HOME BASED DIAKONIA WITHIN THE HIV AND AIDS EPIDEMIC: TOWARDS AN ECCLESIOLOGY OF GRASSROOTS CARE AND IDENTITY AFFIRMATION

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Declaration and Dedication

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and has not previously in its entirety or in part been submitted to any institution for a degree.

Signed: _____ Date: _____

Abstract

The HIV and AIDS epidemic has affected the whole South African society, including the church. The dilemma of adequate reaction to the effects of HIV andAIDS on the pastoral responsibilities of the church is posing serious questions to the church in South Africa as it deals with the care of those affected by the epidemic. The HIV and AIDS epidemic is challenging the church to re-investigate its own traditional way of help and support and to realise that the Christian faith community needs to be part of the team-approach in the fight against HIV and AIDS.A holistic approach to healing will lead us to a new and different understanding of the *diakonia* of the church (*nuwe en anderverstaan van diakonaat*). This study will investigate how care can be administered in such a way that it becomes meaningful to both the infected, affected and those involved in administering care. It will require an ecclesiology that is informed, formulated and structured from the bottom-up rather than the traditional top-down approach. It will be what we can call a "base-community" ecclesiology.

This thesis will therefore, in the light of the challenges that the HIV and AIDSepidemic presents, put forward an ecclesiology formulated on the ground, a grassroots ecclesiology other than the official or traditional formal ecclesiology: an ecclesiology not only directed towards the members of the specific church (membership *diakonia*), but an ecclesiology focused on the broader community in which the church is located: a communal *diakonia*. This thesis argues that in light of the HIV and AIDSepidemic, this is a wake-up call for a new ecclesiology that will lead to the kind of diaconate described above. A bold new manner of ecclesiological being/structure is required: a new openness, frankness, boldness (*parrhēsia*) in dealing with HIV and AIDS. This *parrhēsia*will come from the empowered members of the church as they become the caregivers in the community. Home-based care as it is practised at present runs the risk of a one-sided approach with its main focus on the physical wellbeing of the person. An ecclesiology of grassroots care and identity-formation is needed to fill this void. The research investigates how a theology of affirmation can be integrated into the system/practice of home-based care to become a meaningful part of the help or assistance given to the individual and his/her household. Furthermore, the study explores how pastoral care and counselling to the HIV positive person and his/her household can be enriched through the application of

a paradigm of praxis to the least in society in home-based *diakonia* by applying a theology of affirmation, so as to affirm and restore dignity, give meaning to life and the process of death and ultimately provide answers to the quest for identity and affirmation through an ecclesiology of grassroots care.

This study is also a call for a paradigm shift with regard to ecclesiology and *diakonia* in the South African church that may have a profound effect on the church in South Africa. This shift must happen in three areas:

1. The church must become actively involved in home-based care as part of its ministry and calling to the world amidst the HIV and AIDSepidemic. The church can no longer be a bystander or advisor, or at best a supporter of government and civil actions. Every congregation needs to become active within the community they serve through joint/combined and innovative ways with other churches in their areas in establishing an ecclesiology of grassroots care.
2. The *diakonia* of the church must change. Every member must realise their full potential of utilising their Holy Spirit gifts and fruit in order to serve/minister in the Kingdom of God. Diakonia can no longer be the responsibility of a few ordained or commissioned for the diaconate. The whole church must become active in service to their community and those living around the church. The church needs to break the chains of membership-*diakonia* and open the arms of Christian love to everyone in need, even those who hates us.
3. Perhaps the biggest challenge is the call to change our way of being church in South Africa: our ecclesiology. We must admit that we have come to love the church more than we love God and that we forgot that God so loved the *world* not the church! This realisation will make it possible to become open to the proposal of this thesis: that we become church from the bottom up, that we start to practice a grassroots ecclesiology.

Opsomming

Die MIV en VIGS epidemie het ŉ invloed op die ganse Suid Afrikaanse samelewing, insluitend die kerk. Die dilema van voldoende reaksie op die gevolge van MIV en VIGS op die pastorale verantwoordelikheid van die kerk stel enstige vrae aan die kerk in haar versorging van diegene wat deur die epidemie geaffekteer word. Die MIV en VIGS epidemie daag die kerk uit tot ŉ herondersoek van tradisionele maniere van hulpverlening en ondersteuning asook tot ŉ gewaarwording dat die Christelike geloofsgemeenskap deel moet vorm van ŉ span verband in die stryd teen MIV en VIGS. ŉ Holistiese benadering tot genesing sal lei tot ŉ nuwe en ander verstaan van diakonaat. Hierdie studie is dus ŉ ondersoek na hoe sorg op so ŉ wyse bedien kan word dat dit betekenisvol vir beide die geinfekteerde, ge-affekteerde en diegene betrokke in die hulpverlening kan wees. So ŉ benadering vereis ŉ ekklesiologie wat belig, geformuleer en gestruktureer word vanaf grondvlak in plaas van die tradisionele bo-na-onder benadering. Ons kan so ŉ benadering ŉ basis-gemeenskap ("base-community") ekklesiologie noem.

Hierdie tesis sal dus, in die lig van die uitdagings wat die MIV en VIGS epidemie stel, ŉ ekklesiologie geformuleer op grondvlak ("a grassroots ecclesiology") anders as die amptelike of tradisioneel formele ekklesiologie aanbied: ŉ ekklesiologie wat nie slegs gerig is op lidmate van ŉ spesifieke kerk (lidmaatskap-*diakonia*) nie, maar ŉ ekklesiologie gefokus op die breë gemeenskap waarin die gemeente haarself bevind: ŉ gemeenskaps-*diakonia*. Die argument in die tesis is dat die MIV en VIGS epidemie ŉ wekroep is tot ŉ nuwe ekklesiologie wat mag lei tot die soort *diakonia* hierbo beskryf. ŉ Brawe, nuwe manier van ekklesiologie word dus vereis: ŉ nuwe openheid, waaragtigheid, moedigheid (*parrhēsia)* in die wyse waarop ons met MIV en VIGS omgaan. Hierdie *parrhēsia* sal tot stand kom deur die bemagtigde lede van die kerk soos wat hulle versorgers van die gemeenskap word. Tuisversorging soos wat dit tans bedryf word, loop die risiko van ŉ eensydige benadering wat hoofsaaklik konsentreer/fokus op die fisieke gesondheid van die persoon. Ons benodig n voetsoolvlak-ekklesiologie wat gerig is op identiteits-formering en –bevestiging om hierdie gaping te vul. Die navorsing ondersoek dus hoe ŉ teologie van bevestiging (theology of affirmation) geintegreer kan word in die sisteem of bedryf van tuisversorging om sodoende ŉ beduidende deel van die hulpverlening of bystand aan

die individu en sy/haar huishouding uit te maak. Verder ondersoek die navorsing hoe pastorale sorg en berading aan die MIV en VIGS positiewe persoon en sy/haar huishouding verryk kan word deur die toepassing van ŉ paradigma van praksis (*diakonia*) aan die minste in die samelewing deur tuisversorging en die toepassing van ŉ teologie van bevestiging, sodat menswaardigheid opnuut bevestig of/en herstel kan word; die lewe en die proses van sterwe en dood betekenisvol kan wees, en daar uiteindelik antwoorde gevind kan word in die soeke na identiteits-bevestiging deur ŉ *diakonia* vanuit n ekklesiologie op voetsoolvlak.

Die navorsing is ook ŉ oproep tot ŉ paradigma-skuif met betrekking tot ekklesiologie en diakonia in die Suid Afrikaanse kerk wat verreikende gevolge vir die kerk in Suid Afrika inhou. Hierdie skuif moet in drie areas plaasvind:

1. Die kerk moet aktief betrokke word in tuisversorging as deel van haar bediening en roeping in die wêreld temidde van die MIV en VIGS epidemie. Die kerk kan nie langer voortgaan om toeskouer of raadgewer, of ten beste ŉ ondersteuner van staats- en siviele aksies te wees nie. Elke gemeente moet aktief binne haar gemeenskap dien deur gesamentlike en innoverende aksies ten opsigte van versorging en hulpverlening met ander kerke in die selfde area/gebied sodat ŉ grondvlak ekklesiologie tot stand gebring word.
2. Die diakonia van die kerk moet verander. Elke lid moet sy/haar potensiaal besef en die gawes en vrug van die Heilige Gees aanwend in diens van die Koninkryk. *Diakonia* mag nie langer die verantwoordelikheid van ŉ paar bevestigdes of gekommandeerdes vir diakonie wees nie. Die hele kerk moet diensbaar word in die gemeenskap en diegene wat rondom die kerk bly. Die kerk moet dus die kettings van lidmaat-*diakonia* breek en hul arms van Christelike liefde oopmaak vir elke persoon in nood, selfs diegene wat ons haat.
3. Miskien is die grootste uitdaging die oproep om die wyse waarop ons kerk bedryf in Suid Afrika te verander: ons ekklesiologie. Ons sal moet erken dat ons die kerk meer lief het as vir God en dat ons vergeet het dat God die wêreld liefhet en nie net die kerk nie! Hierdie gewaarwording sal dit moontlik maak om onsself ontvanklik te kan maak vir die voorstel van die tesis: dat ons kerk word van die grond-af-op in plaas van kerk van-bo-af—dat ons begin om ŉ voetsoolvlak ekklesiologie in werking te stel.

Contents

1. Chapter One

INTRODUCTION AND MOTIVATION

Part One: The Research Problem

1.1 Introduction

The scale and magnitude of the HIV and AIDS epidemic has affected the entire South-African society. This has implications for every sphere of society: from government to civil society and every community. There can be no doubt that the Church in South Africa, as the community of believers, is affected. The HIV and AIDS crisis has inevitably meant that the family, the church, and the community must become involved in most care programmes (Van Dyk 2008: 332). HIV and AIDS posed new and unbearable challenges on the healthcare systems of African countries. Hospitals and clinics were flooded with very sick and dying patients and were unable to cope with the demands of the epidemic (Van Dyk 2008: 332). HIV and AIDS also posed new challenges the church in South Africa on several levels particularly to its ecclesiology, diaconate and *koinonia* with regard to care and counselling those living with the illness.

The estimated number of infected people, according to the United Nations UNAIDS 2007 report (www.unaids.org.) has risen to 34 million. Coupled with the sometimes-prolonged time the infection took to run its course and the many opportunistic infections that mark the different stages of HIV infection, the problem is intensified. This places such a heavy burden on already meagre resources that it becomes clear that alternative ways of looking after and caring for persons living with HIV and AIDS is paramount (Centre for Health Policy, Department of Community Health, University of the Witwatersrand, *Home-Based Care for people with HIV and AIDS in South Africa* 2001: 6). The state of the economy and the high cost of hospitalization have compelled governments to look at traditional ways of caring in communities to assist and alleviate this burden as an alternative to long-term hospitalization (Ferreira and Groenewald 2010: 175).

The researcher is in agreement that in the absence of a fully equipped healthcare

infrastructure, home based care plays a vital and critical role in enabling the community to deal with the overload on resources as the HIV epidemic moves into the AIDS peak (AIDS GUIDE 2004/5: 130). It is here that the dilemma of adequate reaction to the effects of HIV and AIDS on the pastoral responsibilities of the church is posing serious questions to the church in South Africa as it deals with the care of those affected by the epidemic.

At the point of writing this thesis, there is still no cure for HIV and AIDS (UNAIDS report 2008, reflecting the situation in 2007). As a way to curb the spread of the virus and ensure HIV management, wellness and positive living to those already infected,is promoted. Prevention and faithful living with one partner is presented as a way of not becoming infected or containing the spread of the virus (Cilliers, Griffith, Chemorion&Katani in *Our Church has AIDS,* 2009: 17). Governments and the media also promote condoms and safer sex practices/methods in an effort to help combat the spread of HIV and AIDS. Several models for combatting the epidemic have been developed by different agencies involved in this field (for example the ABC—Abstain, Be faithful, and/or Condom use—strategy; the SAVE Prevention Methodology—Safer practices, Access to treatment, Voluntary counselling and Testing, and Empowerment). However, the so-called ABC strategy has presented other challenges to the combating of HIV and AIDS by the church, according to the German organisation *Brotfür die Welt* who prefer the SAVE strategy (*HIV and AIDS in Africa*, 2006: 30). The scope of this thesis does, however not allow detail discussion of these issues linked to the ABC or the alternative SAVE strategies.

One other challenge to be faced by the South African Government in combating HIV and AIDS was the establishment of voluntary counselling and testing (VCT) programmes (AIDS Guide 2004/5: 40). The purpose of VCT is firstly so that people can know their status and with this knowledge act responsibly. Secondly, so that this procedure can become the entry point, for those who tests positive, into a model of home based care. Those who test positive for HIV-infection and do not yet require constant care; whose immune system is still strong, are encouraged to join support groups. Here positive living and wellness are promoted, stigma addressed, questions answered and information given on various subjects ranging from the necessity of regular check-ups, nutrition, legal issues, anti-retro viral medicines, and many other

relevant issues.

