

***Using Shiselweni Reformed Home-Based Care as  
Model for the Church's Involvement in the  
Community***

***by***

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## **LIST OF ABBREVIATIONS**

|        |   |  |
|--------|---|--|
| AIDS   | - | Acquired Immune Deficiency Syndrome                |
| ART    | - | Antiretroviral Therapy                             |
| CDC    | - | The Centers for Disease Control and Prevention     |
| HIV    | - | Human Immunodeficiency Virus                       |
| MOA    | - | Memorandum of Agreement                            |
| NCP    | - | Neighbourhood Care Point                           |
| NERCHA | - | National Emergency Response Council on HIV/AIDS    |
| OVC    | - | Orphaned or Vulnerable Children                    |
| PCP    | - | Pneumocystis Carinii Pneumonia                     |
| PSA    | - | Project Support Association                        |
| REC    | - | Reformed Ecumenical Council                        |
| SCC    | - | Swaziland Conference of Churches                   |
| SHBC   | - | Shiselweni Reformed Home-Based Care                |
| SRC    | - | Swaziland Reformed Church                          |
| STI    | - | Sexually Transmitted Infections                    |
| TB     | - | Tuberculosis                                       |
| UNAIDS | - | Joint United Nations Programme on HIV/AIDS         |
| USAID  | - | United States Agency for International Development |

## **AFFIRMING LIFE IN THE MIDST OF HIV/AIDS**

“Coffins for sale” screams the sign  
“abundant life” screams the preacher  
Death stalks  
But life beckons

Tears everywhere  
Everywhere graves  
Somewhere the old rugged cross  
Offers an open invitation

Poverty, sexism and stigma  
Authors of doom and gloom  
Love sacrifice and solidarity  
Fountains of life eternal

Created in God’s image  
Proceeding from God’s hands  
Humans shall prevail  
O HIV/AIDS: Where is your sting?

*Ezra Chitando*<sup>1</sup>

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<sup>1</sup> Cited in Dube (2003:97-98).

## ***Preface***

During 2012 I had the privilege of doing my practical year as theological student in the southern part of Swaziland, known as the Shiselweni district, working under the supervision of the minister, Dr Arnau van Wyngaard, and the church council of the Swaziland Reformed Church, Shiselweni congregation. Much of my time was spent working with a ministry of the Shiselweni congregation, focussed on people with a variety of needs, but mainly on those living with HIV and AIDS. Virtually on a daily basis I worked with the leaders and caregivers of this ministry known as Shiselweni Reformed Home-Based Care (SHBC) and had the opportunity to observe how they take care of people, many of whom are living in unimaginable circumstances.

This thesis is based on my personal observations of what the caregivers are doing as well as many hours of personal conversations with Arnau Van Wyngaard, CEO of SHBC, who had over the past months become a mentor to me, developing my understanding of mission work as part of the church's core business. I am also grateful for his help as he guided me in the finalisation of this thesis.

My motivation for this thesis is my passion for mission and SHBC was one of the best examples I could find of how a church could become God's hands and feet in a practical way in the community where people are suffering and dying.

This thesis could not have been done without the help of God who gave me strength to complete this paper. Swaziland is a broken country with a lot of challenges and that is why I tried to apply 1 John 3:18b to my own life, "Let us not love with words or tongue but with actions and in truth".<sup>2</sup>

Many people, both in Swaziland and Pretoria, became involved with my research and added to my opinions through conversations and discussions. I would like to sincerely thank them. To my family, thank you for your support and the help you gave me in a variety of ways, especially Mom and Dad. Thanks to Arnau and his wife. To the personnel of the Faculty of Theology who have formed me in many ways and especially

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<sup>2</sup> All Scripture references come from the *New International Version* unless otherwise indicated.

to my supervisor, Dr Attie van Niekerk, thank you very much! Also a special word of appreciation to Johanna Joubert who assisted with the language editing and proofreading of my final text, after I decided to present this dissertation in English to make it more accessible to the people of Swaziland.

Last, but not least, to *Make Shorty Khumalo*, COO of SHBC, all the coordinators and each and every caregiver who are part of this amazing organisation: *Ngiyabonga kakhulu! Nkosi inibusise!*



## ***Introduction***

The global AIDS pandemic is perhaps the greatest crisis that the world has ever faced. According to UNAIDS, the world had 34,2 million HIV-infected people by the end of 2011 (Science Insider 2012). There were 2,7 million new HIV infections in 2010, including an estimated 390 000 among children, and approximately 1,8 million people died of AIDS in 2010, (UNAIDS 2011). The church lives in the midst of these people and has the ability to make a huge difference if she wishes to.

The churches have strengths, they have credibility, and they are grounded in communities. This offers them the opportunity to make a real difference in combating HIV/AIDS. To respond to this challenge, the churches must be transformed in the face of the HIV/AIDS crisis, in order that they may become a force for transformation – bringing healing, hope, and accompaniment to all affected by HIV/AIDS (World Council of Churches 2001:3).

### ***The subject and quest of this thesis***

The Human Immunodeficiency Virus (HIV) as well as the consequent Acquired Immunodeficiency Syndrome (AIDS) is a global epidemic – or rather “pandemic” – as AIDS has spread to every inhabited continent in the world (Frist 2003:xiii). Swaziland is the country which has the highest HIV infection rate in the world. The impact that the virus has on people’s lives is becoming an ever-increasing problem as households are falling apart, children are dropping out of school, orphans are left behind and poverty is rising sharply (STAT 2004:15). Looking at these facts and seeing how this epidemic is destroying people’s lives, the church should no longer ask “why” but should rather start asking “how” it can respond to this epidemic.

SHBC is a registered non-profitable organisation in Swaziland. This is a ministry which was started by the minister of the Shiselweni congregation of the Swaziland Reformed Church (SRC Shiselweni), Dr Arnau van Wyngaard. The main question in this thesis will be:

How did the SRC Shiselweni come to the point where it became convinced that it had to give hope to those infected with and affected by HIV and AIDS and why and how we can use the work which is being done through this small congregation, situated in the poorest part of Swaziland, as model for the global church to involve herself with the communities surrounding the church?

## ***Methodology***

This research was done by studying the context in which the people in the rural area of Shiselweni live, by working together with the leaders as well as the caregivers of SHBC, reading a variety of academic papers and books written about Swaziland, HIV/AIDS and the church and having personal conversations with those involved with this ministry.

The first chapter sets the scene by discussing the global AIDS pandemic. I then give some background information on Swaziland before discussing the AIDS problem in Swaziland specifically.

In the second chapter I give a short history and background of the Swaziland Reformed Church and in the third chapter I have recorded the story of SHBC, how it started, the challenges it faced at the time and still face on a continuous basis and the - sometimes unique - solutions they find for these challenges.

I then conclude with a final chapter in which I make some recommendations on what a church needs to keep in mind, should they want to use SHBC as model for their own involvement in the community.

# **Chapter 1 - Swaziland and AIDS**

## **1.1 The Global AIDS Pandemic**

### **1.1.1 A Short Historical Review<sup>3</sup>**

On 5 June 1981, Michael Gottlieb published an article which appeared in the *Morbidity and Mortality Weekly Report* in which a random increase in *pneumocystis carinii pneumonia* (PCP), a rare lung infection, was reported (Gottlieb et al 1981). This came to the attention of *The Centers for Disease Control and Prevention* (CDC) when a drug technician named Sandra Ford noticed that there was an unusually high number of requests for the drug that treated PCP. In an interview she said, “A doctor was treating a gay man in his 20s who had pneumonia. Two weeks later, he called to ask for a refill of a rare drug that I handled. This was unusual – nobody ever asked for a refill. Patients usually were cured in one 10-day treatment or they died.” A few days after the article was published, a task force was formed which started research on this disease. Initially thinking that this new disease only infected homosexual men, it soon became clear that intravenous drug users were also showing symptoms of the disease. At that time people often referred to this disease as GRID (*Gay-related Immune Deficiency*) or ‘gay cancer’.

It was only in August 1982, after it became clear that the disease was not restricted to gay men, that it got its name by which it is known today: AIDS, an acronym for *Acquired Immune Deficiency Syndrome*. In May 1983 the *Institute Pasteur* in France reported that they had isolated a new virus, which they believed to be the cause of AIDS.

On 23 April 1984, Margaret Heckler, secretary for the *United States Health and Human Services*, publicly announced, “We hope to have a vaccine ready for testing in about two years... Yet another terrible disease is about to yield to patience, persistence and outright genius.” But this was not to be. By the end of 1984, there had been 7 699 AIDS cases and 3 665 AIDS deaths in the USA, and 762 cases had been reported in Europe. Matters were becoming worse instead of better.

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<sup>3</sup> Extensive use was made in this section of an unpublished document, “A Historical Overview of HIV/AIDS” written by Van Wyngaard.

In 1987 the first specialist AIDS hospital ward in England was opened by Princess Diana. It was widely reported in the press that she did not wear gloves when shaking hands with people with AIDS. This made a great impression upon the public. One patient was reported to have said, "She shook my hand without her gloves on. That proves you can't get AIDS from normal social contact."

Despite all the efforts made to slow down the infection rate, the numbers kept climbing. By 1993 there was estimated to be 98 000 infected orphans. In South Africa, the National Health Department reported that the number of recorded HIV infections had increased 60% in the previous two years and the number was expected to double in 1993. A survey of women attending health clinics indicated that nationally some 322 000 people were infected. By 1 January 1995 a total of a million cases of AIDS had been reported to the World Health Organisation's Global Programme on AIDS. Eighteen million adults and 1,5 million children were estimated to have been infected with HIV since the beginning of the epidemic. The CDC also announced that in the United States AIDS had become the leading cause of death amongst all Americans aged 25 to 44.

