Building Bridges of Hope

An Evaluation of the Anglican Church of Southern Africa's Response to the HIV and AIDS Pandemic - the Isiseko Sokomoleza (Building the Foundation) Programme: 2003-2006

Social Trends Development Services
josettec@mweb.co.za

July 2006

Commissioned by the Anglican Church of Southern Africa HIV and AIDS Office

SECTION ONE: INTRODUCTION

There are moments in time when certain natural or, social events and phenomena are of such a magnitude and significance that they profoundly affect individuals, groups, nation states and, global communities in ways that shift existing paradigms, mindsets and, ways of behaving. Such events make it impossible to operate as though it were "business as usual" and challenge all of us (as individuals and as a collective) to reach beyond our fears and existing capacity to take on a higher order of leadership required to motivate and mobilise human, material and, spiritual resources and energy to engage with and transcend their short, medium and, longer term impacts.[1]

The HIV and AIDS pandemic is indeed such event. In the past 25 years of its known existence, the disease has ravaged and devastated the lives of millions of people across the globe, most of whom are women and children living in Sub-Saharan Africa. As the disease has evolved it has fundamentally challenged individuals, social groups, institutions, national governments and, the wider global community, to overcome inherent fears and, a sense of powerlessness in the face of the full impact and meaning of the disease, to rise above what is perceived to be possible to respond to the many challenges evoked by the pandemic.

This review looks at how a particular Faith-based Organisation (FBO) in Southern Africa – the Anglican Church of Southern Africa (ACSA) - responded to the challenge of the HIV and AIDS pandemic by designing and implementing a comprehensive capacity building initiative across six countries and 23 dioceses in Southern Africa) - the "Isiseko Sokomoleza"(Building the Foundation) Programme. By tracing the programme's evolution and main outcomes the review aims to identify broad lessons arising out of ACSA's engagement with the HIV and AIDS pandemic for the period 2003 to 2006. Lessons learnt need to be taken into consideration in the design and planning of future programmes.

[1] Examples in history would be: slavery, the holocaust, the nuclear bombings of Hiroshima and Nagasaki, apartheid and forced removals, the first landing on the moon, the Gulf War, 9/11, the Asian Tsunami and, Katrina. All created short and longer term responses that have fundamentally altered the ways in which people – individually and collectively – view themselves and, their wider place and, relationships in the world.

1.1 **Background to the review**

The Anglican Church's Province of Southern Africa traverses six countries and a United Kingdom Dependency.[2] In April 2003, a decade after a small but growing number of Anglican clergy and laity had already started to address the impact of HIV and AIDS in their respective parishes and communities, the Anglican Church of Southern Africa (ACSA) officially launched its first comprehensive and provincial-wide response to the pandemic in Southern Africa – the Isiseko Sokomoleza (Building the Foundation) HIV and AIDS Programme.

Isiseko, the outcome of a relatively extensive planning process with the formal support of key structures of ACSA, was designed as a three year programme (2003-20060, in partnership with Christian Aid and supported by a generous grant from the Department of International Development, UK (DFID). The main purpose of Isiseko was reduce stigma and the impact of HIV and AIDS by building and strengthening the capacity of ACSA to respond to the growing pandemic in Southern Africa in potentially replicable ways for other faith-based organisations.

From the beginning ACSA's ability to manage and deliver these interventions in a coordinated and managed way was dependent upon mobilising buy-in and support for the overall initiative from the 24 dioceses that made up ACSA at the launch of the programme in 2003. To achieve this, ACSA needed to develop (and strengthen) a capacitated layer of new HIV/AIDS Diocesan Coordinators, supported by HIV and AIDS-focused structures (HIV and AIDS Task Teams) at diocesan and, over time, parish levels.

The strategy was that this layer of clergy and laity-based drivers or, champions of the programme, supported by their respective diocesan Bishops, would mobilise church-based structures and groups to incrementally respond to the pandemic. The programme aimed to reduce HIV and AIDS stigma and discrimination in ACSA by focusing on a number of specific intervention areas – leadership; pastoral care; prevention; care and counselling; death and dying; policy formulation on

[2] At the time of the Isiseko Programme the Anglican Church of Southern Africa (ACSA) comprised 24 dioceses across the following countries: Angola, Mozambique, Namibia, South Africa, Lesotho, Swaziland, and the Islands of St Helena and Ascension. The basic unit of the church is the parish, some of which (in the rural areas) have "outstations" which are clustered into archdeaconries.

HIV and AIDS in the Workplace; and, the development of a strategic response to growing numbers of orphans and vulnerable children.

The Isiseko Sokomoleza Programme identified four main output areas:

- Strengthened capacity on the part of ACSA to advocate for and provide an effective and expanded community-based response to HIV and AIDS in partnership with other multi-sector role-players.
- Increased intensity, improved quality and extended geographical coverage of parish and diocesan HIV and AIDS-related services, particularly for the poor.
- A reduction in HIV vulnerability through increased knowledge, encouraging responsible behaviour and promoting positive attitudes to people and families living with and affected by HIV and AIDS.
- An effectively managed programme with timely reporting, dissemination procedures and, replicable lessons.

1.2. **The review brief**

In early 2006, in anticipation of the end of the first three years of the Isiseko funding cycle, the ACSA HIV and AIDS Office, together with Christian Aid, decided to undertake an external evaluation of the programme. The aim of the review was to use its main findings (strengths, weaknesses and, emerging challenges and lessons) to inform ACSA on how best to strengthen and sustain its overall HIV and AIDS-related ministries in the Province.

The ACSA HIV and AIDS Office was particularly keen to identify: which activities that either pre-dated or, were supported by Isiseko should be sustained in the future; what action was needed to strengthen activities where foundations had been built as a result of the programme; and, what new types of interventions may be needed to be build upon foundations laid between 2003 and 2006. The ACSA HIV and AIDS Office was especially keen to tease out broad lessons learnt by those responsible for implementing the programme at various levels of the Church.

In late February 2006, following an open tender process, the ACSA HIV and AIDS Office commissioned an external consultancy firm to undertake an output to purpose review and evaluation of Isiseko, based on an amended (November 2003) log-frame, with a focus on the following aspects:[3]

- main achievements with respect to capacity building; improved quality and extension of HIV/AIDS related services; reduction in HIV vulnerability; and, programme management
- key weaknesses with respect to design, planning and, implementation
- major challenges and lessons learnt for the Anglican Church in Southern Africa
- identification of key lessons for informing the design of further programming
- strengths and weaknesses of the support that the Provincial HIV and AIDS Office provided to the Dioceses in developing their HIV/AIDS related programmes and projects

1.3. **Approach and methodology**

A relatively flexible five stage methodology was designed to guide the overall review process, allowing for adaptations along the way to address changing circumstances, as well as time available to conduct the review as originally planned.

Status quo analysis: Understanding the complexity and diversity of a programme that traverses 24 dioceses across Southern Africa necessitated reading and summarising a vast number of reports and data sets. This exercise began with accessing, selecting and, undertaking a desk top review of relevant documents and reports on the genesis and evolution of the programme pre and post 2003 to ascertain the broad contours, key milestones and, broad outputs of the programme. In addition to reading numerous reports on the history, planning and implementation of Isiseko, an internet search was conducted on key service providers used over the life-span of the programme, as well as a specific literature review was undertaken on the response of FBOs to the HIV/AIDS pandemic, with a specific focus on Southern Africa.

[3] Social Trends Development Services put together a four person research team: N Goniwe and M Stevens (Senior Researchers), N Dudula (Research Intern) and, Josette Cole (Principal Researcher and Team Leader).

Refining the review methodology: The findings of the initial review, followed by field visits to two dioceses in the Eastern Cape (Port Elizabeth and Grahamstown) was used to clarify the site-specific context of the Isiseko Programme (the dioceses and parishes); develop a broad conceptual framework for the review; as well as identify areas for deeper investigation. This phase was also used to determine central questions needing to be answered, as well as identify key informants for the review.

Primary research[4]: The heart of the review was the primary research stage where a number of diverse sources were utilised to unearth new data, insights and, information for the review that included:

- face to face and telephonic interviews with selected informants linked to the programme;
- in-depth interviews with selected Diocesan Coordinators, Administrators and, Bishops;
- participant observation and interviews with selected clergy, people living with HIV/AIDS (PLWA's), project staff, volunteers, chaplains and, youth workers in the dioceses and their related HIV and AIDS projects
- participant observation and informal discussions with Diocesan Coordinators as a participant observer/resource person at a Diocesan Coordinators Workshop (May 2006);
- participation in a number of programme-related meetings at the ACSA HIV and AIDS Office, including a planning meeting regarding the design of a follow up (second phase) Isiseko-type programme.

Workshop and presentation of findings: The original brief anticipated the presentation of research findings at a workshop to be organised by ACSA and attended by a range of stakeholders.Initial findings of the review were presented (power point presentation) to a more limited target audience (ACSA HIV and AIDS Office staff and Diocesan Coordinators) at the latter's annual workshop held at the Mazenod Centre in early May. In addition, a briefing document was prepared and submitted to the Liaison Bishop for HIV and AIDS (Bishop David Beetge) and, Director of the Provincial HIV and AIDS Office, with the aim of incorporating initial findings and lessons into the programme planning process for a future HIV and AIDS programme.

[4] See Appendix One.

The report: A draft report was submitted (23 June) that set out key findings regarding the particular strengths, weaknesses and, emerging opportunities for strengthening and improving the response of ACSA to the HIV and AIDS pandemic. Initial comments and feedback from the draft report have been incorporated into the final report.

The final report attempts to provide the reader with a comprehensive, albeit limited snapshot, of the specific context within which the programme was designed and located; the broad contours of the programme as it evolved over time; as well as some of the key achievements, identifiable weaknesses, lessons and, challenges arising out of Isiseko, for ACSA and its programme implementers and managers to consider as they plan further responses to ongoing challenges thrown up by the HIV and AIDS pandemic in Southern Africa.

1.4 **Limitations of the review**

The Anglican Church of Southern Africa is a vast institutional structure. Its long history and institutional ethos has left clear footprints on its structure and ways of working, not all of which are easily discerned or, fathomed by external (secular) consultants. While this inevitably placed certain limitations on our knowledge and understanding of ACSA's institutional context, it also led to lively debates on the history and role of ACSA in the Province.

A more significant limitation for the review related to the internal logic and calendar of a structure like ACSA (and potentially other FBOS) that invariably competes with and, often "trumps", ongoing requirements of any evaluation or, review. Some of these, not anticipated at the beginning of the review, included: Easter; the ordination of two Bishops; a Synod of Bishops; a Diocesan Coordinators Week; a Diocesan Administrators Meeting; a planning process for the next phase of Isiseko; and, a range of ongoing meetings, training sessions and, retreats taking place at diocesan level.

A further limitation was the length of time allotted (3 months) for the review of a vast programme like Isiseko, especially in light of the calendar of events described above. To some extent this time-frame was linked to deadlines for the design of a new programme proposal and, largely imposed by time constraints and deadlines of external donors. Although an extension of time was eventually negotiated, there was still not sufficient time to undertake as many visits to dioceses as hoped, especially those located outside of South Africa. As a consequence, information on the latter relied to a large extent on internal reports and inputs obtained as a participant observer of the Diocesan HIV and AIDS Coordinators workshop in May, attended by most Diocesan HIV and AIDS Coordinators.[5]

1.5 **Acknowledgements**

Any review is dependent upon the kind and quality of information accessed and support it gets from those who hold or, have access to knowledge and information required. The research team would like to take this opportunity to thank the many people interviewed for this review - from staff in the Provincial ACSA HIV and AIDS Office in Cape Town to People Living With AIDS in towns and small villages and, key informants, who offered important and invaluable insights into their personal and professional experiences of various aspects of the programme and ways of coping with the impact of the pandemic. Without this input and support the main findings captured in this review would not have been possible.

We are especially grateful for information supplied by the HIV and AIDS Coordinators, the Bishops, clergy and, Diocesan Administrators interviewed for the review, all of who made a special effort in the midst of other pressing demands to accommodate our visit and ensure that the review team got a broad overview of the specific diocesan context and how it was responding to the pandemic, in general and as part of the Isiseko Programme. As noted above, we wish we could have visited all dioceses and engage with the broad spectrum of Anglican people (clerical and laity) engaged in the programme. Despite this limitation we hope that we have captured trends and issues that resonate with the realities of dioceses not visited.

[5] A mix of dioceses (seven) were visited and selected on the basis of : availability; urban; rural; strong; weak; best practice; supportive-less supportive Bishops. Dioceses, including projects visited were: Cape Town; Free State; George; Grahamstown; The Highveld; and, Kimberley and Kuruman;

Special thanks to Nicki Bartlett, Wendy Lewin and Marlene Whitehead from the Provincial Office, all of who went the extra mile to provide information requested for the review; Canon Desmond Lambrechts for his ongoing support; and, Frank Molteno and Bishop David Beetge, for having confidence in our team's ability to undertake such a challenging and important review of ACSA's Southern Africa's HIV and AIDS ministry.

The review is dedicated to the many strong women and men we met in the course of the review, many of who are either living with HIV and AIDS or, deeply affected by its physical, social and, spiritual dimensions. To those of you who have managed to rise above and beyond your own human, psychological and, spiritual capacity, to face the pandemic and seize the unique opportunities HIV and AIDS offers to become agents of change and, builders of bridges and hope, for Anglicans and the wider community in South and Southern Africa.

SECTION TWO: PROGRAMME CONTEXT

The implementation of the Isiseko Programme needs to be located against the backdrop of an escalating global HIV and AIDS pandemic with an evolving epicentre in sub-Saharan Africa. During the lifespan of Isiseko (2003-2006) the full impact of the pandemic, only half evident at the time the programme was designed (2002), became more visible and, more devastating, especially with respect to women and children. While the ravages of the pandemic grew and, along with this, a growing number of deaths, new infections and, orphans and vulnerable children, there were new signs of hope - an escalation in responses (public and private, including FBOs) and, the eventual emergence of and, increasingly available, access to anti-retroviral treatment. This section of the report provides a short overview of the programme context which, while not comprehensive, hopefully offers some useful statistics and insights into past and emerging trends and indicators for ongoing and future strategic interventions.

2.1 Poverty, Stigma, Gender, Children, and, HIV and AIDS – a global picture

As a global phenomenon, the HIV/AIDS pandemic demands a global response. Since the early 1990s, the United Nations, largely through its development programme (the UNDP), has been one of the world's most outspoken advocates for a multi-sector response to HIV/AIDS. Recognizing the socio-economic challenge the epidemic poses for developing countries – as well as the international community – it has actively promoted linkages between HIV/AIDS and, development policy and practice.

By 2000, at the time of the X111th International AIDS Conference in Durban, the UNDP had already made HIV/AIDS one of its top organizational priorities, integrating it into broader efforts to support effective democratic governance and poverty reduction policies or, strategies. With the growing realization that current and projected socio-economic impacts of the epidemic were of major proportions, the UNDP realized that fighting AIDS and fighting poverty had become two sides of the same coin and, therefore part and parcel of the same battle.

In 2001, the United Nations and other donors and agencies established a Global Fund to Fight AIDS, Tuberculosis and Malaria. The Fund aims to provide financial and technical support, especially to more marginalized countries where these diseases are more prevalent. The major part of current global support is taken up by sub-Saharan Africa (29 countries), as well as Eastern Europe, in recognition of the fact that sub-Saharan Africa is currently the most seriously affected region, with Eastern Europe having the world's fastest growing epidemic.

2.1.1 **Poverty and HIV and AIDS**

There is general consensus that HIV transmission is profoundly influenced by the surrounding social, economic and political environment. Wherever people are struggling against adverse conditions, such as poverty, oppression, discrimination and illiteracy, they are especially vulnerable to being infected by HIV. Adding to an already heavy disease burden in poor countries, the HIV/AIDS epidemic is deepening poverty, reversing human development achievements, aggravating gender inequalities, eroding the capacity of governments to provide essential services, reducing labor productivity and supply and, putting a halt on economic growth. These worsening conditions are, in turn, making people even more vulnerable to HIV infection and undermining the ability of governments to actively respond to the epidemic.

In both Southern and Eastern Africa there is an apparent exacerbation of the food crisis, an increase in the number of orphans and, a relentless weakening of human capacity in both government and private sectors. AIDS has killed one or both parents of an estimated 12 million children in sub-Saharan Africa, thereby fundamentally changing the fabric and functioning of societies. Hardest hit, are countries that have a weak capacity to implement responses. While poverty does not cause AIDS it does add to people's vulnerability - not only to infection but also to the social and economic consequences of infection. Poverty does not allow households to cope with the costs of AIDS care, as well as maintain nutrition, education, and family cohesion.

2.1.2. **Stigma and disclosure**

Fear of the stigma that individuals and society attach to people living with AIDS prevents many from disclosing their HIV status to family and friends. Across the globe people speak about the moral blame associated with HIV which inhibits people disclosing their HIV-positive status.

Disclosure is one of the most traumatic and important factors impacting on the quality of life of people living with HIV and AIDS. Although disclosure dispels the stigma associated with HIV, without adequate counseling, social support and, improved access to health care and medical treatment, it is difficult to encourage.

Despite these difficulties, disclosure is a first step in breaking down AIDS-related stigma and discrimination, creating the space for people to move away from blaming the victim, eliminate fear and, inspire others. In the ongoing debate on appropriate responses to stigma, some reject calls for all people who are HIV-positive to "come out", saying that disclosure is very difficult where stigma prevails.

In a recent article on a theological response to HIV and AIDS, Professor Denise Ackerman argues that countering stigma is central to combating the global AIDS pandemic. And, at the same time, that any discussion on the subject needs to acknowledge people's legitimate fears of infection from a highly contagious disease that they don't really understand and which, for most people, there is no accessible treatment or, guaranteed cure. She raises the important fact that stigma feeds on pre-existing stigma, "imprisoning people in situations that they are powerless to change and depriving them of their full humanity. For all of these reasons, Ackerman argues "stigma is a complex, multilayered and dangerous reality that demands attention", especially from the Church. [6]

[6] Denise Ackerman, p2

2.1.3 **HIV and AIDS and Gender**

There is growing interest in the link between gender and HIV/AIDS. Women and girls bare the brunt of the impact of HIV/AIDS – as caretakers, breadwinners and those most vulnerable to HIV infection. Women, especially young and single mothers, often struggle to support families, earn an income and, produce food and care for the sick, while suffering from HIV-related illness themselves.

In a predominantly patriarchal society, disempowerment makes it more difficult for women to protect themselves from being infected by their partners, exposes them to violence, limits their access to knowledge about how to protect themselves and, increases the incidence of other Sexually Transmitted Diseases (STDs) that raise susceptibility to HIV infection.

This picture is verified by the global statistics and concerns:

- Globally, HIV infection rates among women continue to rise disproportionately
- In 2005, 17.5 million women were living with HIV – one million more than in 2003.
- Most HIV-positive women live in sub-Saharan Africa, but the epidemic is affecting growing numbers of women in South and Southeast Asia (where almost 2 million women now have HIV) and in Eastern Europe and Central Asia.
- The epidemic's impact on women in sub-Saharan Africa remains disproportionate. Most of the women who die are at the prime of their productive life, depriving families and communities of food producers, teachers, mothers and, carers.