These support groups in the community usually forms part of non-governmental organizations (NGOs). Support groups are grassroots organizations that are able to relate to the needs of the community and have in-depth understanding of the social, cultural and spiritual needs of the communities they serve (AIDS Guide 2004/5: 104). Support groups, according to the article quoted above is the "mother" of home-based care programmes. They were the front-runners of the more formally structured home-based care programme later developed by the South African Department of Health. Laura Diane Smyth, in her Master's thesis entitled "*A Phenomenological Inquiry into the lived experience of social support for black SA women living with HIV* (2004: 110), explains that these support-groups enabled the women who participated with a sense of belonging, support and acceptance.

D. J. Louw (2008: 453) describes home-based care as the care and support provided to a person while he/she is in the home with his/her family, friends and community i.e. family caring system. In this family caring system, Louw (2008: 453) points out, that the family is the primary caregivers assisted by friends or the church. Collins (1988: 50) when he pointed out that the benefits of counselling can be greater when the counselee is part of one or more supportive caring groups, of which the family is one, earlier identified the need for such care and support.

Home-based care has as its essential activity the full time or part time care of an individual suffering from or members of a household affected by HIV and AIDS (Van Dyk, 2008: 332). Different definitions and views on home-based care exist in the literature used in this study.

Common among these definitions are the following:

- It is care to an individual
- Care is provided by a medical/paramedical team
- It is care provided by groups from the medical as well as social sciences
- Counselling forms an integral part of home-based care and is done by trained as well as lay people.
- Whilst medical care is directed towards the sick individual, counselling may

include the affected household as well.

Smart (2004 cited in Louw 2008: 453) sees home-based care as the provision of comprehensive services (including medical/health and social sciences) by formal and informal caregivers such as non-governmental organisations (NGOs), community-based organisations (CBOs) or faith-based organisations (FBOs) in the home, in order to promote, restore and maintain a person's maximum level of comfort, function and health.

This research will investigate how the church in South Africa can play a meaningful role in home-based care through its *diakonia*. It is clear that pastoral care (or pastoral care and counselling) must form part of this strategy, as most of the people infected or affected are members of the faith-community of South African society. The care of people living with HIV and AIDS must be a collective effort by both church and state. As the struggle against the epidemic forces the state to reconsider its attitude and strategies, the clear need for a combined holistic approach to HIV and AIDS become more pressing. Similarly, HIV and AIDS is challenging the church to re-investigate its own traditional way of help and support and to realise that the Christian faith community needs to be part of the team-approach in the fight against HIV and AIDS.

However, in becoming involved in home-based *diakonia*, the church faces many challenges. One of these challenges is our traditional top-down ecclesiology that makes an adequate response to HIV and AIDS on grassroots level very difficult. Louw (2008: 452) describes this as the "intriguing ecclesiological question" that confronts the church with regard to the response of the church to the epidemic. More so, HIV and AIDS is deconstructing existing ecclesiology based on institution, clerical paradigms and hierarchical structures as well as the historical understanding of what it means to be church. This thesis will investigate these challenges and seek to provide guidelines to this effect to the South African situation and context with regard to home-based care and the *diakonia*of the church.

Home-based *diakonia* through pastoral care of the individual must be practised with the knowledge that the caregiver forms part of a collective team. Secondly, that the person living with HIV and AIDS is—because of our African context—connected

with a household, which is in turn connected to a community that forms part of the South-African society as a whole. Venter (1975:3) alluded to this when he argued that: "The terminally ill patient can not and may not be seen and cared for as a separate entity, apart from the family." Louw (2008:170) takes this idea further when he argues that illness and health have a communal dimension. This communal dimension presents the challenge to the church of how to deal meaningfully and comprehensively with HIV and AIDS and home-based care.

This thesis will argue that from an African—and more precisely a South African—perspective there must be a holistic approach to healing "hence the important role of community and basic communal institutions, for example, the extended family and the dynamics of the social groups, in the healing of life." (Louw, 2008:171). However, this confronts not just the basic communal institutions in society, but the church too. The traditional African concept of "*Ubuntu*": a person is a person because of other people/persons" comes into play here. Louw (2008:452) sees the church as strategically located and recognised by the community so as to use its networks, mobilise resources and at the same time stay close to the community as it takes up the challenge of caring for people living with HIV and AIDS through home-based care.

A holistic approach to healing will lead us to a new and different understanding of the *diakonia* of the church (*nuwe en anderverstaan van diakonaat*). Geyser (2003: 93) states that the accent that now falls on relationship demands a reinterpretation of hierarchical congregational management as this will underpin the importance of *koinonial* life of the congregation and the participation of members within the congregation. It will require an ecclesiology that is informed, formulated and structured from the bottom-up rather than the traditional top-down approach. It will be what we can call a "base-community" ecclesiology (Moltmann, 1978: 113-128).

Louw (2008: 452) agrees that the design of such a congregational home-based care ministry will enable the congregation to reach out to the community and may be an invaluable building block to successful and effective koinonia. This implies, according to Geyser (2003: 94), that no one congregation or church has the right to talk exclusively about God on behalf of the unbeliever, but that the unbeliever is included in a "safe" environment where God is discussed. Viewed through the lens of

our research problem, this implies that the church in South Africa through its *diakonia* needs to act collectively and inclusive, on the ground, as part of a team of helpers within the local community it serves.

This thesis will further argue that all suffering brings with it a quest for meaning and dignity. Isolation, rejection, stigmatization, discrimination, lack of support, frustration, guilt and guilt feelings, anger, depression are some of the problematic stumbling blocks faced on the road to meaningful life (and death) of those living with the HI virus. This quest is accentuated in the HIV and AIDS epidemic as the individual, as part of the larger society, confronts existential issues. As noted before, insight and meaning in home-based care is brought about by the pastoral counsellor "being there" and "being with" the HIV positive person, his/her household and the community (Heitink, 1997). This study will therefore investigate how *diakonia* can be administered in such a way that it becomes meaningful to both the infected, affected and those involved in administering care or, how "being there" and "being with" can be established through our *diakonia*. We must keep in mind that home-based care is done by ordinary (in most cases semi-schooled) members of the church community. Members who will practice *diakonia* on behalf of the church are not trained in theology, do not distinguish between ecclesiological structures or doctrine of different churches, and are not concerned about the church-background or even the religion of the sick community member they are treating.

This thesis will therefore, in the light of the challenges that the HIV epidemic presents to home-based *diakonia*, put forward an ecclesiology formulated on the ground, a grassroots ecclesiology other than the official or traditional formal ecclesiology. It is an ecclesiology not only directed towards the members of the specific congregation (membership *diakonia*), but an ecclesiology focused on the broader community in which the church is located: a communal *diakonia*. The argument will be that it is precisely there in the streets and homes of the community and not so much in the wards of the specific congregation, the private office of the minister or through the hierarchical structures of the church that the church will be able to reach its goal of reaffirming people's identity and personhood. In doing so, the church will be relevant and effective as the Apostle Paul beseech the congregation of Rome in Romans 12: 1-2. Ignatius Swart (2010: 289-301) in *Religion and Social Development in Post-*

Apartheid South Africa, speaks out against precisely this traditional exclusiveness of the church's charity services and calls for the need for an innovative praxis and theology as condition for an effective socio-economic engagement. This study will propose such a possible praxis and theology by arguing for a paradigm shift with regard to our practise of *diakonia* and our ecclesiology.

The argument in this thesis is that through the church's engagement with those involved in voluntary home-based care and through its involvement in its programmes, the call for such a paradigm shift may be answered. Collins (1988: 50) points out that despite the talk about cooperation and mutual support, the Western world still tend to value independence and rugged individualism. This is communicated in words like "we admire the 'self-made' man or woman and often assume that personal problems are best handled alone." Collins (1988: 50) too asserts that "counselling was usually a one-to-one relationship: one counsellor, one counselee, one hour in duration, one session per week." Geyser (2003: 109) refers to Klaas who, in *Search of the Unchurched* (1996: 6, 17), points to a transition in local churches away from doctrine to a philosophy of *diakonia*: "People join congregations, not denominations." Therefore this study argues that Spirit-filled Christians needs a church that will enable them to produce and practice a Spirit-filled life (the fruit of the Spirit) both inside the space of the congregation and outside in the space of the community in their daily lives. This need can be fulfilled through the restructuring of our ecclesiology.

Klaas (1996: 2-12) points out seven changes taking place in the church that is forcing the church to restructure:

- The movement away from a church-community to a non-church (seeker) community.
- The needs of people now make them form part of the congregation as these needs are addressed by the congregation in unique and creative ways.
- Denominational loyalty is diminishing.
- The reason for the existence of the congregation has shifted. Previously a congregation existed to make believers better believers, now it is to become intensely involved in the suffering and needs of the community.

- The mission-field changed: from being far away in distant countries to seeing themselves as outposts in a mission-field.
- The missionary has changed: every member is seen as a missionary.
- Denominational communication-systems changed: from communications through the organised channels of one church-structure to another, to easy access through technology and the internet.

It is within this need to restructure the church thus that the need for meaningful home-based *diakonia* and effective ecclesiology practised on grassroots level arises.

Meaningful home based *diakonia* is provided when, together with adequate medical and or palliative care in the case of the terminally ill, the individual is assisted together with his/her household to grapple with and/or come to terms with the illness and, many times in the case of families, the death of those with full-blown AIDS. The person who is diagnosed with HIV and AIDS is challenged with his/her own mortality ("*sterflikheid/verganklikheid*"). On a personal note Venter (1975:195) in his Doctoral dissertation titled "*Pastoral Care of the Terminally ill Patient and the Family*" writes: "It has been my experience that the majority of terminally ill patients, still mentally alert, ask questions about the meaning of life and the meaning of death." As mentioned before, this struggle to make sense of suffering gives rise to existential threats that challenges the healing process. These threats will have to be addressed through home-based *diakonia* in the pastoral process of care and counselling that seeks to affirm identity and restore dignity whilst caring for the patient.

Louw (2008:62-63) lists the following five existential threats that confronts a person in crisis: The existential threat of anxiety, i.e. the fear of being rejected and isolated within the dynamics of human relationships; the existential threat of guilt; the existential threat of despair; the existential threat of helplessness and vulnerability, and the existential threat of disillusionment, frustration, anger and unfulfilled needs. Louw further argues that spiritual healing with its dimensions of peace (*shalom*), healing (*habitus*) and wholeness (*telos*, meaning) will take place as the existential need for intimacy, freedom and hopeful anticipation is met within a functional, available and viable support system based on *koinonia*or fellowship which will in turn provide adequate resources in the need for life fulfilment. The home is the place that

provides the intimate space for effective *diakonia* by the church.

This need for a functional, available and viable support system (Louw 2008: 63) where care and identity affirmation can take place must be fulfilled within the community of the person living with HIV and AIDS. It is precisely here that the church must be relevant and practical in its practice of peace, healing and wholeness. Historically and traditionally, people would go to an office somewhere at a Centrum in the city to be interviewed, analysed or assessed and treated by trained professionals. Home-based care has turned this way of dealing with people around and now reaches out to people where they are, thus addressing the needs of the community in the homes and streets where those with the need lives. HIV and AIDS forces the same challenge on the church in South Africa to reach the lives of people where they are: on the streets of the community and in their homes.

The public role of churches in South Africa, according to Etienne de Villiers (2010:197), has changed "as a result of the political transition and the constitutional and political measures that were introduced to rectify the discriminatory and autocratic features of the apartheid dispensation." HIV and AIDS accentuate this challenge to the church to change its traditional exclusivist way of caring only for their own members or to exist only to reinforce existing traditional church-hierarchy and denominationalism, and from being inward centred to becoming outward focusing by supplying in the needs and addressing the fears of the community they serve.

On discussing the challenges regarding the public role of churches, de Villiers (2010:211) argues that "an adequate public theology needs to be developed that would give direction to South African churches regarding the constructive public role they ought to play in present democratic South Africa." It is a call to a spirituality that is transformational and empowering, creating empathy for the poor and the marginalized and a strong sense of responsibility to contribute constructively to the alleviation of the problems of society (De Villiers 2010: 211-212). The South African Christian Leadership Assembly (SACLA) that came together 7-11 July 2003 in Pretoria named HIV and AIDS as one of the "seven giants" facing the church and the South African community at present and to which the church must respond to in unity.

This thesis would argue that in light of the HIV epidemic, this is a wake-up call for a new ecclesiology that will lead to the kind of diaconate described above. A bold new manner of ecclesiological being/structure is therefore required of the church and its members as its "living bricks": a new openness, frankness, boldness (*parrhēsia*) by the church in South Africa in dealing with HIV and AIDS. This *parrhēsia*will come from the empowered members of the church, as they become the caregivers in the community.

Parrhēsia, according to the *Dictionary of New Testament Theology Volume 2* (1986: 734-737), is the freedom to speak out, speak openly, and speak boldly. When Bultmann, in *The Gospel of John* (1971: 291), writes on the *parrhēsia* of Jesus he points out that parrhēsia does not mean, "…as it originally did in Greek, the right or courage to appear in public, freedom of speech, openness…but as is common later, it refers to actions performed in public." Louw (2008: 32) describes *parrhēsia* as a courage that is not a human quality but a quality that comes from God and Christ: as a pneumatic function as part of the fruit of the Spirit.

