with the *physical*⁹¹, where the other category understands it to be concerned with the *spiritual*. The former tend to be strongly correlated with those who view sin as more 'structural' (AIDS attributable to unjust ultimate social causes) than 'individual' (AIDS attributable to sexual indiscretion, i.e. EPMS). In other words, it is a worldview that understands the church to be the visible and invisible representation of Christ on earth to bring compassion, healing and comfort to a world that is devastated by deep historical injustices. The

⁸⁸ Lisa Sowle Cahill, "AIDS, Justice and the Common Good" in *Catholic Ethicists on HIV/AIDS Prevention* (Wellington House: London, 2000). (ed) James Keenan. Pp. 282

⁸⁹ *ibid*, p. 283. A more primitive form of the same argument was offered by Thabo Mbeki, and invited global mockery because of its failure to distinguish between medical and social causes, thereby overlooking the sexual (medical) aspect entirely.

⁹⁰ Cahill's argument requires further interrogation, though, as there do appear to be cultural norms that hold communities in bondage to structural features that make women susceptible to men's sexual whims. As Dubbey's argument shows, monogamous sexual relations within marriage can satisfy sexual desires within an institution that promotes love and respect between persons.

⁹¹ Responding with compassion to the needs of those who suffer (from any manner of hardship)

latter tend to be strongly correlated with those who view sin as more 'individual' than 'structural'. This group embraces a worldview that sees the church as Christ's body broken and blood shed for individual sinners who would place their trust in Him. They are about 'winning souls' for the Kingdom of God and are more interested in seeing people turn away from a life of sin and place their trust in Jesus than in addressing structural injustice per se.⁹²

Other authors hold that the above concerns, which Cahill dismisses as "myopic", are of indispensable significance. They indicate that churches are likely to be invariably concurrently faced with both political and ecclesial concerns. John Dubbey, for instance, categorises the "social responsibility of the Christian"⁹³ into three dimensions, namely "social action," "political action" and "moral action." Of the latter, Dubbey writes: "This is the area in which Christians will be at their most unpopular."⁹⁴ In answering the question of whether the Christian has any claim on how the world should live, his argument is threefold. Firstly, "the laws of God are universal, intended not just for believers but also as the effective way of life for *all* mankind".⁹⁵ Second, "we have an obligation to oppose all works of evil...we cannot be satisfied to see anyone perish through their sin, whether in ignorance or otherwise."⁹⁶ The desire to honour God

⁹² Attanasi, K. 2008. "Getting in Step with the Spirit: Applying Pentecostal Commitments to HIV/AIDS in South Africa" in *Political Theology*, [PT 9.2] [ISSN 1462-317X] pp. 193-208. This is an idealised overview, as the global tendency amongst churches who see their mission as primarily physical (not spiritual) tend to forsake the doctrine of Jesus Christ as mankind's penal substitutionary atonement (and now exalted) and treat him rather as a mere example, thereby undermining, if not negating, the need for the individual to turn from sin and place trust in Jesus. For a practical theological discussion on the matter, see Driscoll, M and G. Breshears. 2009. *Vintage Church: Timeless Truths and Timely Methods*. (Crossway: USA).

⁹³ John Dubbey, "The Social Responsibility of the Christian" in *The Church Against AIDS*, (Kachere Books: Malaw, 2006). Pp. 11-20

⁹⁴ *ibid*, p. 18

⁹⁵ *ibid*, p. 19

⁹⁶ *ibid*, p. 19

cannot, therefore, tolerate blatant transgression of His commands and rebellion against His authority. Third, and most importantly, “if we remain silent on moral issues, we run the risk of placing others at risk of temptation, and allowing evil to gather momentum.⁹⁷” As a point of relevant comparability, he traces the moral decline of British society - since the 1969 law legalising abortion - with persuasive clarity.

Drawing on Uganda’s example of alleged effective inhibition of HIV transmission, Dubbey concludes that there are three components to success in changing risky sexual behaviour: Strong leadership from the Head of State to mobilise all sectors of society against the ‘invading army’ of HIV. Second, the fight against AIDS “must be recognised as moral and spiritual warfare and contested accordingly.⁹⁸” Third, and most importantly, the battle must be driven by compassion for actual and potential victims. Dubbey also makes much mention of the importance of providing not only ‘physical food’ but also ‘spiritual food’. Therefore, whenever nutrition or some kind of HIV-related intervention was being provided (in Gabarone Baptist Church’s response), the Gospel of Jesus Christ⁹⁹ would always be preached first.

This is then the epitome of what Attanasi would categorise as a Pentecostal/Charismatic intervention that saw the church’s mission as both physical and spiritual, sin as structural and individual, and was accordingly interested in providing physical compassion but also an individual opportunity to turn away from sin and place trust in Jesus Christ. Individual sin such

⁹⁷ *ibid*, p. 19

⁹⁸ John Dubbey, “Government and Condoms” in *The Church Against AIDS*, (Kachere Books: Malaw, 2006). Pp. 89-106

⁹⁹ The good news that though man has sinned and rebelled against God, God had a redemptive plan to send his Son Jesus, fully God and fully man, to die for our sins so that we might have His perfect righteousness imputed to us and be reconciled to God if we turn from sin and trust in Jesus as both Lord and Saviour. 2 Corinthians 5:21.

as fornication and issues of condom usage – under this view – are not merely ‘myopic.’

Sexual morality remains a thorny issue for churches. Fuelling further complexity is Steinberg’s observation that HIV transmission is understood through cultural beliefs rather than through western biomedical explanations¹⁰⁰. Abounding in the culture, for instance, is a strong notion that HIV is contracted through a curse, where a vengeance-seeker may consult a witch doctor, who would send a demon to sleep with the victim and infect them with HIV. This view makes obsolete the idea of individual responsibility for risky sexual behaviour. This is of course convenient in a world where dignity from meaningful employment has been replaced by the search for dignity in sexually satisfying women.¹⁰¹

Despite prolific western intervention in terms of HIV information provision and evidence of ARV-induced recovery, there is still significant reluctance to even test for HIV. Cultural meanings associated with the ‘white man’s needle’ are also indelibly entrenched through a history of protracted struggle between black and white on the homeland/colonial frontiers. For instance, the perception was that before MSF arrived with their needles and testing units, HIV didn’t exist. Moreover, if one doesn’t test, then one doesn’t have it (so the reasoning goes), and thus no behaviour change is necessary.¹⁰²

¹⁰⁰ Christoph Benn also addresses this issue, but Steinberg’s clarity is unparalleled. See Johnny Steinberg, *Three Letter Plague: A young man’s journey through a great epidemic*, (Jonathan Ball Publishers: Johannesburg, 2008). Pp. 11-326

¹⁰¹ Johnny Steinberg, *Three Letter Plague: A young man’s journey through a great epidemic*, (Jonathan Ball Publishers: Johannesburg, 2008). Pp. 11-326

¹⁰² Johnny Steinberg, *Three Letter Plague: A young man’s journey through a great epidemic*, (Jonathan Ball Publishers: Johannesburg, 2008). Pp. 11-326

While these kinds of complexities are not substantially addressed in the theological literature, Garner's study suggests that they can actually be transcended through the preaching of the Christian Gospel. It appears that Garner's 'four dimensions' of indoctrination; subjective charismatic experience; socialisation and exclusion were able to significantly reduce incidences of EPMS. Tellingly, it is plausible that the cultural complexities uncovered by Steinberg in Lusikisiki were also present in Edendale.

Where western 'liberal' approaches – which have taken deep root in many mainline denomination's theologies - have had little success in modifying sexual behaviour, Pentecostal churches appear to have been significantly more influential. Therefore, Garner's four dimensions address Steinberg's complexities to some extent¹⁰³.

3.4. Policy Learning

It is instructive here to examine the literature as it pertains to policy learning. How churches are responding to HIV and AIDS is effectively insignificant as a Public Policy question if not understood as a contribution to Policy Learning. Therefore, this element of the literature review examines the relevant Policy Learning literature.

¹⁰³ For instance, the 'socialisation' of belonging to a tight-knit social group may satisfy the quest for identity and dignity. Instead of identity being found in the ability to pleasure a woman, it is now invested in abstaining from sex until marriage and then satisfying one woman forever.

'Indoctrination', as it pertains to teaching that believers are saints and co-heirs with Christ¹⁰³ - and therefore possessed of new purpose and meaning - may overcome Oster's fatalism¹⁰³ associated with having little future earning potential, and thus serve to increase the marginal costs (and reduce the benefits) of risky sexual behaviour in the mind of the believer. 'Exclusivity' and 'subjective charismatic experiences' may provide profound satisfaction that cannot be replaced by illicit sexual encounter.

“Fostering policy learning is a desirable goal for policy analysis and debate.”¹⁰⁴ Wildavsky asserts that policy evolution is “learning what we are collectively constrained to prefer.”¹⁰⁵ While there is general agreement that policy learning is desirable, there was (until Peter May’s 1992 work) insufficient conceptual clarification of what was meant by the term.

May suggests that there are essentially two forms of policy learning. First, “instrumental policy learning entails lessons about the viability of policy instruments of implementation designs.”¹⁰⁶ Two, “social policy learning entails lessons from the social construction of policy problems, the scope of policy, or policy goals.”¹⁰⁷ He then draws a distinction between these two forms and ‘political learning’, which “takes place within advocacy coalitions, leading to more sophisticated advocacy of particular proposals or problems.”¹⁰⁸

Relevant to the case at hand – the South African state’s HIV and AIDS policy failure – May observes that although policy failure presents opportunities for policy learning, “policy learning does not necessarily follow from policy failure”.¹⁰⁹ Instrumental learning tends to be constrained by confusion over what is actually required to improve policy outcomes, or “by political or other factors that limit the ability to incorporate new understandings into policy design.”¹¹⁰ Social learning tends to be “constrained interest group specialisation and an unwillingness to challenge

¹⁰⁴ May, P. 1992. “Policy Learning and Failure” in *Journal of Public Policy*, Vol. 12, No. 4. p. 331

¹⁰⁵ Wildavsky, A. 1979. “Strategic Retreat on Objectives: Learning from Failure in American Public Policy” in *Speaking Truth to Power*. (Boston: Little, Brown), pp. 385-406

¹⁰⁶ May, P. 1992. “Policy Learning and Failure” in *Journal of Public Policy*, Vol. 12, No. 4. p. 350

¹⁰⁷ *ibid*, p. 351

¹⁰⁸ *ibid*, p. 351

¹⁰⁹ *ibid*, p. 351. See also earlier discussion about other variables that are likely to influence the policy agenda.

¹¹⁰ *ibid*, p. 352

core beliefs.”¹¹¹ In conclusion, May posits that “development of further understandings of policy learning and failure require comparison of different contexts for facilitating or hindering change and learning.”¹¹²

In an article¹¹³ specifically dedicated to the methodological question of whether we can indeed learn anything from different contexts (specifically in the arena of health), Marmor et al. note: “The last decades have seen a growing body of comparative study in health policy, but this growth was not matched by a growing understanding of the processes of policy learning from the experience of other countries.”¹¹⁴ These authors argue that increasing fiscal strain and decreased political support for state intervention undermined the welfare state (in wealthy countries) in general and health policy in particular. While this created pressure to seek policy solutions from abroad, the subsequent research – produced by international organisations like the World Bank and World Health Organisation – consisted of “merely descriptive studies of health care systems and policy measures within national boundaries. The studies pay little attention to the question of what experience can be applied in another country [and] under what circumstances.”¹¹⁵ They thus conclude, much like May (thirteen years prior), that policy makers feel pressurised to change, but have insufficient time to learn from other countries’ experiences. They lament further that: “existing research largely ignores the important difference between the process of learning about other countries’ experience...why change takes place, and drawing lessons from

¹¹¹ *ibid*, p. 352

¹¹² *ibid*, p. 352

¹¹³ Marmor, T., Freeman, R. and K. Okma. 2005. “Comparative Perspectives and Policy Learning in the World of Health Care” in *Journal of Comparative Policy Analysis*, Vol. 7, No. 4, 331-348

¹¹⁴ *ibid*, p. 343

¹¹⁵ *ibid*, p. 344

that experience..." The single case study in this dissertation hopes to offer effective policy learning for a range of countries whose healthcare systems operate under similar contexts.

In the midst of this literature, there has been an increasingly contested debate about the relevance of 'evidence-based' policy-making (EPBM) over more abstract notions of what is 'appropriate'. Sanderson¹¹⁶ has been the primary antagonist cautioning against an over-reliance on 'evidence', although he does not "take a nihilistic view of a world beyond the reach of redemptive politics"¹¹⁷. While most scholars (aside from a few 'post-moderns') would agree on the importance of applying the findings from "social scientific research more systematically in our collective efforts to address social problems and improve the lives of those suffering poverty and disadvantage"¹¹⁸, Sanderson is wary of 'technocratic politics' and the reduction of policy making to an exercise in 'social technology'. His doubts pertain specifically to the feasibility of 'evidence' in relation to "complex, cross-cutting, multi-intervention programmes."¹¹⁹ HIV and AIDS in South Africa certainly present one such policy context. "Such contexts present very severe challenges to evaluators in seeking to derive evidence of 'what works' in terms of an understanding of the causal mechanisms by which an intervention achieves change and how the operation of such mechanisms is influenced by relevant contextual factors."¹²⁰ The alternative he poses is fraught with self-confessed ambiguity and uncertainty that is unpalatable to

¹¹⁶ Sanderson, I. 2003. "Is it 'what works' that matters? Evaluation and evidence-based policy-making" in *Research papers in Education*, Vol. 18, No. 4, pp. 331-345

¹¹⁷ *ibid*, p. 341.

¹¹⁸ Fischer, F. 1990. *Technocracy and the Politics of Expertise*. (Newbury: Sage Publications)

¹¹⁹ Sanderson, I. 2003. "Is it 'what works' that matters? Evaluation and evidence-based policy-making" in *Research papers in Education*, Vol. 18, No. 4, p. 342

¹²⁰ *ibid*

'instrumental rationality' – "the claim that government can actually possess the kind of knowledge sufficient for it to arrive at 'national solutions' to policy problems".¹²¹

Sanderson argues that evaluation is part of a policy process conditioned by interest located in social and political processes operating in particular organisation contexts. "Thus, as an exercise in 'practical-moral reasoning', evaluation takes place within an institutional framework, which differs in significant ways from that which is applicable to the pursuit of 'pure' social scientific knowledge."¹²² Constrained by time, political agendas and pressures, policy formation is not exactly conducive to the kind of research that would contribute to long-term developmental objectives. With a turn to 16th Century 'enlightened' Humanism, Sanderson calls for the extrapolation of policy action from a mechanically instrumental character, in order to ensure "that we take action that is 'appropriate' to situations that are both morally and factually ambiguous."¹²³ Congruent with this line of reasoning, Benatar concludes that: "the improvement of health in South Africa will depend both on enlightened, vigorous reconsiderations of many local policies and practices and on a reshaping of the global forces that affect the health of whole populations."¹²⁴

¹²¹ See Parsons, W. 2002. "From Muddling Through to Muddling Up - Evidence Based Policy Making and the Modernisation of British Government" in *Public Policy and Administration*, Vol. 17, No. 3, pp. 43 – 60, for a critique of 'instrumental rationality'.

¹²² Sanderson, I. 2003. "Is it 'what works' that matters? Evaluation and evidence-based policy-making" in *Research papers in Education*, Vol. 18, No. 4, p. 342

¹²³ *ibid*, p. 343

¹²⁴ Benatar, S.R. 2004. "Health Care Reform and the Crisis of HIV and AIDS in South Africa" in *The New England Journal of Medicine* 351:1, p.

'Enlightened' is a word that evokes much contestation¹²⁵. Certainly, the churches examined in this dissertation would hold a fundamentally different concept of 'enlightenment' to that of Benatar and Sanderson respectively. Our question, however, is whether the case studies under examination – Living Hope especially - can be taken as an example of applied intellect and policy wisdom from which the state can learn. Does it provide policy learning that combines scientific evidence and pragmatic understanding of constraints and the local context as to be both appropriate and applicable in other similar contexts?

3.5. Concluding Remarks

What this review suggests is both that further research - exploratory work that documents the nature and method of church responses to the HIV and AIDS pandemic – is required. Pentecostal/Charismatic churches are particularly under-researched. The review has shown that they are of growing significance for the African continent, especially in terms of their apparent efficacy in reducing rates of EPMS. This confirms the rationale for a dissertation focused specifically on these churches and their responses to HIV and AIDS, particularly because it would appear that they have something to offer the state by way of Policy Learning.