There is an urgent need to improve data collection – not only about infection and prevalence levels, but also about the extent to which HIV and AIDS services are reaching the women who need them. To address gender- based inequities in HIV treatment, care and prevention, requires considering the different needs and constraints of women and men when accessing HIV services in different settings – and design interventions accordingly. For example, women's access is more likely to be affected by restricted mobility, difficulties in accessing transport and childcare and lack of treatment literacy, as compared to men's. In addition, women have specific reproductive health concerns which need to be addressed by HIV treatment and care providers. As gender intersects with age, ethnicity, social and

economic status and other social categories, these barriers can vary across settings and within populations, often creating different sets of issues for adolescent girls and boys, and for women and men in different situations (e.g. migrant workers, sex workers, housewives, others). Women often find safety within faith-based communities and as such use these communities to process their contexts of inequalities and their experiences of stigma and discrimination

2.1.4 **Gender, domestic violence and HIV/AIDS**

Gender-based inequalities put women and girls at increased risk of acquiring HIV. Women's limited ability to negotiate safer sex practices with their partners, including condom use, can place even women who are faithful to one partner at risk of HIV infection. Married adolescent girls may be particularly vulnerable. Sexual violence, including rape, likewise increases the risk of HIV for women and girls. In addition, women usually have less access to education, income-generating opportunities, property ownership and, legal protection than men. This means many women are not able to leave relationships even when they know that they may be at risk of HIV. Gender inequalities also affect women's access to and interaction with health services, including those for HIV prevention and AIDS care.

Women and girls in abusive relationships have limited abilities to negotiate safer sexual practices and as such are unable to protect themselves from HIV/AIDS. Faith-based communities are powerful spaces for women and girls to process their experiences of violence as well as feelings of shame. There are opportunities to deal with stigma and discrimination, which are experienced by many affected by HIV/AIDS.

Studies from Rwanda, Tanzania, and South Africa show up to three fold increases in risk of HIV among women who have experienced violence compared to those who have not. For millions of women, the experience or fear of violence is a daily reality and increasingly, so is HIV/AIDS. Violence against women is well recognized as a gross violation of human rights and a public health problem, an epidemic that often overlaps with the AIDS epidemic.

2.2. **Sub-Saharan Africa and HIV and AIDS**

Sub-Saharan Africa, with just over 10% of the world's population, is home to more than 60% of all people living with HIV (25.8 million), with 13.5 million of all HIV-infected women living in sub-Saharan Africa. HIV infection levels among pregnant women are 20% or, higher, in Botswana, Lesotho, Namibia, South Africa, Swaziland, Zimbabwe. In Swaziland, 56% of pregnant women between 25-29 years old who were tested were HIV positive.

In 2005, an estimated 3.2 million people living in the region became newly infected, while 2.4 million adults and children died of AIDS. An estimated 43% (860 000) of all children (under 15 years) living with HIV are in Southern Africa, as are approximately 52% (6.8 million) o f all women (15 years and older) living with HIV.[7] In other words, almost nine in ten children (younger than 15 years) living with HIV are in sub-Saharan Africa. By 2005 there were some 12.0 million orphans living in sub-Saharan Africa.

In most countries, HIV prevalence observed among pregnant women attending antenatal clinics, for example, differ by wide margins and appears to be location specific. Such localized variance highlights the adaptability of the epidemic and its sensitivity to contextual factors —meaning that prevention, treatment, care and impact-alleviating strategies chosen need to reflect local contexts to become more effective. Prominent among those factors is the social and socioeconomic status of women, who remain disproportionately affected by HIV in this region and, still poorly informed about the epidemic.

With the exception of Angola, national HIV infection levels are exceptionally high and show no signs of abating. (In Angola's case, isolation and inaccessibility of the population during the country's prolonged conflict may have served to restrict the spread of HIV.) However, in Zimbabwe, data from national sentinel surveillance, and national and local community-based surveys show a declining trend in HIV prevalence.[8]

[7] Among young people aged 15–24 years, an estimated 4.6% [4.2–5.5%] of women and 1.7% [1.3–2.2%] of men were living with HIV in 2005. Two million [1.5million–3.0 million] are children younger than 15 years of age.

[8] National adult HIV prevalence is estimated at 20.1% [13.3%–27.6%], down from 22.1% [14.6%–30.4%] in 2003. HIV prevalence among pregnant women attending antenatal clinics fell from 32% in 2000 to (a still-very-high) 24% in 2004, while in Harare it

There are no clear signs of declining HIV prevalence elsewhere in southern Africa—including in Botswana, Namibia and Swaziland, where exceptionally high infection levels continue. In Swaziland, national adult HIV prevalence is estimated at 33.4%. HIV prevalence among pregnant women attending antenatal clinics rose from 4% in 1992 to 43% in 2004. Although many young women report delaying their sexual debut, once women do have unprotected sex, the odds of acquiring HIV are dauntingly high. Sexual aggression appears to be widespread: in a study among high school students, almost one in five (18%) of the sexually active female students said their first sexual experience had been coerced.

Botswana's epidemic is equally serious, with national adult HIV prevalence estimated at 24.1% 2005. Among pregnant women attending antenatal clinics, prevalence in 2004 was 34% overall, and close to 50% among women 30–34 years of age. Prevalence among pregnant women generally has remained at 34%–37% since 2001. According to a recent national household survey, HIV knowledge still lags, with only about one in ten survey participants knowing three ways of preventing sexual transmission of HIV.

Lesotho's epidemic seems to be relatively stable at very high levels, with an estimated national adult HIV prevalence of 23.2%. High infection levels of 27% were observed among antenatal clinic attendees in 2004, when over one-third (36%–38%) of pregnant women 25–34 years of age tested HIV-positive. In urban areas, HIV prevalence among pregnant women remains on the increase. Worryingly, knowledge about the epidemic still lags among young people: only 26% of women and 18% of men aged 15–24 years demonstrated comprehensive knowledge of AIDS when surveyed in 2004.

In parts of sparsely populated Namibia, the epidemic is as intense as in some of its neighbours, with HIV prevalence estimated at 19.6% among adults nationally. In antenatal clinic attendees, HIV prevalence is surpassing 42% in Katima Mulilo (in the Caprivi Strip flanked by Angola, Botswana and Zambia) and, ranging between 22% and 28% in the port cities of Luderitz, Swakopmund and, Walvis Bay. To the north, Angola remains an anomaly, with HIV prevalence

declined from 35% in 1999 to 21% in 2004. In the eastern province of Manicaland, HIV prevalence in young women (15–24 years) in the general population fell by half—from 16% in 1998 to 8% in 2003.

much lower than in any other country in this sub-region. An estimated 3.7% of adults were HIV-positive in 2005. Although the country's HIV surveillance system has improved dramatically in recent years, it remains difficult to discern clear trends in the epidemic. Where comparable data exists—in the capital, Luanda, for example—prevalence rose from 0.3% in 1986 to 4.4% in 2004.

On the eastern coastline, a dynamic epidemic is underway in Mozambique, where the estimated national adult HIV prevalence is 16.1%. HIV is spreading fastest in provinces linked by major transport routes to Malawi, South Africa and Zimbabwe**.** High infection levels are being found in Gaza (from where large numbers of migrants working in South Africa originate) and Sofala provinces (traversed by Zimbabwe's main export route).[9]

Access to antiretroviral therapy has increased more than eight-fold since the end of 2003, with about 810 000 people on treatment in December 2005. About one in six (17%) of the 4.7 million people in need of antiretroviral therapy in this region now receive it. Progress is uneven, however, with coverage reaching or, exceeding 50% in only three countries (Botswana, Namibia and Uganda) but remaining below 20% in most others. South Africa accounts for one-quarter of all people receiving antiretroviral therapy in sub- Saharan Africa. However, there is extensive unmet need in most of the region. At least 85% (almost 900 000) of South Africans who needed antiretroviral drugs were not yet receiving them by mid-2005.[10]

East Africa continues to provide the most hopeful indications that serious AIDS epidemics can be reversed. The countrywide drop in HIV prevalence among pregnant women seen in Uganda since the mid-1990s is now being mirrored in urban parts of Kenya, where infection levels are dropping, in some places quite steeply. In both countries, behavioural changes are likely to have contributed

[9] In neighbouring Malawi, national adult HIV prevalence is estimated at 14.1% [6.9%–21.4%]. HIV prevalence among antenatal clinic attendees provides insight into the long-term trends and has stayed relatively stable at around 20%. Most HIV infections are concentrated in the country's southern tip, where HIV prevalence as high as 33% has been found among pregnant women at some sites. Zambia's epidemic appears not to be relenting either, with adult HIV prevalence estimated at 17.0% [15.9%–18.1%]. There is wide geographic variation, though, with HIV infection levels among pregnant women ranging from under 10% in some places to as high as 30% in others (e.g. Matero and Livingstone). Cities and towns with the highest HIV prevalence tend to be clustered along major transport routes—including Kabwe, Livingstone and Ndola (National HIV/ AIDS Council Zambia, 2005).

[10] The same applied to 90% or more of those in need in countries such as Ethiopia, Ghana, Lesotho, Mozambique, Nigeria, the United Republic of Tanzania and Zimbabwe.

to the trend shifts. Elsewhere in East Africa, though, HIV prevalence has either decreased slightly or, remained stable in the past several years.

The same study showed that more women and men were delaying their sexual debut and were avoiding casual sexual liaisons. Nationally, there appears to have been a substantial increase in condom use since the early 1990s. Such behavioural change is likely associated with a combination of AIDS awareness, relatively extensive health infrastructure and, a growing fear of AIDS mortality. However, a significant part of the decline in HIV prevalence is attributable to high mortality rates. With 1.7 million people living with HIV, Zimbabwe needs to sustain the declining trend in HIV prevalence and dramatically improve the provision of antiretroviral treatment if it is to gradually bring its epidemic under control. An estimated 320 000 people needed antiretroviral treatment in 2005, yet only an estimated about 23 000 were receiving antiretroviral drugs.[11]

2.2.1 **Children and HIV and AIDS in sub-Saharan Africa**

It is argued that children are increasingly missing from the health services. In sub-Saharan Africa, hospitals are overwhelmed with caring for AIDS-affected patients, reducing the ability of health services to care for children with other life threatening illnesses such as pneumonia and malaria. Health systems are further undermined by the loss of staff with UNAIDS, for example, estimating that death rates among health workers in the most highly affected countries in Africa have increased five or six-fold as a direct result of AIDS-related illness.

In sub-Saharan Africa many doctors and nurses, faced with low pay and poor working conditions, are seeking jobs in industrialised countries. Addressing the health staffing crisis is a fundamental prerequisite for placing children at the centre of the global response to HIV/AIDS. Some developing countries have attempted to finance health care through the introduction of user fees for health services.

[11] The picture is starkly different in the island nations of southern Africa. National adult HIV prevalence in Madagascar stood at an estimated 0.5% [0.2%–1.2%] in 2005, but low levels of HIV knowledge and significant risk behaviour mean this could change. Fewer than one in five Malagasy could name two methods for preventing the sexual transmission of HIV when surveyed in 2003–2004, and only about one in 10 young men and one in 20 young women (aged 15–24 years) said that they had used a condom the last time they had sex with a casual partner

These fees often restrict poor people's access to vital prevention, treatment and care, and push HIV/AIDS-affected households deeper into poverty. Several countries that have abolished user fees have seen an increase in the numbers of people attending health centres. This also helps boost prevention, treatment, care and, support for children and adolescents affected by HIV/AIDS.

The course of HIV/AIDS is particularly aggressive in children. Without treatment, care and support, HIV multiplies and destroys the defences to infection, leaving the child less able to resist pneumonia and other opportunistic infections. An antibiotic like cotrimoxazole provides highly effective protection against these opportunistic infections and can postpone the need for antiretroviral treatment. In some settings, it has been shown to reduce mortality in children living with HIV/AIDS more than 40 per cent. Currently, an estimated million children need cotrimoxazole, a low-cost intervention that could make a real difference to children living with HIV/AIDS. Countries need to include cotrimoxazole as part their basic health services.[12]

There is increasing evidence of the effectiveness of balanced and comprehensive prevention strategies for keeping adolescents and young people free of infection and helping them to avoid risk. They need access to schools, because a good basic education ranks among the most effective and cost-effective means of HIV prevention. They need voluntary counseling and testing, which

[12] The U*nite for Children, Unite against AIDS Campaign* will support the commitments by both the 2005 G-8 Summit and the 2005 World Summit to coming close as possible to universal access to treatment and promoting long-term funding for the development diagnostic kits and drugs. These formulations and diagnostics should be adapted to the specific needs children. Suggested action to be supported in collaboration with governments, UN agencies, and non-governmental, faith-based and civil society organizations include:

- Cotrimoxazole prophylaxis for all infants born to HIV-infected mothers, from six weeks after birth until infection has been ruled out; for all infants known to be infected, whether symptomatic or not; and for all symptomatic HIV-positive children.
- A public health approach to paediatric treatment, promoted through increased linkages to relevant child survival programmes – including vitamin A supplementation; immunization; counseling and support on optimal, safe infant and young child feeding practices; oral re-hydration therapy for diarrhoea; antibiotic treatment for pneumonia; and insecticide treated mosquito nets in malarial areas.
- Clinical screening and HIV testing for children born to women living with HIV (after PMTCT interventions during pregnancy and delivery) and to children in paediatric care units, therapeutic feeding centres, primary care facilities, and adult tuberculosis and antiretroviral care points.
- Community capacity for treatment preparedness, literacy and adherence, symptomatic treatment (pain, oral thrush), and palliative care and support. Access to all appropriate and affordable testing kits and medicines, especially those adapted to the special needs of children.
- National and sub-national programmes for behaviour change that provide age-relevant, gender-sensitive sexual and reproductive health information, skills and services to reduce child and adolescent risk and vulnerability to HIV infection. Increased access to youth-friendly health services that offer counseling, testing, outreach, referral and control of sexually transmitted infections.

can help adolescents and young people to choose safe behaviour whether they are HIV-positive or not. Young people need practical help in the form of youth-friendly health services through which they may seek advice and obtain treatment for sexually transmitted infections.

2.3. **South Africa and HIV and AIDS**

South Africa is the only country in the world that has had to simultaneously contend with addressing the impact of the HIV/AIDS epidemic and, the socio-economic legacies of the apartheid era, within the context of a transition to democracy. The country's HIV and AIDS epidemic—one of the worst in the world—shows no evidence of decline. In addition to a rapid expansion, the HIV epidemic in South Africa features distinctive age and gender distributions, with young women of reproductive age appearing to be at greatest risk of infection. Overall the epidemic has affected proportionally more women than men

An extensive antenatal clinic surveillance system, as well as national surveys with HIV testing and mortality data drawn from South Africa's civil registration system, indicate that an estimated 5.5 million people were living with HIV in 2005, with 18.8% of adults living with HIV in the 18-49 age cohort. Almost one in three pregnant women attending public antenatal clinics were living with HIV in 2004 and trends over time show a gradual increase in HIV prevalence. While household surveys with HIV testing done in 2003 and 2005 show lower HIV prevalence, these studies are plagued by high non response rates (over 40%).

The 2005 national household HIV survey found high levels of HIV infection levels among young people (aged 15–24 years). These were almost the same as those found in a national young people survey in 2003, an indicator that the epidemic has not lost momentum. The 2005 survey also revealed high HIV infection levels among men aged 50 years and older: 14% among those 50–54 years of age, and 8% for those 55–59 years of age. On the positive side, almost one-third of the respondents aged 15 years and older said they had been tested for HIV, and levels of stigma appear to be diminishing (although almost one in three said they would prefer to hide the HIV status of an HIV-positive family member). While South Africa's HIV prevention efforts have not made notable inroads against the epidemic, there has been significant progress on the treatment front. With approximately 190 000 people receiving antiretroviral treatment by the end of 2005, South

Africa accounts for a large share of the treatment scale-up in sub-Saharan Africa over this decade. However, this still means that less than 20% of the almost one million South Africans in need of antiretroviral treatment were, in fact, receiving it in 2005.

2.3.1 **Children and AIDS in South Africa**

A visibly rising number of orphans and vulnerable children (OVC) in the country resulted in a collaborative response on the part of the South African government's Social Cluster to the impact of HIV-AIDS related illness and death on children. This has largely taken the form of a National Integrated Plan for Children Infected and Affected by HIV/AIDS (NIP).

The plan has three core strategies: a life-skills programme (Department of Education), voluntary counseling and testing (Department of Health) and, home and community-based care and support (HCBCS) programmes (jointly shared by the Departments of Health and Social Development). The overall objective of the NIP is to "ensure access to an appropriate and effective integrated system of prevention, care and support services for children infected and affected by HIV/AIDS". Achieving this goal anticipates collaborative inter-sectoral partnerships and mutual support between government services and, the non-governmental sector.

While much has improved since 2000, especially with respect to collaboration between various government services and NGOs to deliver home-based care, progress with respect to collaboration and support remains uneven, with no clearly as yet defined inter-sectoral strategies existing at provincial, district or, municipal levels to address the specific needs of children infected or, affected by HIV/AIDS in communities.

2.3.2 **Civil society and faith-based sector responses to HIV and AIDS in South Africa**

Civil society organisations (CSOs) have been at the vanguard of the movement to advance the mutually reinforcing agenda of development and AIDS prevention, consistently drawing attention to the need to link micro-level prevention and treatment efforts with broader issues of poverty, gender equality, governance, human rights and trading agreements

It is impossible to do justice to the topic of the growth and role of civil society and, within that, the role of the faith-based sector, in the context of this review. What is important to note is that growth in response has arisen in response to an unfolding and dynamic epidemic, largely to plug holes not as yet filled by lumbering state apparatuses. While prevention, care and treatment drive the process, issues related to stigma, disclosure, treatment and, more recently to VCT, continue to spark high levels of civil society debate and intervention.[13]

Since 2000 there has been a growing body of evidence to support the importance of the faith-based sector in the promotion of HIV/AIDS prevention, care and, treatment. The literature puts forward a number of reasons why faith-based organisations can assist in fighting the HIV/AIDS pandemic:

- Spirituality is very important in most developing countries.
- Prayer and church affiliation is publicly acknowledged and openly practiced, even in so-called secular settings such as conferences or other mass gatherings. Thus, faith-based institutions provide a good entry point for issues that contain life-and-death consequences.
- Faith-based organisations potentially provide HIV-related leadership, education and community outreach.
- Churches have the capacity to reach further than most other institutions.
- Churches maintain moral authority and espouse values of compassion, care and youth outreach.
- Strong church leaders can motivate responses of prevention, acceptance, and care.
- Churches possess a reservoir of volunteers, local leadership, existing groups, and youth activities to draw on for their community-based interventions.
- Churches are important partners with government.

[13] The Treatment Action Campaign (TAC) became one the most prominent civil society organisations or, social movements in this period, spearheading the fight against HIV/AIDS in South Africa. Its activism has been most visible in its challenge against the South African government's slow progression in the roll-out of ARVs and, against pharmaceutical multinational companies.

- Faith-based institutions are sustainable and ideally suited for long-term community outreach, education and, support, meaning that they can be there for the long haul. They can implement programs relatively quickly which, once established, can be integrated into the volunteer ethos of the church, even when there is not a large infusion of funding.

In Southern Africa, the Church has historically been forced to respond to a context in which poverty, family and, personal destitution and, community disintegration has always been high. Although some mainline churches have had AIDS-related initiatives and programmes for some time, there is evidence of substantial growth on all fronts (lobbying, prevention, treatment and care) within the faith-based sector, particularly since 2000, most of which remains either undocumented or, not publicly accessible.