Thus, we need home-based caregivers as members of the church who will have *parrhēsia: the freedom to be on behalf of Christ because of Christ through the indwelling equipping power of the Holy Spirit!* Voluntary home-based carers should be empowered by the church to have the freedom, boldness, confidence to, despite their lack of education and low standing in the community, act on behalf of the Church in the community because of Christ. Affirmed in their personhood by the church, they in turn can affirm the dignity of those to whom they administer care. Leonardo Boff (1977, translated from the Portuguese by Robert R. Barr, 1986: 5) speaks about Christian life in basic communities when he points out how it is "characterised by the absence of alienating structures, by mutual assistance, by communality of gospel ideals, by equality among members." This freedom on behalf and for each other will happen if there is *parrhēsia*. Louw (2003: 32) equates *parrhēsia* with fortigenesis: that kind of spiritual strength and courage that emanates from our new being in Christ. To enable the church in South Africa to do home-based *diakonia*, we will need a *diakonia* informed and guided by an appropriate theology.

This brings us to the theology of affirmation proposed by Louw (2008: 31) which could be summarised as follows:

- Seeks to deal with ontological issues that affect the status and identity of human beings.
- Describes signification and ascribes human dignity and subject particularity.
- Will help the church to move towards a new public discourse beyond the "isms" of our time.
- Can contribute to processes of de-stigmatisation in the HIV debate.
- It can even open up a new and more constructive understanding of the human body and the place of human sexuality in a theological anthropology (2008:30-31).

An application of a theology of affirmation to persons living with HIV and AIDS will therefore challenge our traditional view of being church in the community.

1.2 Motivation/Rationale for the study

The motivation/rationale for the study is to provide a resource on pastoral care and counselling that can be used to prepare home-based caregivers for their praxis of home-based care in the community.The level of education amongst historically disadvantaged communities remains low. Educated people migrate to cities and in South Africa to previously whites-only suburbs. One sad result is that townships are thus drained of those with professional training. Few trained ministers stay with or in impoverished communities and rather choose to commute in and out of townships thereby removing them from the people and this adds to the community seeing them as part of the elite. Many ministers and laity in the indigenous African churches have no formal tertiary training and may therefore lack the ability to reflect from an informed theological point of view with regard to HIV and AIDS.

This study can be developed into a series of practical workshops to empower members of the community to deal with the spiritual care of those infected with the HI-virus. It can be used to equip clergy on the role of the church with regard to HIV and AIDS, home-based *diakonia,* and the response of the church. Those involved in training home-based care workers may use this in their curriculum so that home-based care becomes more than mere physical care of the body, but a complete and inclusive

care of the holistic needs of a person in need of home-based care. This study may also be used to prepare prospective pastors for the ministry. This study may help those already in ministry to understand what their HIV and AIDS ministry may be lacking or identify areas for improvement.

The level of poverty in South Africa remains high according to the South African governments own statistics (http://www.statssa.gov.za). Unemployment has reached 25,2% in the first quarter of 2012 up from 24% in 2009 out of a population of 50,59 million people (2012 midyear estimate). According to Statistics South Africa's website on the Millennium Development Goals- Country Report that looks at the development plan for South Africa, (http://www.statssa.gov.za/news_archive/Does/MDGR_2010.pdf accessed 11 June 2012) the majority of the South African population qualifies the country as a low-income country where the majority earns less than one American Dollar a day. Almost 25% (24.8%) are living below the food poverty line of R209, whilst 5.2% of the employed population earned less than $1 per day in the year 2000. The report concludes that poverty remains high, with a disproportionate impact on women (43%) than it is for men (36%).

According to Per Strand, KondwaniChirambo (2005:33-35) and Magezi (2007)the link between HIV and AIDS and poverty is clear. The areas in South Africa where HIV infection rate is the highest are also the areas where poverty is rampant (*Millennium Development Report* 2010:32). According to a study done by the Kaiser Family Foundation titled *Hitting Home: How households cope with HIV and AIDS* (2002: 15), those who are involved in home-based care are usually poor middle aged to elderly woman with little or no high school training. This study will aid in the empowerment of these women to play an even more effective role in the combat of HIV and may help to improve their status in the community.

The HIV and AIDS epidemic and its challenge to the church or faith-community, is too great in magnitude to be handled by trained clergy alone. The minister of a congregation therefore has to rely on these community workers (mostly women) in the congregation and in the community to become the hands and feet of the caring Christian community (*diakonia*) through an HIV and AIDS home-based pastoral care

ministry (Magezi 2007:3-4). Through the principle of *parrhēsia*, a new kind of diaconate will come into operation where members have the freedom and courage to practice *diakonia* within their community as part of their faith through an ecclesiology of grassroots care.

The theological presupposition of the study is that God calls every believer through Jesus Christ to minister to the least in society (The Gospel according to Matthew, Chapter 25) through "being there" (Heitink, 1998) for those in need and those suffering. This principle is based on God's identification with suffering people. This thesis will argue that it is through the theology of the Inhabitation (God's Spirit in us working in and through us as the Body of Christ to renew (2 Corinthians 5:17) and to produce the fruit of the Spirit (Galatians 5:22)) that a theology of affirmation takes shape. It is by entering the intimate and sacred space and place of the sufferer that identity, dignity is restored, and we arrive at affirming the new person in Christ. The study argues that the call to care (*diakonia*) takes preference and overrides or rather, determines church structures (ecclesiology) as it seeks to stay obedient to Scripture. Christ died for all and his mercy and care is indiscriminate. His life on earth and death on the cross is illustrative of his all-inclusive compassionate care.

Pastoral care thus indeed proceeds from a *theologiacrucis*(Magezi, 2007:5). We argue in this thesis that it is even more: that an understanding and embracing of the theology of inhabitation and pneumatology (Louw, 2008: 30) eventually brings an understanding of a new identity in Christ and affirms personhood/self and the values, norms and purpose of the HIV infected person through his/her new status in Christ and the work of the Holy Spirit in us according to2 Corinthians 5:17. Thus it is to arrive at a new and meaningful manner of life demonstrated in our new patterns of living or as D. J. Louw (Louw, 2008) states, our 'pneumatic living', through the affirmation of being-functions in being "the congregation from below" (Moltmann, 1978) through a grassroots ecclesiology.

1.3 Research problem

This thesis looks particularly at voluntary home-based *diakonia* to people living with HIV and AIDS from the perspective of the congregation as the local church linked

with other local churches. The quest for identity and affirmation of the HIV positive person and the ability of the South African Church to provide adequate pastoral care in light of existing ecclesiology and diaconate will be investigated.

This study will therefore investigate how the church in South Africa can adequately respond to the apparent need for a church-driven or church-assisted home-based *diakonia* in the struggle against HIV and AIDS through an ecclesiology of grassroots care and identity affirmation.

Home-based care as it is practised at present runs the risk of a one-sided approach with its focus on the physical wellbeing of the person. This further strengthens the argument for an ecclesiology of grassroots care and identity-formation to fill this void. Without a spiritual dimension that focuses on healing as well as health, on medical fitness as well as spiritually-mature faith and affirms the personhood and dignity of a person living with HIV and AIDS so as to bring a new understanding of identity and being functions, home-based care will be missing an important dimension of health, wholeness and healing within the African context.

1.4 Research questions

In the light of the above, the following questions will help to focus the research programme:

1. What is the link between *diakonia*, voluntary home-based care and pastoral care and counselling that is done in the community? A *diakonia* perspective will seek to answer the following:

- How can we make a theology of affirmation formulated by theologians, applicable for the use of home-based caregivers to empower ordinary church-members (lay-caregiving done by lay people) as they practice *diakonia* on behalf of the church?
- How can the church in South Africa add value to or transform home-based care for the sick, driven by the Department of Health (Government/State), to church-driven or church-assisted, community-based, spiritual valued care?
- How can home-based care that includes pastoral care and counselling to people living with HIV and AIDS answer the quest for identity and affirmation in light of their human rights?

2. How then can the theological notion of *diakonia* play a decisive role in a hermeneutic approach to ecclesiology—ecclesiology in context (Van der Ven 1993 "*Theology in context*")? Here the study will investigate how home-based caregivers can be empowered to transform or adapt formal academic theology and traditional understanding of church to congregational theology that breaks through the traditional ecclesiological and *diaconial* understanding of exclusive membership-service by ordained office-bearers for the sake of the denomination to inclusive home-based *diakonia*/service by all members of the church as the Body of Christ.

3. What parameters shall we use to make this possible and will a theology of affirmation used by caregivers be the appropriate provision/space and tool for such restorative healing that will restore dignity and identity and give new meaning to life and death within the community? Thus how appropriate is a theology of affirmation in providing meaningful care to those who have HIV and AIDS: what theology shall we use in home-based care and is this in contrast or continuance of a theology of liberating of the poor?

4. What practical steps do churches need to take to make home-based *diakonia* within a grassroots ecclesiology of care and affirmation possible?

1.5 Hypothesis

For effective home-based *diakonia* within the HIV and AIDS epidemic, the church is challenged to apply an ecclesiology of grassroots care in terms of addressing the impact of HIV on our being human and our quest for identity-affirmation. In order to achieve this, we will need to reframe the *diakonia* dimension of ministry within the context of HIV and AIDS. This will have a direct impact on our ecclesiology, as it will challenge the church to a different approach: an ecclesiology of grassroots care. This implies that the home-based caregiver should be empowered by the church to focus on affirmation of human dignity, new identity, and finding meaning in life and death through a theology of affirmation. Through designing an appropriate paradigm of care for the church in the midst of the HIV epidemic through home-based *diakonia*,

the church will move away from sophisticated counselling in private to an individual in an office or room removed from its daily context, to care (*diakonia*) in the homes of those infected and affected as part of a holistic approach to health and healing that takes our African context into consideration.

Those involved in home-based care are mostly volunteers from the community driven by their passion for the well-being of society. They usually become involve through church or faith-based organizations or NGO‘s with strong links to the church. In South Africa, these caregivers are also in many instances without tertiary education and as a result removed from formal theological standpoints. Therefore an ecclesiology that practise a theology of affirmation that speaks to and empower the ordinary church member, an approach that focuses on being functions, rather than doing functions that affirms the dignity of people, gives meaning to the suffering and promotes identity and affirms norms, values and purpose in life through assistance, emphatic understanding and unconditional acceptance of the person living with HIV and AIDS and his/her family or household, could transform pastoral care from being seen as elitist, out-dated and removed from the community to a functional, practical enfleshed service of the church to the least in the community (Magezi 2007:4).

1.6 Scope of research

The thesis will investigate the challenges and effect of HIV and AIDS on the church in South Africa. The ecclesiological situation in South Africa as far as it helps or hinders an effective response, as well as the effective diaconate of the South African church in light of the HIV epidemic will come under the spotlight. As a result, the notion of human self-worth and dignity will be addressed.

This study will not be an extensive description of home-based care, as it will focus more on the role and responsibility of the Church in South Africa with regard to the practice of home-based *diakonia*. In referring to the concepts *koinonia*, *diakonia*, and ecclesiology the research will embrace a Reformist, Protestant perspective. The researcher is aware that the aspects that will be investigated forms only part of the response of the South African church on HIV and AIDS. The study speaks in very general terms of ‘the church’ and it is meant to include all Christian churches in South

Africa. The researcher is also aware that the change that is required with regard to our response to HIV and AIDS is only part of a bigger change required from the church in the post-modern times we are living in.

1.7 Key-concepts and meanings

1.7.1 Home-based care: Smart (online and cited in Magezi, 2007: 180) gives the following definition of home-based care:

> *Home-based care is the provision of comprehensive services (including health and social sciences) by formal and informal caregivers in the home, in order to promote, restore and maintain a person's maximum level of comfort, function and health. Usually, these are initiatives from NGO, community-based organizations or faith-based initiative*

Alta Van Dyk (2008:332) defines home-based care as follows: "Home-based care is the care given in the home of the person living with HIV and AIDS. It is usually given by a family member or a friend (the primary caregiver), supported by a trained community caregiver." For the purpose of this study, our focus will be on the caregiver as ordinary church-member and the meaningful role she/he can be empowered to play in restoring and maintaining the dignity of the person living with HIV and AIDS.

Thus one can summarize to say that home-based care with regard to HIV and AIDS is the full-time (in the case of family) or part-time care (in the case of home-based caregivers) of an individual or members of a household living with HIV and AIDS. It is usually done by either professional or volunteer members of community based organizations, non-governmental organizations or faith-based organizations trained for this purpose.

1.7.2 Pastoral care and counselling: Pastoral care and counselling comes from pastoral theology. Pastoral theology has been defined many times before and falls outside the scope of this thesis. This thesis will only provide a brief synopsis of what

has been written by noted theologians in response to this question (Seward Hiltner, Collin Brown; Gary Collins, GerbandHeitink, Jürgen Moltmann, Daniël J. Louw).