In July 1996 the 11<sup>th</sup> *International Conference on AIDS* was held in Vancouver, Canada. An optimistic atmosphere existed at this meeting and there was great excitement and anticipation about the findings on combination therapies reported on during the meeting. Some scientists even declared that "aggressive treatment with multiple drugs can convert deadly AIDS into a chronic, manageable disorder like diabetes". One doctor suggested that giving combination therapy to patients in the first few weeks of infection, might mean that the virus could be completely eliminated in two or three years.

But it took someone from South Africa, the then health minister, Nkosazana Zuma, to bring the meeting back to reality when she said that "most people infected with HIV live in Africa, where therapies involving combinations of expensive antiviral drugs are out of the question".

As things stand at the moment, the world has 34,2 million HIV-infected people, of which 22,9 million are in sub-Saharan Africa. Eight million people now receive ARVs, which is 54% of the 14,8 million who need ARVs (Avert 2011a).

Young people, 15 to 24 years old, now account for 40% of new adult infections. Women in that age bracket have twice the number of new infections as similarly aged men; the report notes that many of the HIV-infected women are subject to sexual violence, and they begin sexual activities and marry at a younger age (ScienceInsider 2012).

### 1.1.2 How HIV Causes AIDS<sup>4</sup>

Blood is made up of four main substances: plasma, red blood cells, white blood cells and platelets. White blood cells play a vital role in the immune system of the body. As HIV and AIDS have to do with immune deficiency, it should be fairly obvious that the HI virus prevents the white blood cells in a person's blood from functioning at optimum level, thereby allowing diseases, which would otherwise have been attacked and stopped by the white blood cells, from spreading throughout the body.

In spite of its deadly effects, the HI virus is in fact quite a weak virus (Saayman & Kriel 1992:18). Taken out of its natural habitat, it quickly dies. For this reason the virus cannot be transmitted through the air, for example through sneezing and coughing or touching someone. The only way in which the virus is transmitted is through the exchange of body fluids, mainly blood, breast milk and of course sexual fluids. In all cases the virus has to find its way into the blood stream, which is possible through open wounds, blood transfusions, the sharing of needles, through minute lacerations in the stomach or sexual organs and even through the mucosal linings found in both the male and female reproductive organs.

Once in the blood of the newly infected person, the virus has basically one purpose: to survive in order to make a replica of itself. All living cells have a DNA. There are two broad classes of viruses: viruses whose complete set of genes consists of DNA, and viruses whose set of genes consists of RNA. HIV belongs to this last class of viruses. Like all viruses, HIV can replicate only inside cells, commandeering the cell's machinery to reproduce. But HIV, once inside a cell, uses an enzyme called *reverse transcriptase* to convert their RNA into DNA, which is then permanently incorporated into the host cell's genes. What this means is that the host cell is tricked into duplicating not itself,

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<sup>4</sup> Extensive use was made in this section of an unpublished document, "How HIV Causes AIDS" written by Van Wyngaard.

but rather the virus with which it had been infected. HIV chooses a white blood cell as its host in which to duplicate itself, specifically the CD4 cells. The CD4 cells have a dedicated function: Once an intruder has been detected in the body, a message is sent through the CD4 cells to the bone marrow, which immediately starts producing antibodies to attack and destroy the intruder. Without the CD4 cells, the entire immunity process is brought to a halt, as the bone marrow will no longer receive the message to produce the correct antibodies to attack the intruder.

Transformation of the RNA of the virus into DNA leads to the replication of the HIV virus. When the virus leaves the host CD4 cell, the cell is destroyed. During the initial stage of infection, more than 10 billion new HIV particles are produced daily. Two to four weeks after exposure to the virus, up to 70% of HIV-infected people suffer flu-like symptoms related to the infection, after which there would be no indication of the infection that had taken place.

The normal time from infection until the first AIDS-related symptoms appear, is ten to twelve years. In the interim, even though the infected person may not be aware of it, HIV multiplies and CD4 cells are destroyed. Initially only one in 10 000 CD4 cells is infected. Towards the end, this number goes up to around one in 40. When a person's CD4 cell count drops below 200 cells per mm<sup>3</sup> of blood, then that person is considered to have AIDS.

People don't die of AIDS. They do however die of opportunistic diseases such as pneumonia, tuberculosis, encephalitis, etc. The occurrence of these diseases is further exacerbated by the lack or shortage of sufficient health facilities in most developing countries, such as Swaziland. This can be seen in the high mortality rate as will be discussed in the next section. What is described in First World countries as a "chronic disease", mainly due to wealthy economies, stable infrastructures and developed healthcare systems which enable the majority of people needing antiretroviral treatment to receive it (Avert 2011b), is still a terminal disease in the majority of sub-Saharan countries, including Swaziland.

## **1.2 Swaziland**

In the next section an overview of Swaziland - its history, geography, economy, demographics, and healthcare - will be discussed as each of these aspects has an influence on the AIDS problem of Swaziland.

### **1.2.1 History**

The Swazi nation originated from a group of people who moved southwards to Mozambique in the 15<sup>th</sup> century. Because of constant fighting in the area which is today known as Maputo, they moved to northern Zululand. Fearing the Zulu nation, they moved northwards again to the present Swaziland. During the 1840s, under the leadership of King Mswati II from whom the name of Swaziland comes, they were able to stabilize the southern frontier. He also asked the British authorities in South Africa to assist in preventing raids by the Zulus on the Swazi people. From 1894-1902, Swaziland fell under South African administration, but from 1902 the British took over this control.

In 1921 Sobhuza II became *Ngwenyama* (lion) or king of the Swazi nation. After World War II, due to South Africa's policy of *Apartheid*, the British government started the process towards the independence of Swaziland. Several political parties were formed in this time in an attempt to obtain political and economic independence. On 6 September 1968, Swaziland became independent. On 12 April 1973 King Sobhuza II dissolved the parliament and assumed all powers of government. Furthermore, he prohibited all political activities and trade unions from operating.

King Sobhuza II died in August 1982. After much internal dispute, Queen Regent Ntombi's only child, Prince Makhosetive, was named heir to the Swazi throne. He returned from England where he was attending school in order to ascend the throne and help end the continuing internal disputes. He was enthroned as Mswati III on 25 April 1986. He is the last absolute monarch in Africa. Although Swaziland is a fairly stable country, political instability is still a reality from time to time and presently the country is in a serious economic crisis.

### **1.2.2 Geography**

Swaziland is the smallest landlocked country in Southern Africa - 17 363 km<sup>2</sup>. The country is divided into four regions, i.e. Manzini, Hhohho, Lubombo and Shiselweni, fifty-five Tinkhundla (constituencies) and about 360 chiefdoms. Swaziland's climate varies from tropical to near temperate and receives most of its rain during the summer. The country consists mostly of mountains and hills. Natural resources include asbestos, coal and small diamond deposits. Agricultural products consist mostly of sugarcane, maize, citrus, pineapples and forestry (eucalyptus, pine and wattle).

The mountainous terrain has the effect that certain areas are barely accessible in the rainy season and even in the dry season people have to walk far, sometimes five kilometres or more, to reach the main road from where they can get public transport. One can only imagine, for someone who is already ill, what a gruelling trip this must be.

### **1.2.3 Economy**

With a GDP of \$3,9 billion, Swaziland is described as a "Lower Middle Income" country (World Bank 2012). However, the distribution of income is highly skewed with approximately 69% of the population living below the poverty line of US\$1 per day (WHO 2012). More than 80% of the population rely on subsistence farming for their survival. Sugar and wood pulp remain important foreign exchange earners. Surrounded by South Africa on the north, west and south, Swaziland is heavily dependent on South Africa from which it receives about nine-tenths of its imports and to which it sends nearly three-quarters of its exports (About.com 2005). Exports include items such as sugar, corn, citrus, fruit, livestock and pineapples. Swaziland's currency is the Lilangeni (Emalangeni - plural) and its value is linked to the South African Rand.

### **1.2.4 Demographics**

Censuses are conducted every ten years. The last census was held in 2007. However, shortly after the last census, questions were asked about the accuracy of the door-to-door census. The total number of people counted in the census was 912 229, and this



was 17 489 less than was counted at the previous census, a decade before (Nolen 2008). These figures were later adjusted to the following (CIA World Factbook 2012):

|                                 |                                |
|---------------------------------|--------------------------------|
| <b>Population</b>               | 1,386,914 (July 2012 est.)     |
| <b>Age structure</b>            |                                |
| 0-14 years                      | 37,8% (524 252)                |
| 15-64 years                     | 58,6% (812 731)                |
| 65 years and over               | 3,6% (49 927)                  |
| <b>Population growth rate</b>   | 1,195% (2012 est.)             |
| Birth rate                      | 26,16 births/1,000 population  |
| Death rate                      | 14,21 deaths/1,000 population  |
| <b>Sex ratio</b>                |                                |
| At birth                        | 1,03 male(s)/female            |
| Under 15 years                  | 1,02 male(s)/female            |
| 15-64 years                     | 1 male(s)/female               |
| 65 years and over               | 0,69 male(s)/female            |
| <b>Infant mortality rate</b>    | 59,57 deaths/1,000 live births |
| <b>Life expectancy at birth</b> | 49,42 years                    |

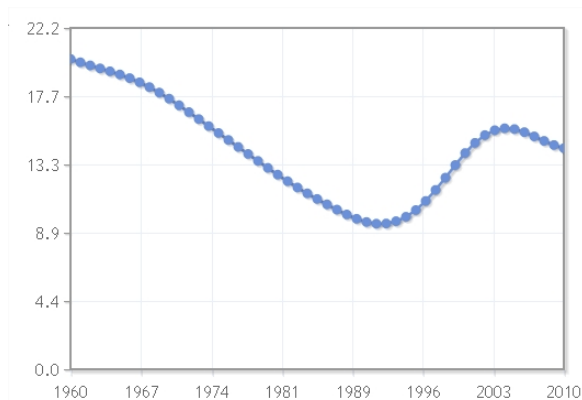


Figure 1: Swaziland Crude Death Rate: 1960-2010

Crude death rate indicates the number of deaths per 1,000 midyear population. The Crude death rate for Swaziland was 14,37 in 2010, with a maximum value of 20,16 in 1960 and a minimum value of 9,46 in 1991 (Index Mundi 2012)