Main-line churches like the Anglican and Catholic Church have been at the forefront of faith-based programmes and initiatives. The Catholic Church, for example, has a network of over 140 service programs for people living with HIV/AIDS in South Africa (hospitals, clinics, hospices, home-based care, prevention of mother-to-child treatment and orphan care) making it the largest service provider in the country after the government. The Catholic Church has been vocal in criticising the South African government for its slow response to the HIV/AIDS epidemic. The Southern African Catholic Bishops, comprising bishops from South Africa, Swaziland and Botswana, have appealed to the government to remove all bureaucratic obstacles to ARV access. As this review shows, the Anglican Church of Southern Africa has been increasingly involved in mobilising its structures, clergy and, laity to respond in various ways to the impact of the pandemic, as well as develop enabling guidelines and policies, especially since 2000.

Prior the availability of treatment, FBOs did enormous 'containing' work in providing an infrastructure for palliative care and providing pastoral care. All this work has been incredibly useful in bearing the load of counseling, pastoral care, death and dying and dealing with orphans and vulnerable children. It has deployed thousands of people to assist infected and affected

communities. However most of these efforts have not moved into the realm of commencing treatment programmes, nor do they address the specific issue of women and girls.[14]

The Roman Catholic Church pioneered and, has possibly the largest AIDS treatment programme in Southern Africa. This started a couple of years ago when the Catholic Church decided to include treatment in the form of HAART as part of its overarching strategy, thereby taking its HIV and AIDS contribution and, role of FBO's in HIV/AIDS work, to new levels of deeper engagement. In many countries in Southern Africa, FBOs are the only organisations that are providing HAART. In an informative and critical appraisal of this programme, Sr Alison Munro, OP, who heads the Southern African Catholic Bishop's Conference (SACBC) AIDS Programme offered the following reflection on how the Church took on this challenge against great odds:

> *The Southern African Catholic Bishops' Conference (SACBC) embarked over the past eighteen months on an antiretroviral programme in twenty two sites, in South Africa, Botswana and Swaziland, three of the most seriously AIDS affected countries in subSaharan Africa. The odds were against the Church's involvement in such a programme because of the high costs involved, the poor infrastructure, the lack of trained medical personnel, the inadequate medical expertise available within the Church, and the lack of pharmacies and laboratory services at local sites. Commitment to the value and sanctity of each human life, and to giving people hope in desperate circumstances when medical science has some partial solutions to offer, and an underlying faith commitment to the call of the gospel to continue the mission of Jesus underpin the gigantic task of attempting to bring treatment to some people.*

2.4. A Global Call to Action - Women, Children, Stigma and HIV and AIDS – The UNGASS Declaration (2006)

This review was undertaken in the shadow of a large gathering of government policy makers, decision makers and, HIV/AIDS activists who recently gathered in New York to assess global progress and challenges (UNGASS 2006). The UNGASS Declaration on HIV/AIDS released in June 2006 from the meeting highlights various commitments and pledges made by member states, especially the impact of the pandemic on women and girls and, treatment. Issues raised for special attention were:

[14] There are numerous instances of this including the ACSA Isiseko programme, the Churches Channel of Hope, the PACSA initiative, work by the CINDI initiative, including the Lutheran Church of South Africa.

- a deep concern at the overall expansion and feminisation of the pandemic, based on the reality that women now represent half of all people living with HIV and, nearly 60 percent of people living with HIV in Africa. There was a general agreement that gender inequalities and all forms of violence against women and girls increase their vulnerability to HIV/AIDS.
- grave concerns that half of all new HIV infections are among children and young people under the age of 25; that there appears to be a lack of information, skills and knowledge regarding HIV/AIDS among young people; and, that 2.3 million children are now living with HIV/AIDS, and that the lack of pediatric drugs in many countries significantly hinders efforts to protect the health of children;
- a profound concern that the pandemic affects every region and that Africa, in particular Sub-Saharan Africa, remains the worst affected region and, that urgent and exceptional action is required at all levels to curb the devastating effects of this pandemic, and recognize the renewed commitment by African governments and regional institutions to scale up their own HIV/AIDS responses;
- a reaffirmation that the full realisation of all human rights and fundamental freedoms for all is an essential element in the global response to the HIV/AIDS pandemic, including the areas of prevention, treatment, care and support, and recognized that addressing stigma and discrimination remains a critical element in combating the global HIV/AIDS pandemic;
- a reaffirmation of the belief that access to medication in the context of pandemics such as HIV/AIDS is one of the fundamental elements to progressively achieve the full realisation of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health;

UNGASS highlighted the importance of partnerships, including those with faith-based groups, as a way to address and scale up work related to HIV and AIDS noting as follows:

- Recognise that we now have the means to reverse the global pandemic and to avert millions of needless deaths, and also recognize that to be effective, we must deliver an intensified, much more urgent and comprehensive response in partnership with the United Nations system, intergovernmental organizations, people living with HIV and vulnerable groups, medical, scientific and educational institutions, non-governmental organizations, the business sector including generic and research – based pharmaceutical companies, trade unions, the media, parliamentarians, foundations, community organizations, faith-based organizations and traditional leaders;
- Recognise also that to mount a comprehensive response, we must overcome any legal, regulatory, trade and other barriers that block access to prevention, treatment, care and support; commit adequate resources; promote and protect all human rights and fundamental freedoms for all; promote gender equality and empowerment of women; promote and protect the rights of the girl child in order to reduce their vulnerability to HIV/AIDS; strengthen health systems and support health workers; support greater involvement of people living with HIV; scale up use of known effective and comprehensive prevention interventions; do everything necessary to ensure access to life-saving drugs and prevention tools; and develop just as urgently better tools – drugs, diagnostics and prevention technologies, including vaccines and microbicides – for the future;
- Convinced that without renewed political will, strong leadership and sustained commitment and concerted efforts from all stakeholders at all levels, including people living with HIV, civil society and vulnerable groups, and without increased resources, the world will not succeed in bringing about the end of the pandemic.

With respect to the specific context of women and children in relation to HIV/AIDS UNGASS delegates made the pledges and commitments as follows:

- Pledge to eliminate gender inequalities, gender-based abuse and violence, and to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and services, including, inter alia, sexual and reproductive health, and full access to comprehensive information and education, and ensure that women can exercise their right to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection, including their sexual and reproductive health, free of coercion, discrimination and violence, and take all necessary measures to create an enabling environment for the empowerment of women and to strengthen their economic independence and in this context, reiterate the importance of the role of men and boys in achieving gender equality;
- Commit to strengthening legal, policy, administrative and other measures for the promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all types of sexual exploitation of women, girls and boys, including for commercial reasons, and all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls;
- Commit to address as a priority the vulnerabilities faced by children affected by and living with HIV, to provide support and rehabilitation to these children and their families, women and the elderly, particularly in their role as caregivers, to promote child-oriented HIV/AIDS policies and programmes, and increased protection for children orphaned and affected by HIV/AIDS, to ensure access to treatment and intensify efforts to develop new treatments for children, and to build, where needed, and to support the social security systems that protect them.[15]

[15] The UNAIDS-led Global Coalition on Women and AIDS meeting at UNGASS in June 2006 issued a new Agenda for Action on Women and AIDS, urging leaders attending the 2006 High Level Meeting on AIDS to keep promises made at previous international meetings to tackle the social, cultural and economic factors that intensify the impact of AIDS on women and girls. 'Five years ago, Member States agreed that gender equality and women's empowerment are fundamental to ensuring an effective response to

In many ways, UNGASS 2006 has set the tone and broad strategic focus and agenda for locating and measuring future HIV and AIDS related work, especially with respect to strategies in sub-Saharan Africa. The message and challenges are clear: an intensified and partner-driven focus to eradicate stigma and discrimination and, address the specific ways in which the pandemic is impacting upon children, young girls and, women.

AIDS,' said Dr Peter Piot, UNAIDS Executive Director. 'Specific pledges were made to promote women's rights, protect women and girls from discrimination, and improve their access to vital services such as education and the prevention of mother-to-child transfer of HIV. Some progress has been made, but major opportunities to stem the global epidemic are being missed.' Dr Piot stressed: 'The ultimate criterion to judge all AIDS programmes is "Does this work for women and girls?"' Clearly FBOs need to address this as part of their programmes.

SECTION THREE: MAIN FINDINGS

3.1 Programme concept, design, and getting started

> *No one should care alone. No one should die alone. For we are all living with AIDS, whether infected or affected. Because AIDS is the new struggle, failing to meet the challenges posed by it means there will be no one left to worship in our churches, attend our schools or take up the challenges of the future. We must act now1*[16]

The Isiseko Programme (Isiseko) was not the first project or, programme, undertaken by the Anglican Church of Southern Africa (ACSA) in response to a growing HIV and AIDS pandemic in Southern Africa.[17] What distinguishes Isiseko from these earlier initiatives, however, is that it was the first attempt by the Anglican Church to engage in a Provincial-wide response to the pandemic through a comprehensive, centrally-managed and, coordinated programme intervention.

As a relatively ambitious initiative, Isiseko became the catalyst for pushing and taking ACSA (as a whole) into wide-ranging and, relatively un-chartered HIV and AIDS and developmental waters. It also became a catalyst to the design of two subsequent programme initiatives – the Siyafundisa "Teaching our Children" Programme and, an emerging Orphans and Vulnerable Children (OVC) Programme. Taken as a whole these three initiatives currently form the backbone of the current Anglican Provincial HIV and AIDS Office's ministry.

Tracing the contours of Isiseko's design and evolution highlights the many challenges the programme has faced in moving from concept to implementation and, as importantly, incrementally mobilising "buy-in" within the structure of the Anglican Church for its vision and strategic thrusts

[16] Quote by the Archbishop of Cape Town, the Most Reverend Njongonkulu Ndungane

[17] A number of dioceses in Cape Town, the Highveld, Johannesburg, Christ the King, and, certain parishes in Kimberly and Kuruman, for example, were already beginning to actively engage in parish and diocesan-based responses to the emerging pandemic.

3.1.1 **Genesis and Strategic Planning Process**

The roots of Isiseko go back to December 2000 when the Archbishop of Cape Town, the Most Reverend Njongonkulu Ndungane, met with international faith leaders in Washington D.C. in the aftermath of a demonstration he had led at the X111th International AIDS Conference in Durban (2000) to raise the importance of voluntary testing. At the December meeting the Archbishop requested financial support from the USA Agency for International Development (USAID) to develop the Anglican Church's overall capacity to more effectively respond to the HIV and AIDS pandemic in the Province.

A few months later (March 2001) the Archbishop of Canterbury tasked the Archbishop with the additional responsibility of developing a Communion-wide understanding of the scope of the AIDS pandemic in Africa. From 2001 onwards, the issue of HIV and AIDS was given an important status within the Anglican Church as a whole and, placed firmly onto the official agenda of the Anglican Church in Southern Africa.

An important milestone in the evolution of Isiseko was the appointment (May 2001) by the Archbishop of Cape Town of Canon Ted Karpf as the Provincial Canon Missioner for HIV and AIDS. Canon Karpf is widely recognised as the main visionary and architect of the Isiseko framework and tragedy. According to those around at the time he had been working behind the scenes since the Washington visit to develop a comprehensive response from ACSA to the HIV and AIDS pandemic and, together with Nicky Shaay and Melanie Judge (POLICY Project), was instrumental in the organisation of the All Africa (Boksburg) Conference of August 2001 which marks the public commitment of the Anglican Church as a whole to address the HIV and AIDS pandemic.[18]

In addition to developing a broad strategic vision and framework to guide the worldwide Anglican Communion's response to the HIV and AIDS pandemic, the Conference endorsed an HIV and AIDS strategy that consisted of six focal areas of concern with a focus on three main at-risk or, vulnerable groups: women, orphans and, people living with HIV/AIDS. This framework became

[18] This watershed conference was attended by representatives from 12 Anglican Provinces and more than 33 African nations, as well as a number of archbishops from Africa, donors, volunteers and staff from the CPSA and donors and observers from non-governmental organisations.

the template for a strategic planning process to be used across Africa and the world-wide Anglican Communion to guide its response to the HIV/AIDS pandemic.[19] According to a report on the planning process, within a day of the Conference, its organisers were able to present a vision and strategic framework to the international diplomatic and donor community at a meeting in Pretoria[20].

In the months following the Conference things appear to have moved fairly rapidly. By October 2001 the Provincial Standing Committee (PSC) and the Synod of Bishops in Southern Africa had considered the proposed strategic planning process and, according to the planning report, "embraced" its six focal concerns. In response to a perceived need for a dedicated institutional mechanism to drive the HIV and AIDS initiative, the PSC endorsed the formal establishment of a Provincial Office of HIV/AIDS Community Ministries and Mission (OHCMM), located within the Office of the Archbishop.[21] Within a month of its establishment the OHCMM, led by Canon Karpf, embarked on an extensive strategic planning process in which each diocese took part in workshops to examine their specific context using "an identical tool and [the] six focus areas/concerns to shape its own unique response to the challenges posed by HIV/AIDS…to ensure some consistency to the HIV and AIDS response across the CPSA".[22]

At the end of the planning process two additional focal areas (OVC and work place policy) were added by the OHCMM team "to ensure that the CPSA response reflected emerging global concerns". It is clear from the documentation of the planning process that its main architects wanted to develop a Provincial plan that could address "Provincial-wide concerns, leaving each diocese the freedom to determine what aspects of its diocesan plan [would] be implemented and what support might be expected from the Province.[23]

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[19] The six focal points identified were: prevention, pastoral care, counseling, care, death and dying and, leadership.

[20] The proceedings of the Conference turned into a "ready-to-use" planning manual entitled: *Planning Our Response to AIDS: A Step-by Step Guide to HIV/AIDS Planning for the Anglican Communion* According to its own reports, this document "appeared in print on the worldwide web only 90 days after the conference ended".

[21] The Office was funded with support grants from the Episcopal Relief and Development (ECUSA); St John's Episcopal Church –Lafayette Square in Washington D.C.; UNAIDS; the USA Agency for International Development (USAID) and Christian Aid (United Kingdom).

[22] See Church of the Province of Southern Africa Strategic Planning Process Report, 24 June 2002.

[23]. The Provincial Strategic Plan, derived from a synthesis of diocesan responses and global strategic concerns with respect to HIV and AIDS, was circulated sent to all dioceses in July 2002. The final plan focused on the following challenges:

Within a few months (April 2002) the Archbishop was in a position to report on the early results and outcomes of the strategic planning process at a meeting of the Primates of the Anglican Communion, following which he was given a renewed mandate to provide ongoing leadership to the pandemic across the World-wide Communion. The April meeting is key milestone in the evolution of the Anglican Church's response to the pandemic and, widely recognised as the first significant global response of a religious body:

> *We raise our voices to call for an end to silence about this disease – the silence of stigma, the silence of denial, the silence of fear. We confess that the Church herself has been complicit in this silence. When we have raised our voices in the past it has too often been a voice of condemnation. We now wish to make it clear that HIV/AIDS is not a punishment from God. Our Christian faith compels us to accept that all persons, including those who are living with HIV/AIDS, are made in the image of God and are children of God*[24]

The Provincial Strategic Plan, derived from a synthesis of diocesan responses and global strategic concerns with respect to HIV and AIDS, was circulated sent to all dioceses in July 2002. The final plan prioritised a number of challenges:

- HIV-specific pastoral care education for clergy and lay leadership;
- Coordination for HIV/AIDS programming and development within each diocese;
- The development of AIDS-specific leadership within each diocese and congregation;
- The expansion or development of community or parish-based responses to support and care for orphans and vulnerable children;
- The study and ongoing discussion on issues and policies or guidelines on care and support for orphaned and vulnerable children within the church;

- HIV-specific pastoral care education for clergy and lay leadership;
- Coordination for HIV/AIDS programming and development within each diocese;
- The development of AIDS-specific leadership within each diocese and congregation;
- The expansion or development of community or parish-based responses to support and care for orphans and vulnerable children;
- The study and ongoing discussion on issues and policies or guidelines on care and support for orphaned and vulnerable children within the church;
- The development of appropriate and effective workplace programmes that ensure the rights of people (clergy and laity) living with AIDS;
- The development of age-appropriate, culturally sensitive materials for sexual education in the church;
- The study and ongoing discussion of issues, policies and guidelines surrounding death and dying

[24] Statement issues by the Primates of the Anglican Communion, Canterbury, 16 April 2002

- The development of appropriate and effective workplace programmes that ensure the rights of people (clergy and laity) living with AIDS;
- The development of age-appropriate, culturally sensitive materials for sexual education in the church;
- The study and ongoing discussion of issues, policies and guidelines surrounding death and dying

In December 2002, the Archbishop formally applied to Christian Aid and DFID for resources to support a 3 year programme. A proposal, jointly crafted by Christian Aid and Canon Karpf was submitted to DFID in February 2003 which anticipated an ongoing role for Canon Karpf in the start up and implementation phase, as well as training, facilitation and, coordination support from POLICY Project.

In April 2003, Isiseko was publicly launched in Johannesburg by the Archbishop of Cape Town at a 3-day public event attended by a range of dignitaries and ACSA representatives from Southern Africa and the wider Anglican Communion. At the launch each diocese was encouraged to appoint a person to oversee HIV and AIDS activities in their diocese and, a team of people to manage and support diocesan efforts.

But, getting started took a little longer than anticipated. With hindsight there is some consensus that the process and plan was, perhaps, not as inclusive or "bottom up" as portrayed in the official documentation and, that the strategic framework and focal areas put forward for discussion, while globally relevant, were in fact pre-determined by the programme design team and, not necessarily based on specific priorities identified by each diocese. Despite this process flaw, there is broad agreement that without the passion of Canon Ted Karpf and, the kind of prophetic and leadership role played by the Archbishop of Cape Town, this important programmatic intervention into HIV and AIDS by the Anglican Church of Southern Africa would not have taken place when it did.

What this meant was that not everybody was at exactly the same level of understanding and support of the plan or, necessarily understood or, agreed with what was expected of them for the implementation of the programme. Other concerns raised were that Isiseko failed to acknowledge diocesan activities and projects already in place at the time and, as importantly, that insufficient time and thought had been given to processes needed to bring the Diocesan Administrators and the Bishops on board. As a consequence a significant part of the start up phase of Isiseko was spent on "public relations" and "diplomacy" work to create a higher level of legitimacy and support for Isiseko within the structures and hierarchy of ACSA.

3.1.2. **Getting started**

Under normal circumstances it is a challenge to turn a vision and plan into strategic and sustainable activities. Getting started means having systems, structures and, the right mix of staff in place. An additional challenge, under-estimated by the original designers of Isiseko, was how to bring each diocese and their respective Bishops on board, in the context of an Anglican Church structure in which dioceses and Bishops are autonomous and, had ongoing programmes and church commitments.

One of the first blows to the programme was the fact that, despite a transparent recruitment and selection process for the Programme Manager, the person appointed to the position declined at the last moment, resulting in a last minute appointment of Rev. Colin Jones into the position in time for the public launch. Secondly, the loss of Canon Karpf and POLICY Project at the start of the programme is viewed as having placed considerable strain on those left behind to get the programme up and running and, guide its initial implementation phase.