Louw (2005:3) agrees with Braaten (1989:20) who argues that pastoral theology is the human quest or search for meaning and human dignity. It is therefore a hermeneutic process for Louw (2008) where pastoral theology is considering the meaning of the human situation and context in the light of our God-image (*coramDeo*). Louw (2008:21) works with a basic hypothesis that a persons understanding and perception of God is a determining factor in the process of faith-development and faith-maturity. According to Louw (2005:3), use of an appropriate God-image in pastoral care will lead to a process of mature faith that will enable a person to effectively make use of faith-sources and handle crisis in life.

1.7.3 The link between home-based care and pastoral care and counselling: Van Dyk (2008:333) sees home-based care as a holistic approach to the well-being of the patient. This includes fulfilling all the needs (physical, social, cultural, psychological, emotional, religious and spiritual) of the patient by the caregiver, the family and the health team. If one accepts that people living with HIV and AIDS does not only need physical care but also need their religious and spiritual needs to be taken care of, then it flows naturally that pastoral care must play an important role in the care of the person living with HIV and AIDS and that therefore those who are involved in caregiving through home-based care in the community must also be equipped to not only care for the body alone but also for the soul.

1.7.4 HIV: The human immunodeficiency virus that causes AIDS.

1.7.5 AIDS: Acquired Immune Deficiency Syndrome.

1.7.6 Congregation: The local gathering of a Christian community under the name/authority of a specific denomination.

1.7.7 Identity: One's self-image and personhood. Finding out who you are and what do you want from life.

1.7.8 Theology of Affirmation: To constitute human identity in terms of the corporate reality of our new being in Christ and our transformed status as children of God.

1.7.9 *Parrhēsia*: Courage that comes from God and Christ, a pneumatic function as part of the fruit of the Spirit. Originally, it meant "confidence and boldness of speech" (1 Thessalonians 2:2 and Philemon 8).

1.7.10 Ubuntu: The *Ubuntu* principle implies that a human being is a person through other persons.

1.7.11 Pastoral Care: Rumbold (1986: 56) see pastoral care as recognising a responsibility to care for the whole person, expressed in a variety of helping acts addressed to the physical, mental, social and spiritual needs of the person.

1.7.12 Volunteer: A person availing him/herself freely to help those in need.

1.7.13 Ecclesiology: The manner of being church. How the church functions as an organisation and as a structure. A basic theological framework for a theological understanding of ecclesiology is determined by the following functions: The function of kerugma (the preaching of the Word), the function of *diakonia (service to one another),* the function of leitourgia (the gathering of the congregation in worship), and the function of paraklesis (comfort).

1.7.14 *Diakonia*: The service of the church to all in need as commissioned by Christ (The Gospel according to Matthew, chapter 25).

1.7. 15 Practical Theology: According to Louw (1999: 149), practical theology tries to interpret and translate the praxis of God in terms of human and existential issues through the action of communities of faith—the ministry of the church in the world. The task of practical theology is hermeneutical. The process involves the interpretation of meaning of the interaction between God and humanity, the edification of the church and becoming engaged in praxis through communities of faith in order to impart meaning in life.

1.8 The value of the research

This study will provide a resource on pastoral care and counselling that can be used to prepare home-based caregivers for their practice of home-based *diakonia* and counselling in the community. It will provide insight as to how the church in South Africa can reclaim their responsibility of pastoral care (diaconate) toward those living with HIV and AIDS. The thesis will provide theological pointers towards a new perspective on ecclesiology and diaconate within the context of HIV and AIDS and home-based care. Thus, the thesis is an attempt to enable ordinary members of the community with the necessary tools as they care for the sick in their communities. Lastly it will provide guidelines to congregations with regards to *paraklesis* (comfort), *kiononia* (fellowship), *diakonia* (service) and *ubuntu* (neighbourliness) with *parrhēsia* (freedom to be through the Holy Spirit) as they involve themselves in caregiving to people living with HIV and AIDS in their communities.

This disease has taken on enormous proportions and for some time now, those involved in the fight against HIV and AIDS spoke of a pandemic. At present scientists refer to its epidemic status again with an estimated 11% of the South-African population infected (UNAIDS 2007 statistics) and an estimated 25.5% of woman and children of Sub-Saharan Africa living with HIV and AIDS. This places enormous restraints on an already crippled health-care system of developing African countries, thus the need for home-based care. The ideal is that home-based care should be done by a team of adequately trained care-givers based on the integrated home-based care model (Uys, 2003:5-7) from the spheres of medical science and social science so as to provide a holistic program of care (Van Dyk, 2008:335). This thesis will focus on how pastoral care can contribute to this holistic approach by applying the principles of the theology of affirmation through its *diakonia*, thereby making home-based care an efficient tool in the hands of the church and its ordinary members for the benefit of the broader community.

The research will explore the biblical principle of care as related to *diakonia* and home-based care within the context of the African belief of *Ubuntu*. It will apply the principles of pastoral care to the praxis of the community of faith in their dealing with

the effects of the HI-virus on persons, their households and the broader society. It will seek to make a theology of affirmation applicable for the use of home-based caregivers, thus transforming it from purely physical care for the sick, driven by medical science, to a holistic church-assisted person- and community focused spiritual valued care that can adequately answer the quest for identity and affirmation. It will thus seek to provide a meaning-making tool in the hands of those dealing on a daily basis with persons who have lost hope and is searching for meaning in their suffering. This is the biblical responsibility of the church through its diaconal service. This thesis will therefore seek to provide answers to the new ecclesiological and diaconal challenges that face the church in the light of the HIV and AIDS epidemic.

Part 2: The research plan

1.9 Research design

The research will be a literature study with critical reasoning. Enough sources have been found on the topic of HIV and AIDS and home-based care, pastoral care and counselling methods, *diakonia* and ecclesiology for an in depth study to be conducted in this manner.

The study will use these sources in order to reflect critically on the impact of the epidemic on the lives of those infected and affected by HIV and AIDS as well as the impact of HIV and AIDS on the church in South Africa and the need for an appropriate method of pastoral care and counselling to argue the hypothesis.

A hermeneutical approach to ecclesiology (ecclesiology in context) will provide clarity on the link between home-based care of people living with HIV and or AIDS and theological reflection (the meaning dimension). The dynamics of text-context will lead to a reinterpretation of existing ecclesial structures and their meaning within the framework of a possible grassroots ecclesiology.

I will also draw upon my years of interaction and counselling of people living with HIV and AIDS as a trained facilitator working with the Christian AIDS Beauro of Southern Africa (CABSA) since 2003, a trained community worker for Khomanani in

South Africa, and a radio presenter on a local community radio station (Radio KC) in the town of Paarl where I specifically focused on highlighting the different issues and challenges with regard to HIV and AIDS. As convener of the Paarl HIV and AIDS Action group for four years and as member of the board of the Drakenstein Hospice, I came into close personal contact with many HIV positive people and worked in liaison with the local clinics and home-base care group. The experience of more than two decades of being a minister in a congregation, while being active in the struggle against the HIV and AIDS epidemic, gives me the opportunity to reflect from a participatory observation perspective.

In terms of theology this thesis will further advocate a theological notion of diaconate (*diakonia*) informed by a hermeneutic approach to ecclesiology centred around a holistic approach to pastoral counselling of those who are living with HIV and AIDS from a comprehensive and existential understanding of healing (Louw 2008:64) in the light of a theology of affirmation.

1.10 The structure

The study will describe the link between *diakonia*, voluntary home-based care and pastoral care that is done in the community. A *diakonia* perspective will seek to answer how we can make a theology of affirmation formulated by theologians, applicable for the use of home-based caregivers to empower ordinary church-members (lay-counselling done by lay people) as they practice *diakonia* on behalf of the church. Therefore, this part of the study will be an investigation as to how, through home-based *diakonia*, we can make the paradigm shift from counselling room to the space of the community. Then, it will examine how the theological notion of *diakonia* can play a decisive role in a hermeneutic approach to ecclesiology—ecclesiology in context (Van der Ven 1993 "*Theology in context*"). Here the study will investigate how home-based caregivers can be empowered to transform or adapt formal academic theology and traditional understanding of church to congregational theology that breaks through the traditional ecclesiological and *diaconial* understanding of exclusive membership-service by ordained office-bearers for the sake of the denomination to inclusive home-based *diakonia*/service by all members of the church as the Body of Christ. Next, it will present practical steps that churches

need to take to make home-based *diakonia* within a grassroots ecclesiology of care and identity affirmation possible. What parameters shall we use to make this possible and will a theology of affirmation used by caregivers be the appropriate provision/space and tool for such restorative healing that will restore dignity and identity and give new meaning to life and death within the community? Thus how appropriate is a theology of affirmation in providing meaningful care to those who have HIV and AIDS. Finally, it will conclude with some practical guidelines concerning the training of those who will become involve in home-based *diakonia*.

1.11 Outline of the chapters: broad outline

The thesis will require five chapters. The outline will be as follow:

1. *Introduction.* The introduction will present the research problem and the research plan.
2. *Essential paradigm shifts in diakonia.* The study will describe the context that forms the framework for the study and the need for a paradigm shift with regard to *diakonia* in the light of HIV and AIDS.
3. *Ecclesiology within the context of the HIV and AIDS epidemic: the challenge to ecclesial structures.* The third chapter will deal with the challenges that voluntary home-based care and HIV and AIDS presents to ecclesiological structures in applying a theology of affirmation and the quest for identity affirmation within the context of the HIV and AIDS epidemic. This chapter will seek to provide some ecclesiological pointers to the challenges.
4. *Identity affirmation: parrhēsia within the parameters of a pastoral anthropology.* The fourth chapter will deal with the quest for identity and will investigate the practice of *parrhēsia* within the parameters of a pastoral anthropology as an essential element in entering the space and place of the person living with HIV and AIDS.
5. The findings of the study in the light of the hypothesis as well as a conclusion will form the final chapter.

1.12 The methodology

The key questions that arose from the problem statement will represent one chapter of the thesis. Chapter 1 will serve as the introduction and will present the background to the study, the research problem and the research plan.

Chapter 2 will investigate essential Paradigm Shifts: From counselling room to the space of the community—a challenge to theory formation in pastoral care and counselling. It will start with an introduction that will put the chapter within the context of the church and HIV and AIDS. This chapter will investigate the shift that took place with regard to the care of people who live with HIV and AIDS (PLWHA). Caring for PLWHA has shifted from being specialised care in hospitals to home-based care done by volunteers in the community who seeks to provide in the needs of PLWHA. It will explore the link between home-based care and the *diakonia* of the church. Thereafter, it will explore how church members can be equipped for the task of *diakonia*. Lastly, it will investigate how home-based *diakonia* has shifted the care and counselling of HIV positive people from counselling rooms to the space of the community.

Chapter 3 will deal with grassroots ecclesiology within the context of the HIV and AIDS epidemic: the challenge to ecclesial structures. It will give an overview of the ecclesiological situation in South Africa. Thereafter, the challenge that HIV and AIDS puts to the ecclesiology of the church in South Africa will be investigated and the dangers to koinonia within the epidemic researched. Thereafter, the study will propose that we move toward a new ecclesiology in light of HIV and AIDS: a paradigm shift towards a grassroots ecclesiology. Some theological pointers will be put forward in order to make this possible. Then, D.J. Louw's theology of affirmation as put forward in his book *Cura Vitae* (2008) is introduced as a "tool" in establishing a grassroots ecclesiology for effective HIV and AIDS care.

Chapter 4 deals with identity formation: *Parrhēsia* within the parameters of a pastoral anthropology.This chapter will deal with the need to equip the ordinary members of the church with the necessary tools to affirm people living with HIV and AIDS in their personhood and quest for identity. A new understanding of *diakonia* is needed in the light of HIV and AIDS in order to answer meaningfully the quest for dignity and

identity formation. Home-based *diakonia* requires *parrhēsia*from the caregiver who must become aware of the intimate space he/she enters when they administer care. This requires some understanding ofthe person, his/her context, culture, God-image, thus: knowledge of pastoral anthropology. As a result, the chapter will investigate the notion of healing within an African context, *Ubuntu*, community care and *diakonia*an African perspective on healing and wholeness. The chapter will then return to *diakonia* and the church in the light of HIV and AIDS to investigate if a paradigm shift is needed. The make-up of a diaconal church based on a practical ethics of love, how to implement change and guidelines on the training of home-based caregivers will form the last part of this chapter.

Chapter 5 will contain the findings and recommendations in the light of the hypothesis. This chapter will also mention possibilities for further research.

2. Chapter Two

Essential Paradigm Shifts: From counselling room to the space of the community—a challenge to theory formation in pastoral care and counselling.

2.1 Introduction

Chapter 2 will investigate essential Paradigm Shifts: From counselling room to the space of the community—a challenge to theory formation in pastoral care and counselling. It will start with an introduction that will put the chapter within the context of the church and HIV and AIDS. This chapter will investigate the shift that took place with regard to the care of people who live with HIV and AIDS (PLWHA). Caring for PLWHA has shifted from being specialised care in hospitals to home-based care done by volunteers in the community who seeks to provide in the needs of PLWHA. It will explore the link between home-based care and the *diakonia* of the church. Thereafter, it will explore how church members can be equipped for the task of *diakonia*. Lastly, it will investigate how home-based *diakonia* has shifted the care and counselling of HIV positive people from counselling rooms to the space of the community.