## 1.2.5 Healthcare

According to the 2006/2007 Service Availability Mapping, conducted by Swaziland's Ministry of Health and Social Welfare and the Ministry of Education (SAM 2008), Swaziland has 154 health facilities, ranging from hospitals to rural clinics. Of these, only 36 have inpatient beds which total 1 755 and converts to 148 beds per 100 000 people (SAM 2008:25). There are 174 doctors, 759 midwives, 197 nurses and 426 nurse assistants (2008:43) which works out at 15 doctors per 100 000 people, (compared to the USA with 230 doctors per 100 000 people). When it comes to health services, the Shiselweni region is constantly the worst off.

| Region       | Population per region | Total number of health facilities | Facilities per 100 000 people | Facilities with inpatient beds | Inpatient beds per region | Inpatient beds per 100 000 people |
|--------------|-----------------------|-----------------------------------|-------------------------------|--------------------------------|---------------------------|-----------------------------------|
| Hhohho       | 331 734               | 40                                | 12                            | 9                              | 383                       | 115                               |
| Manzini      | 249 153               | 35                                | 14                            | 9                              | 302                       | 121                               |
| Lubombo      | 360 248               | 52                                | 14                            | 14                             | 813                       | 226                               |
| Shiselweni   | 241 365               | 27                                | 11                            | 4                              | 257                       | 106                               |
| <b>Total</b> | 1 182 500             | 154                               | 13                            | 36                             | 1755                      | 148                               |

During the 2006/2007 Service Availability Mapping survey, it was found that only two regions (Lubombo and Manzini) had functioning computers for the use of the regional health teams. However, none of these computers had internet access.

| Region       | Population | Doctors |       | Nurses |       | Midwives |       |
|--------------|------------|---------|-------|--------|-------|----------|-------|
|              |            | Number  | Ratio | Number | Ratio | Number   | Ratio |
| Hhohho       | 331 734    | 83      | 25    | 231    | 70    | 239      | 72    |
| Manzini      | 249 153    | 24      | 10    | 130    | 52    | 127      | 51    |
| Lubombo      | 360 248    | 54      | 15    | 207    | 57    | 284      | 79    |
| Shiselweni   | 241 365    | 13      | 5     | 99     | 41    | 109      | 45    |
| <b>Total</b> | 1 182 500  | 174     | 15    | 667    | 56    | 759      | 64    |

## **1.3 Swaziland and HIV/AIDS**

### **1.3.1 The effect of HIV/AIDS on Swaziland**

#### **1.3.1.1 Swaziland Statistics**

The HIV prevalence among pregnant women in Swaziland was 41,1% in 2010 and the HIV prevalence is highest among those aged 30-34 years (53,8%) and lowest among those aged 15-19 years (20,4%). The prevalence rate for the reproductive population (aged 15-49 years) is 26%. Using the eligibility criteria of a CD4 cell count below 350/mm<sup>3</sup>, an estimated 78 127 adults and 12 353 children were in need of ART in 2011 and by the end of the year 80% of all who were in need of ART were receiving it (UNAIDS 2012:2).

However, what is not said in the UNAIDS report, is that it is estimated that only 16% of people aged 15-49 years old have been tested for the virus and know their results (Avert 2011c).

SAfAIDS (The Southern Africa HIV and AIDS Information Dissemination Service) recently took hands with SHBC to implement the MaxART initiative with the following goals:

- To build capacity of civil society organisations to be able to deliver integrated effective combination HIV prevention and treatment messages
- To equip the trainers with the new information on treatment as a form of prevention
- To develop an action strategy and plans towards cascading of the training to reach the community based volunteers.

#### **1.3.1.2 The Plight of the Orphans**

The number of orphans, sometimes called “The Fourth Wave” of the HIV/AIDS epidemic, is rising due to the high AIDS-related mortality rate. An orphan is described as a person younger than 17 who has survived one or both parents (Miller s.a.:7). In 2004 there were 7 400 double orphans younger than 14 years, living in the rural areas of Swaziland (VAC 2004:47). In 2007 Whiteside and Whalley wrote that Swaziland had

130 000 orphaned or vulnerable children (OVC) and predicted that this number would rise to 200 000 in 2010 (2007:v). All attempts to find current statistics proved to be futile. However, regardless of the actual figures, it is clear that an unacceptably high number of children in Swaziland have lost one or both of their parents.

It is often said that, in Africa, there are no orphans, since the roles of mother and father are by definition not vested in a single individual (Ulwazi s.a.) but in all the members in the village - usually referred to as the extended family. But things have changed. “[T]his protection is rapidly being eroded by the deaths of the older members of the extended family” (Curle 2009:142).

### **1.3.1.3 Economic Impact of AIDS**

According to Stover and Bollinger (1999:3), the two major economic effects are a reduction in the labour supply and increased expenditure. They explain the reduction in the labour supply as follows:

- The loss of young adults in their most productive years will affect overall economic output
- If AIDS is more prevalent among the economic elite, then the impact may be much larger than the absolute number of AIDS deaths indicates.

The increase in expenses are attributed to both direct and indirect costs:

- The direct costs of AIDS include expenditures for medical care, drugs, and funeral expenses
- Indirect costs include lost time due to illness, recruitment and training costs to replace workers, and care of orphans
- If costs are financed out of savings, then the reduction in investment could lead to a significant reduction in economic growth.

Since approximately 90% of AIDS cases in Swaziland are projected to occur between the ages of 15 to 49, the earning capacity of households will be reduced significantly.

Stover and Bollinger (1999:3) describe the impact on households:

- Loss of income of the patient (who is frequently the main breadwinner)
- Household expenditures for medical expenses may increase substantially
- Other members of the household, usually daughters and wives, may miss school or work less in order to care for the sick person
- Death results in: a permanent loss of income, from less labor on the farm or from lower remittances; funeral and mourning costs; and the removal of children from school in order to save on educational expenses and increase household labor, resulting in a severe loss of future earning potential.

Orphans often attend school less frequently, due to a lack of financial resources for school fees, uniforms, and books. This becomes a vicious circle as organisations such as UNAIDS, UNICEF and UNESCO are all unanimous in their conviction that people with a higher education level have a smaller chance of becoming HIV+.

Only education can empower young people with the knowledge they need to protect themselves from infection. Only education can combat the discrimination that helps perpetuate the pandemic. And only education can help children and young people acquire the knowledge and develop the skills they need to build a better future - the better future that the international community promised every child a decade ago, at the World Summit for Children (Carol Bellamy, Executive Director, UNICEF quoted in Van Wyngaard 2011:11).

...children's success in school can depend on whether they have learned certain emotional and behavioral skills before they enter school. These skills include: understanding their own feelings and those of others, cooperation with peers and adults, resolving conflicts successfully, and controlling their own behavior.

Evidence also shows that young children with positive relationships with parents, caregivers and teachers are more confident and likely to be successful in the learning

environment. The reverse is also true. Children's emotional development can be hindered by stressful relationships with parents and other adults in problem settings – e.g., homes affected by domestic violence; child care centers with poor teaching; or neighborhoods stricken with poverty. For these children, particularly, effective prevention strategies that strengthen family relationships, improve child care quality, and support transition to kindergarten can facilitate school readiness.<sup>5</sup>

### **1.3.2 Factors Contributing towards the Spreading of HIV/AIDS in Swaziland**

#### **1.3.2.1 Denial**

Van Wyngaard (2004:90-91) indicated that denial might be one of the most important reasons why the AIDS statistics are so high in Swaziland. On a government level, it took many years before the problem was openly acknowledged. Those *not* affected by AIDS also seem to deny the problem. Van Wyngaard quotes a minister from a White congregation in South Africa who said to him, “The people telling us about AIDS are exaggerating when they give us the statistics. They are simply playing with numbers!” (2004:90). But the problem is also often denied by those who have HIV or AIDS, because, for them to admit that they have the disease, would be to admit to an immoral lifestyle.

It is clear that, breaking down the barriers of denial, could lead to a much more effective programme to combat the disease.

#### **1.3.2.2 Migrant Labour**

Zuma et al. (2003 & 2005) did field research on the effects of migrant labour on the spreading of HIV and other sexually transmitted infections (STI). In the one case they did research among women in the Carletonville area (2003) and in the other case

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<sup>5</sup> From the The Kauffman Foundation Report on School Readiness (ACT 2010).

research was done among migrant men in two undisclosed rural areas, where the men leave their traditional homesteads to work in other areas (2005). These men leave their homes to earn money on the mines where alcohol and commercial sex are freely available. These men return to their traditional homes once a month or sometimes even less often. The researchers reached the following conclusion:

Migrant men frequent prostitutes or have sexual contacts with sexually active women during their migration periods. The risky behaviour of migrant men is followed by sexual contacts with their less sexually active rural partners. Their rural partners may have other short-term relationships while their partners are away. If this mixing pattern occurs, a multiple peaked epidemic of HIV/STI may occur and the epidemic will spread rapidly through the small proportion of sexually active men and women (2005:426).

Mark Lurie (quoted in Van Wyngaard 2006b:276) made the following remark about the migrant labour system:

If you want to spread a sexually transmitted disease, you'd take thousands of young men away from their families, isolate them in single-sex hostels, and give them easy access to alcohol and commercial sex. Then, to spread the disease around the country, you'd send them home every once in a while to their wives and girlfriends. And that's basically the system we have with the mines.