While the delay in getting started and implementing key aspects of the planned programme, such as the baseline survey and quantification of existing projects, cannot be fully attributed to these unanticipated turn of events, there is broad consensus from Provincial Office staff around at the time that the loss of strategic and programme management support at the beginning of such a

challenging programme weakened the ability of the Provincial HIV and AIDS Office to initially implement, manage and, monitor such a large HIV and AIDS programme.[25]

The result was that the planned start of the programme (July-August 2003) was delayed, with the small core of staff focusing their attention on logistical arrangements (April and June) such as the relocation of the office from Bishopscourt to Coach House in Kenilworth and, equipping the office with basic infrastructure. While the OHCMM prepared itself to make a once off payment (R25 000) to each diocese to kick-start the capacity building programme, many Bishops still remained divided on the value and role of a dedicated Provincial Office to support ACSA's HIV and AIDS ministry.[26]

The OHCMM staff spent a week in London at the beginning of June with programme staff from Christian Aid (CA) where they were introduced to the procedures and requirements of CA and DFID. It was at this meeting that the necessary adaptations were made to the implementation strategy in light of the departure of Canon Karpf and POLICY Project. The director of OHCMM also used the time to meet with senior CA staff and familiarise himself with the organisation's many resources and wide network of global partnerships, opening up potential new opportunities for a regular exchange of information and resources.[27]

The general period was taken up with logistical arrangements and, an intensive interrogation of demands posed by the programme for the newly appointed staff to ensure that proper management, coordination and implementation took place as per the agreed upon log-frame. Although much was achieved in 2003 there was general agreement that it was premature to talk about "measurable outputs". Year 1 was about staff getting acquainted with the programme, developing a better

[25] The withdrawal from the programme of the Revd. Ted Karpf (who had been integral to its design) and less than adequate handover to the new staff, necessitated a period of familiarization and orientation. In addition, the implementation of much of the programme was predicated upon the ongoing involvement of Policy Project, a USAID funded agency, based in Cape Town which had been contracted by the Revd. Karpf for the two-year lead-up to the creation of the CPSA strategic plan. However, Policy Project was unable to fulfill this role due to changes to their management.

[26] During May 2003 Braehead House, Kenilworth in the Diocese of Cape Town was renovated to accommodate appointed staff and infrastructure needed to support the programme. The establishment of an HIV/AIDS Provincial office for the CPSA created a distinct identity for the programme, as well as providing more adequate operational space for the staff

[27] CA staff made a number of visits to the Provincial Office one of which (September) included addressing the Synod of Bishops of the CPSA and attending its Provincial Standing Committee meeting. Christian Aid view these initial meetings as important in raising the profile of the programme within the CPSA, strengthening the relationship between CA and the CPSA at a high level and, offered CA programme staff opportunities to more fully understand the specific processes and structures of the Anglican Church.

understanding of its nature, formulating new approaches and, gaining a more genuine sense of ownership. From the beginning the Provincial Office staff realised that the programme was essentially about 'building the foundation' and, as a consequence, impact would only emerge by Year 3 and beyond.

The outcome of this initial assessment was the creation of two new positions, agreed upon by CA and DFID: a Programme Training and Development Officer (Frank Molteno); Field Worker (Louisa Sijaji, formerly Office Administrator); and, Pumeza Mhleli as replacement administrator. These additional appointments enabled the Provincial Office to provide more frequent and personal support to dioceses and task teams.[28] These additional appointments meant that by August 2003 there was a stronger team in place to move beyond "getting started" to implementation.

The team hit the ground running and between August 2003 and early 2004 every diocese, with the exception of Angola and Niassa (Mozambique), was visited by at least one member of the OHCMM team. According to one staff member who took part in these assessment visits, it was "during these visits that we became aware of the actual work already being implemented by the dioceses at various levels of competency and resources".

Other important activities at the time included developing partnerships and networking with other role players in FBOs, government, academic and non-governmental organisations to explore ways to collaborate on work in the HIV and AIDS field[29]. Consultations were held with the Deputy President Jacob Zuma to discuss the extension of membership of church representatives on the South African National AIDS Council (SANAC), the outcome of which was an increase in the number of church representative to two on a national body tasked with playing an important role in helping government to finalise and implement a national treatment plan.

[28] OHCMM also contracted the services of a media and communications specialist, the Revd. Lorraine Tulleken of the Diocese of Johannesburg, who generated internal CPSA information, to support the development of diocesan and parish communications and generate and disseminate information to external media.

[29] For example, the (South African Catholic Bishops Conference (SACBC), South African Council of Churches (SACC), Church Unity Commission), Non-Governmental Organisations (Soul City, Lifeline, Christian Aids Bureau of Southern Africa, Human Sciences Research Council

The Archbishop of Cape Town continued to play a strong leadership role as an advocate for the rights of PLWA's, nationally, continentally and, within the world wide Anglican Communion. Staff members also attended a number of conferences at which both networking and raising of the ACSA HIV and AIDS programme and profile were advanced

> *The first reporting period was taken up with ensuring that all key role-players (church leadership) in the CPSA were comfortable with and committed to a programme which equipped them to address the stated core issue of stigma in a way which guarantees the building of a solid foundation of teaching and training in the church. This was incrementally achieved through the OHCMM establishing good communication links with both diocesan facilitators and diocesan bishops, developing relationships with ecumenical partners, actively participating on government bodies – local and national, responding to requests from media to communicate on HIV related issues, and by supporting the Archbishop in his highly visible role, both nationally and internationally, as an advocate for the rights of PLHA's.*[30]

Significant inroads were made with respect to formulating ACSA policy on HIV and AIDS. For example, a meeting of the ACSA Provincial Standing Committee (PSC) in September passed a number of resolutions generated by the OHCMM. [31]

> *During the course of this influential gathering, the many references to the HIV/AIDs epidemic in Southern Africa and its impact on both church and society, showed the growing evidence of the centrality of this issue in the life of the CPSA. The PSC has given strong endorsement and encouragement to the implementation of the provincial HIV/AIDS programme through the OHCMM.*[32]

Other significant activities were: the development of a workplace policy document entitled "Pastoral Standards on HIV/AIDS";[33] the continuation of a provincial-wide training of Master Trainers in Wellness Management, an initiative started by Canon Karpf prior to Isiseko with USAID funds that involved training members of ACSA's main church women's organizations; and, an important initiative aimed at developing a stronger theological foundation for ACSA's

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[30] IBID

[31] A resolution on sex education for children and youth was passed, as well as on workplace policy (Pastoral Standards on HIV/AIDS). A resolution relating to accessing social grants was also passed to the effect that every parish should become a resource for the community on matters relating to social grants. This was a significant intervention as many adults, elderly and children, particularly in poor urban and rural communities do not have the necessary documentation to access grants such as pensions and child support. Relevant materials were collected from Government Departments as well as from NGOs such as Soul City and Black Sash. .

[32] Christian Aid Report to DFID, 2004.

[33] See Appendix Three.

HIV and AIDS ministry. This took the form of workshops comprised of recognised theologians within the broader church who began the important task of developing theological resources on HIV and AIDS, as well as identifying and collating already existing resources.[34]

But, despite these important achievements, there was a niggling concern within the OHCMM team, especially as the programme moved into its second year of implementation, that there was still not enough capacity at the Provincial Office or, at diocesan level to build the kind of foundation needed to respond to the HIV and AIDS pandemic.

> *The financial report to March 2004 indicates a significant project under-spend, in part reflecting the lack of capacity in many dioceses to optimize available funding. Inadequate knowledge and subsequent information about diocesan and parish level activity is indicative of the need to focus on building capacity amongst coordinators. …The under-spend also reflects insufficient human resource capacity within the CPSA office..*[35]

The response was a strategic programme review, held in August 2004, jointly organised by ACSA and CA, to assess "the experience and learning of the fist year and plan for the next two years and beyond". The main aim of the review was to "address bottlenecks and issues and seek solutions to address these and produce a clear, realistic sense of where the programme [was] heading over the next two years".[36]

3.1.3 **The August 2004 Programme Review.**

The August Review is a key milestone in the evolution of Isiseko resulting as it did in significant adaptations to the original programme design. This well attended meeting identified key challenges and lessons for determining a way forward:[37]

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[34] The first of these workshops took place in September and ran for five days. The workshop was facilitated by Professors John De Gruchy, former chair of Religious Studies at the University of Cape Town and Denise Ackerman, Professor of Theology and Gender Studies at the University of Stellenbosch. One of the participants was a HIV-positive priest in the CPSA. Staff members of OHCMM were also in attendance.

[35] Quoted in R Cunningham and Revd. Dr Colin Jones, 2004, Narrative Report: June 2004

[36] IBID

[37] This meeting, organised as a joint initiative of the CPSA and Christian Aid and externally facilitated by Sean Germond of Pygmalion Management Consultants, was attended by Rev Colin Jones, Frank Molteno and Marlene Whitehead (CPSA programme staff); Bishop David Beetge (CPSA on behalf of the Archbishop); Tim Marteneau (DFID); and, Rob Cunningham, Robert Hayward and Dr Rachel Bagley (Christian Aid staff).

- the reality that ACSA was a federation of autonomous dioceses with their own activities that needed to be taken on board in any programme design;
- the reality that the thinking and vision of the Archbishop was ahead of the rest of the Province and that a need existed to find ways to close the gap;
- the fact that the majority of Bishops were not on board despite the planning process and statements of intent emanating from the Anglican Communion and Synod of Bishops;
- finding ways to assist the Bishops to take-on the programme initiative by building diocesan capacity;
- developing an appropriate provincial structure with capacity to deliver anticipated outputs of the programme;
- the reality that there was still not adequate staff capacity in the OHCMM office;
- the need to learn from implications of Wellness Management Programme strategy with respect to utilisation of the Mothers Union (MU) and impact on existing home-based care initiatives across the CPSA;
- a need to re-engage the dioceses in the aims and objectives of the programme post Boksburg;
- the contextual reality of diversity across the dioceses – i.e. the fact that some dioceses already had plans but no money to implement while, in other cases, the nature of the programme grant was misinterpreted with some people thinking that the Anglican Church was "rolling in money".

Conclusions and lessons learnt in the course of the August Review basically set the agenda for the roll out of Isiseko for the next two years (2004/2006). Firstly, it was apparent to all that the "one size fits all" approach as per the original design was flawed, leaving many Diocesan Coordinators feeling that their unique and pre-existing experiences were not understood and, as a consequence, under-valued. This led to two significant shifts in the strategy: firstly, a decision to support dioceses that already had some level of internal capacity (planned or, existing) financially and technically - on application for funding assistance; and, secondly, to do away with the original conditions and make the R12 500 monthly grant available to the dioceses less conditional - to

undertake anything related to HIV/AIDS (the Diocesan Coordinator's salary, food parcels, testing kits etc), as long as the expense fell within the broad strategic or, focal areas of the programme.[38] This was a major shift in the programme's approach with numerous implications for the kind of role the OHCMM would have to play and, for the kind of internal capacity needed to implement Isiseko in Years 2 and 3.

> *This would be done by identifying and providing specific training programmes to which diocesan coordinators and and/or other HIV and AIDS workers would be invited at no cost to the dioceses…absorbed by the Isiseko Sokomoleza Programme. Funds would be made available to dioceses and other CPSA institutions in the form of "Project Grants" upon receipt of proposals focusing on the six key areas of the original programme. The Year 2 budget [was] amended to incorporate the "Project Grants" as a separate line item and the initial funds allocated to this line item for Years 2 and 3….*[39]

Another important shift arising out of the August Review was the decision to restructure the programme's governance structure. The original Advisory Board, appointed by the Archbishop to provide oversight was not deemed to be effective and, therefore, dissolved and replaced by a new Management Committee (MANCOM). This structure was chaired by Bishop David Beetge who, as the Provincial Liaison Bishop for HIV and AIDS, was appointed by the Archbishop and Synod of Bishops and tasked with providing episcopal oversight over ACSA's HIV and AIDS programmes.[40] Another important change was renaming the former OHCMM the CPSA HIV and AIDS Office.

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It is worth mentioning other priorities identified that needed to be addressed to move the process forward:

- encouraging every diocese to have a full-time, paid Diocesan HIV and AIDS Coordinator with a clear job description;

[38] In Year 1 the OHCMM made a monthly grant available to cover the start up costs for the Diocesan HIV and AIDS Coordinators and related costs. The purpose of this, limited to 30% of the budget, was to organize and coordinate activities of the Diocesan HIV and AIDS Task Teams; 30% could be used for education and communication for HIV and AIDS activities; and, 30% for HIV and AIDS activities in the dioceses. The remaining 10% could be used for what were called "unplanned expenses" and "new project work".

[39] Memorandum to Social Trends, 2006, Marlene Whitehead

[40] The initial membership of the MANCOM consisted of the ACSA Liaison Bishop for HIV and AIDS (chairperson), Provincial Treasurer, Revd Jones, Financial Manager, and, the Training and Development Facilitator

- strengthening the programme management skills of Diocesan Coordinators, especially with respect to project design and management and, resource mobilisation;
- improved communication and sharing of information and media between the OCHMM Office and the dioceses, including the setting up of a web-site;
- further training in financial management and reporting for dioceses struggling to submit reports;
- improved levels of advocacy work by the central office and across dioceses, especially regarding feeding schemes, free schooling and, access to social grants;
- improved levels of leadership at all levels through increased mobilisation on the HIV and AIDS pandemic;
- a special focus on continuing to develop and implement educational and theological material across ACSA for use by church leadership and educators, seen as critical to providing a crucial foundation for all other training such as Pastoral Care, Wellness Management and, Death and Dying.

By the time Bishop David Beetge sent a letter to all Bishops in the dioceses informing them of the changes that had been made at the OCHMM office (October 2004), including its renaming and the availability of funds for diocesan HIV-related projects, Isiseko had turned a new corner and was well on its towards systematically building and strengthening ACSA, at parish and diocesan levels, to become more effective in their response to the HIV and AIDS pandemic. The rest of this section of the report captures and reflects upon key achievements, weaknesses and, emerging lessons arsing out the next two years of implementing the Isiseko Programme.

3.2. **Implementation: 2004 to 2006** [41]

The revised log-frame (November 2003) which guided implementation and reporting on the Isiseko Programme has been used as a framework to capture and assess the main outputs and challenges of the programme in some detail. An overall assessment of trends with respect to achievements and weaknesses, as well as emerging challenges and lessons, for ACSA and other faith-based organisations, are teased out and expanded upon in the final section of the report.

3.2.1. **Strengthened Capacity of the CPSA [ACSA] to advocate for and provide an effective and expanded community-based response to HIV and AIDS in partnership with other multi-sectoral role players**

Building the capacity of ACSA - at Provincial, diocesan and parish levels - to effectively respond to the HIV and AIDS pandemic and reduce the stigma attached to the disease lies at the "heart" of Isiseko. Measuring the impact of the programme with pin-point accuracy is difficult for a number of reasons: firstly, because various levels of ACSA institutions (provincial, diocesan and parishes) were involved in different aspects of its implementation; secondly, the fact that no base-line study was undertaken at the start of the programme to determine the extent of the pre-existing ACSA HIV and AIDS ministry; and, as importantly, because measuring changes in capacity requires well targeted and consistent monitoring and follow up of these various structures and beneficiaries.

For the purposes of this review indicators or, signs of increased capacity have been discerned via interviews, reports and, observation of the programme at four levels of potential change:

- capacity built at the Provincial Office on HIV and AIDS;
- capacity built at diocesan level, especially in relation to the Diocesan Coordinators;
- linkages and strategic partnerships aimed at strengthening capacity and sharing resources across and within other institutions;
- strengthened capacity of ACSA to advocate for the reduction of stigma, discrimination, access to treatment and, increased resources for HIV and AIDS prevention and care.

[41] Outputs are derived from the CPSA HIV and AIDS Programme: Revised Log-frame (5 November 2003) which guided implementation and reporting between 2004-2006.

3.2.1.1 **Capacity built at the Provincial Office on HIV and AIDS to manage, administer and, coordinate the Isiseko programme and encourage greater involvement of people living with HIV and AIDS:**

Very few (if any) organisations in South Africa, let alone a complex structure like the Anglican Church of Southern Africa, were fully prepared at the time Isiseko began to meet the range of challenges posed by the HIV and AIDS pandemic such as: finding appropriate institutional, human and, programmatic responses to a dynamic and largely unknown disease that touched on fundamental human issues like living and dying.

For this reason, the inception, evolution and, outcomes of Isiseko need to be understood as an iterative and steep learning exercise for its planners, implementers and, managers. Determining what kind of capacity was needed for what, from whom and, from where, were ongoing questions that demanded ongoing answers from those tasked with managing and coordinating the process at the ACSA Provincial HIV and AIDS Office.

Building the skills and capacity to administer, manage and, coordinate the Isiseko Programme:

Building the appropriate social infrastructure and putting enough human resource in place to drive and coordinate a complex programme like Isiseko through the structures of the Anglican Church, as already noted, was the first hurdle the Provincial Office faced to take the process forward. The relocation of the office, firstly from Bishopscourt to Coach House and eventually into a renovated Braehead House, were indicators of assumed growth and expansion which, with hindsight, was well founded. From early 2004, as we have seen the staff team expanded to include programme staff and, over time, an impressive array of consultants and service providers to assist with various aspects of the programme.

> *When we did the review in August it was clear to all of us that we did not have the capacity we needed to meet the objectives of the DFID proposal, especially if we wanted to get the benefits of the programme down to diocesan level and not just widen the gap. We knew we had to build our capacity to deliver*[42]

[42] Interview, 2006, Frank Molteno

Between 2004 and the present, the ACSA Provincial HIV and AIDS Office team, with the support of external service providers, incrementally developed and improved the capacity of the Provincial Office to undertake a vast range of functions required by the programme: programme administration, financial reporting, programme support ; direct implementation of certain aspects of the programme; and, a grant-making role not anticipated in the 2002 proposal and plan. [43] This innovation, which aimed to and was successful at stimulating the initiation of requests for projects at diocesan and parish levels, placed enormous ongoing demands on the Office's administrative and financial reporting capacity.[44]

The development of strategic partnerships with organisations such as CABSA, who designed the Churches Channels of Hope (CCOH) mobilisation model, and Barnabas Trust in the Eastern Cape, were all part of building knowledge and the kind of programme management support needed by the dioceses to engage in and manage the programme. At the same time, partnerships with organisations like CABSA resulted in innovative new models of intervention, like the CCOH, which dioceses keen to educate and mobilise their clergy and laity could utilise for taking on new or, consolidating existing HIV and AIDS initiatives. This is discussed in more detail elsewhere in the report.

As already noted, tracking what was happening at diocesan and parish levels with respect to HIV and AIDS, through or, outside of the Isiseko Programme, was a huge challenge. Although there were clear attempts to visit the dioceses as much as possible, keeping up with what was happening with respect to actual responses was not easy. A number of attempts that were made to capture and analyse this data, through quarterly reports and an initial baseline data form, fell short of what was required to speak confidently about the scale and scope of ACSA's overall HIV and AIDS ministry. Variance in quality and depth of information supplied made it impossible to track progress or, discern key trends.

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[43] Over the next two years (2004-2006) additional staff and a number of consultants were hired to support emerging functions such as: undertaking a base-line survey of diocesan and parish projects and activities; strengthening the Provincial Office's communications capacity; develop resource materials; evaluate programme initiatives; and, improve diocesan mobilisation strategies and capacity to design and implement projects at diocesan and parish levels

[44] This role was incrementally developed between 2004 and 2006 as a result of strategic decision taken in August 2004 to make grants available to dioceses and parishes for projects, on application..