¹²⁵ CS Lewis called 'enlightenment' chronological snobbery: "the uncritical acceptance of the intellectual climate of our own age and the assumption that whatever has gone out of date is on that count discredited." The idea of 'enlightenment' became opprobrious to him as a Christian convert when he realized that in fact there is little new under the sun and mankind is quite likely less enlightened now than in times when most of society's members believed the gospel of Jesus Christ. See C. S. Lewis. 1970. "Priestesses in the Church?" in *God in the Dock: Essays on Theology and Ethics*, ed. Walter Hooper (Grand Rapids, MI: Eerdmans), p. 238.

4. Research Questions

4.1. Primary Question: How are Pentecostal/Charismatic churches in the Western Cape responding to the HIV and AIDS pandemic?

The question is exploratory in nature. "Because of the unstructured nature of most qualitative research with its associated lack of specified hypotheses, except in a very loose sense, qualitative research is inherently exploratory. As a result of this emphasis, the qualitative researcher embarks on a voyage of discovery rather than one of verification, so that research is likely to stimulate new leads and avenues of research that the quantitative researcher is unlikely to hit upon, but which may be used as a basis for further research. Such research will follow up the leads suggested by qualitative research and will seek to confirm or reject them using the more rigorous framework associated with a natural science approach, i.e. quantitative methodology."¹²⁶

Therefore, the objective of the dissertation is to understand not just *what* churches are doing, but also *how* they are doing it. The hope is that it will provide the platform for future researchers to identify interesting findings and ask meaningful questions accordingly. This exploratory question unpacks the mechanisms that contribute to a programme or institution's establishment and success, and how those programmes or institutions continue to operate under changing constraints. This provides both avenues for future research and Policy Learning.

¹²⁶ Bryman, A. 1984. "The Debate about Quantitative and Qualitative Research: A Question of Method or Epistemology?" in *The British Journal of Sociology*, Vol. 35, No. 1, pp. 75-92

4.2. Secondary Question: What Policy Learning can be derived from the examination of these churches' responses to the HIV and AIDS pandemic in the Western Cape?

The Desktop Study reveals some notable trends and identifies a number of successful interventions. One particularly successful intervention is "Living Hope", a ministry launched and operated from Fish Hoek Baptist Church. It has therefore been chosen as an exemplary case to explore at a depth not possible in the desktop study, from which Policy Learning can be derived. A Policy Learning question is here concerned with two things. First, what elements of Living Hope's success can be replicated or adopted by the state to defeat the HIV and AIDS pandemic in South Africa? Second, the Policy Learning debate is currently characterised by a dispute between 'appropriateness' and 'what works'. What can the apparent success of Living Hope contribute to this debate?

5. The Desktop Study

5.1. Defining the parameters of which churches to include

Defining what constitutes a 'Charismatic' or 'Pentecostal' church is notoriously complicated.¹²⁷

"Pentecostalism is itself an umbrella term with diverse meanings... At the core of the term is an emphasis on the workings of the Holy Spirit, especially as an active force in the life of believers and relating back to the first Pentecost in Acts 2. Pentecostalism is itself separate but related to the religious complex which we call Charismatic Christianity¹²⁸ ... From the late 1950s onwards, the Charismatic movement, which was to a large extent inspired and influenced by Pentecostalism, began to flourish in the mainline Protestant denominations and even the Roman Catholic Church. 'Charismatics' chose to stay within the traditional denominations unlike "Classical Pentecostals," who formed their own Pentecostal congregations or denominations.¹²⁹

Today it has become increasingly difficult to speak of Charismatics and Pentecostals as being part of two separate movements. There is a continuity which stretches between Pentecostalism

¹²⁷ Domeris, W.R and Paul Germond. 2006. "Pentecostal/Charismatic Christianity – A South African Survey", Research Report commissioned by the Centre for Development and Enterprise (CDE: Johannesburg), p. 2. Available at http://www.cde.org.za/attachment_view.php?aa_id=219&PHPSESSID=ff7e1b2fe78ec334e0e9ab974ad1f3af, last accessed June 23, 2009. See also the cited works within this survey, like Anderson et al.

¹²⁸ The word *charismatic* is derived from the Greek word *charis* (meaning a grace or a gift) which is the term used in the Greek New Testament to describe a wide range of supernatural experiences (especially in 1 Corinthians 12-14).

¹²⁹ Given the increasing recognition of the gifts of the Holy Spirit within mainline denominations, the initial splits that often occurred historically on these grounds would be less likely to occur today.

and the modern Charismatic movement.¹³⁰ Yet since neither movement is entirely homogeneous it is also unfair to speak of them as being one movement either. With similar beliefs and viewpoints, 'the difference is primarily one of origins'. Different contexts have led to different worship styles, preaching styles [and] altar ministry methods. Until a more acceptable broad nomenclature is used, it needs to be understood that both movements share a great deal in common, and yet can sometimes be clearly differentiated."¹³¹

Anderson confirms the difficulty of academic categorisation by asserting that, "in SA it is very difficult to draw lines between different 'types' of church using phenomenological or theological criteria."¹³²

Given this definitional complexity, selecting a group of Pentecostal/Charismatic churches to study in the Western Cape is a fraught undertaking. Nonetheless, the defining features offered above are sufficiently useful for conceptualising a particular set of churches as 'Pentecostal/Charismatic'.

Jubilee Community and Fish Hoek Baptist churches serve as a case in point regarding the continuity between 'Charismatic Mainstream' and 'Pentecostal': Jubilee Community Church was

¹³⁰ See also Anderson, Allan. 2005. "New African Initiated Pentecostalism and Charismatics in South Africa" in *Journal of Religion in Africa* Vol. 35, No. 1: 69-70: "... the first Charismatic churches commenced in SA in the mid 1960s, at first confined to middle-class white churches (mainly Anglicans, Methodists and Baptists.)"

¹³¹ Domeris, W.R and Paul Germond. 2006. "Pentecostal/Charismatic Christianity – A South African Survey", Research Report commissioned by the Centre for Development and Enterprise (CDE: Johannesburg), p. 2. Available at http://www.cde.org.za/attachment_view.php?aa_id=219&PHPSESSID=ff7e1b2fe78ec334e0e9ab974ad1f3af, last accessed June 23, 2009

¹³² Anderson, Allan. 2005. "New African Initiated Pentecostalism and Charismatics in South Africa." *Journal of Religion in Africa* 35, no. 1: 66-92. Academic Search Premier, EBSCOhost (accessed April 16, 2009).

formed as an independent breakaway from the mainstream Wynberg Baptist Church. According to the above definitions, Jubilee would fall under the 'Pentecostal' umbrella, as the amicable split occurred as a result of a disagreement over the operation of the gifts of the Holy Spirit¹³³. Jubilee then became a part of Vineyard Fellowship before relating to New Frontiers – a Charismatic movement led by an apostolic team from the UK, of which Terry Virgo is the team leader and founder¹³⁴.

However, at Jubilee, there is not an emphasis on the gift of tongues to the exclusion of other gifts, and the core doctrinal beliefs on salvation are still very similar to Baptist theology. Wynberg Baptist, however, remains a 'non-Charismatic' mainstream church. There are other churches within the Baptist domain (like Fish Hoek Baptist¹³⁵) that are theologically and functionally closer to Jubilee than to each other; these are termed as 'Charismatic' but not 'Pentecostal' simply on the grounds of the former having chosen to remain under a denominational umbrella rather than declaring independence. As such, Fish Hoek Baptist Church remains subject to mainline Baptist features such as 'congregation governance' (democracy) structure as opposed to 'Spirit-appointed eldership' (theocracy), which is another defining feature of some 'Pentecostal' churches, such as Jubilee Community Church.

¹³³ This is inferred from the researcher's own interpretation of the overt emphasis placed on the gifts of the Holy Spirit in Jubilee's statement of belief, while all else (barring a subtle difference between eternal 'separation' from God and 'punishment' for those who do not accept Jesus Christ as Lord and Saviour between King of Kings and Jubilee respectively) remains almost verbatim the same. This has subsequently been confirmed as an amicable split through personal communication with members and elders of Jubilee Community Church. The initial inference has also been positively confirmed.

¹³⁴ Available at <http://www.newfrontiers.xtn.org/about-us/leadership-of-newfrontiers/>, last accessed April 3, 2009. Terry Virgo himself, coincidentally, was trained at a Baptist Seminary.

¹³⁵ Also known as 'King of Kings' Baptist Church. The formal name is Fish Hoek Baptist, but its visible name on the building is 'King of Kings.'

Again, however, Jubilee is distinct from some other 'Pentecostal' churches in that it does not preach a 'Prosperity Gospel'¹³⁶, which is one of the purported characteristic features of 'Pentecostalism.' The academic's problem with definitions in this regard is therefore clearly endless, and further work is constantly required. For the purpose of this desktop study, this researcher's primary proxy variable for identification has been an emphasis on the gifts of the Holy Spirit, as well as freedom from more traditional forms of praise and worship during Sunday services. To bridge the Charismatic/Pentecostal divide, the researcher has chosen to relinquish the distinguishing variable of church autonomy and governance, thus making the term comprehensible to most readers.

Additionally, Anderson's distinction (within Pentecostalism) between 'African Independent Churches' and the 'Mission' churches (planted from outside South Africa or heavily influenced by foreign missionaries) is helpful¹³⁷. This study examines only the latter, indicating that – as invariably is the case in studies of this nature – churches like the Zionist Christian Church (ZCC) still require substantial research and are excluded from this study.

'Pentecostal/Charismatic' Churches that have been included in this study are hereby defined as churches who believe that Jesus Christ is the only means of salvation, having taken the wages of sin (death) upon himself, thus exchanging His righteousness for believers' unrighteousness. They

¹³⁶ This is the idea, imported from US Pentecostal churches (through preachers such as Joel Osteen) that salvation ushers in a flood of material blessings concomitant with 'victory' over sin, disease and torn relationships. See http://theresurgence.com/mark_driscoll_2006-09-12_audio_preaching_and_teaching_jesus_from_scripture_part_5 for Mark Driscoll's critique of unbalanced theology, last accessed June 20, 2009.

¹³⁷ Anderson, A and Gerald Pillay. 1997 "The Segregated Spirit: The Pentecostals", in R Elphick and R Davenport (eds), *Christianity in South Africa: A Political, Social and Cultural History*, (Oxford: James Curry), pp 227-241

share a belief in the operation and gifts of the Holy Spirit, but are not characterised by a 'prosperity' gospel. Although differentiated by forms of church governance, these differences are overlooked for the sake of brevity and clarity in this dissertation.

5.2. Sources of Information

Information has been sourced via emails, telephone conversations and websites, thereby providing a relatively diverse platform, and lending more reliability and accuracy to the study than would have been the case had only websites been consulted.

5.3. A selection of 'Pentecostal/Charismatic' churches in the Western Cape

- Assemblies of God (AOG)
- Vineyard Christian Fellowship
- His People Church
- New Covenant Ministries International (NCMI) – Common Good Foundation (operated out of Common Ground Church)
- New Frontiers – Jubilee Health Clinic
- 'Charismatic' Baptist Churches (Ultimately = Single Case Study – Fish Hoek Baptist)

5.3.1. Assemblies of God

5.3.1.1. Won Life Ministries – www.urbanedge.org.za

"Won Life started as just a dream in June 1999 when a group of like-minded people from the

Durbanville Assembly of God (AOG) Church decided to do something about the hopelessness encompassing the “squatters” at Fisantekraal, but has grown into a vital, non governmental organization serving the health needs of this forgotten yet expanding community. Won Life partnered with the local government and the Department of Health to appropriate land for the construction of a clinic. The clinic has been in operation in its present form since the end of 2001.”¹³⁸

These are some of the words penned by Karin Colsen, whose article appears on the Won Life Ministries web page. “[Aside from the challenge of unemployment in Fisantekraal]...the biggest problem by far is that of AIDS. Anne [the resident nursing sister] recalls the first time she undertook testing for HIV in Fisantekraal. By the end of the day, the number of positive results was so high that she thought she had made a mistake... In the five years that the clinic has been open there has been a marked increase in an understanding of the virus, but there is still a [marked] need for more awareness and education programmes.”¹³⁹

The contemporaneous problems of HIV and poverty are particularly striking in this area. “Anne – [called to dedicate her life to this ministry] - recalled the number of times she has been unable to give children the tablets they need because they haven’t eaten a proper meal that day, or even that week. For the nurses and staff at the clinic there is no pretending that the problems aren’t big, but they live and serve in hope and faith and the reassurance that small things really do make a big difference...”¹⁴⁰

¹³⁸ Colsen, K. “Where There is Hope”, available at <http://www.wonlife.org.za/download.php?view.2>, last accessed March 24, 2009

¹³⁹ *ibid*

¹⁴⁰ *ibid*

In terms of physical services provided by the clinic: “It has been Won Life’s aim to combat HIV, AIDS and TB using the clinic as a base. In 6 years it has grown substantially and now offers primary paediatric health care, HIV and AIDS education and counselling [VCT], home-based care, nutrition programs, vegetable gardens and TB treatment...”¹⁴¹

“Our Voluntary Counselling and Testing (VCT) programme remains in its infancy. The community appear reticent to know their HIV status... We remain proud to have realized our dream of creating an HIV testing station at Fisantekraal and believe that this service remains central to our future HIV and AIDS programme in the community.

Won Life continues to purchase nutritional products that are distributed largely to children suffering the effects of HIV and AIDS, either directly or indirectly.

[In the area of providing food gardens, the staff and volunteers have struggled with motivation to continue in this area.] We will, however, continue to find ways of promoting this essential aspect [of our work] to encourage a healthy lifestyle for all, but especially for those experiencing the effects of HIV and AIDS.”¹⁴²

5.3.1.2. Salt Ministries

¹⁴¹ *ibid.* For a more formal description of staff employment and activities, see the “Chairman’s Report 06/07”, also available on the website.

¹⁴² Chairman’s Report 06/07, Paul Richardson, available from www.urbanedge.co.za, last accessed August 20, 2009.

'SALT Ministries' operates from Table View AOG Church. Their website is still under construction and their response to HIV and AIDS is relatively recent. The majority of their work consists of feeding programmes, where approximately 540 food parcels per month are distributed to patients attending clinics in the surrounding areas.¹⁴³

SALT is an acronym for 'Sharing Abundant Life Together'. Implicit in the name is the Scripture which fuels the ministry: Matthew 5:13¹⁴⁴. Contributing to identified hunger needs in the surrounding areas and responding is an interpretation and application of this teaching, viewing outreach as the practical expression of retaining saltiness. SALT is a foundation aimed at community outreach, registered as a "Non Profit and Public Benefit Organisation, working together with other accredited organisations and Faith Based Organisations in order to bring change and to uplift our local community."¹⁴⁵

In keeping with the Biblical narrative, the primary endeavour of SALT ministries is to assemble and distribute "LIGHT"¹⁴⁶ bags. These are food parcels "aimed at assisting TB, HIV and AIDS patients who are on ARV's and needing nutrition to aid their recovery...[the] parcels contain 8 basic food items [and] each parcel is given to our local clinics that have a relationship with the

¹⁴³ Information conveyed through telephone conversation with Table View AOG's "Salt correspondent", +27 21 557 3948, March 19, 2009.

¹⁴⁴ "Matthew 5:13) in <http://www.biblegateway.com/passage/?search=matthew%205:13&version=47>, English Standard Version, last accessed June 20, 2009. Known as 'the Sermon on the Mount' Jesus teaches: "You [those who would believe in Him] are the salt of the earth, but if salt has lost its taste, how shall its saltiness be restored? It is no longer good for anything except to be thrown out and trampled under people's feet.

¹⁴⁵ LIGHT food parcels "Proposal" that was emailed to this researcher by "SALT" correspondent, Friday 20 March, 2009.