### **1.3.2.3 Sex in Return for Favours**

Not all forms of commercial sex are done formally. Research was done in Durban to determine the occurrence of informal commercial sex and it was found that sex is often given in return for favours or small gifts, such as chocolate, clothes or school fees. Often these gifts are given to the parents of the girl, making her even more vulnerable. Kaufman and Stavrou, conclude, "Clearly those adolescents who are economically disadvantaged are at greater risk of trading sexual favors – often unprotected ones – for money or other financial rewards" (quoted in Van Wyngaard 2006a:276).

#### **1.3.2.4 Breastfeeding**

One of the ways in which HIV can be transmitted, is through breastfeeding. Although the virus will normally not be transmitted through the stomach linings, the virus is concentrated in the mother's milk and enough milk is drunk by the baby to cause infection. Any laceration in the stomach lining can cause the virus to enter the baby's bloodstream, thereby infecting the baby. The obvious solution would be to give the baby only milk formula, but because of the high cost of milk formula and the great poverty among the people, this is usually not possible.

#### **1.3.3 The Church the Hope of the World**

Bill Hybels is known for describing the local church as the hope of the world. In his *Courageous Leadership* (2002:23) he writes:

There is nothing like the local church when it's working right. Its beauty is indescribable. Its power is breathtaking. Its potential is unlimited. It comforts the grieving and heals the broken in the context of community. It builds bridges to seekers and opens its arms to the forgotten, the downtrodden, and the disillusioned. It breaks the chains of addictions, frees the oppressed, and offers belonging to the marginalized of this world. The potential of the local church is almost more than I can grasp.

This is true also as the world seeks a solution for the AIDS pandemic. In an attempt to find ways in which the church can address this problem, Tom Correll (2003:258) quotes from Matthew 22:37-40, "Love the Lord your God with all your heart and with all your soul and with all your mind. This is the first commandment. And the second is like it: Love your neighbours as yourself. All the law and the prophets hang on these two commandments."

He then proceeds to explain this verse in three mandates (2003:258-263):



- **Prophetic mandate:** If the church wants to make a difference and help against HIV/AIDS, it needs to speak prophetically against immorality. God has set certain standards, e.g. abstinence before marriage and faithfulness within marriage. But instead of merely saying “No!” to wrong behaviour, it needs to address the fundamental beliefs, attitudes and circumstances that cause people to partake in promiscuous behaviour.
- **Pastoral Mandate:** God’s command to love our neighbour should motivate us to care for those around us. The hospitals are often filled to capacity with people dying, while others are dying at their homes. When God tells us to love our neighbour, He is actually saying that we need to care for the sick, the dying, the orphans and the widows. The AIDS pandemic is an opportunity for the church to help those in need.
- **Priestly Mandate:** The church needs to act in a priestly manner. It is only God who can change the people’s behaviour as well as their mindset. God alone can change a person’s heart so that they would want to help. God alone can convince someone to become a donor of resources like money, education, medicine and food.

McDonagh (quoted in Van Wyngaard 2006a:267) calls the HIV/AIDS pandemic a *kairos*-moment: In the same way that theology in the past could not close its eyes to the ideology of Apartheid in South Africa, so it cannot close its eyes now. In 2005 Van Wyngaard stated at the *Reformed Ecumenical Council (REC)*, “[A]t times a crisis develops which has the potential for such devastating consequences throughout the world, that it becomes necessary for the church to respond to that crisis, not only practically, but also theologically” (2006a:267). We can no longer speak relevantly about the church without also speaking about HIV/AIDS.

The church needs to give a message of hope. Charles Spurgeon once said that, whoever is able to bring a message of comfort and hope through their sermons, will never lack a congregation. There has hardly been a time when a message of comfort and hope was more needed than in our days. This message of hope will have to play a major role in a Theology of HIV/AIDS if we want it to be relevant for those most in need of the church’s involvement in this pandemic.

*The church owes the world hope* – for both this and the ultimate, new world. Because the church knows that she is a commissioned witness of the coming new order, she has to erect signs of the Kingdom already.

Because she knows that the gates of hell cannot prevail against her, she can risk the impossible. Because she heard God saying: 'Behold! I am making all things new!' (Rev. 21:5), she can already begin something new. Nothing may remain unaffected. The suggestion that things might stay as they are, is the very antithesis of the gospel. It is nothing less than a denial of Christ's resurrection and of the inauguration of the New Age.

Someone who knows that God will one day wipe away all tears, cannot with resignation accept the tears of those who suffer and are oppressed now. If we believe that one day all disease will vanish, we cannot but begin to anticipate here and now the victory over disease in individuals and communities. We believe in God not because we despair of the present and future; rather we believe in the present and future of both man and the world because we believe in God. Precisely because we hope for the eternal and ultimate things, we also hope for the temporary and the provisional.

David Bosch: *Witness to the World*, 1980.

## ***Chapter 2 - The History of The Swaziland Reformed Church***

In the next section I wish to explore the SRC's initial inability to involve herself in the community.

### ***2.1 Swaziland Reformed Church***

The first congregation of the Dutch Reformed Church (DRC) was formed in 1922 in Goedgegun (Nhlangano). In 1944 a second congregation was formed in Bremersdorp (Manzini). In spite of a fairly good relationship between the members of the DRC and the Swazi people, the DRC showed very little interest in the early years to minister to the Swazi people. Initial mission outreaches to Swaziland came from the Presbytery of Ermelo, who investigated as early as 1927 the possibility of starting with missionary work in Swaziland. It was only in 1944 that *Swaziland Sending* (Swaziland Mission) was formed and the first Evangelist, Efraim Khumalo, was ordained at Dwaleni.

Initially the church wanted to reach people with the gospel. In 1945 the first missionary, Rev Frikkie Malan, was called to Swaziland. Together with Evangelist Efraim Khumalo, they would travel throughout the country for months on end, preaching the gospel. One of the practices of Rev Malan was that he always took medical supplies with him and helped people with health issues. This often opened the door to preach the gospel and all over the country there were newly-converted people, even as far away as Lomahasha, on the border to Mozambique.

The first missionary congregation was formed on 24 April 1951 in Goedgegun.

In these initial years the main problems were -

- a lack of trained workers;
- a lack of unity amongst church members because they lived in small groups far apart from each other;
- the need for buildings caused by the lack of funds;

- the fact that the DRC took so long to start with missionary work compared to other denominations that had been working from as early as 1844 (Methodist), 1860 (Berlin Mission Association), 1871 (Anglican) and 1910 (Church of the Nazarene).

In his evaluation of the mission of the DRC which was published in 1982, Prof J J (Dons) Kritzinger reiterated what was said above and added to this the following:

- *The lack of effective social services, mainly in the medical and educational fields* (my emphasis)
- Visibly the DRC was never impressive
- Lack of leadership
- Missionaries carry a huge administrative load.

Kritzinger then concludes with the following summary (Joubert's translation):

All the above indicates that there had been a total lack of strategy and long term goals. Fundamental questions were never asked about the specific task which the DRC had in the country and neither were needs determined on which the church could focus. It seems as if the church was always struggling merely to 'be there' and to survive. This struggle seems to be the only form of continuity in the DRC mission!

Kritzinger sees the future of the DRC Mission as follows:

- To reach the at least 250 000 Swazis describing themselves as "traditionalists"
- Evangelical churches need to become more relevant within the culture while the Zionist churches need a stronger theological foundation. These may be ways in which churches can work together
- *The DRC Mission needs to do more in terms of proclaiming the love of Christ through Godly works, addressing the needs for better education, medical help and other socio-economic needs* (my emphasis)
- The need for working closely with other Evangelical churches is an absolute necessity.

In 1978 it was decided to form three congregations in Swaziland, i.e. Manzini, Ningizimu and Hhohho and a few years later a fourth congregation was formed in Lubombo. In 1985 history was made when four missionaries from the DRC were working in all four congregations of Swaziland:

- Manzini - Wessel Bester
- Hhohho - Koos Louw
- Ningizimu (later Shiselweni) - Arnau van Wyngaard
- Lubombo - Hennie Basson

At this time the church in Swaziland was part of the regional synod of Northern Transvaal of the Dutch Reformed Church in Africa (DRCA). In 1987 it was decided that the church would form its own regional synod of the DRCA. In 1989 this became a reality. However, two years later during a meeting of the General Synod of the DRCA held in Pretoria, the delegates from Swaziland were asked to leave the meeting and to form an independent church within the *Family of Dutch Reformed Churches*. This led to the start of the *Swaziland Reformed Church*.

Wessel Bester accepted a calling to Mozambique and left Swaziland on 28 November 1993; Koos Louw retired on 31 December 1993 and in August 1997 Hennie Basson moved to Ghanzi in Botswana to minister a congregation there. Thus, of the four missionaries who went to Swaziland in 1984-1985, only Arnau van Wyngaard remained. However, a number of Swazi people have been trained as ministers and are working in the different congregations. The congregations also make use of lay workers and “tentmakers” (leaders in some of the branches who fulfill the task of spiritual leaders while also holding a day job).

## ***Chapter 3 - Shiselweni Reformed Home-Based Care***

It is clear from the description of the history of the SRC, that the need of the people of Swaziland was primarily regarded as spiritual. Frikkie Malan's habit of taking a medical case with him wherever he went, is an exception to the rule. Something had to change!

### ***3.1 The Swaziland Conference of Churches' AIDS Conference***<sup>6</sup>

During the second half of the 80s, when AIDS was still almost unheard of in Swaziland, the few who dared to speak about this disease mostly referred to it as God's punishment on immorality. AIDS in Swaziland was almost exclusively caused through sexual contact and once it became clear that someone had AIDS, he or she was immediately suspected of being unfaithful. In 1991 Van Wyngaard came to the conviction that the church had to reveal another attitude, more in line with the love and compassion shown by God. This was also in line with the recommendations made by Kritzinger in his evaluation of the DRC in Swaziland. Van Wyngaard approached the General Secretary of the *Swaziland Conference of Churches* (SCC), the ecumenical body to which all Evangelical churches in Swaziland belong, and suggested that the 1992 General Assembly of the SCC be devoted to the topic of AIDS. This suggestion was accepted and the wheels were put in motion to get Prof Willem Saayman, then professor of Missiology at UNISA, to come to Swaziland to address the delegates about this topic.