This shifted when additional capacity was brought in with the appointment of an information and communications staff person (July 2004) who spearheaded the first comprehensive attempt at a base-line study to capture the wide range of activities taking place across the dioceses. This study, undertaken between late 2004 and early 2005, gathered information from 775 parishes (out of a total of 980) across ACSA. The study provides an impressive snapshot of what was taking place at the time with respect to HIV and AIDS across the dioceses that make up ACSA[45].

With respect to narrative and financial reporting, there is general consensus that the Provincial Office has more than delivered. Christian Aid which has worked closely with the Provincial Office on reporting since 2003 has nothing but praise for the reporting capacity of the Provincial HIV and AIDS Office:

> *From our perspective the financial accounting is excellent. They appear to have a good tracking capacity and if there are no reports from Dioceses there is no money given. We have had visits to the office and dioceses…. and our assessment is that this aspect is generally good and getting better.*[46]

But, as the review shows, keeping consistent capacity at the level of senior management at the HIV and AIDS Office has been a challenge. In early 2005 the Office suffered a setback and another restructuring with the departure of Rev Colin Jones as the Programme Director. He was replaced by Canon Desmond Lambrechts as the Director of the HIV and AIDS Office, a position he has held since then. As a result of this staff change, Frank Molteno (formerly in charge of training support) was appointed as the full-time Programme Manager for Isiseko. Lundi Joko, previously with Fikelela in the Cape Town diocese, joined the team to offer training and mentoring support to weaker dioceses trying to mobilise their clergy and laity to get more actively involved in HIV and AIDS related work.[47]

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[45] The information and communications officer, for example, has played a key role in capturing and writing lengthy and informative six-monthly reports (based on quarterly reports from Diocesan Coordinators) that are submitted to Christian Aid who, in turn, submit reports to DFID.

[46] Interview, 2006, Rob Cunningham, Christian Aid.

[47] Lundi joined ACSA in 2005 from Fikilela where he worked as a youth coordinator on its Survivor Africa programme. His current job involves mentoring of dioceses and working on training programmes with Barnabas Trust. Specific attention has been given to St John's and Zululand Diocese while with others give feedback on proposals sent as well as time on assessing projects. Spent three years with Fikelela as a youth coordinator and developed the Survivor Africa programme where he assisted with project design and resource mobilisation; assisted the task teams with presentations at churches as well as with the formation of task teams. Also sit on management structures at Provincial Office and participate in strategic planning. He was already involved in CABSA work and carried on that role at the Provincial Office along with Frank, so brought existing skills into the Provincial Office

A weakness noted throughout the lifespan of the programme is the high turnover of staff at the level of senior management (programme director/manager) for the HIV and AIDS Provincial Office and, as a result, an inherent inability to provide the kind of consistent and high quality strategic management support needed to strategically direct and manoeuvre a highly complex and multi-layered HIV and AIDS programme in ACSA.

A further drain on staff's capacity to offer dedicated support to Isiseko occurred in late 2005 when most of its staff were required to split their time between the demands of Isiseko and the new Siyafundisa Programme. Although additional staff members were eventually brought in to support Siyafundisa, the new programme raised new human resource challenges for Isiseko.[48] .

Another important learning curve and demand on existing staff's capacity related to a new role the Provincial Office had taken on in 2004, by default rather than design, that of acting as a "grant-maker" to the dioceses and other institutions involved in HIV and AIDS who applied to Isiseko for funds to support "projects" submitted to and assessed by the MANCCOM.

Another important support role played by the Provincial Office is its support role to implementers of the programme at diocesan level, a role that is highly valued, especially by Diocesan Coordinators who over the past three years have relied heavily on the Cape Town office to provide a level of consistent and targeted support for procuring and coordinating a number of centrally managed interventions (Churches Channels of Hope, Capacity Building workshops and, development of resource tools, for example, t-shirts, candles and posters for World Aids Day).

[48] During 2005 ACSA entered into a partnership with Fresh Ministries, an ecumenical organization based in Jacksonville, Florida, and the Episcopal Diocese of Washington to implement an ABY (**A**bstinence, **B**e Faithful for **Y**outh) programme named *Siyafundisa*, funded by a substantial 5-year grant from the Government of the United States, channeled *via* USAID, as part of the President's Emergency Plan for AIDS Relief (PEPFAR). During the last quarter of 2005 the ACSA HIV and AIDS Office appointed a programme manager in the person of Sabelo Mashwama (September 2005), an OVC programme manager, Ms Rozette Jephta (September 2005) and, a Financial Officer, Kelvin Adams (October 2005). At the same time the *Siyafundisa* grant started contributing to the salaries of the Director/ Manager (60%), the Financial Manager (50%), the Communications and Information Officer (50%), the Office Administrator (50% – previously paid entirely by ACSA), the Receptionist (50%) and the Braehead House Cleaner-Caterer as well as contributing to payment of the office's telecommunications costs, municipal services fees and the rent.

As already noted, another area where capacity has been incrementally built is in relation to information, communications and media, a role played by Wendy Lewin in the Provincial HIV and AIDS Office and, highly valued and widely appreciated across ACSA structures. This role was not anticipated in the original plan but had already been identified as a critical omission at the time of the August Review.

> *I was initially brought in on a 6 month contract to work on two things: a) baseline study on parishes and b) to develop a website to improve communication and for sharing of information across and between ACSA and the dioceses and, c) to develop a programme management toolkit. The baseline was done between December 2004 and February 2005 and the Website launched in December 2005. The only problem is that it is only appreciated and used by 25% of parishes who have access to email. In practice more and more communications work has fallen onto my plate and with the loss of Colin in February 2005 more and more fell into my orbit….* [49]

More recently the winding down of what is termed the "first phase" of the Isiseko Programme created new and understandable levels of anxiety, shifts and changes, sparked off by the resignation of Frank Molteno at the end of February 2006. This led the Director of the HIV and AIDS Office with the unenviable task of "developing [and managing another] change management plan that involved an exit strategy and an incoming process and plan," as well as being charged with taking over all aspects of the Provincial HIV and AIDS Office programme" – Isiseko, Siyafundisa and, an emerging OVC initiative.

Another weakness noted with respect to past and current staffing programme arrangements is the lack of consistent and ongoing in-house strategic management to ensure that enough time and capacity exists to monitor, predict, plan for and, implement strategic shifts as and when needed, especially for a large and multi-layered programme like Isiseko. These kinds of skills are more readily honed by individuals who have worked in the wider development field and not always or, easily combined in clergy brought in to fulfil these or other related roles in programmes.[50] .

[49] Interview, 2006, Wendy Lewin

[50] This programme and wider ACSA challenge, of the tendency to appoint rather than recruit at the level of strategic and senior management levels within the Church, was noted by many people interviewed for the review. They point to the SACBC as a role model for best practice when it comes to straddling the dual roles and complex levels of accountability that come with doing development-related work within a FBO structure, something that is dealt with in more depth in the next section of the report.

Increased involvement of People Living with AIDS (PLWA's)

Another key objective set for the ACSA HIV and AIDS Office was to encourage the greater involvement of people living with HIV and AIDS in activities of the programme. As far as can ascertained, this area of activity tends to take place more explicitly at diocesan levels.

From the beginning of Isiseko there was an attempt to involve PLWA's in its meetings, workshops and, brainstorming sessions. The fist recorded time that this issue was more formally addressed by the Provincial Office appears to be in June 2005 when Christians living with HIV and AIDS were asked to apply to attend a two-and-a-half day retreat (12 to 14 August 2005). The invitation was disseminated via Anglican Bishops and HIV and AIDS Coordinators to their dioceses and, published on the ACSA HIV and AIDS website.

In spite of this relatively low-key advertising of the retreat, close to 250 applications were received for 54 places.[51] According to documentation sourced for the review, the event was attended by 52 Christians living with HIV and AIDS - 32 women and 20 men drawn from several different denominations, with over three-quarters Anglicans representing 18 dioceses, as well as the Anglican Students Federation.[52] The participants, only one of whom was a priest, came from four countries: Lesotho, Mozambique, South Africa and, Swaziland.

The programme for the retreat offered a combination of worship (including an opening Eucharist celebrated by Bishop David Beetge and a healing service), short meditations on the themes of 'hospitality', 'compassion', 'justice', 'reconciliation' and 'hope', opportunities for the participants to share their stories with one another, inputs on 'stigma and discrimination' and 'positive living' and, time for socialising, relaxation and, sleep.

One of the lessons from this first 'pilot' retreat for Christians living with HIV and AIDS was that it needed to be slightly longer. Because of this, a second retreat held in December 2005 ran over 3,5 days. Although illnesses and transport difficulties kept the number of participants to 32 , this time

[51] The retreat was held at a Christian retreat centre in Mpumalanga. It was led by the Revd Dr Bill Doubleday of New York and the Revd Japé Heath, African Coordinator for the African Network of Religious Leaders Living with or Personally Affected by HIV and AIDS (Anerela+). They were supported by staff of the ACSA HIV and AIDS Office.

[52] Cape Town, Christ the King, Free State, George, Grahamstown, Johannesburg, Kimberly and Kuruman, Lesotho, Matlosane, Natal, Niassa, Port Elizabeth, Pretoria, St Mark the Evangelist, Swaziland, Mthatha, Umzimvubu and Zululand)

there was a particularly rich diversity of people, geographical areas and, Christian churches represented.[53]

This second retreat, led by Professor Denise Ackermann and Lundi Joko from the Provincial HIV and AIDS Office, was designed to be more of a retreat than the first one with less input and work shopping of 'issues' and more focus on spiritual matters and quiet time for prayer and reflection.

At the diocesan level there is an impressive and growing number of activities aimed at involving and supporting PLWA's, with most dioceses having support groups. All dioceses visited as part of this review had support groups, most of whom were also involved in income generating activities.

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Building capacity within the (23) dioceses to implement the diocesan strategic plans

During the 2002 strategic planning process all dioceses were involved in developing a strategic plan on HIV and AIDS that focused on the six priority areas identified for the three-year programme and, included a short description of the physical boundaries and number of parishes in each diocese.

While it was not possible to audit diocesan activities against each diocesan strategic plan nor, for that matter, to audit each diocese in the course of doing this review, reports and interviews indicate few dioceses working exactly or, systematically according to the original plan. In practice, the implementation of the broad programme plan remains highly dependent upon having local champions in place to drive the process. In cases where diocesan buy in for the programme has developed alongside building capacity at the diocesan level (HIV and AIDS Coordinators and, over time, other structures of the Church) there are clear signs that implementation levels improved (George, Free State) as a direct result of .Isiseko support. In fact, the Free State, which now has a

[53] Churches attending included Methodist, Anglican, Assemblies of God, Roman Catholic, Presbyterian, Evangelical Christian Fellowship, Seventh Day Adventist, Congregational, Free Evangelical and African Traditional Churches. Five of the participants came from Swaziland, the remainder were mainly from the Eastern Cape, North West Province and Gauteng in South Africa. In respect of the participants' occupations, the majority of them were involved in HIV- and AIDS-related work as healthcare workers, home-based caregivers, HIV and AIDS counsellors, as well as in community development programmes, HIV and AIDS support organisations, and hospices.

dedicated HIV and AIDS Ministry (Mosamaria) provides an excellent case study of a diocese that used the programme to build its capacity to take on more and more HIV and AIDS-related work.

The establishment of a supportive infrastructure and a layer of dedicated implementers at diocesan level to champion and implement HIV and AIDS work in line with Isiseko's strategic framework

There is broad-based consensus from people interviewed that the targeted resources, interventions and, ongoing support from the Provincial Office, played a critical role in building the capacity of diocesan structures, diocesan clergy and laity and, especially that of Diocesan Coordinators, to take on various aspects and activities related to the HIV and AIDS ministry of ACSA.

> *We have contributed to building the capacity of those in the diocese keen to be part of an Anglican HIV/AIDS Ministry who are now better equipped and better informed – we have built a sound foundation. In monitoring the diocese have seen some people bloom and become more confident and we have seen the transfer of skills and knowledge – this is perhaps the biggest contribution of the programme - "building people"*[54]

There is ample evidence to support this view. Resources allocated to dioceses via the Isiseko Programme (capital and, operational) through the monthly grants played an important part and essential role in developing a level of basic infrastructure and layer of support staff (full or, part time staff) able to spend dedicated time on HIV and AIDS work at diocesan levels.

A breakdown of resource allocation for a 36 month period provided for this review shows that allowing the dioceses to use this grant as "core funding" gave them the ability to buy office and project –related equipment and furniture, food and medical supplies, initiate and support their own capacity building workshops (counselling, care, youth and sexuality, care for caregivers and church mobilisation), as well as undertake parish and project visits, thereby extending the outreach ability of the Isiseko Programme.

Although not all dioceses were able to utilise the grant and take advantage of the opportunities core money offered them to establish a solid foundation for an HIV and AIDS Ministry and, any future project-related work, the contribution of Isiseko to this cannot be overstated. Even in cases where the grant was stopped due to inadequate reporting and poor lines of accountability for use of

[54] Interview, 2006, Marlene Whitehead

the grant, the ground was laid, through Isiseko, to carry on work started using the passion and commitment of volunteer staff. While not ideal, mobilised volunteers were able to take advantage of other opportunities offered (capacity building support and networks) to keep up a level of HIV and AIDS work in their diocese. [55]

Building this layer of leadership to champion and implement various aspects of the programme – prevention, care, counselling, etc. – has been a critical part of a broader Isiseko capacity building strategy. In fact even before "encouraging" dioceses to put HIV and AIDS Coordinators and Task Teams (or, similar structures) in place, the ACSA (then OHCMM) Office via Canon Karpf had mobilised funds from USAID to train women recruited via the Mothers Union (2001 and 2002). There is some evidence to show that some women who were WMP trainees went on to take on eventual leadership and coordination duties in the HIV and AIDS Ministry.[56]

The WMP consisted of training Master Trainers, 356 of whom were trained (81% of the original target of 400) but, with the exit of POLICY Project, there was inadequate support for follow up at parish level. The WMP experience demonstrates the importance of mentoring support for new initiatives introduced into dioceses through the Provincial HIV and AIDS Office. Isiseko was unable to track the success or, impact arising out of the interventions beyond the initial phase of the WMP which ended in 2003. Information gathered during the course of the WMP review indicates that some dioceses found the model to be a useful. Others found it less so, with choices made regarding whether or, not to use the WMP or, HBC approach to HIV and AIDS care. At the time of this review some dioceses (like George) were arguing that the WMP model still offers a unique approach to care and remains highly relevant to the kind of added value faith-based organisations could offer to this aspect of response to the HIV and AIDS pandemic.

[55] In the case of Kimberley and Kuruman Diocese the monthly grant was stopped by the ACSA HIV and AIDS Office in early 2005 due to inadequate accounting for monies spent. In this case, three volunteers, all of who remain linked into the Diocesan Coordinator network and broader Isiseko related events and capacity building opportunities, continue to undertake HIV and AIDS work in the Northern and Southern parts of the diocese.

[56] The WMP was a specific intervention with respect to care designed between Rev. Ted Karpf and Rev Jean Underwood as a kick-start project even before the office was up and running and systems in place. It was designed to be implemented through existing structures of the Church – the Mothers Union and Anglican Women's Federation, as an intervention that could add additional value to the existing HBC approach, focusing on mind, body and spirit

In the evaluation of the WMP (2004), frustrations were expressed re non-payment of WMP carers versus HBC-trained ones who were well placed to access government stipends. Also, training offered via the WMP was not accredited which undermined the value of WMP as compared to other training on offer. According to the 2004 review, WMP was accepted by about 50% of the dioceses as a model of holistic care.

A major weakness noted (since corrected) was that training materials were done in English and, as a result, not always that user friendly or, accessible to those being trained. At the time of the review no proper impact study had as yet been done on the value and impact of the intervention for dioceses and parishes across ACSA.[57]

> *Ted's [Canon Karpf's] leadership and actions were in retrospect critical interventions but the problem was that the WMP, like the programme, was imposed from above and, because there was a distinction made between the HBC and WMP the HBC process in the Western Cape, for example, got sidelined and collapsed - a textbook example of how not to run a programme.*[58]

Despite the fact that the WMP achieved uneven success, it was a significant intervention that seems to have built a level of capacity within Diocesan structures (MU and AWF) still evident , talked about and, valued in various diocesan structures. In some cases the original plan that the initiative would be taken down to parish level has happened. In other cases, according to the external evaluator of the programme in 2004, the initiative "got caught up in lots of dynamics related to volunteerism, stipends, and, the entrenchment of the role of women as care givers…" She argues that even though the initiative demonstrated uneven success and was difficult to sustain or, monitor post 2004, important lessons as well as insights can be learnt from the experience [59]

[57] See, Penny Morrell, 2004, Evaluation of the Wellness Management Programme of the Church of the Province of Southern Africa

[58]. Interview, 2006, Frank Molteno

[59] The WMP was a specific intervention with respect to care designed between Rev. Ted Karpf and Rev Jean Underwood as a kick-start project even before the office was up and running and systems in place. It was designed to be implemented through existing structures of the Church – the Mothers Union and Anglican Women's Federation, as an intervention that could add additional value to the existing HBC approach, focusing on mind, body and spirit

A key mechanism for sharing knowledge about diocesan activities, building a sense of solidarity, networking, as well as building cumulative knowledge and capacity to engage with HIV and AIDs related work at diocesan and parish levels, are the annual Diocesan Coordinator's Weeks, three of which have been held and supported as part of the Isiseko Programme since 2003.

Inputs and agendas for these events have varied each year, with the one held in 2005 allowing for diocesan HIV and AIDS coordinators who attended to bring one other key representative from their diocese's HIV and AIDS programme. The workshops offer unique opportunities to exchange information and network with Diocesan Coordinators from countries beyond South Africa, including the former Portuguese colonies. They are highly valued by participants as unique opportunities for targeted skills building. By mid-2005 the Provincial Office was able to report that "significant strides had been made in building a Provincial team of diocesan role players who could continue to turn to one another for support and guidance".

One of the key needs identified at the 2005 workshop, already noted in 2004 during diocesan assessment visits, was the ongoing need to train key personnel in each diocese (paid staff and volunteers) on skills which the majority of participants identified as inadequate within their dioceses: doing needs assessments, proposal writing, project management, funds management, monitoring and evaluation, and report writing.[60] In response, the first two capacity development workshops requested by delegates who participated in the Coordinators' Week in August 2005 were held during 2005.[61].

[60] Written materials used to support the training that these workshops offered to participants, were contained in *The New Toolbox – A Handbook for Community Based Organisations* written by Camilla Symes, Training Director of The Barnabas Trust, and published in partnership with the HIV/AIDS/STI and TB Chief Directorate of the South African Department of Health with a grant from DFID.

[61] The first was held from 17 to 21 October 2005 at St Philomena's Hospitality Centre in Durban and was attended by 5 delegates from the Diocese of Natal, 6 from the Diocese of Mthatha (ex-St John's), 5 from the Diocese of Swaziland, 4 from the Diocese of Umzimvubu and 6 from the Diocese of Zululand. The second was held from 7 to 11 November 2005 at St Joseph's Retreat Centre in Port Elizabeth and was attended by 5 delegates from the Diocese of Free State, 5 from the Diocese of George, 6 from the Diocese of Grahamstown and 7 from the Diocese of Port Elizabeth. The purpose of these workshops was to train key personnel in each diocese (paid staff and volunteers) on key skills felt to be needed by the dioceses, namely needs assessments, proposal writing, project management, funds management, monitoring and evaluation, and report writing. Both training workshops were facilitated by Barnabas Trust, a faith-based organisation that provides mentoring to community-based organisations working in the field of HIV and AIDS in and around Port Elizabeth as well as elsewhere in South Africa. Assisting them and representing the Provincial ACSA HIV and AIDS Office was Lundi Joko.