¹⁴⁶ Matthew 5:14-16: "You are the light of the world. A city set on a hill cannot be hidden. 15Nor do people light a lamp and put it under a basket, but on a stand, and it gives light to all in the house. 16In the same way, let your light shine before others, so that they may see your good works and give glory to your Father who is in heaven." Available at <http://www.biblegateway.com/passage/?search=matthew%205:13-20:&version=47>; last accessed June 20, 2009.

patient and monitor their progress. Our goal is to see families uplifted so that they are able to once again take care of themselves.”¹⁴⁷

A food parcel typically feeds a family of four for one week at a cost of R75¹⁴⁸. In 2008, SALT ministries launched their “Feed the Nation” programme, through which they contribute to two other NPOs in their community, namely “Keep a Child in School” and “TCL Ministry” respectively. The former pays school fees for children who cannot afford it, and SALT provides LIGHT bags to these children for their families’ meals every week. The latter is aimed at trying to keep children off the street and begging for food, thus SALT “provides the mother with food parcels to assist feeding these children. 96 Families are recipients of this programme.”¹⁴⁹

In total, then, SALT ministries commits to an average of 900 food parcels a month across all three ministries¹⁵⁰. The operating food expenses alone therefore amount to R67 500 per month.

Of great interest in this “proposal” that the church constructed, was the innovative means of appealing to corporate sponsorship:

- “Advertising opportunity for companies! Printing of new food parcels bags with company logo etc. Cost approx. R40.000.00 per annum. This is a wonderful opportunity for your company to show its support for [those infected with and affected by HIV and

¹⁴⁷ LIGHT food parcels “Proposal” that was emailed to this researcher by “SALT” correspondent, Friday March 20, 2009

¹⁴⁸ Available at http://www.saltprojects.org.za/project_lbp.php, last accessed June 23, 2009

¹⁴⁹ *ibid*

¹⁵⁰ *ibid*

AIDS] in the community and 90% of the food parcels are taken into informal settlements/ and local community...”¹⁵¹

There is opportunity for a future research question that examines the relationship between the type of funding that churches receive regarding HIV and AIDS outreach ministries, and its impact on the type and shape of the associated ministry.

5.3.2. Vineyard Christian Fellowship

5.3.2.1. IkhayaIethemba – www.ikhayaIethemba.com

“IkhayaIethemba is a small NGO birthed out of Vineyard Church, Cape Town South, in 2005. We offer holistic care for children affected by HIV and AIDS in Imizamo Yethu, Cape Town. We aim to develop a model of care that will benefit children throughout the Western Cape. We long for a world where every child has a ‘hope and a future’¹⁵² and the effects of HIV and AIDS are no longer seen...”¹⁵³ This vision is ambitious in character.

The NGO’s Annual General Meeting (AGM) report from March 2008¹⁵⁴ indicates that the organisation has had an unsettling recent past, plagued by the inevitable fluctuations of dependence on donor funding. However, some of the tumultuousness has been placated, and

¹⁵¹ ibid

¹⁵² Built on Jeremiah 29:11: “For I know the plans I have for you”, says the Lord; “plans to prosper you and not to harm you, to give you a hope and a future...”

¹⁵³ Taken from the home page of the ikhayaIethemba website – www.ikhayaIethemba.com, last accessed March 27, 2009.

¹⁵⁴ AGM Report, March 2008, IkhayaIethemba (house of hope), available at www.ikhayaIethemba.com, last accessed March 27, 2009.

operations appear to be continuing in the normal fashion.

“Mission:

iKhayaIethemba is an initiative of Vineyard Church Cape Town South that is developing and delivering a model of psycho-social care for children affected by HIV and AIDS, beginning with the children of Imizamo Yethu in Hout Bay, Cape Town, and rolling out to the Western Cape.

Core Value and Motivation:

At its heart, iKhayaIethemba holds the core value that every child, regardless of race, colour, religion, history or current living situation is individually loved by the all encompassing love of God. It is this love that causes us to seek the very best for every child we work within every aspect of that child’s life – physical, social, educational, emotional and spiritual. It is our belief that this love is able to bring fullness of life, freeing and empowering children to walk with God in His plans for them.¹⁵⁵

The NGO has rolled out a prolific number of current programmes in Imizamo Yethu since September 2007, and completed several others in that year too. These are described in more detail on their website, but essentially cover educational and care work for children either infected or affected by HIV and AIDS.

¹⁵⁵ ibid

Funding

Little is known about conditions attached to donor funding in respect of HIV and AIDS church work. As mentioned above, this is an area for future research, as donor funding may play an influential role in the type of prevention messages and treatment care that is offered by churches.

Either way, IkhayaIthemba demonstrates transparency of reporting:

“Funding Partners:

Funding Partner	Amount	Funding Period
MSAT – City Council	R30 000	July 07-June 09
Mustard Seed	R46 000	Oct 07- Oct 08 (also promised for a further 2 years)
Breadline Africa	Shipping container donated, also considering an application for salary	
Macmillan Publishng	Donation of readers for children	
BiblioneF	Donation of new books for children	
Private individuals and churches	R 55 000	Jan-Dec 07 (further promise of R35 000 for 08)
Oslo Vineyard	R 49 800	Donation for building fund
Previous Fundraising efforts	R 53 000	Set aside for building fund

The salary for the director is guaranteed for 3 years from October 2007 through a funding partnership between Mustard Seed and Kenilworth Vineyard Church. Further funding applications are pending with Lotto and Breadline Africa. Each application, if successful, will cover our operational expenses and salary for all other staff for the year beginning July 2008.”¹⁵⁶

It is interesting to note the financial contribution of local government – the City of Cape Town – to an organisation that is explicitly Christian, as this is certainly not the ‘western’ norm.

¹⁵⁶ AGM Report, March 2008, IkhayaIthemba (house of hope), available at www.ikhayaIthemba.com, last accessed March 27, 2009.

5.3.2.1 His People Church

Czegledy provides an anthropological exploration of how Pentecostals view themselves in relation to their social environment, using His People Church (Johannesburg) as a representative case. He argues that the church is embracing of the goal of the nation state, essentially a project in neo-liberal materialism that “does not undermine the sacred”.¹⁵⁷

However, even though one of the brochures photographed for the study includes “social development projects” as one of the primary “walks of life” through which His People Church aims to disciple all nations, the author does not examine these as part of the study. The cases examined below signify social development projects that bear little resemblance to ‘neoliberal ambitions of the nation state’. If anything, they are interventions of necessity birthed as a response to neoliberalism’s production of inequality.

5.3.3.1 Themba Care Grabouw¹⁵⁸

The informal settlement in Grabouw has an estimated population of 50 000 people, of which 34% are estimated to be HIV positive. The local health clinic services a large geographic area,

¹⁵⁷ Czegledy, A. “A New Christianity for a New South Africa: Charismatic Christians and the Post-Apartheid Order” in *Journal of Religion in Africa*, Vol. 38, pp. 284-311. The study is typically anthropological and offers some provocative insights. There are some assertions, however, that require assumptions to be examined before conclusions can be drawn. For instance, hosting “prayer for the nations” is not in itself sufficient grounds for assuming a subtle endorsement of the ‘nation state’s neoliberal project’, as the author has too confidently inferred.

¹⁵⁸ Available at http://www.thembaletsha.org.za/index.php?option=com_content&view=category&layout=blog&id=43&Itemid=62, last accessed 21 June, 2009

and treats between six and eight thousand patients per month. With the exponential increase in demand for treatment with a high prevalence of TB, HIV and AIDS in the midst of poverty, it is a workload that is overwhelming at best: “A matter of great concern to doctors, nursing staff and caregivers is that other than our temporary 6 bed facility, there are no overnight facilities available in Grabouw.”¹⁵⁹

Themba Care’s mission is essentially to provide comprehensive spiritual and physical care for TB, HIV and AIDS sufferers in the face of the state’s failure to do so.

There is a proposal on the table for a new Palliative Care Centre to be built: “In consultation with the local community in Grabouw, we have identified the most urgent need as a Palliative Care Centre. The Care Centre should provide for both adults and children, have qualified doctors, nurses and staff, and the facilities to accommodate overnight patients...”¹⁶⁰

The projected capital outlay for the project is estimated at R 6,023,698. This includes building, vehicle and equipment costs. Operating expenses are expected to run to R 113,585 per month (or R 1,363,020 per annum).¹⁶¹ An appeal for funds is annotated with a list of special incentives for donors in terms both of tax exemptions and public recognition, again pointing to the need for academic exploration of the relationship between donor funding and type of ministry.

¹⁵⁹ *ibid*

¹⁶⁰ Available at http://www.thembaletsha.org.za/index.php?option=com_content&view=category&layout=blog&id=43&Itemid=62, last accessed 21 June, 2009

¹⁶¹ http://www.thembaletsha.org.za/index.php?option=com_content&view=category&layout=blog&id=43&Itemid=62

5.3.3.2 Themba Care Athlone¹⁶²

“Themba Care Athlone is an 18-bed palliative care centre for babies and children. HIV or AIDS is no longer a death sentence, [as] we offer our babies a second chance at being a child and growing up to be a healthy, productive adult. In some cases, though, all we can do is offer the child dying of AIDS love, compassion and a dignified, peaceful death. We also offer follow-up, home-based care.”¹⁶³ Similar in nature to Themba Care Grabouw, this operation is also dedicated to providing spiritual and physical care for those suffering from HIV and AIDS and/or TB.

“ThembaCare Athlone was the first palliative care centre to open its doors in March 2002. It remains one of very few dedicated palliative care centres for babies and children who have AIDS.

Funding

The Centre’s running cost needs total R 1,882,560 per annum for 2007, and its envisaged capital costs stand at R 59,700 per annum.

Both Grabouw and Athlone ThembaCare partner with the following groups: CHAIN (Children’s HIV and AIDS Network), NACOSA (Western Cape Networking Aids Community of South

¹⁶² http://www.thembaithsha.org.za/index.php?option=com_content&view=category&layout=blog&id=35&Itemid=54

¹⁶³ Available at http://www.thembaithsha.org.za/index.php?option=com_content&view=category&layout=blog&id=35&Itemid=54, last accessed June 21, 2009

Africa) and City of Cape Town MSAT (Multi-Sectoral Action Team)”¹⁶⁴.

5.3.4 New Covenant Ministries International (NCMI)

“(NCMI), headed by Dudley Daniel, originally in Johannesburg but now resident in Australia, has formed churches in several other African countries and elsewhere... These churches are mostly led by South African pastors and attract white South Africans who have settled in these countries... The churches planted overseas usually ‘relate’ to a pastor of a South African megachurch¹⁶⁵, and in the case of NCMI, to an ‘apostolic team’ dominated by (if not exclusively consisting of) South Africans. They are usually highly patriarchal in leadership; leaders tend to make unilateral decisions based on the ‘leading of the Spirit’. Annual conferences of the NCMI called ‘Leadership Training Times’ are held in different parts of the world, and these are usually presided over by South Africans.”¹⁶⁶

Common Ground Church, one of Cape Town’s two ‘New Covenant’ churches, is situated on the fringes of Rondebosch Common. Previously known as ‘Friends First,’ they renovated their old

¹⁶⁴ *ibid.*

¹⁶⁵ It must be noted that this is not only the case with ‘overseas’ plants – all local plants also relate to this apostolic team, as is the case with New Frontiers (who have subsequently dropped the ‘International’ from their name for legal reasons), which have planted roughly 650 churches in the last 50 years across a multitude of nations – see www.newfrontiers.xtn.org

¹⁶⁶ Anderson, Allan. 2005. “New African Initiated Pentecostalism and Charismatics in South Africa.” *Journal of Religion in Africa*, Vol. 35, No. 1: p. 86. Anderson’s writing on this movement is pejorative and some of his more radical conclusions are debatable at best. For instance, as shall later be seen on the question of ‘call’ (a central component of Christian ministry and outreach), Anderson levels the accusation that NCMI in particular are guilty of abusing the term ‘call’ to justify racially motivated emigration. There is, however, little evidence presented to substantiate this claim.

premises, and upon moving back in 2008 rechristened the church as 'Common Ground'. Their social impact ministries are housed under the umbrella of the Common Good Foundation:

5.3.4.1 The Common Good Foundation¹⁶⁷

"Partnering with the poor for the common good of the city..."

At the common good foundation we hold a picture in our hearts and minds of a city in which individuals and communities experience spiritual, personal, social and economic well-being through the demonstration of Christ's love.

In contributing towards the attainment of this picture, the Common Good Foundation was formed as a non-profit organisation in 2006 to mobilise Common Ground Church to respond to social ills in our city. The foundation was established to help people help people."¹⁶⁸

HIV and AIDS is the focus of one of nine ministries currently dedicated toward addressing social ills in Cape Town. It is strongly recognised as a pandemic, rather than merely a physical disease; one that is not only robbing people of their "God-given destiny, but also destroying the very fabric of our society – the family unit."¹⁶⁹ There is also prominent recognition given to the damaging latent effects of AIDS such as "orphaned children, the old caring for the young, unemployment, poverty, crime, exploitation of children, stigma...For many, especially babies

¹⁶⁷ The researcher is thankful to Margie Jansen for her time in explaining to me Common Ground's theological disposition toward socially orientated ministries.

¹⁶⁸ Available at <http://www.commongroundchurch.co.za/commongood/HIVandAIDS.aspx>, last accessed June 21, 2009

¹⁶⁹ *ibid*

and woman, HIV is not a disease acquired through illicit sexual behaviour. Many women who test HIV positive have only ever been married and faithful to one partner. For these women, testing HIV positive also reveals the infidelity of their partners - double sorrow.”¹⁷⁰

It is clear that much thought has been invested in the wording of this message, as the words ‘innocent’ and ‘guilty’ have been purposefully excluded. However, the Biblical exhortation to respect sex as the strict preserve of faithful, monogamous marriage is strongly conveyed. At the same time, strong recognition is given to the socio-economic complexities of HIV contraction: “This complex epidemic is fuelled by high risk sexual behaviour (especially in our large youth population). Effective prevention involves dealing with the roots of high risk sexual behaviour which include: low self esteem, sexual coercion, transactional sex (sex for money or things), and lack of parental communication, pessimism, peer pressure and poor education.”¹⁷¹

Concepts of abstinence and condom usage are avoided, instead placing emphasis on understanding the difficult socio-economic context in which HIV is transmitted. In contrast to Domeris and Germond’s assertion that Pentecostal/Charismatic churches are more concerned with legalistic judgement than care, Common Ground’s approach suggests otherwise. Common Ground does not avoid the preaching of abstinence amongst their congregation¹⁷², but the

¹⁷⁰ *ibid*

¹⁷¹ *ibid*

¹⁷² “Designer Sex: Worth the Wait”, sermon by Terran Williams. Available at

http://www.commongroundchurch.co.za/content/uploads/sunday%20talks/2009/Sex_in_the_City_Part1_01March09_Terran.mp3, last accessed June 21, 2009.

potential trajectory toward legalism is reversed by 'lifting a finger' to help¹⁷³. The Common Good Foundation is tackling social problems in a holistic manner, understanding Loening's exhortation¹⁷⁴ full well.

In terms of physical programmes, Common Good elicits the service of a number of volunteers who provide support to a Gugulethu-based NGO called Izandla Zethemba: "The organisation currently provides care and support to 84 families who are infected with or affected by HIV..."

5.3.5 New Frontiers

Jubilee Community Church is one of eleven New Frontiers Churches in the Western Cape. It is situated in Observatory, Cape Town. New Frontiers have been particularly active in the poorer parts of the globe¹⁷⁵, and the exhortation to address HIV and AIDS has been particularly strong:

¹⁷³ The phrase is repeated across the Bible's four accounts of the Gospel, the most prominent of which is from Matthew 23: "1Then Jesus said to the crowds and to his disciples: 2The teachers of the law and the Pharisees sit in Moses' seat. 3So you must obey them and do everything they tell you. But do not do what they do, for they do not practice what they preach. 4They tie up heavy loads and put them on men's shoulders, but they themselves are *not willing to lift a finger* to move them." Available at <http://www.biblegateway.com/passage/?search=Matthew%2023:&version=31>; Last accessed June 21, 2009. Jesus consistently provides examples of 'lifting a finger to help', showing remarkable empathy – in a largely abusive patriarchal society – to women. See John 4:1-42 and John 8:1-11 for examples of how Jesus responds to a promiscuous Samaritan women (Samaritans were in those days despised) and a Jewish woman supposedly caught in adultery (with the offending male notably absent) respectively. Providing help to those in need is seen as an integral part of preaching the Gospel of Jesus' life, death and resurrection.

¹⁷⁴ Loening, W. 1992. "Adolescent pregnancy: a medical perspective", in S. Burman & E. Preston- Whyte, eds., *Questionable Issue: Illegitimacy in South Africa*. (Cape Town: Oxford University Press.)