The untimely death of Prof David Bosch in April 1992 forced Prof Saayman to take over as head of the department of Missiology, and he had no option other than to cancel his appointment with the SCC. Van Wyngaard was then asked to speak in his place. He had three sessions with the delegates and spoke about the following topics:

- Background of and Future Visions for AIDS
- The Fight against AIDS
- Counselling People in an AIDS era.

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<sup>6</sup> Van Wyngaard shared this story with me during one of my interviews with him.

It was especially in the last lecture that the speaker urged the church to reveal a new attitude towards those with AIDS, not condemning them but reaching out to them with love. Although these sessions had very little effect on the Evangelical churches in Swaziland, Van Wyngaard is convinced that, if nobody else changed, at least he personally changed. On 21 April 2000 the moderamen of the SRC, of which Van Wyngaard is the General Secretary, decided to appoint Evelyn Mngomezulu as AIDS worker in the Manzini hospital. Day after day she visited AIDS patients and their families at the hospital and brought hope and comfort into their lives<sup>7</sup>.

### **3.2 The Reformed Ecumenical Council General Assembly**

In 2004 the General Secretary of the *Reformed Ecumenical Council* (REC), Dr Richard van Houten, asked Van Wyngaard to adapt his 1992 lectures for publication in the *REC Focus*. This was done under the title, “Why are we losing the Battle against AIDS?” (Van Wyngaard 2004:89-97). A few months after this article was published, he was asked to conduct three workshops about the church and AIDS during the 2005 General Assembly of the REC which was scheduled for July 2005 in Utrecht in the Netherlands. The themes of the workshops were:

- Towards A Theology of AIDS
- The Social Circumstances Conducive to the Spreading of AIDS
- The Social Consequences of HIV/AIDS<sup>8</sup>

Van Wyngaard realised, while preparing and presenting these papers, that he could no longer merely reflect on the topic of HIV/AIDS academically. If he wanted the church to live out its calling among those with HIV and AIDS, then he had to set the example. Two days later he received God’s calling to start with an AIDS ministry in Swaziland. He shared his story on his blog:

In 2005 I had a life-changing experience that brought me face to face with the grace of God. As this had been such

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<sup>7</sup> Mngomezulu will be going on pension at the end of February 2013.

<sup>8</sup> These lectures were later published under the title, “Towards A Theology of AIDS” (Van Wyngaard 2006a).

a deeply personal experience, I have until recently been reluctant to share the story that would ultimately lead to the founding of *Shiselweni Reformed Home-Based Care*:

Since 1989 I have had a deep interest in the problem of HIV and AIDS, specifically in Swaziland. I had done a lot of research on the topic, published an article about this pandemic with the title: *Why are we losing the battle against AIDS?* and found myself in 2005 preparing for a number of workshops which were to be held in Utrecht in the Netherlands as part of the General Assembly of the *Reformed Ecumenical Council*, where I was asked to lead the workshops on the task of the church in this time of AIDS. The lectures I delivered in the Netherlands were entitled: *Towards a Theology of HIV/AIDS*. However, while preparing for these workshops, I had a sense that God was expecting me to do more than merely presenting a number of lectures.

While attending the assembly in the Netherlands, all the delegates were invited to attend church in Rotterdam one Sunday morning. In spite of the wealth of the majority of the people in Rotterdam, this city, which hosts the busiest harbour in the world, has a large number of people normally regarded as outcasts, people such as drug addicts and prostitutes. *The Scots International Church* in Rotterdam, the congregation which had invited us to visit them, has the vision to reach out to these outcasts and to serve the poor and the destitute of the city. Although this vision was clearly displayed at the entrance to the church, it was only later that I experienced firsthand how this church indeed lived out their vision.

After the church service all the delegates were invited to lunch. Most of the delegates were prominent church leaders in their countries: professors, theologians, moderators, general secretaries and people of similar stature. It was while we were busy with lunch that something happened to me that changed my life in a profound way. I noticed a man entering the dining room who displayed clear signs of mental retardation. With a slight feeling of discomfort I kept an eye on him, wondering how the local church leaders were going to handle the situation and expecting them to guide this man outside the church, at most with a sandwich in his hand. And then, instead of doing what I expected (and what I perhaps would have done myself in similar conditions), this man was approached with warmth and sensitivity by two female members of the congregation and invited to share our lunch! And it was at that moment that I knew that, had



Jesus been on earth that day and at that place as a human Person, He would have done exactly the same. While sitting at my table I inwardly cried out to God and said that I wanted my own congregation in Swaziland to be like this: The people in Swaziland had to experience Jesus in the way that this man had experienced Him that day in Rotterdam.

While on our way back from Rotterdam to Utrecht in a luxury coach, reflecting on what had happened that day, I realized that I might just have experienced one of the most important moments in my life; a moment I could not ignore. As I was privileged to sit on my own, I had the chance to pray quietly to God and asked Him what He was trying to teach me. I didn't hear voices! I saw no flashing lights! But in that coach I knew beyond any doubt that God was laying a vision for our church in my mind: We had to become the hands and the feet of Christ within the communities surrounding our church. Our congregation has several "preaching points" spread throughout the Shiselweni region of Swaziland and with growing excitement I became convinced that each of these communities of faith could become a beacon of hope for the sick and the dying within the community where it is situated.

### ***3.3 Taking the Vision to the Congregation***

Arriving back from the Netherlands, he went to his congregation and shared with them what had happened in the Netherlands. He was convinced that God was calling his church into a ministry to work with people with HIV/AIDS. It broke his heart, when visiting a hospital in Swaziland, to be surrounded by people in beds, resembling something that reminds one of the holocaust; people who are just skin and bone (literally); babies only a year or two old dying through no choice of their own; young people who should have been in the prime of their lives but clearly on the point of dying.

Sunday after Sunday he preached about God's vision for the church; about God's caring attitude; about the way that Jesus reached out and touched the man with leprosy (Luke 5:12-15). After a few months he arranged a meeting with the church members and asked them if they would be willing to become the hands and feet of Christ in their community. And the truly amazing thing happened that they said "Yes". The reason why this is so amazing is because the church members are really extremely poor. Because

of their poverty they have learnt through the years that they cannot really do much for anyone else. They were the ones who had to be helped. They were the ones who had to receive from others. One of the worst effects of poverty is that it takes away one's sense of dignity and eventually one starts believing that one means nothing. But these people were willing to give themselves so that others could be helped. However, it was still not clear what needed to be done and the church members committed themselves to pray about this.

### **3.4 First AIDS Conference**<sup>9</sup>

In an attempt to find a way forward, it was decided to organise a conference on AIDS in the town of Nhlngano. A number of people who understood Swaziland's AIDS problem were invited to speak at the conference. The person who opened the day with Scripture reading and prayer (presently CFO of SHBC and Chairperson of the Board) did this by paraphrasing the story of the tax-collector and the Pharisee in the temple, but changing the word "tax-collector" to "AIDS sufferer"! This really touched the audience.

One of the other speakers had been involved with home-based caring for many years. After lunch the attendees broke for group discussions and the answer was clear that they should become involved in home-based caring. It was decided to have a second AIDS conference in the rural area of Dwaleni, not to inform the people about AIDS, but to hear from the community members, some of whom were already caregivers, how they experienced the AIDS pandemic personally.

### **3.5 Second AIDS Conference**<sup>10</sup>

This meeting took place on 3 December 2005. Van Wyngaard was appointed as chairperson of the meeting and he decided that the greater part of the day would be used to allow the existing caregivers to share their stories. But as the day progressed,

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<sup>9</sup> A complete report, including the minutes of this conference can be accessed at <http://www.swazimission.co.za/Documents/AC-2005-11-19.htm>

<sup>10</sup> A report on this meeting can be accessed at <http://www.swazimission.co.za/Documents/AC-2005-12-03.htm>

he found that he was nearly driven to tears to hear what these people were experiencing in the homes they visited: poverty beyond imagination; people with hardly any clothes and no warm bedding; homes without adults to care for the children. In one instance there were six children in one homestead who were orphans. The oldest was eighteen years of age. That year he had received a scholarship to go to school and at the age of eighteen he had finished grade one! The younger children had never been to school. Adults were being cared for as if they were babies. Some of them were too weak to get up to go to a toilet and when the caregivers arrived, the clients had to be washed and their bedding changed.

And then the group made a commitment: If Van Wyngaard was willing to arrange training, they would be able and willing to do this work even better. He committed himself to arrange for training to start as early as possible in 2006.

### ***3.6 Vision and Mission***

It was important to have a strong united vision before starting with this work. In the words of Adeyemo (2003:286):

Where sight sees problems, vision sees potential.

Where sight sees plight of men, vision sees power of God.

Where sight sees barriers, vision sees bearings.

Where sight sees dead ends, vision sees divided highways.

Where sight sees despair, vision sees hope.

The following Vision and Mission statements for SHBC were formulated:

**Vision:** To become the hands and feet of Christ in this community

**Mission statement:** In a community devastated by poverty, sickness, broken families and death, we want to bring back true Christian hope, not only through our words but also – following the perfect example of our Lord, Jesus Christ – by reaching out in love to those in need, comforting and supporting them by all means available to us.