Social mobilisation – educating the Church to respond to the pandemic

With hindsight one could argue that the original vision and plan assumed that a certain level of mobilisation and education on the HIV and AIDS pandemic already existed within ACSA. The reality is that while some did exist, it was uneven across dioceses, with limited interventions taking place at parish levels in most dioceses. For this reason, mobilisation of the Church should have been placed at the top of a list of strategic objectives from the beginning. Once this reality became apparent to the HIV and AIDS Office staff (early 2004), more targeted and strategic interventions were initiated and, designed, to move the Church to action.

Social mobilisation as it has taken place within the Anglican Church appears to have a number of elements: with the support of the HIV and AIDS Coordinator finding appropriate way (s) to: educate the Church about the pandemic in order to acknowledge and reduce stigma; once mobilised establish structures (HIV and AIDS Task Teams); working with existing structures at parish levels (MU and AWF) to champion the issue; and, identifying and managing the emerging parish response.

Clearly social mobilisation does not always unfold in a linear way but, elements of this kind of approach can be clearly discerned in the ways in which various Diocesan Coordinators and others involved in the HIV and AIDS Ministry – from Kuruman to Niassa - have approached this important and ongoing activity, supported by Isieko, often with impressive results.

Although difficult to quantify, the baseline survey (2005) identified 775 parishes (out of 980) with HIV and AIDS structures, of which 65% identified themselves as "HIV and AIDS friendly". The HIV and AIDS Coordinator for Fikelela (Cape Town Diocese), Rachel Mash, reported that 103:135 parishes in the Cape Town Dioceses now have HIV and AIDS Task Teams. And, by the end of 2005, the Free State diocese could report that 46% of its parishes were "HIV and AIDS friendly"[62]

[62] Indicators for being HIV and AIDS friendly include percentage of messages and support for HIV and AIDS in liturgies, prayers and sermons at parish level.

A key initiative for developing capacity at diocesan and parish level and mobilising the Church has been the training of Diocesan staff, clergy and volunteers in the Churches Channels of Hope Programme (CCOH), aimed at mobilising congregations and their leaders to respond appropriately and effectively, as Christians, to the enormous practical and spiritual challenges of the HIV and AIDS pandemic.

There is overwhelming agreement from those interviewed for the review that the CCOH initiative, a joint venture of the ACSA HIV and AIDS Office and the Christian AIDS Bureau for Southern Africa at Huguenot College (CABSA), has been one, if not the, most important contributions Isiseko has made to date to build the foundation to respond the HIV and AIDS. According to information supplied for this review, a total of seven provincially-organised CCOH workshops have been held since May 2004, with more than 140 people trained in the methodology, 71 of who have reached level 2 and 3 status[63]

The CCOH approach has three core elements:

- "de-frosting" – communicating the "heartbeat of God"; changing attitudes, providing correct factual information;
- a congregational focus – communication, building leadership, identifying target areas within ministries in the congregation, formulating action plans and, networking;
- a community focus – doing an environmental scan, external networking, doing a needs analysis and, identifying ways to activate the congregation towards action

This view is echoed by a staff member at the ACSA HIV and AIDS Office who is trained as a Master Trainer for the CCOH and, therefore, has become an invaluable resource for mentoring the implementation of the programme within ACSA. According to him, the CCOH has made a

[63] The CCOH is a CABSA initiative developed by one of their key facilitators when he was doing peer education at Old Mutual who linked up with the Christian Aid Bureau and trained the first batch of facilitators in 2002. Trainees apply and are selected via an application process. The training is not only for Anglicans, attended by others involved in mobilisation activities. Key role of the person trained is to act as a mobilising agent or animator in the Church using the methodology and tools gained through Churches Channels of Hope. There are six modules dealing with own attitudes and beliefs; basic understanding of HIV/AIDS; Christian response to HIV/AIDS; how to develop an integrated prevention strategy; development of a response or action plan at parish level, including practical project planning exercises; and, mobilisation strategies. The course runs over 6 days for master trainers – Sunday to Friday. The programme is an evaluative one in which those trained receive a written assessment and are graded in terms of Levels 1-3. Levels 2-3 are most competent whereas Level 1 is for a facilitator who can do educational sessions as part of a team. Areas assessed relate to facilitation skills, core knowledge of HIV/AIDS; ability to strategise around a Christian response and, an ability to rise above their own prejudices.

number of significant contributions: its has become a tool to formulate responses to emerging challenges within the Church; it has developed relevant materials; it has captured lessons learnt to date; and, it allows for diversity in different dioceses and a range of appropriate responses. He views the strategy as "a good adult education approach that is able to simplify difficult concepts.[64]

One of the key findings of the review is that some Diocesan Coordinators trained using the CCOH methodology (Johannesburg, Grahamstown and, Free State dioceses, for example) have already taken tools learnt through the CCOH and applied them to mobilise their own churches and, reach youth, clergy and, task teams engaged in HIV and AIDS work.

A growing number of Diocesan Coordinators, clergy and volunteers from the Anglican Church have been trained (with support from Isiseko) using the CCOH approach, some of who have actively taken and adapted the training methodology for use in their own diocese through workshops they run at parish level. Some of these have already become benchmarks against which others can measure their own mobilisation response.

> *The diocese of Johannesburg is the first diocese to have reached a 'critical mass' of people who have been trained through Churches, Channels of Hope . These people form the core of their Diocesan Implementation Team. During July and August 2005 the team visited 71 of the diocese's 75 parishes, meeting with leadership and, on some occasions, addressing the congregants. The visits triggered a high level of interest and enthusiasm, with many parishes asking for assistance in initiating their own parish projects. After an evaluation of the visits by the implementation team, a day-long meeting was held with parish HIV and AIDS coordinators and other representatives from over 30 parishes. The meeting was very successful and will be followed up by 2 to 3 training workshops for the relevant representatives…*[65]

In the Diocese of Niassa, located in Mozambiqueb with an escalating HIV and AIDS prevalence rate, staff and volunteers embarked on an extensive education, awareness, mobilisation campaign in October 2004, based on CCOH, that soon began to see "tangible" results. By 2005 the ACSA HIV and AIDS Office was able to report that 24 of the 96 new projects taking place across the Anglican Church (that could be tracked) were in the Diocese of Niassa.

[64] Interview, 2006, Lundi Joko
[65] See, 2005, Christian Aid Report to DFID

But, while some Diocesan Coordinators have implemented skills learnt, in other cases those trained still appear to lack the confidence, especially if laity, to offer training to clergy. In these cases the tendency has been to call on the Provincial Office to assist with training interventions in their Church structures.

Another important weakness noted and openly acknowledged is the fact that not enough mentoring and support was built into the design of the programme.

> *…. There is no structured mentoring and support process designed or in place to allow people to attain the next level and, not enough capacity in general to do all that needs to be done once parishes are mobilised. Others who have the concept have not as yet applied it or, or customized it for use in own churches. Level 3 is not easy because most who attend the course do not have the generic understanding or skills needed to absorb and use what is transferred and materials are not translated into vernacular languages. It requires a certain level of self-development to be a trainer or, facilitator. My sense is that CCOH has not been indigenised enough to one's own context and levels of skill…There is definitely a need for more level 3 trainers at each diocese.*[66]

The CCOH initiative remains an impressive intervention and tool for the Church to use in its ongoing mobilisation of its structures, as well as its clergy and laity.

Death and Dying

Spiritual counselling for the dying (and living) is a specific domain or, niche area for FBOs. Yet some people argue that it is an area which has not, perhaps, received enough dedicated attention over the past few years in terms of building the capacity of clergy, staff and, volunteers in ACSA to offer this kind of support as part of an HIV and AIDS ministry.

During 2004 the Provincial HIV and AIDS Office facilitated an initial exposure to a 7-day wilderness training programme on "living and dying", presented by EDUCO Africa to a limited number of dioceses (George, Namibia, Natal, the Highveld, Umzimvubu and Zululand). One of the Diocesan Coordinators who participated in the experience describes it as a profound and moving personal journey, recommending that it be made available to others within the church.[67]

[66] Interview, 2006, Lundi Joko
[67] Interview, 2006, C Drude

As a way to ensure that more people got exposed to this experience the ACSA HIV and AIDS Office began to develop its own internal capacity to run such programmes. The Provincial Office requested EDUCO Africa to offer a repeat of the 7-day programme (*The Practice of Living and Dying – A Wilderness Experience)* followed by a 5-day training course (*The Practice of Living and Dying Training Course for Facilitators – Where Hospice and Rites of Passage Meet*), as a way to begin the process of preparing local people with the capacity to facilitate similar wilderness courses run under the aegis of the Anglican Church in the future. Both courses were held at EDUCO Africa's Outdoor Learning Centre in the Groot Winterhoek Wilderness Reserve near Porterville in the Western Cape.[68]

Pastoral care

From the inception of Isiseko there has been a recognition of the importance of infusing an understanding and sensitivity to the impact on the HIV and AIDS pandemic amongst clergy who are tasked with not only passing on the core principles of the Church – compassion and care – but who are increasingly called upon to minister and bury those infected and affected by the pandemic.

Despite numerous interventions through mechanisms like the CCOH, grants made to the Theological College of Transformation in Grahamstown and, a number of clergy schools held in the lifespan of the Isiseko Programme, the overall sense gathered from people interviewed, especially at diocesan level, is that the majority of Anglican clergy, even when mobilised, do not easily translate moblisation into concrete action at either diocesan or, parish levels.

A number of reasons are put forward to explain this – fear, lack of confidence to engage with the issues and, more importantly, what is perceived by a number of people to be the poor formation of clergy within the Anglican Church at the moment which has failed to equip them to effectively and

[68] The central purpose of the wilderness programme is to help those who work as caregivers of the ill and/or dying to become re-acquainted with humanity's natural surroundings and to explore therein the four seasons of people's own process of living and dying (Summer = childhood; Autumn = adolescence; Winter = adulthood; Spring = enlightenment) through discussions, solitary time in nature and deep, meaningful storytelling. The participants, with the guidance of the facilitators, listen to one another's stories and explore the personal, evolving ethos of each individual through a process of 'mirroring'. The aim is both educational and therapeutic. This provides a platform for those who require further experience to facilitate training sessions as well as for those who simply wish to use the mirroring skills in their daily lives. By listening, people are able to do the work of self-reflection and personal healing that evokes the deeper levels of our humanity, offering the possibility of a reconciliation with self and others that is sacred, humbling and ultimately life-changing.

sensitively deal with the kinds of theological and spiritual challenges posed by the HIV and AIDS pandemic.[69]

> *The reality is that what is happening is still not good enough. It is true that our own clergy are poorly equipped and trained to take on this role. The Church is paying for the fact that so little time and resources has gone into building a strong clerical and spiritual base for the Church at a time when the Church is being called upon to fulfil this role. There is the Grahamstown College but we need to be giving the clergy ongoing training and equip them to deal with the contingencies of the day.. There is a great need when it comes to spirituality. Because these values are not internalised and preached we have clergy who get involved for the wrong reasons, who abuse funds and get greedy. It is values and attitudes that need to be addressed….*
>
> *The level of training and teaching in the Anglican Church is poor and the level of spirituality for most clergy is dubious to say the least… The kinds of roles demanded by HIV and AIDS – bereavement counselling – is beyond the capacity of most. They are not even being truthful about themselves and the virus. So few have disclosed and are living a lie and not dealing with it because they cannot face the stigma. In our context where human sexuality is not acknowledged it becomes a blockage to doing something about the pandemic. The Church is reaping the bitter harvest of centuries of preaching sexual ethics that denies that we are sexual human beings. In our CCOH workshops there are never less than 65% of clergy who admit to having more than one partner. So, even they are sexually active.* [70]

There are differences on opinion on how to strategically address this issue, with some clergy and theologians arguing that no "quick fix" solution exists. Others argues that in light of this reality one will have to rely on the laity, rather than the clergy, to provide leadership to respond to the pandemic in the Anglican Church for a long time to come. Some continue to work quietly behind the scenes to influence clergy formation where it is taking place.

At a central level at least two "clergy schools" have been directly organised by the Provincial Office since 2005, one of which took place in the Diocese of Swaziland in October 2005, attended by 36 clergy representing all 22 parishes in the diocese, including the Bishop of Swaziland who attended for the entire week. The workshop, facilitated by Creative Potential Consultancy, covered a number of areas of concern for clergy in Swaziland that included: stress, burn out and, facts

[69] This view expressed by Professor Denise Ackerman and echoed by many clergy interviewed (priests and Bishops) in the course of undertaking this review. The challenge presented to ACSA by this finding is dealt with in more detail in the final section of the report.

[70] Interview, 2006, Professor Denise Ackerman

regarding HIV and AIDS transmission and prevention; behaviour change; positive living; care and pastoral counseling; basic counseling skills; VCT; pre- and post-test counseling; grief counseling; disclosure and supporting people living with HIV; social and spiritual support; networking; and, how to integrate messages into sermons and action plans

Feedback from participants captured in the workshop report indicates that it was welcomed and seen to be a very positive experience, with priests feeling that they had been given useful coping mechanisms on how to set boundaries and assert themselves, as well as deal with personal stress more effectively. Most indicated that they gained valuable factual information, knowledge and skills with respect to HIV and AIDS. Clearly scope exists for more clergy schools in the future.[71]

The diocesan quarterly reports and end of year assessments sent to the Provincial Office in preparation for the May 2006 Diocesan Coordinators Workshop, indicate an increasing number of activities, including giving inputs at various colleges, taking place at diocesan level to influence the clergy's theological response to HIV and AIDS. The Namibian diocese, for example, is planning to hold its own clergy school in the future.

Establish effective (strategic) linkages and partnerships with other church, faith-based and community organisations, government and the private sector to strengthen capacity, advocacy and partnerships and share resources

There is broad agreement, given the multi-dimensional nature of HIV and AIDS and challenges posed, that strategic partnerships need to be forged between a range of public, private and faith-based organisations. The importance of this is echoed in the UNGASS Declaration of 2006.

During the lifespan of Isiseko an impressive number of linkages and partnerships have been brokered, at both provincial and diocesan levels. At a central level these range from POLICY Project at the planning phase of the programme to current ones like CABSA, with whom the ACSA HIV and AIDS Office has worked in partnership with regarding the CCOH and, establishment of the Christian AIDS Bureau Resource and Information Service (CARIS) at Fontainebleau Community Church in Gauteng.

[71] In addition Isiseko supported the College of Transfiguration in Grahamstown; the Theological Chair at the University of Natal; and, as already mentioned, the Churches Channels of Hope which includes aspects of pastoral care in the training..

The reality is that the review unearthed a lengthy list of ecumenical institutions and service providers which have been utilised to support various aspects of Isiseko. In most cases service providers have been used to build the in-house capacity of ACSA, at provincial and diocesan levels, to deliver identified outputs of the programme.[72]

The list of partnerships built at diocesan level is equally impressive, especially with respect to government linkages at both provincial and local government levels. Most dioceses appear to work with a number of other denominations on specific areas of HIV and AIDS work, with some, not all, increasingly developing working relationships with inter-faith groups.[73]

Advocacy

ACSA began its renewed HIV and AIDS ministry in 2000 with high profile interventions at international and national levels, especially with respect to voluntary testing for clergy and access to treatment. While the Archbishop continues to use every opportunity presented (sermons, media statements, international addresses) to make statements on the HIV and AIDS pandemic, the review found no evidence of a clearly defined advocacy strategy with respect to the media or, government with respect to HIV and AIDS during the past two years of the programme. Here one is talking about the Anglican Church, as an institution, taking on a visible role to advocate for the kinds of issues that concern those working on HIV and AIDS issues on the ground – i.e. improved access to social grants for people infected with the virus.

There is growing consensus amongst many organisations who have been working in the field of HIV and AIDS that a lot more could be and more needs to be done on the advocacy front. Most, like ACSA, have been caught up in meeting the more practical demands of the pandemic, with less time spent on responding to broader policy and advocacy issues.

[72] At Provincial Office level the list includes: Anarela, Barnabas Trust, CABSA, EDUCO Africa, Heartbeat, Lifeline, the HSRC, the National Association of Child Care Workers (NACCW), Soul City, the University of Pretoria Centre for the Study on AIDS and, numerous church-related bodies and institutions.

[73] Cape Town Diocese for example works closely with Positive Muslims, Grahamstown Diocese works with the Hindu Community on OVC Projects and, in the NIASSA Diocese Muslim children are part of their OVC pilot

3.2.2 **Increased intensity, improved quality and extended geographical coverage of parish and diocesan HIV and AIDS-related services, particularly for the poor**.

There is ample evidence to support the fact that Isiseko has contributed in many ways to an increased coverage and intensity of HIV and AIDS related service provision at diocesan and parish levels since 2003.

The post August 2004 shift in strategy marks the beginning of intensified capacity building across the dioceses. In addition to the ongoing promotion and support of a dedicated pool of Diocesan Coordinators, significant resources and inputs were made available across dioceses for their use on a range of HIV and AIDS related activities and projects, as long as they fell within the strategic focal areas and were followed by regular (quarterly) narrative and financial reports.

For stronger dioceses (Johannesburg, the Highveld, Cape Town or, Grahamstown) the post 2004 resource shift opened the way for them to consolidate and expand existing or, planned activity areas, as well as move into more innovative areas of work.[74] For other dioceses, only beginning to develop an HIV and AIDS Ministry (Free State, George, Swaziland, Namibia, Niassa, St Marks the Evangelist), Isiseko offered them a unique opportunity to develop the kind of solid foundation they needed to build their staffing, skills, infrastructure and, project support capacity within the context of a provincial-wide programme that was backed up by the resources (material and human) of the ACSA HIV and AIDS Office.

Within a remarkably short space of time, fuelled by an expanding and dynamic HIV and AIDS pandemic, an increasing number of clergy, laity and, staff of the Anglican Church of Southern Africa became more and more actively involved in responding to the challenges of the pandemic. While it is impossible to do justice to the full extent of this work, it is useful and important to highlight (in broad terms) the nature and scale of responses across the dioceses by looking at some key points of intervention.

[74] For example, the Cape Town Diocese expanded its work on youth and peer education; Grahamstown moved into an expansion of its VCT outreach through a mobile unit supported by Isiseko and, the Highveld expanded its Home-based Care outreach.

3.2.2.1 **Care and support**

Care and support for the needy and the sick is a traditional role for the Church as a structure and, especially for the women who make up the majority of its congregants. In the period under review there has been an exponential growth in care and support as a response to the impact of the HIV and AIDS pandemic – from national governments, civil society organisations and groups and, faith-based organisations. In the past few years, care for women and men living with HIV and AIDS has increasingly shifted towards care and support for children - orphans from families where one or more parents have died from AIDS or, vulnerable to becoming infected or, affected by the social and economic impact of the disease.

It is therefore not surprising to find that all dioceses involved in the Isiseko Programme have responded in small and, for some, larger ways to this important aspect of the pandemic. Not surprisingly, quite a sizeable part of the budget (diocesan grants and project grants) have been allocated towards care and support activities which cover home-based care; care for the caregivers; and, orphans and vulnerable children (OVC).