2.2 The Context

When Louw (2008: 415) describe the HIV scenario, he points out that it is unfolding so rapidly on a daily basis that it is very difficult to keep up with developments and statistics. Louw (2008: 416) argues that HIV has become a structural and systemic epidemic and not merely an individual issue. Louw calls for a change in community structures in order to cope successfully with the epidemic. It is the proposition of this thesis that such change must include the structures and the being of the church in South Africa too.

UNAIDS (UNAIDS/WHO, *Epidemic Update, 2005 online* www.unaids.org/en/HIV_data/epi2005/default.asp *[accessed 21 May 2012])* observes that southern Africa remained the epicentre of the global HIV epidemic with 32% of

people living with HIV globally in this region and 34% of global AIDS deaths occurring here. By 2006, the provision of Anti-retroviral treatment (ART) saw more than one million peoplereceiving ART with South Africa mentioned as a country where a big "scale-up" effort was underway in this regard.

However, an audit of home/community-based care (HCBC) by the Department of Health and the Department of Social Development done for the years 2002-2003 (*Appraisal of Home/Community-Based projects in South Africa 2002-2003*) shows that out of a total of 892 HCBC-related projects around South Africa, only 31 were run by faith-based organisations (FBO's). The audit further shows that churches also only provided about 1% of the funding for HCBC projects. Yet the church is called to care in a manner that is relevant, applicable and holistic (Louw: 2008: 417). Voluntary home-based care is one such way in which the church must care for those living with HIV and AIDS. Ferreira and Groenewald (2010: 186) is of the opinion that churches must critically examine the ways in which they render care and what ideas and values they utilise in order to engender transformation. HIV and AIDS forced the church to examine critically the manner in which we care as well as the appropriateness of the structures of the church to face this epidemic.

There are numerous obstacles in the path of the church that makes it difficult for the church to become involve in the ways that Louw (2008: 417) is challenging us. Traditionally individuals would be counselled in an office provided by the church by trained professionals if the situation were ideal. Such counselling would be for members only and the exclusive domain of the pastor. Ferreira and Groenewald (2010: 186) describes the typical situation in townships where many of the churches are not physically located or based in the township or the ministers do not stay in the township or the church initiatives has commenced elsewhere and has not yet been touched or extended to the township. In the first chapter of this thesis, the same point is made. He further notes (2010: 188) that the majority of the ordained ministers in a study conducted on an unnamed village acknowledged that not a single person has ever come forward to disclose their HIV status to them.

This non-disclosure of status might, according to Ferreira and Groenewald (2010: 188-189) stem from a variety of factors, including:

- Fear of rejection: the church might react in a judgemental fashion.
- Embarrassment or fear because the disease is likely to have been transmitted sexually.
- Anxiety about confidentiality, particularly as the community is so small and the consequence of being known as HIV positive might mean stigmatisation or labelling.
- Not knowing what support the church might be able to offer.
- The perception that the church is good at paying lip service to compassion and love, but that in reality churches are good at rejection, albeit subtly.

Ferreira and Groenewald suggest (2010:189) that these ministers living outside the township may well not see HIV and AIDS to be an urgent or relevant issue. Another stumbling block that is pointed out (ibid:189) is the hierarchical structure of the churches that decides on and formulates policy in relation to HIV and AIDS from above expecting it to percolate to the local parish level which is not always the case. This study seeks to provide an alternative to this situation by proposing an ecclesiology of grassroots care.

2.2 Voluntary Home-based Care

According to VhumaniMagezi (2007: 202), home-based care formally originated in the USA in 1986 with the Committee on a National Strategy for AIDS (CNSA), but in Africa, family care has always been part of normal life, though it was not formalised.

Ferreira and Groenewald (2010: 180) is of the opinion that from an institutional point of view, home and community-based care are currently regarded as the best complimentary interventions within the continuum of care services, which mitigates the impact of HIV and AIDS. Ferreira and Groenewald (ibid 180-181) refer to the South African Government's Department of Social Development (Department of Social Development, *Guidelines for Establishing Home/Community Care & Support Programmes* developed by SibusisoMcanyana, Human Capital Management Services (HCMS), Pretoria (not dated)) that describes home-based care as "the provision of comprehensive services, which include health and social services by formal and informal caregivers in the home of the HIV and AIDS directly affected family in order to promote, restore and maintain an individual member's maximum level of

comfort, function and health, including care towards dignified death."

Home-based care has become the answer to the significant challenge that the extremely high levels of HIV and the demand of a large number of people with AIDS-related illnesses a pose to the South African situation. This was pointed out by the Centre for Health Policy, Department of Community Health of the University of the Witwatersrand (*Home-based Care for People with HIV and AIDS in South Africa*, 2001: i). However, this report states that home-based care services are in some cases virtually non-existent or access to it is very limited (2001: 31).

According to Uys (2003:4), people seen by caregivers can fall anywhere in the ill-health continuum: from being without symptoms to being bedridden. Counselling may also include the friends and family of the person as well as children in the household (significant others). The psychological and emotional experiences and needs of a person living with HIV and AIDS can be many and varied. These needs according to Alta van Dyk (2008: 266-288) include physical, psychological, emotional, spiritual and cultural needs.

In line with what was noted earlier in chapter one, the Lutheran World Federation in its manual *Grace, Care and Justice: A Handbook for HIV and AIDS work*(2007: 64-65) defines home care as "the provision of health care by formal and informal caregivers in the patient's home, rather than a hospital, and includes physical, psychological, psychosocial, palliative, and spiritual activities." For this organization the aim is to maintain the patient's independence as far as possible, to provide the best possible quality of life, as well as to provide in the multiple needs of the patient that includes his/her physical, psychological, social, and spiritual needs (ibid: 64). Under spiritual needs, it is then to keep hope alive and sustain the will to live; reassure them of their purpose in life and discovering self-worth. Patients must be reminded of their sacred worth and that they are loved by God. Caregivers will also "reaffirm that death, whenever it may come, is not the final word for those who trust in God's promises." (2007: 65).

The effect of home-based care can be summarised as follows:

- It helps to alleviate/remove/fight stigma and rejection.

- It provides companionship/*koinonia*: keeping the person in contact with the greater community.
- It provides a comforting and caring environment
- It has a positive effect on the person, household and community.
- It allows the person to maintain dignity and have a sense and experience of belonging to be able to be sick and cared for within the familiar space of home.

Thus one can summarise to say that home-based care with regard to HIV and AIDS is the full-time (in the case of family) or part-time care (in the case of home-based caregivers) of an individual or members of a household living with HIV and AIDS. It is usually done by either professional or volunteer members of community based organizations, non-governmental organizations or faith-based organizations trained for this purpose. These individuals are in most cases members of a church in the communities they serve. This provides the ideal opportunity for the involvement of the church in home-based care (Magezi 2007: 202). Therefore, this leads us to the question about the link between home-based care and pastoral counselling.

2.3 The link between Home-based care and the pastoral care of the church

According to Robert Kysar (1991: vii) the church is called to care and is compelled to do so by its biblical understanding. Patricia J. Nickson (1993: 211 in *The Ecumenical Movement Tomorrow*, eds. Reuver, Solms, and Huizer) notes that Christianity came into the world as the religion of healing, in its broadest sense, and brought a doctrine in which caring was emphasised. Nickson concludes (1991: 221) that the church not only has a unique opportunity to reach communities, but also has a unique commission to heal. It is also the argument of Magezi (2007: ii) that the whole congregation should be involved in loving and providing care for the HIV and AIDS-affected people in the community.

Bruce Rumbold (1986: 44) notes that a central image for pastoral care is contained within the name itself as *pastor* is the Latin name for shepherd. Therefore pastoral care draws on the tradition of shepherding care that runs throughout scripture. This connects with the well-known definition of shepherding care (Hiltner 1958: 89-172) as the healing, supporting, guiding and reconciling of troubled people.

Rumbold(1986: 53-54) suggests that pastoral care must contain at least the following elements:

- It is the work of the whole church and not the clergy alone.
- It must occur within the community of the church and reaches out of that community to the broader community.
- It is a stance or attitude that finds expression in helping acts.
- It is concerned with the meaning of human experience.

Heitink (1998: 14) describes pastoral care as "zielsorg" (*curaanimarum)*, becoming involved in the life of the person so as to care about their existence, their faith and hope, trials and sorrows, angst and pain. Developing this idea further, Louw (2008: 11) sees pastoral care as *cura vitae* (the healing of life). For Louw, *curavitae* is "about hope, care and the endeavour to give meaning to life within the reality of suffering, our human vulnerability, and the ever-present predicament of trauma, illness and sickness."

Collins (1988: 16) makes a distinction between pastoral care, pastoral counselling, and pastoral psychotherapy where pastoral care refers to the church's overall ministries of healing, sustaining, guiding, and reconciling people to God and one another as pointed out by Clebsch and Jaekle (1964). He notes that this is sometimes called "the care of the souls." Pastoral counselling (Collins 1988: 16-17) is the more specialised part of pastoral care usually done by an ordained pastor that uses a variety of methods with the goal to help counselees experience healing, learning, and personal-spiritual growth. Pastoral psychotherapy, Collins notes (ibid: 17) is the work of a trained specialist who will be involved in a long-term, in-depth helping process. This study supports the view of Collins with regard to pastoral care as it differs from pastoral counselling and pastoral therapy and will therefore concentrate on the aspect of pastoral care.

Rumbold (1986: 56) see pastoral care as recognising a responsibility to care for the whole person, expressed in a variety of helping acts addressed to the physical, mental, social and spiritual needs of the person. These helping acts, according to Ferreira and Groenewald (2010: 180-181 in *Religion and Social Development in Post-Apartheid South Africa*, eds. Swart, Rocher, Green and Erasmus) includes provision in the need

for medical care, provision of food, care for the family, the joining or setting up of support groups including home-based care, supporting the terminally ill and bereavement counselling. Referring to home-based care and the role of the church, Magezi (2007: 175-177) notes that the church is ideally placed to provide this care through its members as the church is sometimes the only institutional structure in poor communities to provide this support system to affected people.

Both Magezi (2007: 175) and Van Dyk (2008) note the shortage of medical resources in health care delivery systems with regard to HIV and AIDS. On the other hand, there is general agreement by both these scholars that the church can play a vital role in providing the personnel and the systems for effective home-based/community care. It then follows that the church should be involved in home-based care. If we accept that the HIV and AIDS epidemic is too great in magnitude to be handled by the trained clergy alone and that there must be a greater reliance on the broader community of believers as the body of Christ for this task, the church must empower its membership for its *diakonia* by equipping voluntary members to do home-based *diakonia* and should therefore reframe its ecclesiology.

There is a definite link between home-based care as physical care and pastoral care as spiritual care. Van Dyk (2008:333) sees home-based care as a holistic approach to the well-being of the patient. This includes fulfilling all the needs (physical, social, cultural, psychological, emotional, religious and spiritual) of the patient by the family and the health team. If one accepts that people living with HIV and AIDS does not only need physical care but also need their religious and spiritual needs to be taken care of, then it flows naturally that pastoral care and counselling must play an important role in the care of the person living with HIV and AIDS.

Pastoral counselling that excludes its *diakonia* dimension in the ministry of the church in society or the community it serves will be incomplete. The argument of this thesis is that home-based *diakonia* can only truly flourish in the space of an ecclesiology of grassroots care. James Barnet (1995: 167), when he highlights the character and place of the diaconate, points out that "the diaconate challenges our constructs of ministry and calls us to new ways of thinking and acting shaped and molded (sic) in the image of Christ." According to Barnet (1995: 3), the first principle of the pre-Nicene church

was that it was *laos,* the people of God. The understanding was that the Church was called into being by God and made "a chosen race, a royal priesthood, a holy nation, God's own people" (1 Peter 2:9). Every member of the church was *laos*and there were no words to distinguish between clergy and laity as we do today. Sven-Erik Brodd (2008: xvii), when he writes about *Ecclesiological Elements in understanding 'Church' in the HIV and AIDS Pandemic,* argues that the communality of the Christian experience forms the inescapable basis of all that is the church. Therefore, he argues, ecclesiology becomes fundamental for the understanding of Christian faith and life as it includes manifold ways of being Christian in communion (ibid: xix).

The *diakonia* of the congregation to those who are living with HIV and AIDS will therefore inform and shape its ecclesiology. It is here that the Body of Christ analogy forms a hermeneutical framework and offers possibilities for doing constructive biblical theology from below, a theology that includes the contextual experiences of the local churches (Brodd, 2008: xxiii).

2.4 Equipping the Saints: The *Diakonia* of the congregation to those who are living with HIV and AIDS

Ferreira and Groenewald (2010: 182) is of the opinion that caring, in the Good Samaritan sense, should also mean "looking beyond one's congregation, community or nation" to the root causes of the epidemic and confronting the economic and social issues that fuel it. With regard to our topic it will mean to address the challenge that HIV and AIDS presents to ecclesiology, *diakonia* and *koinonia* of the church.