¹⁷⁵ Although many New Frontiers churches are based in the United Kingdom, the very name of the movement is indicative of the fact that most New Frontiers church plants have been in places that are severely characterised by poverty. "Simon Pettit, who died in January 2005 but in 1998 was then leading Jubilee Church in Cape Town and bringing apostolic oversight to many *Newfrontiers* churches in Africa, spoke a prophetic message to our Leadership Conference in Brighton UK. 'If we are going to see a great end-time revival, if we are going to see the masses swept

“The statistics never fail to shock me... I find that people are overwhelmed by the devastation being wrought by the HIV pandemic. When we study the statistics, I try to focus delegates and students on the Gospel, because it is the only true route to behavioural change and we know that behavioural change is the key to arresting spiralling HIV infection rates. So I point students towards Jesus’ response to the Samaritan woman in John 4¹⁷⁶ and marvel again at how he affirmed her and yet was able to challenge her behaviour and offer himself as a route to salvation... Since none of us is without sin¹⁷⁷, I ask workshop participants, ‘Who amongst you can say that you have never committed any act for which you have felt regret or shame?’ For those who receive an HIV-positive diagnosis, their greatest problem is often their own sense of failure and guilt. But we share a Gospel which removes guilt and enables a change in behaviour and liberation in Christ.”¹⁷⁸

into the church, we must remember the poor. We must.’ As he preached about ministry with the poor being an apostolic injunction from Gal 2:10 all who heard knew that God was telling us to be more active in our involvement with the poor.” Available at <http://www.newfrontiers.xtn.org/about-us/social-action/brief-history/>, last accessed June 24, 2009. Remembering the poor is not a subversive means of attaining the goal of church growth. The love offered the poor is unconditional.

¹⁷⁶ See earlier footnote on John 4. Jesus comes into contact with a Samaritan woman drawing water at Jacob’s well. She is there in the heat of the day so as to avoid coming into contact with Hebrew women (there was something of an apartheid between Jews and Samaritans around this time – between 30 and 33 AD). Jesus asks her for some water, and then proceeds to tell her that if she knew who He was, she would ask Him for water, as He is able to provide living water by which she would never thirst again. She is understandably perplexed, when Jesus suggests that she fetches her husband. She tells him that she has no husband. Jesus responds by telling her that she is correct and that in fact after four divorces, the man with whom she now lives is not her husband. She is visibly astounded at this truth, and proceeds to proclaim that the Messiah will come and reveal all things. Jesus responds by telling her that He actually is the Messiah. She believes and ventures forth to preach His name across Samaria. This story has become a seminal foundation on which Christian outreach is premised – care without condemnation; compassion without judgement; the provision of a living hope through repentance of sins and faith in Jesus, accompanied by a demonstration of ‘lifting the finger’ to help.

¹⁷⁷ John 8:1-11 and Romans 3:23 are just two prominent Biblical passages that speak of the fact that no one is without sin and - for this very reason - in need of gift righteousness.

¹⁷⁸ Available at <http://www.newfrontiers.xtn.org/magazine/current-issue/hiv-focusing-on-the-positive/>, last accessed June 21, 2009.

The above is an excerpt from an article that communicates New Frontiers' heart and purpose in the HIV and AIDS arena; the emphasis of approach is in communicating love, a message free of judgement or condemnation. This stands in stark contrast to the common perception that Pentecostal churches are merely distributors of judgement. However, it deals with the difficult issue of sexual behavioural change and emphasises the Gospel's ability to effect this change as a result of spiritual transformation (as opposed to following a legalistic set of rules).

Jubilee Community Church's local response is twofold, consisting of both prevention and care activities. Their mission pertaining to the latter is worded thus: "Believing that we can and need to play a strategic part in this war against HIV and AIDS by bringing hope to the hopeless, Jubilee Community Church is seeking to rise to the challenge by providing practical help and support for those who are living with HIV and AIDS in our own church family. We also provide HIV Testing and Counselling [aside from more general healthcare interventions] as part of the Health Centre run at the church."¹⁷⁹

The preventive arm of Jubilee Community Church's HIV ministries – Think Twice – "envision[s] and empower[s] young people to make **responsible decisions** in the area of sex and relationships."¹⁸⁰ In 2008, Think Twice impacted a total of 2 156 learners "with a message of hope" through the "Undiluted High School Programme, [that] challenges teenagers about their attitudes towards relationships and equips them with the facts regarding pregnancy, abortion,

¹⁷⁹ http://www.jubilee.org.za/hiv_counsel.html

¹⁸⁰ Available at <http://www.jubilee.org.za/think.html>, last accessed August 20, 2009

STI's and HIV (as well as addressing the stigma of HIV and AIDS and looking at ways to support those infected or affected.)” One recipient’s response – by no means anomalous – is telling: “The programme gave me strength to be strong for any challenges. The message that I got from Think Twice is good because now every time I do something wrong I am aware of that; and I can remember everything I have been taught. I think to wait for marriage [to have sex] is the best thing because today some people don’t really love you but just want to use you. (Female learner)” Given that the programme operates in socio-economically impoverished areas, where gender discrimination is notable, the impartation of this kind of empowerment is likely to be significant in the battle against HIV and AIDS.

5.3.5.1 Jubilee Community Church - The Clinic

“Owing to the current costs of and lack of availability of Primary Health Care services and a substantial lack of income in the homes of the poor, basic medical treatment continues to be inaccessible to many. As a result a high percentage of local people are frequently sick and unable to work because basic ailments go untreated, are treated too late and treatments aren’t administered (e.g. inoculations, pap smears, TB tests, worms, head lice, HIV testing etc). In response to this, the Jubilee Health Centre offers professional, confidential and affordable primary health care to the needy in its sphere of influence through its clinic. As part of our response to the issues within our community, one of them being the HIV and AIDS pandemic, we offer HIV voluntary counselling and testing (VCT). The clinic has a Doctor, Caryn Wilson, and two Nurses, Rachel Lilliot and Glynn Massingham. It is open three days a week and sees about 40 patients over those three days, where they receive a lengthy consultation and medicines

are prescribed if necessary.”¹⁸¹

The clinic is housed within the church community centre building, and does not have a specific reputation of providing HIV VCT. As such, and because it is not observable from outside the building at all, it avoids any potential problems of stigmatisation¹⁸². This was an intentional move on behalf of the church, and the physical construction and functional space of the clinic lends itself to the professional ethic of confidentiality. In a context where people living with HIV and AIDS are still stigmatised, the demonstrated sensitivity around VCT is an appropriate Policy Learning for the state.

The Clinic was founded as a response to HIV and AIDS. At a time when formal HIV infection rates were very low (late 1980's to early 1990's), many women attending Jubilee's pregnancy crisis centre were testing positive for HIV. This is not publically stated because its functional design is to avoid potentially stigmatising attention. However, the current purpose and vision of the clinic is to provide holistic¹⁸³ healthcare, not HIV and AIDS treatment at the expense of other ailments.¹⁸⁴

This researcher spent some time volunteering at the Jubilee clinic. Below is a condensed version

¹⁸¹ Available at http://www.jubilee.org.za/health_centre.html, last accessed June 21, 2009

¹⁸² See Steinberg's book *Three Letter Plague* for an account of how community members watched MSF's mobile testing unit. If a person took a long time in the post-test counselling room, those watching discerned that they probably had HIV. Though never spoken, those people were immediately stigmatised. At the Jubilee Clinic, people can't watch what goes on, nor can they tell anything by the amount of time a person spends in the clinic, as all consultations, regardless of ailment, occupy the same amount of time.

¹⁸³ This word has unfortunately become a broad nomenclature with myriad meanings, but generally it suggests that physical, spiritual and emotional health is attended to. The specific meaning of the word in this context is expounded by way of fieldwork observation.

¹⁸⁴ Personal communication with Jeremy Cons in December, 2008.

of his fieldwork¹⁸⁵.

“The Jubilee health clinic is situated within the church building itself, an old Italtile Warehouse in Observatory, Cape Town. There is another clinic nearby¹⁸⁶, and more than a few healthcare facilities in close proximity. An explanatory question for future research is: Why do people choose to attend the church clinic instead of a state clinic?

This researcher had the privilege of being present in consultation with four patients on the first day.¹⁸⁷ The clinic employs a markedly different model to any secular clinic that offers similar facilities; this calls for explanation: The doctor who now manages Jubilee clinic was dismayed at the way that conventional medicine is practiced in the state system. She observed that it has little time for people and still less emphasis on healing as a holistic entity. Ultimately, she sought an opportunity to administer medicine differently, to “minister to the soul”¹⁸⁸ of her patients. She testifies that God called¹⁸⁹ her to manage the Jubilee Clinic as a means of employing her years of state experience in crafting a new health care model.

¹⁸⁵ This methodological approach is not strictly in keeping with the original design. The fieldwork was conducted as a means of ascertaining what questions may be instructive for future work that is more rigorous, i.e. a multiple-case survey. Some observations were of relevance to the topic question and therefore maintained in the body of the thesis.

¹⁸⁶ The clinic in Spencer Road deals specifically with Sexually Transmitted Diseases (STDs).

¹⁸⁷ The researcher assumed the position of volunteer in the hope of reducing any potential awkwardness of a researcher taking notes. His presence in the room does not seem to contribute in any way to the patients’ responsiveness or openness in responding to the doctor’s questions.

¹⁸⁸ These are the doctor’s own words, quoted verbatim and recorded during the volunteer time at the clinic.

¹⁸⁹ Jubilee Community Church does not create ministries for their own sake. Each ministry is founded on the premise of a member’s call from God. The ‘call’ is presented to the elders (a plurality in which there is mutual accountability), who then discern its validity, and consequently either provide their blessing or advise alternatively.

Therefore, the second part of the consultation involves caring for spiritual needs. This is treated as the most important element of the clinic's operation and is built on the foundation of Mark 10:46-52:¹⁹⁰ "...*And Jesus said to him, "What do you want me to do for you?"*"

Thus, aside from the practice of otherwise standard biomedicine, the emphasis is clearly on imparting the Gospel of Jesus Christ. Each patient is therefore asked whether they know Jesus, and what they desire Him to accomplish for them. Whatever the person requests is then prayed for¹⁹¹.

The final consultation of the first day is particularly interesting.¹⁹² A Congolese patient presents with symptoms of (and is diagnosed with) a STD. Professing to know Christ, he also raises no objections at the implication that he has been concurrently sleeping with multiple partners.¹⁹³

¹⁹⁰ "And they came to Jericho. And as [Jesus] was leaving Jericho with his disciples and a great crowd, Bartimaeus, a blind beggar, the son of Timaeus, was sitting by the roadside. And when he heard that it was Jesus of Nazareth, he began to cry out and say, "Jesus, Son of David, have mercy on me!" And many rebuked him, telling him to be silent. But he cried out all the more, "Son of David, have mercy on me!" And Jesus stopped and said, "Call him." And they called the blind man, saying to him, "Take heart. Get up; he is calling you." And throwing off his cloak, he sprang up and came to Jesus, *And Jesus said to him, "What do you want me to do for you?"* And the blind man said to him, "Rabbi, let me recover my sight." And Jesus said to him, "Go your way, your faith has made you well." And immediately he recovered his sight and followed him on the way." Available at <http://www.biblegateway.com/passage/?search=Mark%2010:46-52;&version=47>., last accessed June 21, 2009

¹⁹¹ Naturally, requests to have God gratify sinful desire are gracefully declined.

¹⁹² A young man from the Democratic Republic of Congo, French-speaking, comes in and describes the basic symptoms of a STD. His exact words were "eh, my penis...not working." The patient also has high blood pressure and Dr. Wilson pleads with him to keep it in check: "You are a strong young man with your whole life ahead of you; it would be terrible for you to get sick from something that is entirely treatable and preventable." The love and compassion in the space of treatment is striking.

¹⁹³ Given that there is a state clinic in the near vicinity that deals very specifically with STD's, it is noteworthy that this patient has chosen to come to the Jubilee Clinic. The doctor asks him whether he has children, and he replies that he has two children back home. He is divorced from his wife, and so the doctor asks whether he has a girlfriend here in Cape Town. He replies with typically French vigour that "of course" he does. The doctor does not flinch. She asks him whether his girlfriend has any similar symptoms. He says she does not. It is then recommended that he use condoms to protect her (and himself) from infection, especially if he is sleeping with numerous partners. He does not offer any objection to

It is at this moment that questions for the researcher are raised. The common perception amongst secular commentators (and many professing Christians) is that Christianity is synonymous with a certain kind of 'moralism' where monogamous heterosexual marriage is automatically understood as an inexorable part of the doctrine. Now, because it is true that the Christian gospel commends faithful monogamous marriage¹⁹⁴, the disparity between this particular patient's behaviour and his declaration of knowing Jesus begs a question. Explaining the anomaly is worth further research.

Said patient did not return for his VCT appointment, at which there would have been a trained male counselor. However, there are some patients who have consulted biomedical super-specialists who are unable to help; they come to the Clinic because word has travelled that they will be holistically cared for. An interesting question for further research is whether patients are naturally more predisposed toward attending a biomedical clinic than a church clinic. If the latter is a 'last resort', why? And if the visit is 'successful', do patients return and encourage others to do the same on this premise?¹⁹⁵

the suggestion of concurrent sexual partners and the change in his body language – from masculine exuberance to sober realisation – indicates that faithfulness may not be a priority. Dr. Wilson then exhorts that "first prize is to be faithful to one woman; you know how it is in relationships, it's tricky – better to give yourself to one person only."¹⁹³ The patient is then asked whether he knows Jesus. He replies with a big smile that he does, and that Jesus is everything to him.

¹⁹⁴ The command is not a matter of salvation by moralistic behaviour, but rooted in an understanding that the Christian has been bought at a price, their body is now a temple of the Holy Spirit and therefore subject – with His help – to refrain from all lusts of the flesh (including extra or pre-marital sex). See 1 Corinthians 6 for a clear Scriptural reference.

¹⁹⁵ I am incredibly grateful to Dr. Caryn Wilson, Rachel Lilliot, Glynn Massingham, and David and Bethany who welcomed me as part of the team and answered gladly my many questions.

For a more representative overview of the clinic's activities and achievements, and the way it is conceptualised by the staff, please consult the Clinic Newsletter, available online.¹⁹⁶

5.3.5.2 Analysis

The above case study reveals three points relevant to Policy Learning that Jubilee Church would advocate:

One, HIV and AIDS is not to be treated in a manner that fuels further stigmatisation. The treatment of secondary infections may be an avenue through which to suggest VCT, but the overriding objective is to provide treatment in a manner that is markedly different from the overburdened state system.

Two, health is a holistic entity, and to focus on one illness at the expense of others is futile. Emotional, spiritual and physical needs are all elements of health – the state system risks merely attending to patients' physical needs. Of course, the state health system would be less burdened if basic services such as water and shelter were more adequately provided. Nonetheless, for the purpose of establishing Policy Learning, health should be conceptualised as a holistic intervention rather than a merely medicinal one.

Three, for a patient to meet with Jesus is much more important than the provision of mere biomedical treatment. Similar to the observation that spiritual needs are an important element of

¹⁹⁶ Available at http://www.jubilee.org.za/health_centre.html; there is a "click here" link for the downloading of the newsletter. Last accessed June 22, 2009.

holistic healthcare, Jubilee's health clinic is intent on sharing Jesus with its patients as a means of addressing this need. However, offering a holistic healthcare intervention is not a subversive means of persuading patients to believe in Jesus and/or adopt a particular set of moral behaviours. This is verified by the fact that both pre and post abortion counselling is offered, as opposed to only pre-counselling, and Think Twice ministers to people regardless of whether they adhere to Biblical proclamation or not. Ultimately, the purpose of the church's HIV and AIDS ministries is to impart a hope in Christ that transcends current circumstance.

Jubilee's partnership with other churches¹⁹⁷ across Cape Town to provide 'pregnancy crisis' counselling is further evidence of these churches being far more interested in love than in judgement, especially considering that no public kudos is bestowed on any individual church. In this way, even motives such as public recognition are made obsolete.

5.3.6 'Charismatic' Baptist Churches

King of Kings Baptist Church¹⁹⁸ is situated next to Long Beach Mall, between Kommetjie and Fish Hoek. There are three social impact ministries housed under the Fish Hoek Baptist Church Community Trust, one of which deals specifically with HIV and AIDS, while the other two deal with related socio-structural injustices. This holistic approach erodes fertility for HIV transmission that is prevalent in impoverished societies. Living Hope, Living Grace and Living Way "have all come into being in the past decade, but the beginning of the story extends back

¹⁹⁷ Available at <http://www.jubilee.org.za/pregnant.html>, last accessed June 22, 2009.