### **3.7 Training the first group at Dwaleni<sup>11</sup>**

A South African organisation, *Project Support Association* (PSA) indicated their willingness to assist the church in Swaziland in training their first group of caregivers at Dwaleni. During the week of 23 - 27 January 2006 a total of 36 volunteers were trained in the following topics:

- What is home care?
- What to do when you enter the home?
- Qualities of a good care supporter
- What is HIV/AIDS?
- How is the virus transmitted?
- What are ARVs?
- Why is HIV different to other viruses?
- How does the body defend itself?
- Why do so many people with AIDS also contract TB?
- Palliative care
- What causes trauma and how do we handle it?
- Orphan programmes

After a week of training, the church was ready to send the caregivers into the field. A committee was chosen to lead the group. The most important person on the committee is the coordinator. This is the person who has to have regular contact with the caregivers, encouraging them, advising them and assisting them so that the work can be done. But the coordinator is also the one who has to have regular contact with Van Wyngaard who, at that time, was the Project Manager of SHBC (now CEO). The coordinator who was chosen, was Shorty Khumalo (who is now the Chief Operating Officer of SHBC).

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<sup>11</sup> A more complete report on the training can be read at <http://www.swazimission.co.za/Documents/AC-2006-01-23.htm>

The Sunday after the training was held, the congregation had a special church service. The whole community was invited as well as the different leaders of the community. This service had three goals:

- To dedicate these people and what they were planning to do to the Lord
- To help the community understand that this work was a response to what God, through Jesus Christ, had done in their lives
- They wanted the community to see the caregivers and to understand that they were being sent out into the community to assist the community members.

The caregivers often have to face terrible situations. The sores on some of the clients' bodies would normally necessitate hospitalisation. However, in Swaziland this option does not exist. Hospitals are filled to capacity with people who are chronically and terminally ill. Therefore hundreds of patients who should have been hospitalised are sent home where others have to take care of them. This is the reason why it has become critically important to train home-based caregivers.

As people witness the caregivers at work, they are able to see something of Christ's attitude being demonstrated daily in this country. These caregivers are truly becoming the hands and feet of Christ amongst people who have a desire to experience the love of Christ in a tangible way.

### ***3.8 Day-to-day Caregiving Practices***<sup>12</sup>

Once the caregivers are trained, they are asked to identify people close to their homes who may be potential clients. Many of the caregivers are already taking care of their sick family members. By looking for clients close to their homes, it means that the caregivers do not need to travel by bus or taxi to visit their clients. They are asked to volunteer 20 hours per week of their time for SHBC. One day in a week the group will meet and share their stories and discuss problems and victories which they have encountered. While sharing these stories, clients' names are never revealed, thereby ensuring anonymity.

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<sup>12</sup> Information obtained through a personal interview with the COO of SHBC, Shorty Khumalo.

Caring includes anything which may have become an obstacle in the life of the client. This includes tasks as fetching water from the closest river if the client is no longer able to do this, cleaning the house and other domestic tasks. The caring of the client includes the cleaning of wounds such as bed-sores or *Kaposi's sarcoma*, conditions which in any Western country would have necessitated hospitalisation, but which - in Swaziland with its inadequate health facilities - need to be taken care of in the home of the client by willing volunteers.

The caregivers supply holistic care, which includes the physical, social, psychological and spiritual care of clients (Wasner et al., 2005, p. 99). Although SHBC is a Christian organisation, it does not require caregivers wishing to be part of the organisation to be Christian in their faith, and caregiving services are rendered to any person in need, regardless of gender or faith. Most caregivers will however share a part from Scripture with the clients and pray for them, something which is mostly highly appreciated by the clients:

Generally [home-based care] clients appreciate it when the caregivers pray for them, and the majority of clients give permission that a portion from the Bible may be read to them. In both of these instances, the caregivers are encouraged not to take it for granted that the client would want the caregiver to read and/or pray for them. As the Christian faith is built upon the reconciliation between God and man through the death and resurrection of Jesus Christ, permission may be given, after a bond of trust has been built between the caregiver and the client, that the caregiver may share with his/her client how to start this relationship with Jesus Christ. This is done with great sensitivity, ensuring that nobody is forced into a decision for Christ (Van Wyngaard quoted in Root 2011:13).

Although the caregivers are not qualified HIV/AIDS counsellors, they are called upon to convince community members to be tested to determine their HIV status and if they are HIV-positive to continue with the next step to determine their CD4 count so that they can start with ART if their CD4 count is below 350. An important part of the caregivers' task is to support those on ART to continue meticulously with their treatment.

The effectiveness of this approach can be seen from a report which was submitted to USAID in 2012:

With an adult prevalence rate of 26% and an antenatal prevalence rate of 42%, Swaziland is the country in the world with the highest HIV infection rate. Shiselweni is one of four regions in the Kingdom of Swaziland, the area most affected by the HIV pandemic. Fuelled by denial and the fear of stigmatization, it seemed that there was no way in which an impact could be made in this region, with its population of 208 000. There was a need for a new initiative:

- to convince people that AIDS is not a death sentence;
- that it is crucial to be tested, and
- if the person qualifies for it, to start anti-retroviral therapy (ART);
- to continue taking the prescribed medication meticulously;
- and to provide holistic care to PLWHA in a way that restores dignity and hope to the client, their family and their community.

The report then concludes with the following:

From 2008 - 2011:

- 13 351 people were referred for HCT
- 7 893 were referred for ART
- 10 528 people were referred for TB testing
- 1 001 of the clients are on ART
- 358 of the clients are on TB treatment

From the following statistics taken from 2008 to 2011, it can be seen that the death rate of SHBC clients in the rural communities of Shiselweni has dropped drastically from 35.3% to 14.8% – probably the most significant proof of the positive impact of the SHBC’s holistic approach.

- 2008: 621 of 1 758 clients died (35.3%)
- 2009: 506 of 2 397 clients died (21.1%)
- 2010: 448 of 2 577 clients died (17.4%)
- 2011: 395 of 2 665 clients died (14.8%) (Van Wyngaard 2012).

Because of the trust placed in the SHBC caregivers (Root 2011:27), they are often confronted with situations where they need to facilitate conversations between husbands and wives, where the one party has to acknowledge their HIV-positive status to the other:

‘I told the man, “I have a plan [so you can tell your wife you’re HIV positive]”. I knew the husband and wife each was positive, and that the other didn’t know. I told him I’d come to their home one Saturday with a slaughtered chicken and ask her to cook it with porridge . . . I visited and we all told stories. Then the man said, “Now, my wife, what if I told you I’m HIV positive?” She said, “I would just accept you as you are, because you are still a human being”. I said, “This is your chance”. So he said, “I am HIV positive”. She said, “I’m also positive”, and went to get her handbag. “You see this? I never, ever put it down, because it has my tablets [antiretroviral therapy]”. My heart was so sad, because the man had hidden his tablets under a tree outside the homestead. He dug a hole and everyday he’d go to the tree [to take the ART in secret].’ (Root and Van Wyngaard, 2011:174-175).

This story had a happy ending when the two married partners accepted each other fully.

### ***3.9 Monitoring and Evaluation***

SHBC has developed a recording system whereby every visit by a caregiver is entered on a form (Addendum 1). These forms are then handed to the coordinator at the end of the month who compiles a report for the entire group (Addendum 2). The information from the coordinators’ forms is then compiled into a monthly report which gives an overview of the organisation’s work in one glance (Addendum 3). These monthly reports are used to compile an annual report on the work of SHBC (Addendum 4).

*Swaziland’s National Emergency Response Council on HIV/AIDS (NERCHA)* has since endorsed the effectiveness of SHBC’s reporting system when their M&E director described SHBC’s reporting system as “a best practices case study on effective M&E”, proposing that other NGOs in Swaziland use the same method when reporting on their work.



### 3.10 Expanding into Other Areas

After the initial group of volunteers were trained at Dwaleni, requests came from other communities to start with similar programmes. It was decided to work with one group only for a year, in order to sort out any teething problems. In January 2007 a second group was trained at Matsanjeni and shortly afterwards a third group was trained at Somtongo. Requests for training came from other areas and by the end of 2007 a total of six groups were part of SHBC. In 2008 another six groups were trained and in 2009 nine groups were trained, bringing the total number of communities where SHBC was working to 22. In 2010 and in 2011 four groups were trained in each year and up to the end of August 2012 two more groups were trained. This brought the organisation to a total of 31 communities, where 830 volunteers are caring for more than 2 800 clients<sup>13</sup>.



Figure 2: The 31 communities in the Shiselweni area of Swaziland where SHBC is working are indicated with the AIDS ribbon.

<sup>13</sup> Actually more than 1 100 people had been trained since 2006. Some had died. Others had been offered positions in organisations such as World Vision. Some had themselves become too sick to continue the work while others had left the organisation.

### **3.11 Courageous Leadership Award**

In 2008 SHBC was nominated, together with two other finalists, for the *Courageous Leadership Award*, sponsored by *World Vision* and the *Willow Creek Association* from Chicago, USA. Competing against two USA churches, both with millions of dollars at their disposal, SHBC - with a budget of less than R300 000 for an entire year - eventually shared the second position. In his commendation, Richard Stearns, president of World Vision, wrote:

Van Wyngaard's church is located on the frontlines of the pandemic. The devastating effects reach right into his community. As the pastor of a small church, it was hard to know where to start. But Swaziland Reformed Church focused their AIDS work on training home caregivers. By concentrating their focus on that one area, this small church, with very little financial resources, has been able to have a significant impact in their community and beyond (Van Wyngaard 2012).

### **3.12 Board of Directors**

In 2009, as SHBC grew, the organisation realised that it needed to appoint a board of directors. It was necessary in order to be registered as a non-profit organisation, but it also meant that the responsibilities associated with running such an organisation could be shared. In line with the way in which SHBC operates, it was expected of board members to do this work voluntarily, without receiving any salary and attending meetings on their own cost. Once again, what was expected of caregivers, needed to be modelled by all leaders, including the board members. Board members are elected on the basis of certain competencies needed within the organisation.