Geyser (Doctoral thesis 2003: 151) refers in this regard to "*selfverloënendeliefdedadebinne die spesifiekevocatio of roeping van die lidmaat.*" He shares the opinion of Hybels&Hybels (1995: 178) and Warren (1995: 372) that sees every member as a minister and the pastor as the one who equips members for service rather than the pastor doing everything on his own. *Diaconia* to those living with HIV and AIDS must begin with members who apply their spiritual gifts creatively and spontaneously. Geyser (2003: 153) points out that this is in contrast to what Schillebeeckx (1985: 121-123) describe as the position in most churches where there is a hierarchic-authoritarian view of the different offices in the church and the

structure of its ministries centres on the minister.

However, Magezi (2007: 38) and in line with Brodd (2008: xxiii) is of the opinion that the church in Africa is strategically located as one of the few structured community institutions to effectively disseminate information on HIV and AIDS and is therefore able to play a central role with regard to equipping its members who are the caregivers with adequate information in order to offer effective and informed care. Louw (2005: 4) connects well with this when he argues that pastoral care must give attention to the question of method in order to communicate the Gospel effectively.

Informed and empowered congregants who volunteer to do home-based care will be able to precisely this through the application of a theology of affirmation. The argument of this thesis is that identity-affirmation through an ecclesiology of grassroots care is best achieved through a *diakonia***by** the people **for** the people **through** the church. The question arise then as to how we can make a theology of affirmation formulated by theologians, applicable for the use of home-based caregivers so as to fulfil the needs of people living with HIV and AIDS? The fourth chapter will provide pointers in this regard.

Painfully relevant, however, is the observation made by Ferreira and Groenewald (2010: 195) referring to the situation of churches in a particular village about the failure of the South African church to react to the challenge HIV and AIDS poses despite all the resources they possess:

> *"…, the mainline churches have not sought to do so, despite the resources they possess. Nationally, they have not sought to liaise with organisations such as the Treatment Action Campaign or the Love Life Campaign, which are involved in efforts to secure access to treatment for HIV and AIDS or in preventative education. None of the churches are involved in international networking, whether to obtain funding from the Bill and Melinda Gates AIDS Foundation or to assess the impact of the abstinence campaign by Ugandan churches. Few churches have raised their heads above the parapet to talk about the human suffering and injustice of the unaffordability or inaccessibility of treatment. Equally, only a few if any have put aside fears about their survival and viability to talk about social injustice and poverty that are the root causes of the epidemic in sub-Sahara Africa. In this regard therefore,*

the creation of a faith-based people's movement that is geared towards development is lacking."

It is beyond doubt that churches do inspire voluntary action (Ferreira and Groenewald 2010: 196), but these agencies/volunteers do not network effectively either amongst themselves or with other NPOs, CBOs or FBOs. Such ineffective networking, according to Ferreira and Groenewald (ibid: 196), may largely account for the failure of churches to have responded to the challenges of HIV and AIDS in a manner that was expected of the church, given their enormous potential, particularly in a South African context. This study will argue that such ineffectiveness can not be ascribed to its inability to network properly, but much more to its traditional hierarchy, its lack of *koinonia* and its out-dated diaconate.

If one concedes that the challenges that the HIV and AIDS epidemic poses to the church is too complex and multifaceted to be handled by trained clergy alone and that the church do have vast resources of which its members are the most appropriate and powerful to combat HIV and AIDS, then it must be that the church must open its eyes to these sources in a new way. The ordinary members of the Body of Christ must therefore begin to play a prominent role. HIV and AIDS is calling us to shift away from counselling in counselling rooms done by a professional to the space of the community with the involvement of volunteer caregivers.

One such organisation that may be the seed for such a shift toward the involvement of ordinary members is the Christian Aids Bureau of South Africa (CABSA)'s Churches, Channels of Hope programme. This programme, according to Ferreira and Groenewald (2010: 195), aims to challenge and empower churches and faith communities to utilise their enormous networks, human resources and leaders to influence policy and people so that a sustainable difference can be made towards turning the tide of the AIDS epidemic at all levels, including at grassroots level.

The vision of CABSA is to energise leaders and faith communities through changing attitudes and action in relation to HIV and AIDS. According to Ferreira and Groenewald (2010: 185) CABSA provides fourfold assistance to churches, namely by supplying information, sensitisation, mobilisation through empowerment of the

individuals and faith communities and finally, facilitating contacts between churches and other networks thereby using religion as a force for change in the way human beings relate to and care for each other.

Other such faith-based initiatives is the *Fikelela* Programme run by the AIDS-desk of the Anglican Church and their Hope Africa initiative; The Methodist Church's AIDS department; the Catholic AIDS Network and Catholic Welfare and Development Agency and their Hope Association project; the Christian based Philippi Trust. However, these organisations generally operate in isolation with little or no cooperation between each other whilst vying for the same donor money and duplicating of programmes within communities.

How then can we transform home-based care for the sick, driven by the Department of Health (Government), to church-driven, spiritual valued care grounded in the principles of practical theology and more specifically pastoral counselling based on the spiritual needs of those living with HIV and AIDS? Patricia J. Nickson (1993: 221) points out that the church, with its ability to reach the urban and rural poor, has a unique opportunity to develop health care programmes that respond to the needs of the people. Unfortunately, she points (ibid: 222), the church in many areas is unable to exploit its community based orientation because of the constraints within and upon the organisational structure.

The challenge for the South African church in this regard is to connect its pastoral care (*paraklesis*) to its outreach (*diakonia*) in the community. Ferreira and Groenewald (2010: 197) summarise it as follows:

- Churches are called upon to revert to their basic function of building values and the provision of purposeful opportunities in living a meaningful life amidst poverty and misery. The affluent would find it meaningful to reach out in love and care to communities in need.
- Members of congregations can be empowered through training and practical applications in living out their calling to be caretakers of others in need. They would require knowledge and skills in this regard. This function can be strengthened if special task teams amongst congregants can be synergised in performing their mission.

- Churches and FBOs need to network far more and far more effectively, not only amongst themselves, but also with secular organisations.
- Through the practice of community and the building of congregant relationships, social bonding, social capital and social control may be promoted much more strongly.
- Leadership needs to be exercised in these areas. Leading by example may be more effective than mere talking. However, sound theological reasoning and practice seems to be a key element in creating a new awareness of responsible sexual behaviour, as well as reaching out to those affected by HIV and AIDS.

2.5 From counselling room to the space of the community: a paradigm shift.

As noted in chapter 1, HIV and AIDS poses new challenges to the church in South Africa on several levels particularly to its ecclesiology, diaconate and koinonia with regard to care and counselling of those living with the HIV and AIDS. Home-based care is the care and support provided to a person while he/she is in the home with his/her family, friends and community (Louw 2008: 453). These carers are able to relate to the needs of the person and the community as they have in-depth understanding of the social, cultural and spiritual needs of the community they serve. Magezi (2007: 203) also stresses that caregivers must have a relationship build on trust (being functions) in order for people to open up about their fears, anxieties and despair.

As congregations become "base-communities" with their ecclesiology informed, formulated and structured from the bottom-up rather than the traditional top-down approach (grassroots ecclesiology), a shift will take place in the way they care (Moltmann 1978). Moltmann (1993) continues this train of thought when he argues that "the community which is filled with the different energies of Christ's liberating power is therefore not an exclusive community of the saved, but the initial and inclusive materialisation of the world freed by the risen Christ." Such a congregational home-based care ministry will then enable the congregation to reach out to the community in a new way (Louw 2008: 452) with an ecclesiology not only directed at its members, but to the broader community in which the congregation is located.

It is such communal *diakonia* (Romans 12: 1-2) that will enable the caregivers to reach the goal of comfort (*paraklesis*) and care (*diakonia*) as it takes home-based care into the streets and homes of the community in order to affirm new identity and personhood in Christ through the working of the Holy Spirit. According to Moltmann (1993: 269), the gifts of the Holy Spirit through which believers serve both those within and outside of the church, are by no means to be seen merely in what he calls 'the special ministries' of the gathered community. He states, "Each member of the messianic community is a charismatic, not only in the community's solemn assemblies but every day, when members are scattered and isolated in the world." As stated in the previous chapter, HIV and AIDS challenge the church to reach the lives of people where they are: on the streets and in their homes thereby practising an ecclesiology of grassroots care.

Previously, as was noted by Collins (1988), counselling was done with an individual in private in a counselling room by a professionally trained person. The HIV and AIDS epidemic has however turned this way of caring around. Moltmann (1993: 301-302) argues that through our baptism, all believers are charged to be a prophetic people who through its life and the style of that life bears witness before the world of the promise of God and its future. All believers are also charged to be the priestly people who intercede for others and bear witness before the world of the liberating representation of Christ. Because they serve the liberation of the whole in common, and each in his own way, Moltmann argues, they are the kingly people who participate in the divine rule. Moreover, because of the liberty found and gained in Christ, believers are a messianic people, no longer "a dumb and passive crowd". Instead, "every individual and all individuals together live from the Spirit, in which they experience their identity, finding their place and their charge in the history of God's kingdom." Thus, it is through the practice of the priesthood of all believers, within an ecclesiology formed and informed from the bottom up, that the possibility of every member partaking in the *diakonia* of the church is opened up.

The liberty or freedom (*parrhēsia*) that church members experience will give them the courage to take the care (*diakonia*) of the church to all who are in need, those who cry out for it as well as those who don't. People will therefore not have to come to the

church for care and counselling as the home-based caregiver, equipped for their task by the church and empowered in their own personhood, will bring the care of the church to the person living with HIV and AIDS into his/her home. Congregational home-based *diakonia* then becomes more than mere physical care, but part of a complete and inclusive care of the holistic needs of the person.

What will it cost? Those who want to be involved in home-based care from the side of the church will have to be trained on how to provide care. An excellent guide in this regard is the book titled *Listening with Love* (not dated) by Fr. Robert Igo OSB, on behalf of the World Council of Churches, Geneva. The congregation can also assist by designing a home-based care ministry (Magezi 2007: 202) as part of their integrated approach to HIV and AIDS. According to the CABSA training manual (2009: 6/13) the implementation of congregation and community-focussed ministries could require skills building and more advance training to be able to address the needs of the congregation and community regarding HIV and AIDS. Magezi (2007: 196) argues that care for the HIV and AIDS-affected people is the responsibility of all believers. He is also of the opinion that "the people should be equipped for this ministry (Ephesians 4: 12ff) by the church leadership."

This will mean that the pastor will have to relinquish his "title" of "sole-carer of the souls" as he empowers these caregivers who are mostly women, mostly semi-schooled and because of their gender and a patriarchal society, on the fringes of the community-life (*Gender Mainstreaming in HIV and AIDS*, 2005: 5) to a new status within the church and the broader community.

2.6 Conclusion

This chapter explored the role of the church in home-based care in the light of the task of pastoral care that is one of the core functions of the church. It points out the numerous obstacles that face the church in South Africa in the struggle against HIV and AIDS. As much as HIV has become a structural and systemic epidemic that calls for a change in community structures (Louw 2008: 416), it also calls for a change in the structures of the church in South Africa. The manner in which we care as well as the appropriateness of the hierarchical structure of the church hinders effective action

against HIV and AIDS.

The situation in townships where ministers or pastors do not stay in the township where the congregation is located or that ministers are not in touch with what is happening on grassroots-level, adds to an ineffective response of the leadership to the epidemic. The effects of hierarchy and denominationalism in the church coupled with confusion as to the role and function of ordinary members also adds to the church's inefficiency in the fight against HIV and AIDS.

This chapter also pointed out that the work of caring for those living with HIV and AIDS is too vast to be done by clergy alone. The help of the whole congregation must be sought in this regard. To enable this, the study suggests that the church involve its members in voluntary home-based *diakonia*.

This chapter further established that there is a definite link between home-based care and pastoral care. The need to equip the congregation as faith-community and members specifically as caregivers was pointed out. The need for a paradigm shift with regard to pastoral care and counselling to move from counselling rooms to the space of the community, in the light of emerging methods of community-care, was established. This chapter pointed out that people living with HIV and AIDS not only needs physical care but that their religious and spiritual needs must also be met through the *diakonia* of the church involved in home-based care. For such a paradigm shift to take place, the pastoral care of the church needs to transform its *diakonia* especially with its focus on grassroots ecclesiology. The implications of this paradigm shift will be discussed in the following chapters.

3. Chapter Three

Ecclesiology within the context of the HIV and AIDS epidemic: The challenge to ecclesial structures.

3.1 Introduction

Chapter 3 will deal with grassroots ecclesiology within the context of the HIV and AIDS epidemic: the challenge to ecclesial structures. It will give an overview of the ecclesiological situation in South Africa. Thereafter, the challenge that HIV and AIDS puts to the ecclesiology of the church in South Africa will be investigated and the dangers to koinonia within the epidemic researched. The study will propose that we move toward a new ecclesiology in light of HIV and AIDS: a paradigm shift towards a grassroots ecclesiology. Some theological pointers will be put forward in order to make this possible. Then, D.J. Louw's theology of affirmation is introduced as a "tool" in establishing a grassroots ecclesiology for effective HIV and AIDS care. The following questions will be of relevance in this chapter:

How appropriate is the existing ecclesiological structures of the church in South Africa in light of the HIV and AIDS epidemic? Did HIV and AIDS change the ecclesiological landscape? Does HIV and AIDS calls for ecclesiological change to traditional church structures? How will a theology of affirmation challenge and or provide in the need for a new ecclesiological practice with regard to HIV and AIDS? What challenges do HIV and AIDS pose to the present situation? In conclusion, this chapter will investigate some theological pointers towards an HIV and AIDS-effective ecclesiology for the church in South Africa.