¹⁹⁸ The church is known formally as Fish Hoek Baptist, but the inscription "KING OF KINGS" adorns the outer wall of the church building. I have used the names interchangeably.

more than twenty years. It is a multi-faceted narrative that clearly demonstrates God's hand at work throughout."¹⁹⁹

5.3.6.1 Living Hope

Living Hope is the branch that deals directly with HIV and AIDS. Their mandate is to "bring the hope and compassion of Jesus Christ to the chronically sick and dying in a holistic way and do everything possible to prevent the spread of HIV and AIDS."²⁰⁰ The two main arms of the ministry are prevention and palliative care, combined with a transcending and intervening arm of social support services.

On the prevention front, Living Hope employs 26 Life Skills Educators who are employed to teach across 13 primary schools in various underprivileged areas in Cape Town. While the Christian Gospel is explicitly forbidden from being shared in the classroom, these educators also help to run children's clubs in which the Gospel is freely preached. Health counsellors are employed across government clinics as well as at the Trust's own health care centre, both to conduct HIV Voluntary Counselling and Testing (VCT) and post-test counselling should the patient's results reflect 'positive.' The Trust also operates twenty-two support groups for all people and their families who are suffering any kind of chronic disease.

The palliative arm consists of home-based visits, where thirty workers venture into six communities across the Peninsula and provide care for those living with HIV and AIDS.

¹⁹⁹ Fish Hoek Baptist Church Community Trust. 2009. Official "Tour Script", provided to visitors, received 6 April, 2009. P. 1.

²⁰⁰ Ibid.

Additionally, there is a 22-bed health care centre that looks after terminally ill patients. A local doctor is employed part-time, and patients are received on referral only. Both the centre and the home-based carers provide ARV drugs to those in need. Adherence Counsellors are soon to be employed to ensure compliance with a strict but necessary drug regimen.²⁰¹

Living Hope is a ministry birthed in a fascinating history and has grown into one of the largest, most comprehensive HIV and AIDS interventions in the Western Cape. Certainly it is the largest intervention by any single faith-based organisation in the region, and therefore calls for further exploration.

5.4 Discussion/Concluding Remarks

Barbara Schmid composed a dissertation of similar subject content (written from a theological perspective and more evaluative than exploratory in nature.) She evaluated the responsiveness of thirty churches (or church affiliated NGOs and FBOs) in the Cape Town area to HIV and AIDS in terms of value and appropriateness. In conclusion, it was found that while church responses were indisputably valuable, they were not necessarily appropriate²⁰². This study shows that the response of Pentecostal/Charismatic churches to the HIV and AIDS pandemic are indeed valuable, but arguably uncoordinated and haphazard²⁰³. However, a proviso is in order:

²⁰¹ This information is sourced both from personal communication with Living Hope Staff and the reference, *ibid*, above.

²⁰² Schmid, B. "The Churches' Response to the HIV/AIDS Pandemic: A Case Study of Christian Agencies in the Cape Town Area," Dissertation submitted in partial fulfillment of the requirements for the degree of MSocSci in the Centre for the Study of Religion, University of Cape Town, February 2002. Appropriateness was defined according to practical theological criteria. Those criteria are not employed in this study.

²⁰³ The terms are not used in any pejorative sense, but simply to convey that many of these ministries are birthed as a response to a pandemic that is proliferating seemingly uncontrollably, rather than as a pre-emptive, planned, well co-ordinated effort.

Churches are not the state. Their primary mandate is not to respond to HIV in a way that one would expect from a state that is well resourced with taxpayers' finances. Additionally, churches' outreach programmes are largely volunteer-based and financed by people who are already paying taxes. Therefore, researchers and theologians should be careful about placing onerous expectations on churches. Moreover, churches' responses are often initiated and sustained by the injunction of a 'call' on one or a few persons' lives - doing that which they believe God has asked of them for a season in time. There is strong evidence in nearly every case above of a sense of 'call' to serve the poor. If this happens to be a clinic in Bonteheuwel or a schools nutrition programme in Delft, then that is valuable and perhaps appropriate in light of churches' mandates to serve their local communities.

The following discussion evaluates the findings of the desktop study in light of some of theoretical HIV and AIDS epidemiology literature.

In a paper that examines the impact of HIV and AIDS in Southern Africa, Jane Fortson observes "that there are large declines in [numbers attending school], related to local HIV prevalence, even after excluding orphans and children growing up in households with infected members. I also find that men experience significantly larger declines than women, consistent with the higher mortality risk among men in the early part of the HIV and AIDS epidemic."²⁰⁴ Given the high HIV and AIDS prevalence in the areas covered in this study, interventions by churches at school level may be both appropriate and significant for at least three reasons:

²⁰⁴ Fortson, Jane G. "Mortality Risk and Human Capital Investment: The impact of HIV/AIDS in Sub Saharan Africa". (Becker Center on Chicago Price Theory: University of Chicago), September 2007.

One, it is difficult to educate a hungry child. Therefore, churches that are providing nutrition to schools are making a significant educational contribution. Two, taking an active role in classroom and extra-classroom activities provides a source of input into children's lives that is often lacking at home. The associated teaching to refrain from pre-marital sexual activity is likely to take effect because the underlying message of personal value is being lent credibility through this active participation. Three, any competent contribution to the educational process may increase the prospect of future income earning potential, thus potentially reducing the likelihood to engage in risky sexual behaviour.

On the third point above, Emily Oster argues that propensity to engage in risky sexual behaviour is largely attributable to the value that people attach to their lives in terms of foreseen future utility (approximated and measured by income). In other words, the discounted value of engaging in sexual activity that might result in HIV contraction is higher than the potential cost of contraction because income (in Africa) is likely to be lower than elsewhere in the world: "Consistent with existing literature, I find very limited responsiveness of sexual behaviour in Africa to the HIV rate directly. However, responsiveness is higher for richer individuals and those who should expect to live longer. When I consider the responsiveness to the calibrated price of a sexual partner, I find consistent decreases in risky behaviour in Africa."²⁰⁵

However, another study indicates that 'religious' people are more likely than their non-religious counterparts to be fatalistic in their general life choices (regardless of income earning potential,

²⁰⁵ See Oster, Emily F. "HIV and Sexual Behavior Change: Why Not Africa?" in *NBER Working Paper No. W13049*. April, 2007. The results are open to speculation, although the data from which the conclusions are inferred is reliable.

ethnicity or denominational affiliation)²⁰⁶. However, studies overwhelmingly show that Christianity - especially Pentecostal/Charismatic churches - significantly reduces EPMS regardless of fatalistic propensity or income earning potential.

One such study reads thus: "In the absence of widespread condom use, lower levels of EPMS [Extra and Pre-Marital Sex] are desirable for two reasons. First, to reduce the chance of early parenthood, which adversely affects the economic prospects of both men and (especially) women. Second, and much more importantly, to limit the spread of HIV... Does church membership make any difference to sexual attitudes and behaviour? The evidence presented suggests that only Pentecostalism does this unequivocally²⁰⁷ ... Two outcomes are predicted. First, that Pentecostals in South Africa and elsewhere will experience lower rates of HIV infection. Second, and in consequence, upward socioeconomic mobility will ensue for Pentecostal individuals and households, relative to members of other religious groups."²⁰⁸

Moreover, Granger and Price confirm Garner's finding: "We find that except for gay males, religion actually constrains risky sexual behaviours. This suggests that if conformist peer effects

²⁰⁶ Jacobson, C.K. "Denominational and Racial and Ethnic Differences in Fatalism" in *Review of Religious Research*, Vol. 41, No. 1. Autumn, 1999, (Religious Research Association, Inc.) pp. 9-20. It must be noted that this study was conducted in the US, though, and cross-country differences have not been controlled for. Moreover, there is insufficient clarity on how 'fatalism' was defined and how it relates to a nonetheless strong propensity to follow Biblical statutes. Nonetheless, according to the quantitative research in these two respects, the impact of religion in terms of affecting risky sexual behaviour in a context rife with HIV/AIDS would, at best, be ambivalent.

²⁰⁷ This is a strong word, and studies in pioneering fields should perhaps be hesitant about making emphatic conclusions. Either way, in Garner's defence, he is talking specifically about the study he conducted, and this is not a universally applicable sweeping statement.

²⁰⁸ Garner, R.C. 2000. "Safe Sects? Dynamic Religion and AIDS in South Africa" in *The Journal of Modern African Studies*, Vol. 38, No. 1, pp. 41-69. See also Liebowitz, J. "The Impact of Faith-Based Organisations on HIV/AIDS Prevention and Mitigation in Africa" for Health Economics and HIV/AIDS Research Division, University of Kwazulu-Natal, October 2002. Pp. 1-63.

are operative in Faith-based HIV and AIDS public health interventions, such interventions are likely to be effective in reducing the incidence of HIV and AIDS among all demographic groups at risk except gay males...Our results suggest religion and religiosity as measured by frequency of church attendance and believing that the Bible is the literal word of God have the effect of reducing the demand for sexual partners, sex frequency, and extra-marital sex - all risky behaviours associated with contracting HIV and AIDS.”²⁰⁹

In summation, then: HIV and AIDS prevalence is likely to result in lower levels of school attendance due to the constraints it places on families both in terms of nutrition provision and ability to pay school fees. Risky sexual behaviour is more likely to occur in contexts where the marginal benefit outweighs the cost (because the cost is discounted against a low likelihood of income earning potential). Schnittker shows that: “Education improves health, and its effects are larger at lower levels of income. Moreover, education reduces the strength and curvature of the income-health relationship. Consequently, those with more education have better health for all levels of income, and fewer income-based disparities exist among the well educated than among the less well educated. The linear "gradient" relationship between income and health is, thus, more characteristic of groups with higher levels of education.”²¹⁰

Therefore, interventions that provide nutrition, educational stimuli and/or fees are likely to keep children in school for longer (provided that these programmes are maintained and do not suffer

²⁰⁹ Granger, M. Price, G. 2009 “Does religion constrain the risky sex behaviour associated with HIV/AIDS?” in *Applied Economics*, Vol. 41 (6). Pp. 791-802

²¹⁰ Schnittker, J. “Education and the Changing Shape of the Income Gradient in Health” in *Journal of Health and Social Behaviour*, Vol. 45, No. 3 (Sep., 2004), pp. 286-305 (Published by: American Sociological Association)

donor fatigue.) This alleviates some of the burden on children's parents or extended family to provide meals, uniforms and fees, and contributes significantly to the future earning potential of these children. The influence of Biblical theology in these settings is also likely to contribute to reducing the prevalence of extra-and-pre-marital sexual encounter²¹¹. These are particularly significant in terms of their potential ability to reduce the incidence of transactional sex - by empowering women both to see themselves as valuable children of God and equipping them to make career choices that elevate them from socio-economic dependence on males to more equal producers in the market place.

Providing treatment care to those who have neither access nor funding is also an invaluable contribution to society in the face of failed state policy. The negative relationship between HIV and AIDS and economic productivity levels is relatively undisputed. Therefore, any contribution from civil society that keeps potentially productive people alive for longer is economically valuable. If the intervention is able to ensure continued or improved productive capacity, there is a multiplier effect at work in terms of ultimate value. But even if the intervention can only serve to provide beds for the terminally ill, it is still providing a service where the state has failed to do so; this relieves some of the burden on the state and its taxpayers. There is therefore much to be learned from how Pentecostal/Charismatic churches are intervening in the social landscape, especially in the HIV and AIDS arena.

The case below serves as a further means through which to answer the dissertation questions.

²¹¹ This is admittedly debatable as a significant element of Pentecostals' lower rates of EPMS were the combination of high degrees of indoctrination, socialisation, experience and exclusivity. It is not clear that this same combination is at work through outreach programmes, although it may simply take on different forms.

6. The Single Case – Living Hope Ministries

6.1. Introduction

The Literature Review reveals that Pentecostal/Charismatic churches are an interesting and understudied phenomenon. It also examined the Policy Learning literature as a lens through which to answer the research questions. The desktop study responds to the demand for further research and examines a selection of Pentecostal/Charismatic Churches' responses to HIV and AIDS. It pointed to a variety of interventions. These were often 'ad hoc' in nature. In other words, they were reactionary (in no pejorative sense of the word), rather than overtly proactive. The study also elucidated that Living Hope is a successful church intervention and is thus conducive to answering the research questions, particularly the Policy Learning question: By way of reminder, 'Can Living Hope be taken as an example of applied intellect and policy wisdom from which the state can learn? Does it provide policy learning that combines scientific evidence and pragmatic understanding of constraints and the local context as to be both appropriate and applicable in other similar contexts?'²¹²

The case will develop from three angles. First, it provides a historical analysis of how Living Hope was birthed out of Fish Hoek Baptist Church. Second, it examines the operation and structure of the ministry through an institutional lens. Herein is an exploration of constraints imposed by the 'conditionalities' of donor funding. It concludes, thirdly, with a brief discussion

²¹² This is a repeat of the topic question from the literature review section that covered the field of Policy Learning.

on what the state can learn from Living Hope, and whether 'what works' was influenced more by purported scientific 'efficacy' or through a pre-existing belief about what is 'appropriate' (with suitable adaptation to the local context.)

6.2. Historical Analysis

The story of Living Hope Ministries essentially begins with the story of John Thomas' arrival at Fish Hoek Baptist in January 1987. He had arrived to take up his assignment as Senior Pastor of the church, and "by late that year, Pastor John had developed a burden for a group of several hundred squatters who were living illegally on a piece of private property in Sun Valley known as Green Point."²¹³ The language of description is important to note here, as "developed a burden" is synonymous in Christian terminology with "God laid 'x' on my heart," or "I sensed a call to 'x'". It confirms an observation in the Desktop Study that church responses to structural socio-economic injustices are invariably grounded in this phenomenon of a 'call' from God.

On the question of 'call', Anderson tends to be a little more suspect about Pentecostals' use of the term: "At the present time, while these South African Pentecostal networks [abroad] provide transnational platforms for white Pentecostal church leaders, there is little evidence that they have influenced the receiving countries to much extent beyond providing 'places to feel at home' for South African immigrants... Religious reasons are often given for immigration (such as a divine 'call' to plant a church or 'support' someone who has done so); but, subconsciously, the

²¹³ Part of the "tour documentation" that is given to visitors, also available at

http://www.livinghope.co.za/index.php?option=com_content&view=article&id=1&Itemid=8, last accessed June 22, 2009.

reasons are much wider than that, including disillusionment with the new South Africa and the perceived diminishing opportunities for economic and educational advancement there.”²¹⁴

However, it seems clear that the ‘call’ John Thomas felt to intervene was firmly rooted in the physical and carried no ‘subconscious disillusionment’ with South Africa: Approaching the church leadership with the idea that they should ‘reach out’ to the Green Point ‘squatters’ was a politically risky move, as the Apartheid government was less than excited at the prospect of white churches helping people who were subjugated and oppressed through the National Party’s liberal twisting of the Scriptures to create a theologically-grounded ideology of superiority. If anything, the courage here shown in the face of political risk stands as testimony to the genuineness of the ‘call’.²¹⁵

The church ultimately decided “to show *The Jesus Film* in Xhosa (the local language of the Green Point inhabitants), on a [television] John set up in the back of his car.”²¹⁶ The entire community attended the screening. At the point of Jesus’ crucifixion, “the residents were incensed at the injustice of an innocent man being executed, and picked up stones to throw at the TV. This startling occurrence opened John’s eyes even more to the injustice against oppressed blacks, while also helping him see the Gospel in a new light.”²¹⁷ The profound irony is that Jesus

²¹⁴ Anderson, Allan. 2005. “New African Initiated Pentecostalism and Charismatics in South Africa.” *Journal of Religion in Africa* Vol. 35, No. 1: p. 86. While Anderson makes this potentially plausible claim, there is little evidence offered other than that which is merely anecdotal. This cynicism toward Pentecostals is also evident in his treatment of NCMI, mentioned in the desktop survey too.

²¹⁵ As opposed to those who allegedly abuse ‘calling’ as a proof-text excuse for all manner of Biblical commandment-breaking; One hears occasionally of absurd rationalisations for adultery by those in ministry, such as “God called me to sleep with her.”

²¹⁶ Available at http://www.livinghope.co.za/index.php?option=com_content&view=article&id=1&Itemid=8, last accessed June 22, 2009

²¹⁷ *ibid.*

is depicted in the film as a handsome white man²¹⁸. There is evidence here for what Locke called the 'judicious sentiment'²¹⁹, even though Apartheid's efforts at socialising race over justice had been horribly effective – especially in those who benefited materially.