The board consists of the following members<sup>14</sup>:

Neville Curle - Chairperson & CFO

Arnau van Wyngaard - CEO

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<sup>14</sup> More background about these board members can be found on <http://www.shbcare.org/index.php/board-of-directors>

Shorty Khumalo - COO

Doward Sihlongonyane - Member of Parliament

Johanna Joubert - Talent Management Specialist

Netty Khumalo - Coordinator Representative

Zachie Prins - Local Businessman

### **3.13 Four Focus-Areas**

After initially starting with home-based caring, the community leaders approached the SHBC leadership with the request that a *Neighbourhood Care Point* (NCP) be started at Dwaleni where orphans could be fed. Initially children were fed three times a week but soon they received food five days a week. With the \$40 000 prize money received for the *Courageous Leadership Award*, a kitchen was built at Dwaleni. In 2012 a second kitchen was erected at Matsanjeni and in total more than 150 Orphaned or Vulnerable Children (OVC) are receiving a well-balanced nutritious meal daily.

Shortly after the feeding programme was initiated, the community came with another request, that the church start a preschool. The preschool was started in 2006 at Dwaleni and presently has one fully qualified teacher and two teachers who are busy with their training. Approximately 30 children attend the preschool.

In 2011 a fourth focus area was identified when the need for wheelchairs became apparent. Through the cooperation of a number of organisations in the USA, South Africa and Swaziland, 80 wheelchairs were delivered to disabled people. In 2012 another shipment of 225 wheelchairs was received, presently being distributed.

Thus SHBC has four focus areas:

- Home-based caring (SHBC's core business)
- Feeding of orphans
- Preschool
- Wheelchairs

SHBC is a dynamic organisation continually seeking new and innovative ways to address the needs of the community.

### **3.14 The Need for a Professional Approach**

SHBC places a high priority on professionalism. The organisation has distinguished itself on many terrains: on academic level; in terms of leadership; receiving national and international recognition; binding a group of volunteers spread over an area of 1 390 km<sup>2</sup> around one vision. They have proven that they can compete with mega-churches with budgets running into millions of dollars and they can be a worthy partner to corporates in their corporate social responsibility programme. They have put the words of Paul into practice, “Whatever you do, work at it with all your heart, as working for the Lord, not for men” (Colossians 3:23).

#### **3.14.1 Academic Recognition**

This section wishes to highlight the contribution that the SHBC model is making in the academic domain, which contributes to the sustainability of the organisation.

An academic paper was published about the work of this NGO in *Verbum et Ecclesia* in 2006: *On Becoming the Hands and Feet of Christ in an AIDS-ridden society in Swaziland* (Van Wyngaard 2006a).

Van Wyngaard regularly addresses audiences, both locally and internationally and has published various articles in academic journals on the topic of HIV/AIDS and the church. He holds a PhD from UNISA and recently completed the *Advanced Health Management Programme* (cum laude) from Yale University, also receiving the *Best Student Award* during the graduation ceremony<sup>15</sup>.

He is also a Research Associate in the *Department of Science of Religion and Missiology*, University of Pretoria.

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<sup>15</sup> Although the *Advanced Health Management Programme* is primarily focussed on medical personnel in senior management positions, it is noteworthy that the Best Student Awards for both the *Advanced Health Management Programme* as well as the *Certificate in Advanced Health Management* were given to clergy, the latter award going to Reverend Meleney B. Kriel, the chairperson of the Viva Foundation of South Africa.

In 2011 the CEO of SHBC was the keynote speaker at the PMR.africa Awards ceremony in Swaziland, challenging leaders and achievers in the corporate world to partner with NGOs in terms of their corporate social responsibility to combat HIV/AIDS in Swaziland (Joubert 2011).

SHBC has been identified by Prof. Robin Root, a medical anthropologist and public health researcher at Baruch College, City University of New York, as a “best practices case study” in a project to explore the high impact potential of faith-based organisations in southern Africa; specifically, to improve and extend the quality of life for people with HIV/AIDS.

In a recent report written by HopeHIV, after training a group of SHBC volunteers, it is stated, “Participants showed understanding about the need to provide holistic support to ill parents and their children during home visits” (HopeHIV 2011).

### **3.14.2 Leadership**

SHBC has opted for a Servant Leadership model, in compliance with the Biblical principle of leadership in Luke 22:26, when Jesus said, “the greatest among you should be like the youngest, and the one who rules like the one who serves”, which He modeled when He washed the feet of His disciples.

SHBC’s servant leadership model is further embodied in its non-hierarchical organisation design as well as its consensus-based decision-making process.

When a new group of volunteers is trained, the CEO attends the last day of training. The newly-chosen committee of the group is asked to come forward and take a seat. After the CEO has explained the significance of the feet-washing episode in John 13, both he and the COO then proceed to physically wash the feet of the committee members. In the words of John 13:15<sup>16</sup>, the leaders are then encouraged to become greater servants.

Each volunteer receives a towel as symbol of their calling to become servants, rather than to stand on their right to be honoured. Volunteers are empowered, through their

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<sup>16</sup> “I have set you an example that you should do as I have done for you” (NIV).

knowledge and abilities which are constantly developed, to become leaders within the community. The CEO sets the example of continuously learning new skills and encourages the volunteers to learn new skills themselves.

In 2011 a Talent Management specialist volunteered to help with the identification of competencies which would enable the coordinators to become even better at their tasks, should development be focussed on those competencies. A distinction was made between what was described as “Price of Admission” competencies, Mission Critical competencies and Very Important competencies. Instead of merely doing leadership training, it is now possible to focus training on those competencies which will enable the coordinators to become specialists at their tasks (Addendum 5).

### **3.14.3 Campaigning and Advocating the Work of SHBC**

It is important to understand that it is necessary for the sake of sustainability and visibility that opportunities be utilised to make known the work done by the church within the community.

In 2010 SHBC had the opportunity to make a number of presentations to churches as well as Rotary Clubs in California, after which the Rotary Club in Fresno decided to partner with SHBC to start the wheelchair ministry.

Proposals are written using the format and methodology described by international funding organisations, e.g. the EU, UNAIDS and UNICEF. It is important, when applying for funds, that the correct methodology be followed when submitting proposals.

Except for bi-monthly newsletters sent out electronically to people who are interested in the work of SHBC, they also make use of social media like Facebook to update those who have joined their page on a regular basis through short news reports and photos.

SHBC now has a number of partners, including foundations, corporates, other NGOs and churches, both locally and internationally because of the advocacy of the work being done.

### **3.14.4 Branding**

Each volunteer receives a shirt on which the vision is printed in siSwati as well as a small medical bag with the name of the organisation printed on. These items have become synonymous with SHBC and wherever the caregivers move, people recognise them as SHBC caregivers.

Annually a colourful calendar is printed and handed over to all the caregivers so that they can share them with their clients. These calendars also appear in prominent public places such as border posts between South Africa and Swaziland so that people can take note of the work being done by SHBC. In this way an increasing number of people can benefit from the work of SHBC, either as client or as volunteer.

### **3.14.5 Financial Discretion**

SHBC works with a very small budget. Administrative costs are managed to not exceed 1% of the total expenses.

An Adopt-A-Caregiver<sup>17</sup> initiative was started to obtain small but sustainable donations on a monthly basis through which caregivers can be supplied with food and medicine.

SHBC's financial books are audited annually by a chartered accountant and the financial year reports are posted onto its website<sup>18</sup>.

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<sup>17</sup> <http://www.shbcare.org/index.php/adopt-a-caregiver>

<sup>18</sup> [http://www.shbcare.org/images/stories/Documents/SHBC\\_Financial%20Reports%20SHBC%202012.pdf](http://www.shbcare.org/images/stories/Documents/SHBC_Financial%20Reports%20SHBC%202012.pdf)

## ***Chapter 4 - Conclusion***

### ***4.1 Final Observations about SHBC as Model***

#### **4.1.1 Key Features of the Model**

The Bible calls on all Christians to reach out to those who suffer because Jesus Christ had not only come to save people's souls nor only to heal physical illnesses, but also to bring wholeness to those who had been rejected and stigmatised because of their sickness. This is to bring *Sjalom* to the world, well-being in the widest sense of the word, prosperity, bodily health and contentedness (Beck and Brown 1976:777) and is also the intention of SHBC's mission statement. Jesus identified with suffering people when he said, "I tell you the truth, whatever you did for one of the least of these brothers of mine, you did for me", (Matthew 25:40), and His commandment that we should do unto others as we would have them do to us (Matthew 7:12) is a basis for the church to become involved and respond with compassion to the need around.

SHBC's journey outlined in this thesis is one model of how the church may reach out. Some of the most important lessons that the SHBC model has taught me these past few months are:

- Like the church at Dwaleni, a congregation does not have to be wealthy to develop what is needed to become involved in the community and really make a difference.
- It is possible for the church to develop the competencies, structures, systems, management practices and tools to reach out to the community.
- Instead of acting like a rescuer that bends down to help the community, the SHBC model teaches a new way of reaching out that empowers the community to help itself.
- The SHBC model demonstrates how important it is to keep proper records of the work being done.



- Every individual involved in SHBC – from the Caregivers to the Board members, some of whom come from corporates – had to be willing to learn new skills to undertake the tasks required.
- SHBC ensures its visibility in the community through its branding (T-shirts and other branded materials); this is important in guarding its reputation and also being a recognisable entity in the communities where they operate. The volunteers publicly identify with what SHBC stands for: “Becoming the hands and feet of Jesus Christ in this community”. It is a constant reminder of the shared vision of the 830 individuals who operate across SHBC’s geographic spread of 1 390 km<sup>2</sup>.
- SHBC adopts a Biblical approach to every aspect of its work as a non-profit organisation, and it applies good management practices from the corporate environment as well.
- The SHBC model has been cited internationally as a best practice case study for effectively reaching out into the community; in this way it is a light to the world in terms of diligence and commitment.
- Because SHBC makes use of volunteers, it can continue to do its work with the minimum funds. However, the more funds it has to its disposal, the more it can do in terms of supplying food and medication to those in need. SHBC has the confidence to apply for funds because it has an excellent track record of good stewardship.