Home-based care (HBC)

Although no existing data-base appears to exist or, is readily available to capture the full extent of ACSA's work or outcomes with respect to HBC, all dioceses (from Angola to Namibia and beyond) appear to be involved in a variety of HBC activities. Some dioceses that have been active in this field for some time, like the Anglican Diocese of the Highveld, which covers the former East Rand in Gauteng and the Eastern Highveld region of Mphumalanga, used additional resources mobilised through Isiseko to "consolidate" and, expand HBC and support work already going on, as well as explore new models and networks. In Gauteng, for example, where the Department of Health began to implement a home-based care programme in 2000, the Highveld Diocese has both assisted community-based home care projects with additional project expenses and needs and, initiated two Anglican-run home-based care projects – Tshepo-Hope Care and Counselling Centre (Tsakane) amd Zakheni Home-based Care (Tembisa West).

Another important aspect of their approach is that women from the AWF trained in HBC were encouraged by the Diocese to offer assistance to existing projects in their communities rather than establish competing projects. Parishes in this diocese are then linked to various projects "to ensure a steady stream of clothes, blankets and bedding, aqueous cream, vaseline, household detergents, food, toys etc into the projects". In addition, the Diocese has developed in-house capacity to assist small projects with obtaining an NPO number so that they become self-sustaining in the short to medium term.

Although the WMP never became fully integrated into care and support at parish level in the way it was originally envisaged, resources from Isiseko were used by the Highveld in late 2004 to train people from 20 parishes by trainers from the 2003 Wellness Management Programme to provide a more holistic approach to HBC.[75] There is little doubt that within the Isiseko Programme and network, the approach taken by the Highveld to HBC provides another benchmark against which other dioceses can measure their HBC initiatives.

Care for the Caregivers

There is growing consensus across South and Southern Africa and, globally, that the number of people involved in care and support as a result of the pandemic (women and, in increasing number children in child-headed households) has grown exponentially over the past 3-6 years; that most of them are women; and, that many have been given minimal psycho-social (or, material) support and, as a result suffer high levels of stress and burn-out.

While this aspect of Isiseko is not well articulated or defined, there is growing concern for the physical, psychological and, spiritual needs of caregivers, openly articulated across reports and in dioceses and parishes visited in the course of this review. A number of Dioceses (Free State and

[75] In fact the legacy of this earlier training can be seen across other diocese – in Kimberley and Kuruman, although access to Isiseko resources have been limited, women trained as part of the WMP work as volunteers in a parish-based "centre" and, in George, more than 239 people from parishes all over the diocese have been trained by Master Trainers who went on courses offered in 2003 and 2004.

the Highveld) have taken proactive steps, offering retreats and regular workshops to caregivers linked to the Anglican HIV and AIDS Ministry.

The Highveld Diocese, like the Free State and Zululand, has also been actively involved in facilitating the training of caregivers. According to a recent report prepared by the Diocese, more than 1200 caregivers have been trained since 2003. Other dioceses, like George, Kimberley and Kuruman, are keen to move deeper into this area of work. They see a direct linkage between the kind of training offered through the WMP and the kinds of role volunteers from parishes could play to support caregivers. .

Orphans and Vulnerable Children

During the 2002 strategic planning phase for Isiseko very few dioceses prioritised the issue of OVC, leading the programme designers to add it into the programme framework as one of two "global concerns" added. One of the diocese that has been actively involved in caring for children affected or infected by the pandemic is the Cape Town Diocese. Through its Fikelela AIDS Project it has established two children's centres, as well as an outreach clinic for HIV positive children "to support them until they begin receiving anti-retroviral treatment".[76]

> *The launch of Heaven's Nest in Strandfontein (Cape Town Diocese). The second Children's Centre to be opened in the Diocese of Cape Town, Heaven's Nest has already opened its doors to 16 children orphaned or made vulnerable by HIV and AIDS. As with its sister-centre, Fikelela Children's Centre, Heaven's Nest acts as an emergency foster and medical care centre, until children are well enough to be placed with permanent foster families in the surrounding community. Aid is given to these families in registering for grants, and homes are monitored at least monthly. Heaven's Nest is run by the task team of St Francis of Assisi, Strandfontein.* [77]

During the period under review Isiseko has largely been responsive, rather than proactive, in regard to OVC, with more and more resources requested and offered through special project grants for work in this area. An analysis of the diocesan monthly grants also indicates that some dioceses have been using a percentage of their monthly grants to support OVC activities.

[76] Fikelela Children's Home in Khayelitsha and Heaven's Nest in Strandfontein.
[77] Christian Aid Report to DFID, 2004

By the time of the Diocesan Coordinator's Workshop (May 2006), all dioceses were either already involved or, planning to get involved in OVC-related work. According to the Coordinators evaluation reports at least 15 dioceses had projects related to OVC running in their diocese. Although not all are funded through Isiseko, 18 of the 24 projects established in the Niassa Diocese as an outcome of their mobilisation initiatives (funded through Isieko) in 2005 include care for children as an activity, some of which are what are called "orphan clubs" where children (vulnerable and not necessarily all orphaned) play and learn together and are given informal psycho-social support, as well as HIV and AIDS education.

The Diocese of the Highveld has a relatively large number (13) OVC projects in its diocese, most of which have organically grown out of home-based care and support. The expansion of work in this area recently led the diocese to appoint a Children's Advocate (September 2005) to manage and supervise a separate OCV Programme. Two pilot projects involving child-headed households are in the process of being established in Tokoza and Katlehong using the Isibindi model used by the National Association of Child Care Workers (NACCW).

Growth in this area is echoed in the Diocese of the Free State which has recently expanded its HIV and AIDS ministry to children:

> *Two "Journey of Life" workshops were held for a total of 97 children orphaned by HIV, ages ranging from 7 to 20 years. The purpose of these workshops was to make the children more aware of how HIV and AIDS affected them, their families and communities and how they could support each other with the challenges of life. These objectives were met by asking the children and young people to draw their life as a journey and indicate the good or bad events along the way, followed by group discussions, role play and demonstrations and feedback from all the groups around the issues which arose.*
>
> *The participants wanted to support each other in a practical way, and it was decided to visit sick friends, pray for each other and to form two support groups for children orphaned by AIDS to be based at the two parishes which participated in the workshops. The purpose of these meetings is to support and give education about child abuse, human sexuality and moral behaviour as well as to identify problems and, if necessary, refer the children and young people for help. They are also offered help in the form of school uniforms, food and social support. The diocese has established a partnership with Childline in order to provide follow-up support to the children and young people.*[78]

[78] See, 2005, Christian Aid Report to DFID

A substantial amount of Isiseko funding has been spent on an OVC Pilot initiated by the MU in the Eastern Cape, in partnership with Heartbeat and Barnabas Trust who were brought in to train and establish an infrastructure to support OVC initiatives in four dioceses in the Eastern Cape. This initiative has been recently evaluated in order to ascertain whether it is a replicable model for other ACSA dioceses.

> *The Mothers' Union OVC Pilot programme is well underway. The Diocesan OVC representatives have all been chosen, the 20 parishes for the first phase of implementation have been identified and training has begun in all four dioceses participating in the project. In the Diocese of Umzimvubu a household assessment has been done in the community, children who have been orphaned have been identified, the forum has been established and is meeting, and they have a service delivery programme prepared*[79]

At the time of the review the newly appointed OVC Programme Manager was busy pulling together the outcomes of this review, as well as her own audit of existing OVC initiatives across the dioceses in order to develop more targeted support to OVC care and support initiatives beyond and, learning from the Eastern Cape OVC Pilot.

VCT and Counselling

Activities related to VCT, as well as pre and post counselling that accompanies it, has grown alongside the availability of ARV treatment and, more and more testing sites in health facilities. VCT is widely recognised as a critical part of the battle with the pandemic for those who test positive or, negative. A review of diocesan activities and expenditure for Isiseko indicates a growing level of interest and activity in this important aspect of ACSA's response to the pandemic. Some examples are St Raphael Centre in the Diocese of Grahamstown which is a best practice example of how to respond to VCT in a holistic way. Isiseko supported a mobile unit for the Centre to enable wider rural VCT coverage across the diocese. The Diocese of Johannesburg recently prioritised VCT as a strategic focal point for its HIV and AIDS ministry, aiming to establish a VCT clinic at a local parish in partnership with an NGO (New Start):

[79] IBID

The Diocese of Johannesburg has placed the need for VCT at parish level as one of its main priorities since they believe that only once people know their HIV status, will they be able to take the necessary precautions to halt the further spread of HIV and live healthy lifestyles, whether the results are positive or negative. To this end, the diocese has entered into a formal partnership with New Start, an NGO that is able and willing to provide VCT services at church sites. In the run-up to a VCT clinic being held at a particular church, the parish will be responsible for mobilising their members to test and, to help them do so, New Start will provide the necessary materials as well as training of the volunteers who will be involved in the mobilisation process. New Start will themselves run the actual VCT clinics although a possible development of the partnership between the Diocese and New Start might include the training of church volunteers to provide the pre- and post-test counselling and assist in other ways with the running of VCT clinics at churches.

Counselling is integrated into various activity areas reported by dioceses such as: home-based care; WMP; VCT; and, OVC. Once again the Diocese of the Highveld has made major inroads, using its archdeaconry structure to train 396 HIV and AIDS counsellors since 2003, 18 of whom are clergy:

These volunteer counsellors provide much needed support to individuals, family members, parish and community projects and clinics. Monthly meetings in the Archdeaconaries follow the initial training [to] provide ongoing training and support for the counsellors. [80]

3.2. 3. **Increased knowledge, encouraging responsible behaviour and promoting positive attitudes to people and families living with and affected by HIV and AIDS**.

Increased knowledge

It is not possible to measure, in qualitative or quantitative terms, how much knowledge has increased as a result of inputs and activities supported by the Isiseko Programme. At the same time, everybody involved in HIV and AIDS-related work in ACSA has been challenged to learn about: the evolution of the disease; ways and means to respond; which organisations and support systems exist or, if not, how they can be created; what interventions work and which one's create more problems than solutions; how to deal with disclosure; how to care and support people living with HIV and AIDS with a level of compassion that fosters dignity; how to counsel the bereaved – young and old; how best to care for orphans and vulnerable children; and, how to rise above one's own prejudices and moral judgements. In other words, HIV and AIDS has forced individuals, groups and, institutions to grow and learn in ways unimagined at the start of the pandemic.

[80] Anglican Diocese of the Highveld, 2006, Report of HIV and AIDS Work in the Diocese

There is no doubt that the Anglican Church of Southern Africa, through its HIV and AIDS Ministry and, through resources made available through the Isiseko Programme, has created important opportunities for people inside and outside of Church structures to learn and grow in the context of an unfolding pandemic that has demanded responses at numerous levels. In addition to knowledge gained through exposure and engagement in a practical HIV and AIDS ministry, the programme has created a range of other more tangible interventions that build and share knowledge and experience.Examples of this are: FBO-related training via Churches Channels of Hope; EDUCO Africa Wilderness Camps; pilot interventions via Heartbeat and Barnabas Trust (OVC in the Eastern Cape); counselling for care and, care for the caregivers workshops; promoting and supporting an emerging Theology of AIDS, including the circulation of HIV and AIDS relevant liturgies, prayers and sermons; commissioning surveys, research and, evaluations on critical issues (stigma, youth and human sexuality); and, the establishment of information nodes in the form of CARIS (Christian AIDS Resource and Information Service) in partnership with CABSA and, an impressive Website launched by Isiseko at the end of 2004 [81]

[81] The Christian AIDS Resource and Information Service (CARIS) was established as a key partnership between Christian AIDS Bureau of Southern Africa (CABSA), the ACSA HIV and AIDS Office and, Fontainebleau Community Church, with direct funding from the ACSA HIV and AIDS programme with funds from the Christian Aid/DfID grant. To the two existing CARIS databases, the resource and materials database and the projects and organizations database, has been added a third one specifically for HIV- and AIDS-relevant sermons. At the end of 2005 approximately 80 sermons have been placed on the database. All three databases are accessible on the internet at www.cabsa.co.za and are functioning well. The projects and organisations database now contains approximately 300 'live' items including the majority of the Anglican Church's directly HIV- and AIDS-related projects as well as most of the Methodist Church's HIV and AIDS projects. The resource and materials database now contains approximately 2,500 items. An improvement made to the CARIS website during the current reporting period was the introduction at the foot of every article contained in all three websites, of a small feedback form inviting the user to indicate how helpful s/he found the article in question and providing space for comment. The 'physical' CARIS resource centre at Fontainebleau Community Church in Randburg is developing well and continuing to prove a valued, local asset.

Churches and other faith-based organisations are encouraged to establish HIV and AIDS resource centres to serve their local communities but as yet there has not been the capacity to be proactive in the pursuit of this objective. One small but encouraging development is that the Christian AIDS Task Force of Zimbabwe, more than one of whose staff members were trained as *Churches, Channels of Hope* facilitators in a training course run under ACSA auspices, are preparing to establish a small CARIS-linked resource centre in Bulawayo during the first half of 2006.

During the latter months of 2005 good progress was made with the preparations for an ACSA-based equivalent to the Fontainebleau resource centre to be located in Braehead House, Cape Town, planned for opening in March 2006. In the process of cataloguing the books, leaflets, videos and other materials accumulated over the past two-and-a-half years for the Braehead Resource Centre, the ACSA HIV and AIDS Office has been both adding items to the central, web-based CARIS database as well as assisting with the refinement of the categories being used by CARIS.

Encouraging "responsible" behaviour:

From the beginning of the Isiseko Programme the Anglican Church took a position that argued that everybody is affected by the HIV and AIDS pandemic. Over time this prophetic message has become more and more apparent at global, regional, national and, local community levels as more and more people have become sick, needed care and support, died or, in more recent times, been on various forms of treatment increasingly available to treat various aspects of the virus. Educating clergy, laity and, communities about how to prevent contracting the virus has been a critical part of the ACSA HIV and AIDS response to the pandemic.

An integral part of "building the foundation" has been aimed at prevention through promoting "responsible" behaviour. As a virus largely, although not entirely, transmitted through human sexuality, HIV and AIDS has challenged the Church to move out of it's comfort zone when it comes to talking about sexuality, something that has led to numerous and often controversial debates on the specific role and messages the Church can or, should be sending out in this regard.

The linkages between the issue of human sexuality in the Church and stigma are obvious and, some people would argue, a major reason why so many clergy seem unable or, unwilling, to act despite ongoing attempts at educating and mobilising them.

> *Given that HIV is transmitted largely through sexual contact, the disease introduces the realities of human sexual behaviour into the public domain. The inter-relation of HIV infection with assumptions of promiscuity and immorality poses a threat to the moral authority and respectability of churches and religious institutions and may thus be seen as provoking denunciations, rejections and dismissals of those deemed to have committed such "moral transgressions"…committing such perceived moral transgressions is seen as a failure to observe the tenets required of membership to a particular faith and expulsion is therefore considered an appropriate sanction*[82]

Prevention-related strategies promoted during the lifespan of Isiseko have largely been based on ABC (Abstain, Behave and Condoms) promoted though various workshops run at diocesan, as well as provincial level. More recently, through the Siyafundisa Programme, more attention has been given to the promotion of abstinence, something which in turn, has generated a lively and as

[82] CADRE/ACSA HIV and AIDS Office, 2005, HIV/AIDS, Stigma and FBOs: A Review, p15,

yet unresolved debate within the structures of the Anglican Church and the ACSA HIV and AIDS Office.

Despite differences in strategy and approach between the two programmes there is general consensus that youth, both young women and young men, need to be more systematically and strategically targeted. Many dioceses have begun to pay special attention to the issue of youth and sexuality in an attempt to prevent as many young people as possible from contracting the virus, from an informed position regarding the risks of having unprotected or, safer sex.

A number of important interventions and innovations have been supported over time by Isiseko to build and apply knowledge in this area, especially in relation to sex. education These include: the development of a model of intervention called "Time to Talk", currently on hold; support for a number of initiatives undertaken by Fikelela (Cape Town Dioceses) that include: the Africa Survivor Programme, a pilot "Agents of Change" peer education pilot; and, a seminal study on youth and sexuality in the Anglican Church. The latter, according to many people interviewed, seems to have come as a wake up call to many clergy and congregants keen to get more involved in youth, sexuality and prevention work.

This research study undertaken by the Fikelela AIDS Project in 2005 looked at Youth and Sexuality amongst Anglican youth between the ages of 12-19 in the Diocese of Cape Town.[83] The research was unique in that it aimed to establish whether church-going youth adhere to the principle of "no sex before marriage" or, if they succumb to "other competing voices and pressures". Other research questions were whether or, not these youth were practising risky sexual behaviour – i.e. with multiple partners, with no protection and, if levels of sexual violence was a factor? The survey was undertaken to ascertain the seriousness of challenges faced and, secondly, on the strength of results found, devise ways for the Anglican Church to become more effective in dealing with issues of young people and sexuality.[84]

[83] Rev Rachel Mash and Roselyn Kareithi, 2005, Youth and Sexuality Research, Fikelela Aids Project, Diocese of Cape Town, South Africa

[84] Field research was conducted between October 2004 and January 2005, involving a detailed questionnaire and focus group discussions

Research findings indicted that church-going young people are not excluded from general risks faced by others in society, Of the 1,306 respondents, 30.5% had had sex – 40% male and 21% female; 44% black; 26% white; and, 30% coloured – irrespective of urban or rural location . The research shows that young people are practising vaginal, oral and anal sex or, any combination of sex.

With regards to their first sexual encounter, only 35% used any form of contraception, with 90% having the first sexual encounter with school mates or friends and the first encounter taking place at their home or, partner's place. Of concern was the fact that casual sex was common, with 66% having sex with more than one sexual partner and, sexual violence reported by 6% who aid they were forced to have sex with somebody else. Of the coerced group, 12% have themselves demanded sex fro somebody else.

The research also revealed a gap between the traditional teachings of the Church of "no sex before marriage" and the realities of the way in which young people behave, leading the researchers to argue that to be effective with young people the Anglican Church needs to be prepared to act "decisively"

: *..we should no longer hide our heads in the sand and pretend that our young people are not at risk. This research has certainly identified several areas of concern…it has also revealed encouraging information, as young people are interested in influencing change for the better…*

There is an urgent need to support young people in building healthy relationships. Parental workshops are an important intervention in order to enable parents to teach their children about sexuality, using an age-appropriate approach. Peer education should be adopted: that is training key opinion leaders in each church so that they can provide effective peer pressure. In addition the church should take a stand against sexual messages seen in the media; silence implies consent. The church must clearly communicate its stand to society at large. [85]

Another initiative, designed by the ACSA HIV and AIDS staff in 2005 is *Time To Talk*, an innovative approach to peer education, involving parents at parish level. This was eventually "put on hold" due to the fact that it was deemed to be difficult to implement as originally designed and, more costly than anticipated. While both its pioneers and supporters were unhappy with this"last

[85] Youth and Sexuality, page 2

minute decision", there was broad consensus at the time of the review that the model still remains appropriate to current strategic needs and, that the considerable amount of work and resources that had gone into its design should not be lost but built upon in a new phase of Isiseko[86]

3.3.4 **Project is effectively managed with timely reporting**

When the Anglican Church of Southern Africa launched Isiseko in 2003 it took the Anglican Church into an HIV and AIDS and development field at a time when it was not that well equipped to handle. As one can see from the overview on the genesis and evolution of Isiseko, ACSA's capacity to effectively manage, coordinate and, steer this large programme was not inherent. It had to be incrementally built from within or, with the support of external service providers.