After this initial outreach, Thomas returned to assess the situation, only to find bulldozers flattening shacks and police removing the squatters. Forced removals were a particularly abhorrent aspect of Apartheid. The lasting impact that these removals have had on people's lives plays a significant role in the identity of many South Africans today. Thomas had to stand by and watch as the police executed their brutality. He was the only white person present, and eventually "spoke up on [the residents'] behalf and attempted to negotiate with the authorities to allow residents to at least gather their belongings."²²⁰ The police ignored him. However, it was a move which brought him (and the church) credibility amongst the community as an advocate against oppression.

Despite the removals, the settlement shortly re-appeared and continued to grow. The church erected a temporary structure "to serve as a meeting place for worship services and other ministries."²²¹ The declaration of the Gospel of Jesus Christ was the central focus of these

²¹⁸ History proves that Jesus was not white, and Isaiah prophesied that there was nothing in His appearance that would attract us to Him: Isaiah 53:2 (English Standard Version). "For he grew up before him like a young plant, and like a root out of dry ground; he had no form or majesty that we should look at him, and no beauty that we should desire him." Available at <http://www.biblegateway.com/passage/?search=Isaiah%2053&version=47>, last accessed 8 June, 2009

²¹⁹ "Justice and truth are the common ties of society; and therefore even outlaws and robbers, who break with all the world besides, must keep faith and rules of equity amongst themselves; or else they cannot hold together". See Locke, J. 1690. "An Essay Concerning Human Understanding", available at <http://www.dca.fee.unicamp.br/~gudwin/ftp/ja005/humanund.pdf>, last accessed June 22, 2009, pp. 47

²²⁰ Available at http://www.livinghope.co.za/index.php?option=com_content&view=article&id=1&Itemid=8, last accessed June 22, 2009

²²¹ *ibid*

initiatives, but because Apartheid had separated people not only geographically, but also linguistically, Pastor John went in search of a pastor who could speak Xhosa. He found a man by the name of Philip Mokson (stationed at Guguletu Baptist Church), whom Fish Hoek Baptist had already been supporting financially (on a deficient amount of R50 per month). "Philip agreed to begin leading a Bible study at Green Point and the ministry continued to grow."²²² Given the importance of language as an integral feature of culture, the employment of a pastor fluent in Xhosa served to bring further credibility to the work of Fish Hoek Baptist Church.

Tragically, Pastor Philip Mokson was murdered while serving the Lord in January, 2007. His life had served as a significant contribution to the work of Fish Hoek Baptist in reaching out to an impoverished community.²²³

Subsequent to the decision taken to employ Pastor Mokson, the government began to make plans for the construction of Masiphumelele Township. The Green Point residents – "who by now [the early 1990's)] had forged a strong bond with Pastor Philip – demanded that their church be situated in a prime central location within the new community, a spot where the local school, town hall and health clinic would also be located."²²⁴ Contributing to half the funds for the construction of this new church building, Fish Hoek Baptist acquired the land in 1993 and officially opened the church in 1995.²²⁵ By the time Living Hope was birthed as a formal

²²² *ibid*

²²³ See the original history for further details of this tragedy: Available at

http://www.livinghope.co.za/index.php?option=com_content&view=article&id=1&Itemid=8, last accessed June 22, 2009

²²⁴ Available at http://www.livinghope.co.za/index.php?option=com_content&view=article&id=1&Itemid=8, last accessed June 22, 2009

²²⁵ *ibid*.

ministry in 2000, Masiphumelele Baptist Church was already well established in a community suffering high rates of HIV and AIDS.

How, then, did Fish Hoek Baptist Church progress from a being an institution generally concerned with social injustice, to being specifically concerned with HIV and AIDS?

In an interview aired on a documentary film - 'Dealers in Hope' - Pastor John recalls his experience thus: "Girls trade their virginity – in our area – for a sit-down meal at Macdonalds. In late 1999 I heard a statistic, which turned out to be incorrect, but I heard that 44% of the people in our area were HIV positive. It actually turns out that then it was about 17%, but God used that to kick me, and say "You're a pastor in this area; What are you going to say to me on judgement day when you have done *nothing* about the HIV and AIDS crisis all around you?" We had no clear mapped-out plan, but as a relatively small church, we stepped out - a little step - but with faith in a great God who is able. We have been stunned by what He has done. In seven years, Living Hope has grown to 150 paid staff, serving in 6 geographic areas around our church. In 2006, we ministered to 7 619 patients."²²⁶

Pastor John's experience of being 'kicked' by God is congruent with the trajectory of the 'call' or 'burden' he experienced upon first arriving in the area in 1987. It was a prompting reflective of a general desire to serve the poor, which had been previously demonstrated.

²²⁶ "Dealers in Hope", *Documentary Video on Fish Hoek Baptist's HIV/AIDS Ministry*, available at <http://www.youtube.com/watch?v=xPy5HZEL5sg>, last accessed June 6, 2009.

To answer the question posed above, Historical Institutionalism would posit that an institution already established to reach out to poor people would automatically transpose into helping people with HIV and AIDS, as the disease correlates most strongly with poverty-stricken areas. However, the weakness in this approach is that it undermines individual agency.²²⁷ While it is true that ‘intervention’ in impoverished areas was already institutionalised – insofar as a church and its building had been established – there is no guarantee that had God not ‘kicked’ Pastor John, Living Hope would at all have been established. Therefore, the phenomenon of a ‘call’ and its long-term implications serves as a more robust explanation for the establishment of Living Hope Ministries. Other approaches may critique the exercise as a benign outworking of ‘the White Man’s Burden’²²⁸. However, the critique is countered by the ‘burden’ being equally shared by Pastor Philip Mokson (who ultimately gave his life for the cause of serving the poor of Masiphumelele), and other black pastors like Reverend Patrick Diba (now the chaplain at the health centre) who followed in his footsteps.

The initial work was all conducted from the building of Fish Hoek Baptist Church. A decision was taken that the outreach work would “concentrate on community development with an emphasis on education and health. To determine community needs, Pastor Mokson [as the chosen facilitator] introduced the team [the trustees] to various leaders in Masiphumelele.” This is a classic example of employing pragmatic wisdom and ‘appropriateness’ rather than expensive hours of collecting social scientific ‘evidence.’

²²⁷ See Hay, C and D. Wincot. 1998. “Structure, Agency and Historical Institutionalism” in *Political Studies*, XLVI, pp. 951-957 and Hall, P. and R. Taylor. “The Potential of Historical Institutionalism: A Response to Hay and Wincott” in the same edition of *Political Studies*, pp. 958-962

²²⁸ See W. Easterly. 2006. “The White Man’s Burden” in *The Lancet*, Volume 367, Issue 9528, Pages 2060-2060

As Living Hope's work proliferated, "the need for a centre separate from the church was becoming urgent."²²⁹ "In July 2000 an ideal property very close to Masiphumelele came up for auction and was purchased by the church for R815 000. This was done entirely as a faith project as the church had no earmarked resources towards such a property."²³⁰

Having signed the papers, Pastor John discovered, "to his horror"²³¹ that he would have to pay an immediate deposit of 10%. It was money he neither had nor that the church had been prepared to spend. "He spoke to the auctioneer and promised to find the R70 000 needed within a week."²³² In an exemplary display of ethical behaviour, "...unwilling to commit the church without having been through formal decision-making processes, he signed the deed of sale in his own name... Almost immediately after signing, a friend of John's approached him and said, "I would like to give you R100 000 towards the purchase of this property," which more than covered the deposit. The church paid for the building within nine months... This property had sufficient ground to allow for future expansion and provided a centre from which to allow participation, partnerships and networking with other areas...

From these humble beginnings, Living Hope's programmes have grown rapidly...and include women's health consultation, dressing clinics, home-based nursing care, nutritional support,

²²⁹ *ibid.* In July 2000, Pastor John [through a newspaper advert, observed] that a site opposite Masiphumelele, in the Capri area, was coming up on auction the next day. He called some church leaders to a meeting, where it was agreed that although the church had no money at the time, they would...make an offer at the auction for the property. Pastor John won the bid for the property at a reasonable price and proceeded to sign the papers."

²³⁰ "Preamble" to *Deed of Trust and Constitution of Fish Hoek Baptist Church Community Trust*, February 2, 2008

²³¹ Available at http://www.livinghope.co.za/index.php?option=com_content&view=article&id=1&Itemid=8, last accessed June 22, 2009

²³² *ibid.*

community vegetable gardens, craft work, HIV and AIDS pre-and post-test counselling, HIV teaching with moral values in the school classrooms, support groups for HIV and AIDS-positive community members, and after-school children's clubs to bring young people together for the learning of Biblical values. Today (in 2009) the staff at Living Hope has grown to nearly 180.²³³ By April 2005, the staff component was numbered at 55. In the space of 4 years, that is an explosive growth of 227,3%.

Two years after the purchase of the Capri property, planning for the building of a hospice began. The initial idea had been to create a space in which people could die with dignity and care²³⁴. It is now known as the Health Care Centre "because so few die here."²³⁵ From when the centre opened in November, 2004, to 2008, a remarkable trend reversal occurred. In its first year of operation, "85% of admitted patients ended up dying. By 2008, only 15% of admitted patients passed away. Housing 22 patients for as long as is necessary for their recovery, the Health Care Centre employs a part-time doctor and "serves approximately 230 HIV and AIDS and other patients a year with over eighty percent of them able to return to their homes."²³⁶

In continued provision that defies secular explanation, "Pastor John was phoned and offered a building that is now the Living Hope Ocean View Centre. It had been a drug dealer's home and a brothel where young girls performed sexual services for older men. The house was completely wrecked as the community took action against this drug lord... Pastor John [met with the bank]

²³³ *ibid*

²³⁴ Personal communication with Pat Ball, Living Hope Public Relations Officer (from fieldwork visit to the Capri Site in April, 2009.)

²³⁵ Available at http://www.livinghope.co.za/index.php?option=com_content&view=article&id=1&Itemid=8, last accessed June 22, 2009

²³⁶ See http://www.livinghope.co.za/index.php?option=com_content&view=article&id=42&Itemid=10, last accessed June 8, 2009

and after 25 minutes, signed a deal to buy the property for R100. Over time, the Lord provided the finance to repair the building...²³⁷

Expanding from the base in Capri, Living Hope extended to Ocean View and then in 2003 to Red Hill, where “Dr. Sandy Haegert [one of the organisation’s first nurses] introduced home-based care... Pastor Mokson facilitated the placement of the first container to serve as Living Hope’s offices in Red Hill... From Red Hill, Living Hope extended further and in 2006... a nurse, Agnes Ward, began home-based care in the area... a vacant piece of land was wonderfully leased to Living Hope rent-free. In August 2008, a container park building was completed debt-free.”²³⁸ In all these areas, health and HIV and AIDS programmes, in addition to children’s ministry activities, are in place.

On the spiritual front, “the spread of the Gospel was hampered by the inability of the senior workers to speak Xhosa. In 2002, Pastor Nobunto Matholini was appointed as pastor and counsellor. She did sterling pioneering work... The spreading of the good news of Jesus Christ continues to be carried out by staff members and pastors appointed for this ministry. Their work has been blessed and many cases of changed lives are evident.”²³⁹

Living Hope has given birth to two other ministries that are an integral component of the church’s provision to provide holistic social interventions in impoverished communities across the Cape Peninsula. These are Living Way, which “seeks to spur economic development for the

²³⁷ Available at http://www.livinghope.co.za/index.php?option=com_content&view=article&id=1&Itemid=8, last accessed June 22, 2009

²³⁸ Available at http://www.livinghope.co.za/index.php?option=com_content&view=article&id=1&Itemid=8, last accessed June 22, 2009

²³⁹ *ibid*

poor and needy in under-resourced communities”²⁴⁰, and Living Grace, which “seeks to transform the shattered lives of the destitute through the love of Jesus.”²⁴¹

Extraordinarily, the FHBCC “has never taken a bond in any of its facility purchases. Everything that has been accomplished has been paid for with cash after trusting God and having received clear direction from Him...”²⁴²

6.2.1. Conclusion of Historical Analysis

Here is evidence of a church that sees its mission as both ‘physical’ and ‘spiritual’ – concrete interventions are intertwined with the preaching of Jesus as the only salvation and hope in a hopeless world. In light of Attanasi’s work²⁴³, one might expect this to be anomalous. However, the Desktop Study suggests that it is not. A future research question may ask why the disparity exists between the literature’s expectations and what is evidently occurring.

The formation of Living Hope is best explained as a response to God’s ‘calling’. The plurality of buy-in (from the church eldership to pastors to board members to donors to staff to people who simply commit to praying) has served to strengthen the institution. Agency has driven the institution, rather than the other way around, although the possibility of a dual feedback mechanism between the two is plausible. In other words, the momentum created through an

²⁴⁰ ibid

²⁴¹ ibid

²⁴² ibid

²⁴³ See the literature review for an exposition of Attanasi’s research: Attanasi, K. 2008. “Getting in Step with the Spirit: Applying Pentecostal Commitments to HIV/AIDS in South Africa” in *Political Theology*, [PT 9.2] [ISSN 1462-317X] pp. 193-208

institution being developed and starting to function effectively can itself be an encouragement to persevere and expand. That no debt has been incurred in the midst of significant financial and physical undertakings is a remarkable testimony to the creation of an institution that defies secular explanation. The ministry is built on a premise that Biblical values and principles is the only antidote to socio-economic, structural injustice. This concept of 'appropriateness' is the driving force behind an organisation that 'works'. Appropriateness in this context is built on the presupposition that the Bible is absolute Truth and contains instruction applicable to all of public life.

6.3. Operational Analysis

Living Hope Ministries is guided by a vision that "seeks to bring the hope and compassion of Jesus Christ to the chronically sick and dying in a holistic way and do everything possible to prevent the spread of HIV and AIDS."²⁴⁴ The objectives delineated in the FHBCC Constitution are revealing and serve to corroborate some of the observations made in the previous section:

"Keeping in mind the needs of all cultural groups, the principle objectives of the FHBCC Trust as decided by the Fish Hoek Baptist Church on 19th November 2000 are: -

3.1 To spread the Good News of Jesus Christ... and to encourage people to follow Christ. (This objective is irrevocable. Any attempt to tamper with this clause will result in the dissolution of the Trust and all the assets being automatically returned to the Settlor.)

²⁴⁴ ibid

3.2 To undertake community development inter-alia through education, social and health related programmes.

3.3 To play a vital role in the prevention, care, treatment and support of people infected and affected by HIV and AIDS and other chronic illnesses.

These will be achieved through Public Benefit Activities, inter-alia:

- Evangelism and Bible based training
- Promoting, strengthening and restoring the Biblical values of family life
- Engaging in HIV and AIDS awareness, education and care programmes
- Providing hope and care for special groups (eg, HIV and AIDS sufferers, orphans, the terminally ill, etc.)
- Undertaking research and evaluation
- Training and developing members of the communities
- Networking and partnering with other churches and organisations

The Trustees are specifically authorized and charged with the above stated objectives and activities and are given the powers set out below...²⁴⁵

The Trust has adopted the Statement of Faith from “the Association of Evangelicals in S.A.”²⁴⁶, which is relatively orthodox and consistent with most Pentecostal/Charismatic churches globally. The board members are an impressive, diverse array of people. Among them is Professor Robin Wood, who is “presently the Director of the Desmond Tutu HIV Centre, Principal Investigator of the Cape Town Clinical Trials Unit and Site Leader for the DTHC Clinical Research Site at the

²⁴⁵ “Objectives”, chapter 3 of *Deed of Trust and Constitution of Fish Hoek Baptist Church Community Trust*, February 2, 2008

²⁴⁶ Available at http://teasa.org.za/index.php?option=com_content&view=article&id=5&Itemid=25, last accessed on June 8, 2009.

University of Cape Town. [He] also holds a post as visiting scientist at Harvard Medical School, Boston, MA, USA and [is] an elected member of the governing council of the International AIDS Society and a founding member of the Southern African HIV Clinicians Society.”²⁴⁷

Living Hope operates across six distinct – all impoverished – communities across the Cape Peninsula. These are Capricorn, Masiphumelele, Ocean View, Red Hill, Mountain View and Overcome Heights.