In order to answer these questions, it is necessary to investigate critically the traditional or historical ecclesiological structure of the church in South Africa and point out the difficulty and challenge that HIV and AIDS confronts the church with, with regard to the current ecclesiological context. Thereafter a proposed answer to this challenge in the form of a theology of affirmation applied by the members of the church under the reformation principle of the priesthood of all believers and the

church as the Body of Christ will be put forward as a possible answer to the search for an appropriate ecclesiology for the church in the light of the HIV epidemic. We must be aware, according to Hendriks (2000: 5) that ecclesiology can never provide a blueprint, but merely provides the methodology that draws the guidelines within which the missiological praxis of the church is lived.

HIV and AIDS presents a challenge to the traditional ecclesiological structure of the church in South Africa and around the world. It challenges us to move away from traditional, official and many times hierarchical structures of doing church to becoming church from the ground up—a "grassroots-based" type of church (Moltmann) with a grassroots-based ecclesiology. If being church is about being in relationship (with both God and fellow humans) then we must reinterpret traditional hierarchical church-structures in light of the HIV and AIDS epidemic and the call for effective *diakonia*.

3.2 An overview of the ecclesiological situation in South Africa.

Peter Gunning, in "*Meeting the Future: Christian Leadership in South Africa*" (1995: 189-190) points out that over the past fifty years the system of apartheid affected and influenced the ecclesiological scene in South Africa. Apartheid divided the family of God in racially segregated churches, churches that endorsed apartheid, churches that fought apartheid, as well as churches who claimed to be apolitical. When ElfriedeStrassberger discuss ecumenism in South Africa over the years 1936 until 1960 (1974: 109), she too notes that "the multiplicity of churches and mission societies, the complicated racial situation, the growing racial tensions within which mission work remained essential, and especially the lack of official, effective interdenominational communication, were some of the stumbling blocks in the life of the church in South Africa." This situation did not change much and it is the experience of the researcher that the South African church remains a divided and largely fragmented church.

Now we find that the members of the congregation do not always stay near the church building or place of worship. Many travel a significant distance to get to their church or place of worship. The traditional rural setting of the church in the centre of town

with all those belonging to it living in close proximity has changed. These days, in our post-modern world, only a few of the people living around and near the church belongs to that particular church. As a result, there is a distance between the church-members and the local people.

In the case of South Africa, and more specifically the townships, this distance can be ascribed to the history of decisions made by the apartheid government and the after-effect of the group areas-act. Church-members were moved far from their churches because of these laws and were scattered over vast distances in several townships. The influence and involvement of the local church over the area it is situated in therefore is diminished as church-members fail to identify with the circumstances of those people surrounding their church. Instead of living out the *missio Dei*, churches became inward-centred, preserving and managing what they have with little or no contact with their immediate surroundings.

Another aspect that affects the ecclesiological situation in South Africa is the divisions that lead to the many formations of churches. People choose to belong to a church that suits them and thus leave the church in which they grew up. Divisions between churches because of doctrinal differences resulted in the focus of the church being more on doctrinal point scoring than concentrating on the missiological and ecclesiological responsibility of the church.

The perceived discrimination of traditional mainline churches against African Indigenous Churches (also referred to as African Independent or AIC's) with their African traditional practices has added to this divide. African Indigenous Churches has grown, according to the South African Yearbook 2000, from being a small presentation of the South African population to more than 11milion people or more than a quarter of the total population (approximately 35% of the Black population, and 35% of all church-members). These churches have become a space where Christian theology is being inculturated within an African worldview. Their influence on society cannot be ignored and their stance and view on HIV and AIDS and healing must be taken into account. Already in 1995 AIC's was seen as "becoming South Africa's new mainline churches" by JurgensHendriks (1995: 25). According to Hendriks (1995: 26) AIC's are churches among the poorest of the poor that has an

ethos of helping one another in all walks of life. They have strong family ties and work at the upliftment of their people. However, African Indigenous Churches are to a large degree being ignored by traditional mainline churches, despite the need to connect and cooperate with this significant part of the South African establishment in the fight against the epidemic. How then do we overcome these divides to become meaningful to those who are HIV positive?

3.3 The challenge that HIV and AIDS puts to this situation: HIV and AIDS and the challenge to a grassroots ecclesiology.

Moltmann (1978: 113-126) argues that this difficulty may be overcome by what he calls "the congregation from below". He argues (1978:113) that the church can only become meaningful when isolated individuals can become part of the community of the church. Moltmann express doubts (ibid: 114) whether a church experienced as an institution in which individuals receive something but find no community, can persist. He argues (ibid: 115) that God as love can only be experienced and represented in the comprehendible congregation in which one sees and recognises the other, and accepts the other as he or she is accepted in Christ. He continues that the doctrine of the justification of the sinner "for the sake of Christ," puts an end to religious belonging and creates freedom in community. For Moltmann such a base community or grassroots community can exist only where there is freedom in and *koinonia*/fellowship with and because of the Holy Spirit.

On the premise of our argument it is to be agreed with Moltmann when he argues (ibid: 115) that it is possible for a congregation to live "from its base up. It is possible that out of a church *for* the people which takes care of the people, there could come a church *of* the people, a *congregational* church." Even though Moltmann's argument leads him to propose new ways of coming into this community on the basis of free will (he concentrates on the sacrament of baptism in this instance as the fundament of the established church, ibid: 124), I want to argue that it is even more—that the HIV and AIDS epidemic and human suffering, poverty and all forms of injustice can and may lead to the formation of new ways of being church if one wants to be true to the Gospel of Jesus Christ and the role and purpose of the Church. HIV and AIDS do not respect historical church boundaries or traditional ecclesiological structures. On the other hand, those who become involve in caring for fellow community members are

not concerned with the membership or church affiliation or even the religion of the sick person. In line with this thinking is the argument of John S. Pobee (in "The Ecumenical Movement Tomorrow" 1993: 398) that we need the development of what he calls "a proletarian church" that lives for others and has experienced *kenosis* in order to stand with the people to develop renewed African identities.

3.4 The dangers to *koinonia* within the epidemic

The challenge of appropriate and lasting involvement in the community with regard to restoring the dignity of those infected with HIV and AIDS confronts the divided church. According to Gibbs and Coffey (2001: 224), the scriptural models of church call for a holistic approach where basic communities become the very building blocks on which the church is build and expand. This, they say (ibid: 224), is the heart cry of most postmodern people: where the spiritual is not divorced from the practical and where the church no longer invites people to come but is willing to go to where the people are in their everyday struggle (Gibbs & Coffey 2001: 181). However, the legacy of apartheid and the history of the Protestant church endanger such a way of being church within the HIV epidemic.

Yet the church is the space where the apostolic functions of *kerugma*, *koinonia* and diaconate find it fullest expression (D.W. De Villiers, 1972:3 "*Kerklikebedieninge in die Stad"*). De Villiers (1972:3) then already advocated for a church where, because of the involvement of its people with regard to the mission of the church (the *missio Dei),* there is a break with all the old forms, ideas and structures. He prophetically envisaged a church of the future that no longer functions as a religious institute, but as a community of people. De Villiers had the (whites only) Dutch Reformed Church of South Africa in mind when he took this prophetic stance, but his views are even more relevant today if applied to the broader South African church and HIV and AIDS.

As mentioned earlier in chapter 3 (3.1) the South African situation with regard to doctrine, different views on illness and the legacy of apartheid as well as discrimination and competition between churches in South Africa is a danger to the establishment of an ecclesiological situation that will be effective in the combat against HIV and AIDS.

The different denominations with opposing doctrines with regard to the epidemic does not help either: church as the ecclesia; church as exclusively for believers or believers-only churches; church as a "hetero-*koinonia* club" (Louw 2008: 424) where so-called "deviants" are not welcome; church as wellness club where there is no place for the sick and the poor: a prosperity church that view poverty as a curse; a racially divided church that provides only for a certain race group and view themselves as superior to other people. Then there is the sad history of the church with regard to unity: schisms; the divide between Roman Catholic and the Protestant Church-community, Protestant and Evangelical, Evangelical and Pentecostal; the distance between African Independent and so-called mainline churches; the divide between white communities and coloured and black communities. All these churches differ on how HIV and AIDS is viewed: some have a moralistic approach; others apply a cause-and-effect paradigm, while some advocate the notion of sinful behaviour (AIDS/HIV as punishment from God).

The inability of the church to adapt to post-modern culture also plays a role in the fight against the HIV and AIDS epidemic. Daniel Geyser (Doctoral thesis 2003: 11) is of the opinion that within both Reformed and Charismatic traditions in South Africa there remain strong antagonistic attitudes towards the postmodern culture. This antagonism has affected the way one church view another as well as how the church views the world around it. The modern theological landscape further shows a strong doctrinal animosity towards other denominations and wants to put one denomination above the other (Geyser 2003: 95). It is precisely this attitude of "us against them" that is a major obstacle when it comes to a joint and united action against the HIV and AIDS epidemic. Geyser (2003: 98) argues that unless the congregation shifts its ministry towards the community and the needs of people, the church will regress toward elitist selfishness with a narcissist focus on comfort and self-preservation.

3.5 Towards a new ecclesiology in light of HIV and AIDS

The HIV and AIDS epidemic therefore calls upon the Christian community to respond in a new way with regard to our ecclesiology as well as the diaconate of the church. The HIV and AIDS epidemic leave us with no choice but with the imperative to be

church in a new way. Louw (2008: 417) states that an effective response to the situation requires a relevant, applicable and holistic caring model on "being the church". HIV and AIDS is challenging the church to move away from *doing* church, where we concentrate more on structure and emphasising difference, to *being* church, practicing *koinonia* and actively seeking out ways to be of service to the whole community and not just its own members. HIV and AIDS is forcing traditional doctrinal differences and dividing ecclesiological structures to take a backseat when it comes to helping those who are in need thereby challenging the parameters of Reformed/Protestant spirituality.

Lewis S. Mudge (1998: 119) points out that the patterns of practice by which Christian faith communities make their moral witness in today's world turn out to be shaped in a variety of ways. Mudge argues that these configurations have hardened into "communions" or "denominations" with contemporary bureaucratization of ecclesial arrangements that arose in circumstances other than those we face today and therefore we need to escape from this sort of fragmentation with its divisive fixations if the church wants to remain relevant in today's world. This idea is also expressed by James Barnett (1995: 11) when he argues that "the church must indeed adapt itself to the age in which it lives, and has been given not only the latitude and the freedom it needs but also the power of the Holy Spirit to guide it according to the times and circumstances."

Deon Beyers, in *Draers van die Waarheid: NuweTestamentiesevisiesvir die gemeente*(2002: 323),writes about the structure of the church in the New Testament and argues that the 21st century church cannot merely duplicate the structures of the New Testament church as it only provides foundational guidelines. The post-modern world we live in and events like the HIV and AIDS epidemic forces the church to do such introspection and take the courage to change or adapt accordingly.

Mudge argues further (1998: 120) that churches cannot live effectively in solidarity with the suffering of the world while they themselves remain divided. We must therefore surmount the ecclesiastical barriers that separate Christian communions in order to demonstrate the capacity of the gospel to bring about the vision of the *oikoumene*: the household of God. When the church act as a moral community in the

power of the Holy Spirit and lives out its witness where the Spirit is also at work, it will extend to others the sense of *koinonia* that is intrinsic to the Eucharistic community as such (Mudge 1998:127).

One of such new ways to challenge the parameters of Reformed spirituality is described by C.B. Ludick (1992: 156) in his M.Th.-thesis titled *Koinonia in die stad: Verhoudinge in die stadsgemeentes van die Ned. Geref.Kerk*.Ludick (1992:157) argues that the search for true *koinonia* that is inclusive despite the diversity and is free from historic ecclesiological shackles so that it includes and not exclude, is part of this challenge. This is precisely the challenge that the HIV and AIDS epidemic poses. HIV and AIDS is presenting the church in South Africa to no longer see themselves only as a group representing its denomination in a particular city, township or village but as part of the body of Christ within a particular area who must cooperate jointly with their fellow Christian brothers and sisters on a grassroots level for the sake of the Kingdom.

Ludick then opts for the theory of the congregation as the "Body-model" (1992: 159) with its complimentary *koinonia* relations rather than the practice of the traditional "shepherd-flock model" of being church. It is within this model, he argues (1992: 160), that the charismatic structure of the congregation reaches its fullest potential and where congregants realize their interdependency. This study supports his view. This model is also proposed by Louw (*Die Stad in die mens* 1980: 153-157) when he argues that the ministry of the church must concentrate on the needs of the individual within the context of the group if it wants to be effective. Its is to opt for a public rather than private ministry writes Donna Schaper in "*Envisioning The New City*", (1992: 38) or as she calls it: the *communidades de base* (1992:39). The needs of the individual within the context of the group that Louw mention will be discussed in detail in the fourth chapter.