The management of Isiseko takes place at two levels – at the ACSA HIV and AIDS Office and, at diocesan level, with the latter being responsible for regular financial and narrative reports on progress and projects. As discussed earlier in the report, the capacity of the central office has been incrementally built over the past three years with respect to infrastructure, staffing and, capacity to track and report on a regular basis to its principal donor, DIFID, via Christian Aid.

There is broad consensus from CA that the level of compliance with respect to reporting and, overall accountability for funds received and disbursed is impressive and, that the capacity of the ACSA HIV and AIDS Office has grown from strength to strength since the programme was first launched in 2003. The office has a good working relationship with Christian Aid and DFID with respect to financial accounting, with regular visits from the former to oversee and attend to any bottlenecks that may arise, especially regarding poor compliance at diocesan level. Financial staff from CA have, on some occasions, accompanied Isiseko financial staff on diocesan visits to clear up emerging procedural or, accounting issues when required.

However, while work related to the overall HIV and AIDS ministry has expanded, particularly in relation to new programmes such as Siyafundisa and, an emerging OVC Programme, the ACSA HIV and AIDS Office has not expanded its administrative and financial staff, with the exception of

[86] Interviews 2006, D Ackerman, F Molteno, and P Morrell

an additional staff person dedicated to work on the financial accounting and monitoring side of Siyafundisa. This rapid programme expansion in 2005, placed alongside the loss and re-eployment of programme staff and, reality that staff who have left have not been replaced given the fact that the current phase of Isiseko is coming a close, additional work responsibilities have been taken on by a small core of staff working on both the winding up and, forward planning of the programme.

At diocesan levels, the reporting capacity of Diocesan Coordinators remains uneven but seems to have incrementally improved over the course of the progamme's lifespan, especially with inputs organised from the Provincial Office. By the end of 2005 the Provincial Office was in a position to report that "capacity development workshops, run on a diocesan cluster level (by the ACSA HIV and AIDS Office) and archdeaconry and parish levels (by the respective diocesan teams) had led to "a noticeable improvement in reporting by the parish and diocesan teams".

Regular visits by ACSA HIV and AIDS Office staff members are welcomed at diocesan level and appear to have contributed to improved accountability in project and financial management. Project Management toolkits to support the latter have been provided to parishes via Diocesan Coordinators to ensure greater capacity on a parish level. At the same time, administrative and financial capacity at diocesan level remains uneven, with Diocesan Administrators and their support staff sometimes finding it a challenge to juggle the dual demands of programme reporting and ongoing diocesan reporting and administrative demands. Despite inputs to date, the area of project management and monitoring at a broad diocesan level remains an issue for reconsideration for future programme planning.

SECTION FOUR: CONCLUSIONS AND EMERGING CHALLENGES,

The message from the Archbishop in 2000 was clear with respect to HIV and AIDS and the Church – the time had arrived for everybody to respond because everybody, inside and outside of the structures of the Church, were affected. The past three years with respect to Isiseko's programme design, implementation and, management have not been easy, especially in a context in which critical institutional and human resources shifts were needed to steer a comprehensive and multi-layered programme like Isiseko through the complexities of the Anglican Church in Southern Africa.

While the road has not been easy, it has provided those who took the journey – at the centre and on the periphery – with unique opportunities to grow and learn as they came to understand and implement such a wide-ranging HIV and AIDS programme across 23 dioceses and six countries in Southern Africa. The story of Isiseko is essentially about how the Anglican Church responded to the call to address the pandemic by building the capacity of dioceses to respond to emerging challenges.

As the review shows, the Anglican Church through its Isiseko Programme has done remarkably well. This final section of the report teases out some key achievements and identifiable weaknesses. It concludes with some strategic challenges facing the ACSA HIV and AIDS Office and wider Church as it moves forward into a new phase of programme planning.

4.1 Broad achievements

The Isiseko Programme initiative was a major strategic intervention for the Anglican Church of Southern Africa placing it, alongside the Catholic Church, as FBO pioneers with respect to HIV and AIDS related work. As importantly, through resources mobilised by Isiseko ACSA, as an institution, became an active and more visible player within a much wider HIV and AIDS response in Southern Africa that was working collectively to design and support a range of activities to reduce stigma, provide care and, mitigate against the further spread of the pandemic.

At the same time, Isiseko became an ongoing and consistent mechanism to persuade (or, exhort) ACSA as a structure to consistently address HIV/AIDS more centrally, at a critical moment in the evolution and impact of the pandemic in Southern Africa and, globally.

While its programme structure had some clear fault lines, dealt with elsewhere in the report, its framework nonetheless created specific focal points that helped guide Bishops, Diocesan Coordinators and, Diocesan HIV and AIDS Task Teams and, over time, parish-based ones, to focus on targeted activities and projects aimed at addressing and, potentially mitigating the impact of the pandemic. And, with direct support from Isiseko, an important social infrastructure (church-based structures and a layer of mobilised human resources) has been built which made it possible for the Church to incrementally build or, deepen, its HIV and AIDS response at both diocesan and, parish levels..

This catalytic role of Isiseko is unquestioned. Isiseko brought about the ACSA HIV and AIDS Office and, over time, affected changes to its structure, form and, focus as needs and strategic choices were made to implement, as well as adjust the programme. It brought shifts and changes at the diocesan level, exposing the challenges of trying to do development related work across dioceses, some of which had a vast geographical scale, often traversing more than one provincial boundary. At parish level, once mobilisation took place, Isiseko challenged clergy and laity to actively respond to the HIV and AIDS pandemic in different ways.

As part of a comprehensive response to the HIV and AIDS pandemic the programme made it clear to those who were open to hear that it was no longer “business as usual”. While not addressed in the body of the text, largely because it is a topic in its own right and beyond the scope of this review, Isiseko contributed to a number of Bishops and staff in dioceses realising that, to be effective, the structures of the Church needed to be used in different ways, especially the archdeaconry structure used increasingly by dioceses to mobilise and manage the responses. And, in some cases, Iseseko revealed that certain structures were in need of transformation for responses to be effective.

As a comprehensive and multi-layered approach, backed by flexible and understanding donors, Isiseko was able to support a range of interventions. And, when confronted with implementation challenges, as was the case in August 2004, its staff showed themselves up to making and implementing strategic decisions aimed at turn it around with a new focus and direction.

The resources it had at its disposal made it possible for the programme to be innovative in its project support and, as importantly, explore or, support new models and ways of working with a range of strategic partners and service providers, the most notable ones being partnerships with Barnabas Trust (capacity building) and CABSA (CCOH and CARIS). Its resources directly supported 87 projects with grants provided to dioceses and HIV and AIDS related projects across six countries.

While many continue to lament that the Anglican clergy are not yet fully on board when it comes the HIV and AIDS Ministry, there are definite signs of increased awareness and understanding of the pandemic amongst its clergy, some of who are beginning to get more actively involved. Significant capacity, although not as yet measurable, has been built within the wider structures of the Anglican Church – the MU and AWF – through a range of targeted interventions over the past 4 years such as : the Wellness Management Programme (WMP) and, Churches Channels of Hope.

Its biggest contributions have been firstly, to build a significant layer of leadership with incrementally developing project-related skills at various levels of the Church who, over time, could become (some already are) highly skilled in project management and monitoring at Diocesan and parish levels; secondly to develop an emerging infrastructure for an expanding HIV and AIDS ministry, a solid foundation upon which many other initiatives and programmes can be built; and, because of this, mobilising additional resources and support to people infected and affected by the HIV and AIDS pandemic in Southern Africa. Its contribution to the reduction of stigma, still said to be rife within the Anglican Church and wider community, while not measurable at the time of this review, goes without saying, linked as it is to the many activities, inputs and, projects the programme has supported to create a safe and enabling environment within the Church for those ready and willing to disclose.

4.2. **Emerging weaknesses**

There is broad agreement that the programme design could have benefited from more time spent on building on and, using existing experience and knowledge that had been built across some dioceses between the early 1990s and 2003, as well as understanding specific needs and context of such a diverse range of dioceses in Southern Africa. The original design assumed more strength than there already was and, was not based on an audit of activities and projects across the Province. As a result, the programme did not necessarily build upon what was already happening in the dioceses that were already engaged. The lack of significant involvement of Bishops in the design and inception phase impacted on its ability to "take off", compounded by the loss of the programme's main architect at the beginning of its lifespan. .

The programme was also based on an assumption that over time dioceses would be in a position to take on more and more financial, administrative and, management responsibility for the programme. While this has happened in some cases it is the exception rather than the norm, with only 4 dioceses at the end of this phase of the programme indicating an ability to support the ongoing salary and support costs needed to sustain the same level of HIV and AIDS work at diocesan level. This is clearly something that needs to be more seriously addressed in terms of structuring any new programme intervention.

Another important weakness (sometimes a strength), is the structure of the Anglican Church itself, made up as it is of autonomous diocesan structures that can be "exhorted" but not directed to comply with centrally managed initiatives emanating from a structure like the ACSA HIV and AIDS Office - irrespective of statements of intent or, policies passed at Synods or, the PSC. Finding creative and positive ways to manoeuvre programmes like Isiseko through the structure as it exists looms as a crucial challenge.

With hindsight one can discern that the growing gap between weaker and larger, urban and rural, dioceses, something which has not as yet closed due to an inability for some weaker dioceses to absorb or, utilise development resources on offer. More attention could have been given to support some of these dioceses more directly, bearing in mind the structure of the Anglican Church where negotiation and diplomacy work and, directives are not easily welcomed or, entertained.

An inability to keep a consistent programme staff team together for the full duration of this phase of Isiseko's lifespan may have undermined its implementation capacity at the level of the ACSA HIV and AIDS Office. In some cases, Diocesan Coordinators have also not remained consistent..

The appointment, as opposed to formal recruitment of key programme staff, has meant that the most competent people are not always placed in control to manage or, lead the programme. Finding people at senior level with the ability to provide broad strategic leadership, as well as Church and wider diplomacy, remains a challenge for the ACSA HIV and AIDS Office and the Anglican Church, especially as it moves deeper into HIV and AIDS and, development work.

In some cases, Diocesan Coordinators, for a range of reasons, have not been able to exercise or, apply new skills and knowledge gained in the context of a hierarchical and patriarchal Church structure. The issue of gender, at institutional and programmatic levels, presents itself as a huge challenge for ACSA to confront in the months and years ahead.

The demands of project monitoring that flow from strategic decision taken in 2004 to move into the realm of direct funding for projects via dioceses has escalated with time, with limited administrative and financial support staff to effectively deliver on this role in the medium to longer term. Effective and impressive financial management and monitoring has taken place, but the cost to existing staff has been high and cannot be sustained in the medium to longer term. This needs to be looked at in more detail in the planning days and months ahead.

The review and interviews with various role players across the dioceses indicate some lost opportunities during this first phase of the programme to link and learn from practice – especially where dioceses are pioneering new ways of working or, have developed best practice around a particular focal area or issue like social mobilisation, HBC, Care for the Caregivers or, OVC. . The new clustering of dioceses provides a good platform for more learning and mentoring tot ake place across dioceses in a future programme.

Although not entirely within our brief, there are some notable weaknesses at the level of governance and overall accountability for both the day to day and broader strategic direction of the programme. As the scope and functions of the ACSA HIV and AIDS Office have grown, governance and human resource issues have grown apace. It may be a timely to review the programme's existing governance structure and, staffing, as part of the forward planning process for a post phase 1 of Isiseko, especially with respect to strategic management and support.

4.3. Some priority challenges

A number of challenges derive from achievements and weaknesses captured above, as well as the broad findings of the review.. These are outlined in broad strokes relate as part of the conclusion to this report with the aim of identifying some critical issues for a follow up Isiseko Programme or, wider ACSA HIV and AIDS ministry, to consider.

4.3.1. Strategic focal areas

4.3.1.1 Stigma and discrimination

Eradicating the causes and consequences of stigma, especially in the Church still looms as a fundamental issue for any HIV and AIDS strategy, given the important role it plays in facilitating or, blocking the ability of people living with or, affected by the virus, to disclose and, as a result of this, change the way they live, relate to it or, make choices about how they deal with its impact on their lives. This review, together with current research being undertaken by the HSRC on stigma, hopefully provide an impetus to and, pointers, on how the Anglican Church of Southern Africa can make a more intensified and explicit effort at eradicating the causes and consequences of stigma in the Church and wider community.

4.3.2 **Prevention**

Even though sub-Saharan Africa, the main context within which ACSA exercises it broader and HIV and AIDS ministry is the epicentre of the pandemic, millions of young and older citizens, as well as children, are not yet infected by the virus. This calls for a renewed effort and intensity it programme and initiatives aimed at prevention, especially for women, youth and children.

Sexual education looms a large area of work and challenge for the Church. Any future programme initiative needs to place sexual education, especially the kinds of peer education being adopted by Fikelela or, proposed in the suspended "Time to Talk" initiative high on the list of support priorities.

Given the fact that the contextual review highlights the fact that two ACSA dioceses – Angola and St Helena – do not as yet have high prevalence rates, it may be worth firstly, investigating why this is the case and, secondly, what contextually-specific interventions may be required to ensure that the virus does not spread amongst the population of these dioceses.

4.3.3. **Gender and the Church**

Although touched upon in various ways in Isiseko reports and documents and, implicit in some of its work, the past HIV and AIDS initiatives did not explicitly tackle power relations between men and women in the ambit of its programmes. Global as well as evidence arising out of sub-Saharan Africa has begun to demonstrate the correlation between HIV and AIDS and gender, especially gender-based violence which is rife in many poor, as well as wealthier communities.
The 2006 UNGASS Declaration and statements deriving from this meeting make a clear call for those involved in HIV and AIDS to pay special attention to this issue, using opportunities emerging to ensure that it is actively addressed. Many people alluded to the rampant nature of gender discrimination in the Church, this is something that needs to be unearthed and addressed in any future HIV and AIDS programme.

4.3.4 **Orphans and vulnerable children**

It is clear from the findings of the review and current programme planning taking place at the HIV and AIDS Provincial Office, that OVC is clearly on the radar screen of ACSA, especially at diocesan and parish levels. The evaluation confirms the strategic importance of the issue, including a need for any HIV and AIDS programme to scale up support and, investigate advocacy issues at diocesan that can be addressed through strategic Church interventions.

4.3.5. **Treatment and VCT**

There is growing evidence within the current programme of increased activity with respect to VCT (including counselling) and, treatment for People Living with AIDS the Church. The review has also noted the pioneering role the Catholic Church, through the HIV and AIDS programme of the SACBC, to extend treatment to remote areas through its church structures. A number of people at diocesan level keen to move into work in this area could benefit from lessons learnt by the SACBC and, an exploration on how ACSA should strategically engage with this issue, based on lessons learnt and, the specific Anglican Church context. The 2006 UNGASS Statement and declarations are clear, with stigma, prevention, gender, orphans and vulnerable children, treatment and more sensitive care for those who act as carers for the infected and affected high on the global and world agendas. These all resonate with the kinds of priorities articulated by a range of informants during this review.

4.3.6 **Documenting and disseminating models of intervention**

The review has also highlighted a number of intervention models that have been used at provincial and diocesan levels to address very aspects of the pandemic, as well as mobilise the structures and human resources of the Church. As far as can ascertained none of these are captured or, evaluated as a package of interventions available to institutions to use in their HIV and AIDS strategy. The ACSA HIV and AIDS Provincial Office is well placed to consider documenting this and, disseminating the findings for internal, as well as external application.

4.3.7. **Learning from practice – capturing best practice from the field**

The review has picked out a number of best practice examples with respect to HBC, Care for Caregivers and, social mobilisation in the Church. There are more best practice experiences and, limited opportunities within the structure of the current programme to prioritise this as an essential and critical part of any HIV and AIDS programme, especially for an FBO that is assumed, as opposed to validated, as a strategic mechanism for HIV and AIDS interventions.

4.3.8**. Profile and position**

There is a strong sense that not enough is known about the vast amount of work that the Anglican Church has undertaken with respect to HIV and AIDS, some of which goes back to the early 1990s. Linked to this is the fact that outside of its current sphere of influence and partnerships, the Anglican Church does not have a consistent and visible profile. A lot more could be done in terms of positioning and profiling ACSA, as a major role player in the FBO and HIV and AIDS field, with a view to highlighting its role and place more generally with respect to responding to the HIV and AIDS pandemic in sub-Saharan Africa and, globally.

4.3.9. **Strategic partnerships**

The review has highlighted the range of strategic partnerships that have been forged at Provincial, diocesan and, parish levels during this phase of Isiseko. In the next phase of its involvement ACSA is challenged to widen, as well as consolidate, carefully selected partnerships that resonate with and, take forward its strategic objectives. Partnerships with national and provincial government could be strengthened..

4.3.10. **Strategic leadership**

As already noted, the current Isiseko programme has had to contend with a waxing and waning of strategic leadership since its inception. It is clear from the size and scale of the programme that the programme needs a dedicated in-house person to provide such leadership on a daily basis, especially regarding decisions that need to be made on options and choices emerging in a highly complex and demanding HIV and AIDS environment..

4.3.11 **Sustainabilty**

The issue if longer term sustainability looms as a large challenge for any future HIV and AIDS programme. It is quite clear from the fact that only four Diocesan Coordinators and their dioceses are in a position to support their ongoing HIV and AIDS work that it is going to take a much more strategic range of interventions to figure out how sustainability for the programme can be built, especially for resource-poor dioceses. While sustainability remains a critical challenge it is important to acknowledge that HIV and AIDS is a recognised as a global emergency and, until more fully eradicated, will continue to demand more resources than any institution can provide, without external support.

4.3.12. **Programme monitoring and management**.

The review highlights the need for more systematic and ongoing monitoring of ACSA's programme interventions, especially at diocesan and parish levels to ensure that existing, new and, planned initiatives, are documented and, properly supported. This is especially important for weaker dioceses in need of special attention. To ensure that changes can be measured and monitored any new programme will need to start by undertaking a comprehensive quantitative and qualitative audit and assessment of current initiatives happening at diocesan and parish levels. This should be done in collaboration with Diocesan Coordinators. .

4.3.13. **Governance**

As already mentioned, governance in relation to the ACSA HIV and AIDS Provincial Office and, along with that, lines of wider accountability have gone through various permutations over the past three years. The current transitional moment in the lifespan of Isiseko offers ACSA a unique and strategic opportunity to review its current governance arrangements to assess what would be an appropriate future governance and accountability structure for its expanding HIV and AIDS ministry..

4.4 Concluding comments

The review has tried to capture and assess the specific contribution the Anglican Church of Southern Africa has made as its unique response to the impact of HIV and AIDS on its own congregants and, the wider community within which the Church is inserted.

Through the Isiseko Programme ACSA has managed to stimulate and support a range of important activities and interventions across its diocesan network. As a consequence, it has become an important FBO role-player in the area of HIV and AIDS. Although not all lessons arising from the design and implementation of the programme have necessarily been internalised, many lessons have been learnt from engaging with the impact of the pandemic in Southern Africa.

The review has argued that the HIV and AIDS pandemic demands extra-ordinary responses from those who have listened and responded to the call to engage. While the Anglican Church of Southern Africa has actively engaged with the impact of the pandemic through Isiseko, it is challenged to reach higher and go deeper to discern the unique role it and other FBOs can play to address the spiritual and, more empowering side of the pandemic. To reach this new level of engagement, Anglican Bishops and clergy are needed to provide a combination of compassionate, spiritual and, strategic leadership. The review indicates that mobilising and empowering the clergy of the Anglican Church to offer this kind of leadership lies at the core of any future ACSA HIV and AIDS programme or, ministry..