In Capricorn, “Thousands are ravaged by HIV, with nearly 20% infected with the disease. [Statistics from Masiphumelele] suggest that approximately 23-28% of the population is HIV positive, and many of these are affected by TB as well. As a result, there are many orphaned children and many who have to support families on their own.”²⁴⁸ In Ocean View township, “thousands of lives are being destroyed by the local drug culture, where a drug called tik (crystal meth) is being sold for as little as R5 (less than \$1)... HIV is also a problem; the estimated infection rate is about 8-13%.”²⁴⁹ In Red Hill Township, “it is estimated that around 80% of the population are unemployed, which leads to a range of other issues. There is widespread alcoholism and women and children often suffer as a result. Coupled with crippling unemployment rates, around 20% are infected with HIV and TB, and the community has very little access to healthcare and emergency services.”²⁵⁰

²⁴⁷ Available at http://www.livinghope.co.za/index.php?option=com_content&view=article&id=26&Itemid=9, last accessed June 8, 2009

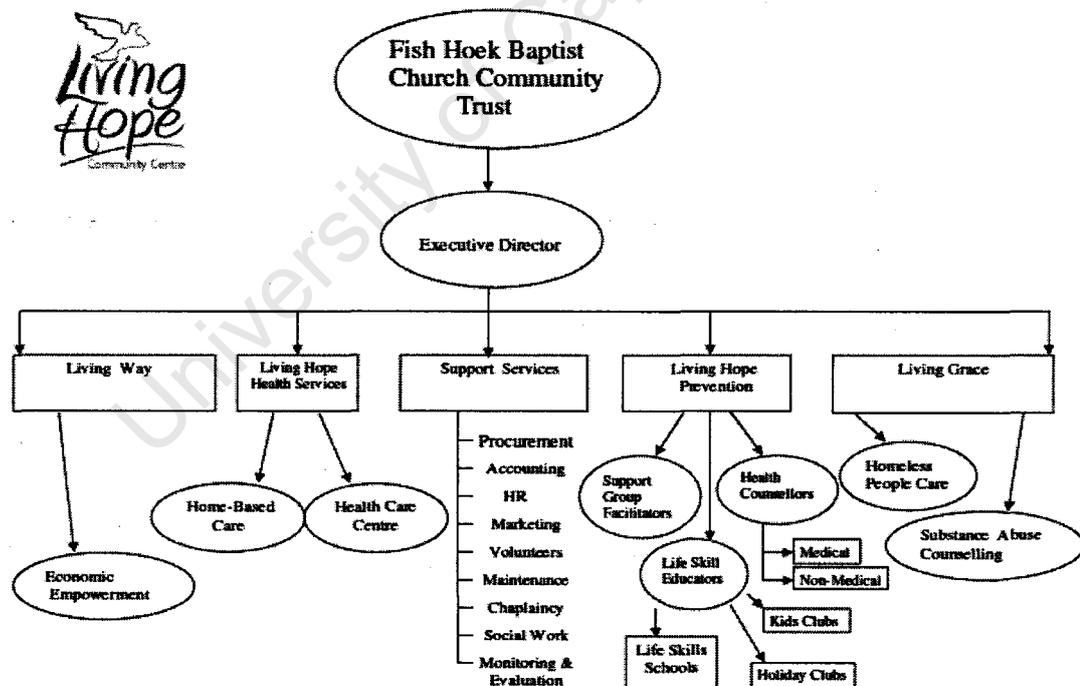
²⁴⁸ Available at http://www.livinghope.co.za/index.php?option=com_content&view=article&id=19&Itemid=27, last accessed June 8, 2009.

²⁴⁹ Available at http://www.livinghope.co.za/index.php?option=com_content&view=article&id=25&Itemid=32, last accessed June 8, 2009.

²⁵⁰ Available at http://www.livinghope.co.za/index.php?option=com_content&view=article&id=21&Itemid=31, last accessed June 8, 2009

The basic history and analysis of each community's structure and needs - on Living Hope's website - indicates an acute awareness of each local context. This suggests a belief that effective intervention is contingent on understanding case-specific contexts; correct diagnosis can only follow from accurate assessment. In this respect, interventions are adapted accordingly, although the underlying driver is a belief that the Gospel is appropriate and relevant to any case, no matter how different. However, physical intervention suggests a strong desire to lift a finger to help²⁵¹, rather than to merely preach hypocritically.

Living Hope is essentially divided into treatment and prevention branches, although these are connected in important ways to the other ministries, and are supported through the same support services that uphold all ministries:



²⁵¹ See earlier footnote for an exposition of this turn of phrase.

Falling under “Living Hope Health Services” in the diagram, “Palliative Care is the specific type of health care Living Hope provides to our clients and patients in the battle against HIV and AIDS. [It] includes caring for the patient in a holistic manner from the diagnosis of the disease through to the bereavement process for the patient’s family. We operate a 22-bed Health Care Centre at our Capri Property and Home-Based Care Services in all the communities in which we work.”²⁵² As mentioned briefly in the historical analysis, “The Health Care Centre is a place of healing where Christian compassion and care is a priority; [it is the heart of Living Hope’s work]. One of the largest such facilities in the Western Cape, it serves approximately 230 HIV and AIDS and other patients a year with over 80% of them able to return to their homes... [In addition], 26 Community Based Carers visit close to 8,500 more people and advise them on all aspects of community health and well being.”²⁵³

On the prevention front - which Living Hope sees as its most important intervention – is a targeting of schools. By invitation of principals only²⁵⁴, they operate at thirteen schools across the region.

“The team of 26 Life Skill Educators target children 4-14 years of age and work in 8 Primary schools and 9 preschools during the mornings. They teach a values-based Life Skills curriculum, based on the Department of Education’s guidelines. In the afternoons this lively, creative and vibrant team of young people run clubs for children at 13 different venues in the community

²⁵² Available at http://www.livinghope.co.za/index.php?option=com_content&view=article&id=42&Itemid=10, last accessed June 8, 2009

²⁵³ *ibid*

²⁵⁴ Personal communication with Pat Ball, Living Hope Public Relations Officer (from fieldwork visit to the Capri Site in April, 2009.)

areas in which we serve. During the school holidays, 3 hour clubs are run in the various communities, encouraging children to make positive, Biblically based life choices. Running parallel to this programme is the “wait 4 me” campaign which encourages children to sign up and commit to “abstain from sex until marriage,” and the “Eve Project,” which is a project whereby we encourage donors to donate feminine hygiene products to encourage young girls to continue their education while they are menstruating.”²⁵⁵

In a world that is increasingly permeated by the notion that abstinence does not work, Living Hope advocates celibacy until marriage and exclusive faithfulness within marriage. However, contrary to popular perception²⁵⁶, Living Hope is distinctly cognisant of the structural social factors contributing to early first-time sexual encounters. Essentially, there is an understanding that underpinning risky sexual behaviour is both socio-economic depravity and a search for identity. If, for young men, in the absence of employment opportunity, identity is sought in belonging to a gang (in which sexual violence and activity is the norm), then Living Hope is offering Jesus as an alternative living reality from whom to receive dignified identity. For young women, the same principle applies, where Jesus is offered as a hope that does not disappoint even when the temptation to trade virginity for a meal seems overwhelming. Whether this approach ‘works’ will forever be debated, but the message carries credibility because grace and compassion for those who suffer is being concomitantly demonstrated.²⁵⁷

²⁵⁵ Available at http://www.livinghope.co.za/index.php?option=com_content&view=article&id=9&Itemid=18, last accessed June 8, 2009

²⁵⁶ The perception amongst some treatment advocacy organisations is that churches blindly preach abstinence without understanding the pressures associated with a desperate political economy.

²⁵⁷ This argument is built on the analysis of each geographic area offered on the Living Hope website, Pastor John’s evident understanding of the context of transactional sex, and personal communication with Pat Ball, Living Hope Public Relations Officer (from fieldwork visit to the Capri Site in April, 2009.).

Health Counsellors constitute another branch of the prevention effort. "Living Hope presently has 23 health counsellors working in 5 government clinics, 2 satellite clinics, 2 local hospitals and a mobile clinic. The Health counsellors are involved in pre-counselling with [individuals] who are going to be tested for HIV and then post-counselling once the person has received their test result. They educate their clients on how to live a sexual lifestyle which does not transmit HIV and promote [instead] a healthy, Biblically based sexual lifestyle. Some of the counsellors are also involved in preparing those needing to go onto Anti-retroviral treatment for this life-long commitment and then following them up to ensure they do not suffer any adverse effects from the treatment and that they do not default from the treatment, [which may lead] to resistance. The mobile team are based at our Capricorn site and run counselling and testing clinics for HIV and TB at various community venues, such as taxi ranks, shopping malls, community events, and even beaches. The Health counsellors require specialised training and are a dynamic, committed team of passionate men and women representing Living Hope and more importantly Jesus, wherever they work."²⁵⁸

"The way we see it: When somebody contracts HIV, they have two choices. Let's estimate that they have twenty years to live. They have these years either to spread HIV, or to spread the Good News of Jesus. We obviously want them to do the latter."²⁵⁹

"Living Hope runs both Chronic Disease and HIV positive support groups in all the communities in which we work. 24 members of the community who have been trained in basic health

²⁵⁸ Available at http://www.livinghope.co.za/index.php?option=com_content&view=article&id=10&Itemid=19, last accessed June 8, 2009

²⁵⁹ Personal communication with Pat Ball, Living Hope Public Relations Officer (from fieldwork visit to the Capri Site in April, 2009.)

education run these groups. The meetings are held in various homes and community venues and each meeting has a time of reading the Bible and praying. In the chronic disease support groups the clients learn about high blood pressure, diabetes, foot care, nutrition, eyecare, physical exercise, TB, HIV and other diseases that we feel need to be covered in conjunction with the local clinic in that area. Due to stigmatisation... those who are HIV positive prefer to meet with other HIV positive people to receive psychosocial support and information specifically relating to being HIV positive. They also discuss the importance of disclosure, knowing [one's] CD4 count, good nutrition and ARV treatment. These leaders are educated on all that the chronic disease support groups cover because many HIV positive people succumb to these chronic diseases due to their [compromised] immune system.

A new development has been that of support groups for HIV positive mothers who have just given birth. We have an extremely successful prevention-of-mother-to-child-transmission (PMTCT) programme in the area but have found that there is a need for more support and education for the mothers of newborns.²⁶⁰

The importance of follow-up is crucial for Policy Learning. Doctors Without Borders (MSF) convincingly demonstrated that the success of AIDS treatment is contingent on three factors: One, close proximity/geographic access to local healthcare clinics; Two, sufficient staffing and supplies (of drugs, needles and basic equipment); Three, support groups to ensure adherence to the laborious ARV drug regimen.²⁶¹ Living Hope is meeting all of these criteria, thus inviting the

²⁶⁰ Available at http://www.livinghope.co.za/index.php?option=com_content&view=article&id=8&Itemid=17, last accessed June 8, 2009

²⁶¹ Bedelu, M. Ford, N. Hilderbrand, K. Reuter, H. "Implementing Antiretroviral Therapy in Rural Communities: The Lusikisiki Model of Decentralized HIV/AIDS Care" in *Journal of Infectious Diseases*, 2007; 196:S464-8

praise of international recognition:

“Fish Hoek's initiative is the largest local church response to HIV and AIDS in South Africa, and likely the world. It has become the model for multitudes of local churches that now have their own AIDS initiatives. It has also been recognized by governments worldwide, including that of the U.S. “This church [Fish Hoek] is making its mark, applying resources at its disposal to the needs of the hurting, the diseased, and the poor,” said Bill Hybels, senior pastor at Willow Creek Community Church [the second largest church in the US]. “The [Courageous Leadership] award inspires leaders by honouring churches doing their part to help meet the holistic needs of those whose lives are devastated by AIDS.”²⁶²

6.4. Donor Support and Constraints

A significant portion of Living Hope's funding has come from the United States' Presidents Emergency Plan for AIDS Relief (PEPFAR), currently valued at \$703 893 per year. While some conditionality imposed by this funding acted as a minor constraint on Living Hope's work²⁶³, “the Opt-out program... allowed [us] to opt out of certain aspects of the program like Condom education and distribution amongst children and youth.”²⁶⁴ On the home page of Living Hope's website is a letter penned by Pastor John explaining the latest developments on donor funding from Washington:

²⁶² Owen, D. “Courageous Leadership Award: Engaging the AIDS Pandemic”, available at http://www.worldvision.org/news.nsf/news/200708_courageous?Open&wvsrc=enews&lpos=rightnav&lid=courageous200708, last accessed on June 6, 2009.

²⁶³ See also overview in Desktop Study for more details

²⁶⁴ Thomas, Pastor J. “Letter to Partners”, available at <http://www.livinghope.co.za/>, last accessed June 8, 2009

“I wish I could begin the letter by telling you that all is well and that... Washington has changed its mind and the funding is on again. Unfortunately that’s not the case. An ideological shift seems to have taken place... We will be seeking to... understand what the new Administration plans to do about the many children and youth across South Africa who will be dropped in the process... In a nutshell, the new administration's policies look set to result in the total withdrawal of all funding to Living Hope in time.”²⁶⁵

Secular opposition to PEPFAR’s perceived hitherto favouring of FBOs over other organisations in HIV prevention work has been well documented. The conventional wisdom that abstinence programmes are outdated and irrelevant is gaining momentum to the extent that “an article... appeared in *USA TODAY*, stating Obama Budget cuts for abstinence-only sex education.”²⁶⁶

The letter carries a tone of uncertainty – “We still have no idea how we are going to reach the target of US\$ 313,670 for the Prevention Department”²⁶⁷ - against a sombre acknowledgement of God’s sovereignty. Interestingly, the crux of the letter is reflected in the view that “this is [possibly] God’s way of nudging us to... fund Living Hope differently, without reliance on the Government. While we are extremely grateful for all the US Government has done through the PEPFAR program, this is God’s work and we need to trust God to supply the funding, primarily through His people... I’m absolutely convinced that if we can get one thousand people who would give us \$1 a day, this would solve our immediate financial needs for now. Across the

²⁶⁵ *ibid*

²⁶⁶ *Ibid*, and http://www.usatoday.com/news/health/2009-05-11-abstinence-only_N.htm?POE=click-refer, last accessed June 8, 2009

²⁶⁷ *ibid*

many churches that support Living Hope this is perfectly possible. There must be close to 20,000 people in various churches who have become great friends and partners. In that way the risk is spread very evenly and if one or two drop out, Living Hope will not be hurt. We would ask you to pray and think through this as a possibility. I do not want people to redirect their church giving into Living Hope, but feel that a dollar a day is a workable solution...We really believe that it is absolutely possible to get 1000 people who will give Living Hope \$1 a day and this would help us meet our immediate needs...We are trusting God that He will see us through no matter what happens."²⁶⁸

6.5. Discussion and Policy Learning

In the 'Introduction', two respective questions were posed. One, what can the state learn from Living Hope, and is 'what works' influenced more by purported scientific 'efficacy' or through a pre-existing belief about what is 'appropriate' (with suitable adaptation to the local context)? Two, Does this case provide Policy Learning that combines scientific evidence and pragmatic understanding of constraints and the local context as to be both appropriate and applicable in other similar contexts? The discussion below seeks to answer these questions.

There is much to be learned from Living Hope. Built on a 'call' to serve the poor in their local areas, and an unyielding belief in Biblical values and principles, Pastor John and Fish Hoek Baptist Church have established one of the strongest HIV and AIDS interventions by any single organisation in the Western Cape. Not everything that contributed to Living Hope's success is

²⁶⁸ *ibid*

attributable to the members' own vision or foresight. Living Hope's institutional history has been punctuated with unforeseeable events, some of which defy secular explanation.

Four specific features of policy learning stand out in the church's approach. First, the late Pastor Mokson carried credibility in the community through being a Xhosa-speaker – connection through language is an undervalued commodity in a society attempting redress and reconciliation. Second, the church carried credibility through an already well-established reputation of demonstrating concern for the poor. Third, they understood that endless attempts at trying to 'scientifically' establish community needs was likely to be a sub-optimal exercise. The researcher is by no means criticising high quality evaluative diagnostic work that ensures an efficient allocation of resources. However, public participation forums can often be an inhibition to productive work rather than a constructive form of contextual diagnosis. In the case of Living Hope, consultation with community leaders was sufficient to make effective interventionist inroads into the community²⁶⁹. Finally, their premise of intervention was ultimately not built on 'scientific' understanding of the community's needs, but rather "over-arching all of [their] programmes is a firm conviction that a return to Biblical values and principles is the answer to society's needs."²⁷⁰ It is clear that Fish Hoek Baptist Church's approach is that what is 'appropriate' is likely 'to work;' the antithesis of 'what works' as being 'what matters'.