## ***4.2 SHBC’s Replicable Success Factors***

From the research conducted, a number of factors can be identified that are probably the most critical contributors to SHBC’s success and which can serve as model for any church wishing to get involved within their community. These are:

### **4.2.1 Volunteerism**

Probably the cornerstone of SHBC’s success is volunteerism. No single SHBC volunteer is paid for their services. Each contributes their bit not for reward or payment but because it is a matter of the heart and a true desire to “be the hands and feet of

Christ in this community”. SHBC does lose some caregivers to other organisations who have the resources to pay their workers, but some have come back to SHBC because they found the belonging to a community of volunteers more rewarding.

Through the Adopt-A-Caregiver programme the financial sponsorship is used to support the entire caregiver group with food parcels, which they often share with their clients to ensure that the ARV treatment can continue.

Board members support SHBC through their expertise in such fields as financial management, project management, human resource management and development. SHBC also invites church and student groups to undertake occupationally-directed visits. Examples of such visits include –

- Medical students accompanying caregivers on their visits to clients and teaching them additional skills
- 4x4 club members mapping out the scope of coverage of SHBC
- Qualified preschool teachers within visiting teams advising and sharing tools with the staff of the SHBC Preschool at Dwaleni.

The principle is that people are more committed when they are not controlled by something external such as compensation but are self-committed instead. This seems to increase the strong sense of joint ownership that exists within SHBC.

#### **4.2.2 Engaging the Community**

SHBC follows an approach of equipping members of the community with the necessary skills to provide a full service within their own community. In this way SHBC makes an impact by relieving the pain of clients while also uplifting the caregivers and coordinators themselves through skills development. Engaging the community the way that SHBC has been doing, ultimately ensures that the care-work of SHBC will continue.

SHBC also respects the community structures, and will therefore engage with the Chief of each community before undertaking training for people in the community. SHBC’s reputation has spread by word of mouth, and thus far all training has taken place

following a request by community leaders to have people from their community trained in order to help community members who are sick.

















### 4.2.3 Leadership and Organisational Competencies

SHBC continues to build the skills of its people – whether it is the CEO, the coordinators, or the caregivers. This is the way SHBC ensures that there is continuous improvement of the skills of its people and that the organisation continues to improve its practices.

In 2011 members of the SHBC board with the CEO did some development work on the competencies required of the leadership of SHBC to lead the organisation into the future. Below is an extract from the proficiency rating that SHBC Coordinators did of the CEO. The results were used to identify development areas for the CEO. Coordinators were so impressed by the usefulness of the exercise that they asked to have the same done for them. The proficiency rating below shows the definition of the required competency, and then on a 4-point scale the coordinators had to rate how satisfied they were with the CEO's proficiency levels:

11 MAY 2011

19

|   |  |   |   |   |
|---|--|---|---|---|
| 46. Kucabanga ngaphimbili kokutsi kwenteke tintfo   |  |  |  |  |
| 50. Kuhlela tintfo ngendlela tintfo tilandzelane ngendlela yato (nomalefanele)  |  |  |  |  |
| 58. Kuhlela tintfo ngesikhatsi ngaphambili kwekuba tenteke. Ubukele kube umnyaka munye noma mibili kungake nteki loku lokuhlelelayo |  |  |  |  |
| 7. Kunakekela banakekeli bakho ngendlela lefanele   |  |  |  |  |

### 4.2.4 Managing Problems

SHBC is structured in such a way that problems can be identified and discussed at Caregiver level, escalated to Coordinator level and finally escalated to the CEO if all

else fails. Disputes between SHBC and its donor partners are unheard of, but the partnership *Memorandums of Understanding* do make provision for handling disputes.

#### **4.2.5 SHBC brings Hope**

The church brings a message of hope and redemption. Bringing hope to people with HIV/AIDS is a comforting message of God's grace. Whenever the church wants to get involved with the HIV/AIDS pandemic, they must remember that Hope and God's grace play a big part in helping those in need. We do not have all the answers or the right plans to cure HIV/AIDS, but we can give hope that is found in God.

Van Wyngaard (2006a:272) said:

...our strength lies in admitting our inability to produce a final answer, and by saying to each other that we need each other as we, as ambassadors of Christ, seek to do something which will bring hope to individuals, families, communities and entire countries facing inevitable death.

And in the words of the World Council of Churches (2001:3):

The churches have strengths, they have credibility, and they are grounded in communities. This offers them the opportunity to make a real difference in combating HIV/AIDS. To respond to this challenge, the churches must be transformed in the face of the HIV/AIDS crisis, in order that they may become a force for transformation -- bringing healing, hope, and accompaniment to all affected by HIV/AIDS.

### **4.3 Conclusion**

This thesis looked at a model for the church to become involved in the life of the community. Using Shiselweni Reformed Home-Based Care as example, I followed the journey of a humble church congregation: how God had prepared a vision in the heart of Van Wyngaard and how that vision came to life through the Reformed congregation of Dwaleni; I followed their journey to where it became a separate Section 21 not for profit organisation and where it is now seen as a best practice case study in

home-based care. This is the journey of only one church congregation. Looking at the great need in society, there are many more journeys for the church to take.

My experience working alongside the SHBC Caregivers and the CEO, is that there is an increased awareness of the scope of the need as one becomes more deeply involved.

Shifts took place within the church as a result of the work of SHBC which had a positive influence on the community. In 1982 Kritzinger identified certain challenges which faced the DRC and made suggestions on how the church could have a greater influence in Swaziland. Through SHBC, many of these challenges and suggestions were met:

| <b>The Challenges and Vision for the Church in Swaziland as identified by Kritzinger</b> | <b>Progress made</b>  |
|--|---|
| Visibly the DRC was never impressive   | By not focussing on itself but rather on the needs within the community where the church is situated, the SRC Shiselweni became visible in the community  |
| Lack of leadership   | The church started the conversation about the needs of the community. Anyone who could make an input, without regard for hierarchy and formal position within the church structure, was allowed to partake in the discussion. Potential leaders naturally stepped forward as they became inspired by the vision |
| Missionaries carry a huge administrative load  | The administrative load increased after SHBC was formed, but through training and delegation every caregiver, coordinator and board member share in the load  |
| A total lack of strategy and long term goals   | From the conversation with community members about the AIDS problem, the dream was born to care for the people. This dream was later refined in a well-formulated vision and mission statement, shared by every caregiver   |

|   |  |
|---|--|
| Fundamental questions were never asked about the specific task which the DRC had in the country and needs were never determined on which the church could focus                         | The church, through SHBC, was able to address the prophetic mandate (speaking prophetically about people's sexual behaviour), pastoral mandate (loving our neighbour by caring for those around us) and priestly mandate (trusting God to bring change in people's lives). In all three of these, the church now reflects an understanding of the task which is not restricted to the spiritual needs of the community but rather the holistic needs of every community member |
| It seems as if the church was always struggling merely to 'be there' and to survive   | Instead of being concerned about her own survival, the church focussed on making life bearable for people in the community, thereby finding itself surviving, if not flourishing   |
| Evangelical churches need to become more relevant within the culture  | Structures within the community are honoured, e.g. the chief and other traditional leaders and the needs of the communities are taken seriously  |
| The DRC Mission needs to do more in terms of proclaiming the love of Christ through Godly works, addressing the needs for better education, medical help and other socio-economic needs | This is what SHBC is all about   |
| The need for working closely with other Evangelical churches is an absolute necessity   | Less than 5% of all caregivers in SHBC are SRC church members. The majority belong to other Evangelical churches. SHBC also has partnerships with Evangelical churches locally as well as internationally. SHBC has even taken hands with corporates who share the vision of SHBC  |

The effect of all of the above, in the years since SHBC has been founded, are shifts in the communities where the organisation is operating:

| <b>From...</b>   | <b>To...</b>   |
|--|--|
| Fear of stigmatisation among people living with HIV/AIDS | Experiencing unconditional acceptance through the loving care of the SHBC caregivers |
| Living a depressed life in the shadow of death           | Experiencing relief through the understanding that HIV/AIDS is not a death sentence  |
| The darkness of ignorance                                | The light of knowledge about the disease and how to live a quality life              |

|   |  |
|---|--|
| Being often surrounded by people who did not understand the needs of the person living with HIV/AIDS  | Experiencing increased care of family members and friends who have learned through the SHBC caregiver how to take care of someone living with HIV/AIDS |
| Suffering additional risk by not taking ARVs regularly and correctly                                  | Understanding the importance of following the prescriptions correctly and consistently   |
| A depressing death toll   | A decrease in the number of SHBC clients who have passed away  |
| The gospel being limited to mainly what is being shared at church and through church-bound activities | The gospel being taken into the homes of SHBC clients, exponentially increasing the number of people exposed to the gospel in this way                 |
| Hopelessness...   | Hope, and a future!  |

Or, using Ezra Chitando's poem quoted at the beginning of my thesis:

| <b>From...</b>                      | <b>To...</b>   |
|-------------------------------------|--|
| "coffins for sale"                  | "Abundant life"                                      |
| Death stalks                        | Life beckons   |
| Tears everywhere, everywhere graves | The old rugged cross which offers an open invitation |
| Poverty, sexism and stigma          | Love, sacrifice and solidarity                       |
| Authors of doom and gloom           | Fountains of life eternal                            |

"Created in God's image  
Proceeding from God's hands  
Humans shall prevail  
O HIV/AIDS: Where is your sting?"

ADDENDUM 1: CAREGIVER REPORT FORM



ADDENDUM 2: GROUP COORDINATOR MONTHLY REPORT FORM

ADDENDUM 3: PROGRAMME COORDINATOR MONTHLY REPORT FORM

## ADDENDUM 4: ANNUAL REPORT FORM

## ADDENDUM 5: SHBC COORDINATOR: Competency definition report



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