On the prevention front, Living Hope shunned the conventional wisdom that abstinence programmes are likely to be unsuccessful. They did so on the dual premise that condoms neither

²⁶⁹ This is perhaps fortunate, as many communities consist of self-appointed 'gatekeepers' who eschew any external attempts at community development.

²⁷⁰ See <http://www.livinggrace.co.za/service.htm>, last accessed June 23, 2009.

work well in an African context (because they do not overcome transactional sex or trust issues), nor do they reflect God's heart for sexual pleasure to be enjoyed only within the confines of heterosexual marriage. It is as yet unclear whether these programmes have been successful. However, measurement and attempts to discern causal mechanisms may prove ultimately unfruitful because of complex intervening variables that determine sexual behaviour. Arguments will therefore probably eternally remain over whether the abstinence approach 'works' or is even 'appropriate.' Living Hope, though, clearly decided on 'appropriateness' ahead of purported scientific efficacy. They believe that Jesus is a sufficient provider of identity and source of fulfilment for people susceptible to transactional sex or gangsterism. As these are seen as root problems in poor communities, Jesus as the 'appropriate' response is also understood to be 'what works'. In essence, the Gospel is what works because it is appropriate, not the other way round. Advocating the Gospel as a standard of 'appropriateness' in HIV prevention efforts is potentially opprobrious to secular policy makers, but it should not be overlooked for that reason alone.

Much can also be learned from Living Hope's treatment interventions. Supported by competent administrative staff, home-based carers, counsellors and medical staff have made significant contributions to the communities in which they operate. Trust is established through an evident display of compassion. Community members develop confidence in these carers because they are prepared to follow up and ensure that HIV and AIDS patients are being properly cared for and adhering to their drug regimens. This is a policy learning built on Biblical values of community (support groups) as an essential component of the Christian life. That it works is again – in the eyes of Living Hope – a product of its 'appropriateness', rather than the result of 'scientific' learning. The Gospel is employed as a holistic response intervention to societal ill, though, and the teaching of abstinence is not divorced from the call to be compassionate and care

for those who suffer. In fact, the exhortation to abstinence is only carries credibility in light of the fact that care is lovingly and unconditionally provided for those who suffer. In similar fashion to Jubilee Health Clinic, care is not provided as a subversive means of manipulating people into accepting the Christian gospel. It is provided as an act of love, regardless of the response of the recipients.

Living Hope have managed their constraints admirably, both through the way that their funding mechanisms have been designed, and through institutional flexibility. The purchase of the Capri building that is now the Health Care Centre is a remarkable display of institutional flexibility. There is a policy learning here that is difficult to transpose into the arena of state bureaucracy in health care. It is not as though the minister of health could purchase a property she felt 'called' to, in order to effect better healthcare. Thus, the institutional structure of Living Hope (and Faith-Based Organisations generally) is flexible enough to allow for behaviour that is unusual, yet appropriate, without actually undermining the processes in place. The policy learning, therefore, is for the state to consider the outsourcing of some of its functions to organisations that are more flexible than itself, yet whose work is not driven by problematic profit motive (in an era of privatisation of public goods provision).

The current ideological shift from Washington poses significant funding challenges, but the networks and potential support bases that have been developed over the years may well serve to steady the financial ship and reduce the risk of relying on a single large donor.

A thorough understanding of their local contexts, as indicated by the socio-economic area analyses presented on the website, offer a seminal policy learning. Correct diagnosis is critical to

an optimal response. Moreover, if local communities sense that they are heard and understood, health interventions are more likely to be well received. Living Hope's interventions have been strongly informed by contextual analysis, yet never constrained by it. The overriding belief in the power of the Gospel to change lives (through lifting a finger to help and not merely preaching religious rules) is the most striking policy learning that the case offers.

"This HIV and AIDS is a dark, dark hole, that needs more and more resources... We touch the lives of people with the Gospel truth. And I go to sleep, in my mind knowing that I have brought a message of hope... touched the life of a person who might have stopped believing, just waiting for death. And that makes me excited."²⁷¹ In the words of Pastor John Thomas: "We're here to give hope. We are dealers in hope. We love to deal the hope of the Lord Jesus Christ."²⁷²

²⁷¹ Reverend Patrick Diba, Health Centre chaplain. "Dealers in Hope", *Documentary Video on Fish Hoek Baptist's HIV/AIDS Ministry*, available at <http://www.youtube.com/watch?v=xPy5HZEI5sg>, last accessed June 6, 2009

²⁷² Pastor John Thomas' closing words in "Dealers in Hope", *Documentary Video on Fish Hoek Baptist's HIV/AIDS Ministry*, available at <http://www.youtube.com/watch?v=xPy5HZEI5sg>, last accessed June 6, 2009.

7. Tentative Conclusions and Policy Learning

7.1. Significance of Pentecostal/Charismatic Churches in HIV and AIDS arena

Pentecostal/Charismatic churches are of growing general significance in South Africa, both because of their high growth rates and increasingly cross-cultural congregations. They are of particular significance in their apparent ability to reduce extra-and-pre-marital sex (EPMS) amongst congregants. In a country where HIV transmission appears to be more exacerbated by concurrent sexual relationships than serial monogamy (promiscuity) per se, genuine reduction in any sex outside of faithful, monogamous marriage is to be welcomed. Of course, that the explanation of success in reducing EPMS lies largely in the effects of belonging to a church community, reducing EPMS amongst people who do not attend church presents a formidable challenge. Nonetheless, there is opportunity for further research in this regard as well as preliminary Policy Learning to be derived.

7.2. Exploratory Question Findings:

- How are Pentecostal/Charismatic churches in the Western Cape responding to the HIV and AIDS Pandemic?

One, responses are nearly always *rooted* in a phenomenon known as a 'calling'²⁷³. Typically, one or a few members of a congregation will sense a calling – a burden on the heart, a strong impression on the mind – into ministry that is concerned with providing compassion for the suffering. In a South African context, suffering in general is difficult to disentangle from HIV and AIDS in particular. This 'calling' is often what *sustains* the ministry when those involved are tempted to relinquish it (even if the ministry has developed a certain institutional momentum). The work is depressing and often requires supernatural determination to persevere. A 'calling' from God is also the source of fulfilment in HIV and AIDS ministry; when interventions seem to bear no visible fruit, the 'calling' serves to overcome temptations to quit the ministry should it fall into difficult times;²⁷⁴ satisfaction is derived from knowing that one is working for God and not for man.

Two, because specific 'calling' is at the root of these ministries, they tend to be initially 'reactive' as opposed to proactive. This is no indictment, as much public policy is also reactive (as opposed to carefully planned in advance). What it means, though, is that the responses are not generally rolled out on a large scale - Living Hope is slightly anomalous in terms of size and scale of response. For the most part, HIV and AIDS ministries are small and volunteer-based. As volunteers are doing the physical work rather than the work of gathering data and performing evaluations, their work often remains undocumented and its impact unmeasured.

²⁷³ The term is not free from abuse, and thus most churches insist that a 'call' be scrutinised by a plurality of eldership in which there is mutual accountability; this team would discern whether a 'call' legitimately was from God and advise on the timing and form it may practically acquire.

²⁷⁴ See Guinness, Os. 2003. *The Call: Finding and Fulfilling the Central Purpose of Your Life* (World Publishing USA: United States)

Three, churches' responses are of a multivariate nature. There appears to be a robust understanding of HIV and AIDS as both a socio-economic and behavioural issue. Behavioural intervention lies not in superficially preaching abstinence and faithfulness, but in knowing that such preaching will only carry credibility where genuine compassion abounds for those who suffer. Abstinence and faithfulness are compellingly presented as the most personally (and communally) beneficial means of rescinding HIV transmission; the antithesis of adhering to a merely legalistic set of rules. The message appears to be credibly received because recipients simultaneously see the care being offered to those who now live with or suffer from HIV and AIDS. Because HIV and AIDS is also understood as a social, cultural and politico-economic issue, many of the response programmes documented in this thesis are orientated toward assuring that recipients are equipped to not succumb to (or perpetrate) transactional sex. Many educational programmes²⁷⁵, for instance, involve communication of self worth (particularly to young women) and the ideal (for men) of satisfying one woman forever (rather than the cultural norm of a number of women at the same). The significance of these Gospel-based interventions is that they impart both a sense of inner value and a set of moral values, which are concomitantly likely to reduce the propensity to perpetrate or succumb to transactional, polygamous or promiscuous sex.

7.3. Policy Learning Question Findings

- What Policy Learning can be derived from the examination of these churches' responses?

²⁷⁵ Think Twice is one such programme. The same principles are also taught in all of Living Hope's educational programmes across six of the most impoverished and gangster-ridden areas of the Cape Peninsula.

One of the possible latent implications of HIV and AIDS ministry being instigated and sustained by a 'calling' is the presence of *competence* and *passion*. It appears that the ministries under observation are achieving notable success in the face of limited resources and mainly volunteer staff. Small as they are, that these ministries exist at all is significant. Passion and competence are key components to HIV and AIDS interventions. The applicable Policy Learning here is that the state (by way of its public healthcare system) should be positively disposed toward supporting (financially and with technical assistance) churches whose ministries are making an evidently significant contribution to the battle against HIV and AIDS. Inter-church, church-state and church-multinational (corporation or NGO) collaboration would probably contribute to scaling up the response. However, these kinds of collaborations bring with them all manner of potential bureaucratic politics and shortfalls. The idea should by no means be abandoned, but policy practitioners and ministry leaders should tread carefully.

The selection of Pentecostal/Charismatic churches under review has demonstrated the importance of a *holistic* approach to healthcare, and to HIV and AIDS specifically. There are two marked components to this approach. On the one hand, health is understood to consist of the spiritual, the physical and the emotional. One cannot be detached from another. The clear message of abstaining from any EPMS is far more likely to be received by a patient who feels that they have been treated humanely. Where the state is likely – for reasons of limited skill and capacity – to treat patients as mere numbers, churches are demonstrating the importance of addressing spiritual and emotional needs beyond the physical. On the other hand, health is importantly understood by churches to be just one of many variables punctuating the development landscape. While this study has focused specifically on HIV and AIDS interventions, it is to be noted that churches do not view the pandemic as an isolated problem.

Concomitant intervening factors such as transactional sex are well understood and health interventions are often combined with efforts to educate (as a means to future income earning), seek employment and look after the destitute. Therefore, the study reveals that churches' responses to HIV and AIDS are holistic both in health and development terms. This imparts a significant Policy Learning to the state. The state's current proclivity is to deal with matters such as HIV and AIDS separately from development in general. Coordination across different levels of government (National, Provincial and Local) and within each is necessary to defeat HIV and AIDS and develop simultaneously.

The 'Mbeki Administration' was arguably guilty of creating obfuscation around HIV transmission. If HIV was not sexually transmitted, then campaigns advising ABC (abstain, be faithful, condomise) were opaque and confusing at best. Even ABC itself was never likely to be effective because of its ambiguity. Additionally, for various historic, social and politico-economic reasons, none of these prescriptions were likely to be taken seriously. Pentecostal/Charismatic churches, however, appear to be successful in reducing EPMS amongst their congregations. Their message is clear – faithful, monogamous marriage is God's design and therefore the most optimal way for society to operate. It is not loaded with ideological debates about origin of disease or western pharmaceutical conspiracies to decimate Africa. In light of socioeconomic and cultural circumstances that are not conducive to condom usage or monogamy, where abstinence is eschewed as unrealistic, and HIV continues to ravage South Africa as a result, EPMS reduction is the critical antidote. To suggest that the state should outsource its prevention efforts to Pentecostal/Charismatic churches, however, is an opprobrious suggestion to the intellectual framework that governs contemporary democratic thinking. Indeed, this researcher would be hesitant to endorse such a recommendation for fear of churches simply

being subsumed into the state; here we should learn from history's woes. However, the state's current HIV prevention efforts appear to be ineffective. It may well be plausible to partner with these churches in some way that is not inherently destructive to democracy. If the final result is simply that the prevention messages become less ambiguous and obfuscated, and more clear and digestible, then that would be a worthwhile undertaking.

The churches under examination demonstrated that intervention success was contingent both on institutional flexibility and the establishment of credibility within the communities in which they operate. Government officials, for reasons of varying palatability, are often ill disposed toward developing genuine relationships with the communities in which they operate. Passion and competence are essential causal mechanisms in the process of effecting genuine, compassionate relationships with communities. Government officials should be encouraged to learn the local languages and cultures, thereby engendering credibility through their involvement in these communities. Additionally, where state departments are insufficiently flexible to complete an evidently necessary task, they should consider outsourcing the work to (or partnering with) church organisations such as Living Hope (which is the case with the Western Cape Department of Health being a substantial donor of Living Hope).

Finally, the Policy Learning literature reveals that debates still proliferate as to whether appropriateness is more optimal than evidence-based-policy-making (EBPM) or vice-versa. Appropriateness is usually built on a set of presuppositions that determine a set of prescriptions. EBPM, on the other hand, looks to learn from previous policy failures (delineated by 'scientific evidence') and react accordingly. Interventions undertaken by the churches in this study are a curious combination of both approaches. Certainly, their 'first premise' (as it were) is that the

Gospel of Jesus Christ is absolute Truth, and therefore a necessary presupposition for determining what is appropriate. Any ministry is built on this foundation. However, the belief in the Gospel as being an appropriate policy response to all societal ills does not result in mere preaching of this Gospel. It is practically demonstrated as being a genuine message of love, hope and compassion by providing observable compassionate care for the suffering. At the same time, this practical demonstration is by no means arbitrary. Interventions are built on evidence-based understandings of how HIV is transmitted, perceived and responded to in the various communities in which they work. This is evidenced by earnest attempts to change the social environments that are currently fostering transactional sex and unfaithful polygamy. However, the sense of appropriateness is such a strong component of the work, that even if the evidence would, for instance, suggest that EPMS is not declining, the behavioural component of HIV and AIDS interventions would not cease placing emphasis on sexual intercourse as being solely appropriate within the domain of faithful, monogamous marriage. Moreover, compassionate care would continue to be provided regardless of the efficacy of attempts to reduce EPMS. This is ultimately what sustains churches' credibility in communities.

The seminal lesson for the state is that a robust presupposition of appropriateness is necessary if a particular policy ambition is to be successful. 'Evidence' – especially in a field as complex as HIV and AIDS, with its multitude of intervening variables – is only likely to be intelligible against presupposed appropriateness. Building a policy on the grounds of 'evidence' in the absence of presupposed appropriateness is likely to lead to wildly oscillating responses to HIV, as has been witnessed in South Africa. This creates confusion and erodes positive progress that may have been achieved. Therefore, these churches have imparted the important lesson of combining appropriateness with evidence to inform their responses to HIV and AIDS.

On a hesitant note of recommendation – with a view to the activation of new policy - these churches should collaborate to influence national HIV and AIDS policy strategies. As fruitful as the interventions documented in this thesis are, they remain in large part a reaction to past state policy failure at a symptomatic level. It would be a more strategic approach to influence the public policy agenda and process at a higher, causal level. However, the fruitfulness of their approaches at a symptomatic level is the very means by which they will credibly influence policy formation itself. The above findings stand as useful grounds on which to engage and formulate policy input at a national level.

7.4. Questions for future research

The programmes documented above do not make for easy, comparable, or quantitative assessment in terms of their impact on HIV and AIDS prevention and treatment in the face of state policy failure. However, their value cannot be overlooked, and the researcher can plausibly speculate as to the long-term impact of these programmes, all the while pointing to constructive areas for future research. Once sufficient case data has been obtained, and a database established, the 'natural scientific' quantitative work of cross-case comparisons and hypothesis testing can begin. The following questions are worth asking:

- To what extent does the type of funding for a HIV and AIDS ministry determine the ultimate shape of that ministry?
- What explains the variation in Pentecostal/Charismatic Church responses to HIV and AIDS?

- Why is there a disparity between what the literature on Pentecostal/Charismatic churches asserts regarding their social interaction and what has been discovered in this dissertation?
- Is the preaching of sex as exclusively appropriate in the domain of faithful, monogamous marriage a more effective HIV prevention message than ABC?
- Why do people choose to attend church clinics instead of state clinics?

This dissertation has sought to answer two under-researched and provocative questions. It has done so adequately and the conclusions serve more to provoke further research and Policy consideration than they do to provide emphatic prescriptions.

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