Another of the ways of becoming a grassroots church is to accept the challenge of taking the church to the streets of the community. This thesis will suggest that it can be done through what one can term "a theology of the least" based on the Gospel of Matthew chapter 25 and the Gospel of Luke chapter 4 as well as the many other instances where Jesus reached out to the marginalised in the community. In every

instance, we are called by Christ to affirm the dignity of all people and to identify with their plight and become the neighbour that that is available to alleviate the needs of those who suffer in the community. This must become part of our being (the parable of the Good Samaritan, Luke 10: 29-37; The sermon on the Mount, Matthew 5-7).

Such affirmation and restoration of dignity is best done by and in the community within which the HIV-positive person is living in. Moltmann (1978: 125) states that community can only exist where persons really know each other. Relationships or fellowship is then not only functional, but becomes personal in its demonstration of love (John M. Perkins *"Beyond charity"* 1993: 67-71). Therefore, the response to the ecclesiological question posed to the church by HIV and AIDS must be a response as the Body of Christ (Kelly, 1999). In South Africa with its notion of *Ubuntu*, this would be the natural practice to show interest, love and provide care for the neighbour or community member in need. This notion of *ubuntu*will be elaborated upon in the fourth chapter.

Louw (2008: 417) in response to this situation adds the following question: How can pastoral ministry be designed so as to merge the African and church family systems for effective HIV care and support in contexts of poverty where the luxury of sophisticated medical care or even counselling facilities and resources do not exist? This question can even be taken further as to how the church can respond in unity in communities ravaged by the effects of HIV so that we can be the church effectively? Louw (2008: 424) then contends that the HIV epidemic challenges our understanding of being church in such a way that it forces the church to reframe fixed ecclesial doctrines and rigid clerical convictions, thereby making it impossible for the church to remain aloof. Louw, however, does not elaborate on this point.

3.6 Some theological pointers.

The implication of the argument above means that the South African churches must move from preserving its hierarchy and thereby binding congregations to its denomination to freeing its denominations to be church for the community within the community it serves; from being individualistic, self-preserving and member oriented

to working together for the good of God's Kingdom, thereby developing communal thinking. This break with the past also implies a move away from traditional ecclesiology in terms of structure affirming the denomination and its offices to an ecclesiology affirming people and the important role ordinary (lay) people as part of the priesthood of all believers play in the ministry of the church and in fighting this epidemic. In a sense, it is a call for the continuance of the Protestant Reformation.

Some factors that made the Protestant Reformation incomplete, according to Stevens (1999: 45-48), with regard to the priesthood of all believers and our ecclesiology must be taken into consideration:

- The Reformation was more concerned about soteriology (salvation) than ecclesiology.
- The preacher replaced the priest.
- Inadequate structures for renewal did not provide for an ecclesiology comparable to its rediscovered soteriology. At the beginning, the Reformation took the ministry of all believers seriously but now it has 'gravitated' to the pre-Reformation clergy—lay distinction.
- The Catholic seminary system was eventually adopted that led to the enculturation of pastors into a clerical culture.
- Kingdom ministry has been almost totally eclipsed by church ministry advancing the church rather than the Kingdom.
- Ordination is retained almost universally for the full-time supported church worker; no adequate recognition of lay ministries in society exists. Ordination is regarded as conferring a priestly character rather than recognising Christian character and call.
- An adequate lay spirituality has hardly ever been taught and promoted.

Although one finds it hard to agree with his last point, much of what Stevens puts forward points to the need for the renewal of ecclesiological thinking or an '*ecclesiogenesis'* as Boff (1977 translated by Robert R. Barr 1986) chose to term it. Moltmann in turn chooses to see the church on the move away from comparative ecclesiology in the direction of Christological ecclesiology or as he puts it: "on the way from the river to the source, from the churches to Christ" (Moltmann, 1977 translated by Margaret Khol 1993: 12).

A natural progression on schematised theology and historical ecclesiology and even liberation theology would be to not only redefine the role of the church in the world as liberator from poverty (as Boff would see base communities), but also as empowerment-instrument. HIV and AIDS is forcing the church to go beyond the foundation of liberation theology (to be freed from) towards a new purpose in our ecclesiology: to be free for—a church that can affirm the dignity of the people in the community through Christ so that every member of the community is affirmed in their being through the church being present, available, indiscriminate and inclusive in the community it is called to serve.

The church dealing with HIV and AIDS therefore is more than an "event" (Chung Hyun Kyung in "*The Ecumenical Movement*" 1993: 257) and is more than a threat to established hierarchical ecclesiology, but "new beings" being transformed by the Spirit and the Word to a spiritual ecclesiology that comes alive in the practice of the basic communities (L. Boff, 1985: 126). Despite all this HIV and AIDS affects everyone and every church in South Africa; what then shall we use to liberate and empower? The following paragraphs will propose that we make use of a theology of affirmation to help us achieve a grassroots ecclesiology.

To be 'freed for' imply space to be the new creation (new being) and to function from without of a new identity (2 Corinthians 5:17). The argument of this thesis is that a theology of affirmation can provide such a space to understand one's own new status in Christ and to affirm the identity of others because of Christ and the Spirit at work in and through us as the "living bricks" of the church. A grassroots ecclesiology requires a change in attitude both toward each other in the church and toward those who are the receivers of the *diakonia* of the church.

In a theology of affirmation, the dynamics of space is used as a hermeneutical tool in order to interpret what is going on within a spiral model and the pastoral space of encounter and communication. This model points out how attitudes may create a certain atmospheric environment and how attitudes influences human responses (Louw 2008: 34). As Louw points out: "In order to accept and to change one's attitude, it is of paramount importance to be affirmed in one's being quality. Who you

are, or your being functions, determine the quality of your responses."

3.6.1Louw's theology of Affirmation as a "tool" in establishing a grassroots ecclesiology for effective HIV and AIDS care.

Louw (2008: 9) argues that illness creates a new understanding of our calling in life, a new understanding of our calling to represent the loving care of God in the world and to become involved in the suffering of others. In order to do this Louw argues (2008:16) we must embark on a spiritual journey that will move us away from schematised theological paradigms with fixed confessional answers and depictions of God, and away from a theology of liberation and reconstruction to a theology of human affirmation. In order to establish a grassroots ecclesiology of care and identity-affirmation within the HIV and AIDS epidemic, this journey is of paramount importance.

A theology of affirmation is in essence also a theology of space and place (Louw, 2008: 28). Louw (ibid: 26) describes space in terms of the Greek word *chora*, indicating an open space or land. Use of this notion in a theology of affirmation means that *chora*"becomes an indication of how humans fill space with values, perceptions and associations in order to create a dynamic relational environment and systemic network of interaction where language, symbol and metaphor shape the meaning and discourses of our life." When applied to healing in pastoral care, Louw (ibid: 27) argues that *chora* "shifts the debate from performance and production to care and nurturing in order to support, surround, protect, incubate and to give birth to life." According to a Platonic understanding (Louw, 2008: 26-27) *chora* is related to *topos*, a particular, definable place of human encounter with God. Grassroots ecclesiology with its emphasis on service to one another because of us being the Church of Christ creates such a space.

For Louw, space in a pastoral sense "determines the *quality of place* and therefore of our experience of meaning and dignity." To be healed requires changing the space in order to live in a very specific place. Louw asserts that this can be done even if that place is a hospital, a frail-care unit, or a family home. The *ekklesia*, the fellowship of believers, should create such a space, *koinonia*, in order to support people who are to

be healed and to help them discover meaning in their *topos.* The argument of this chapter is exactly this: that in order for a theology of affirmation to become effective in the life of a person living with HIV and AIDS, the ecclesiology of the church as well as the *diakonia* that characterise it, must change in order to create a space and place for healing and wholeness or care and identity-affirmation to take place. Such a space is provided by the Spirit at work in and through His church.

In this theology of affirmation Louw (2008: 16-17) opts for a pneumatological approach with its starting point in inhabitational theology where the theological question in the pastoral ministry of the church is about how the disabled and vulnerable God of the theology of the cross (*theologiacrucis*) and the transforming and affirmative God of the resurrection (*theologiaresurrectionis*) can open up new avenues for pastoral care and counselling, as well as for a pastoral anthropology and theological ethic. This issue will be discussed further in the following chapter.

Louw's proposed theology of affirmation is, according to Louw (2008: 16), within the theological parameters of an eschatological approach to life and our human quest for meaning (the status and identity of human beings) as it refers to the ontic state of our new being in Christ (ontology). Louw (2008: 30-31) opts for this approach (a theology of affirmation) to health and healing as oppose to a theology of schematisation, liberation theology, a theology of reconstruction and a theology of proclamation.

A theology of affirmation (Louw, 2008: 32) has to do with the healing of attitude and position in order to create an atmosphere within which a person positions him/herself within the space of a human encounter. It is the argument of this thesis that home-based *diakonia* that operates from a grassroots ecclesiology will indeed restore identity and affirm one's "new being" in Christ. According to D. J Louw, two things must take place:

1. Firstly, there must be an emphatic valuation of the person that is constructive, positive as well as realistic. The person is exposed to the experience of being affirmed through the "atmospheric healing of space." This is done through the bipolarities of disengagement and embracement within a spiral model and systems approach. Louw argues that both disengagement (distance) and

embracement (nearness) are necessary for healing to take place. Disengagement allows for the unique input and subject energy of the person. This allows the person to express his/her existential fears, to do critical self-reflection and self-confrontation. Embracement on the other side, allows the person space so that an atmosphere of intimacy is created and unconditional love and regard (full acceptance of the total person) is experienced. Embracement that allows for intimacy and unconditional love therefore becomes an act of affirmation.

2. The second thing that must happen, according to Louw, is change and transformation that is directed towards meaning/significance and growth. The person will see him/herself in a new light; their illness (status) in a new light, and will be able to celebrate their transformed state of being because of the Spirit at work in them.

The bipolarities of disengagement and embracement therefore entail "being with" and "goal directed action" as part of the therapeutic atmosphere. Being with allows for the creation of an atmosphere where there is space for lingering and a sense of being at home (intimacy and identity affirmation). The atmosphere of goal-directed action creates the space for change and hope. For Louw (2008: 33) affirmation becomes to a certain extend a prerequisite for transformation and change. One must, however, take note that between disengagement (in his model Louw calls this the "cold side") and embracement ("warm side") there is a neutral stance where the being qualities play a fundamental role (2008: 33-34).

Thus, we see that affirmation takes place within a space: a space provided by ecclesiology—a grassroots ecclesiology. The current context of the ecclesiological situation in South Africa is perceived, as pointed out earlier, as inadequate as it serves denominational structures and hierarchy. On what basis then shall we practice a functional *diakonia* in home-based care based on a grassroots ecclesiology? Our basis must be the compassionate example of Christ.

Patricia J. Nickson (1993: 218) states that Christ identified himself with people in their needs and healed them within the context of the salvation that He brought. She

also affirms that the ministry of healing belongs primarily to the congregation as a whole as it is called to pray, to love, to help in practical way, and to share in Christ's mission. One is in agreement with her, however, when Nickson laments (1993:222) that unfortunately the church is unable to exploit its community based orientation because of the constraints within and upon the organisational structure of the church.

Robert Igo (not dated: 32) argues that "our motive in pastoral counselling, for standing with others in their pain and being present to them as they express their concerns, comes from our faith in Christ. We move in this way easily between basic human issues of fear, anxiety and practical problems, to theological and spiritual explorations of where God is to be found, how to pray and where to focus on hope. In pastoral counselling, therefore, we are not doing something *to* others or even *for* them. Instead, we are simply walking with others on their journey, as Jesus did with his disciples on the road to Emmaus (Luke 24: 13-35)."

Louw, (2008: 455), contends that the congregational home-based care approach can be most applicable to supplement the integrated home-based care system described by Uys and Cameron (2003: 5 cited in Louw 2008: 454). According to this system (model) service providers are linked with families in a continuum of care—from diagnosis until death (Louw 2008: 454).

A functional ecclesiology (Louw 2008: 455) comes about when the link between the African home (family) and the church is recognised with the church dealing with the question as to how to cooperate with families and support them in order to bring about an appropriate caring system. According to Milan Opocensky, in *The Ecumenical Movement Tomorrow* (1993: 385), Christians are called to side with the poor in this world as in this encounter they experience Christ present in the world. He argues (1993: 385) that Christians "cannot continue on their travel to Jericho if the road is spread with thousands and millions of the wounded and dead, sick and dying children."

3.7 Conclusion

This study agrees with the proposal made by Louw (2008: 41) that health care,

medical science and all forms of assistance should make use of a systemic and holistic approach to wellness and healing. This, according to Louw, will have two major results:

1. People will be regarded as relational and social beings who act within a cultural context. This requires that medical science take the psychosomatic and socio-cultural side of the illness/health continuum into account.
2. The view that the unique human being is a discrete entity within the totality of ongoing communication processes is rejected. It is on this basis that this study argues for a *diakonia* that includes the individual and his/her context, the principles of *Ubuntu* and a grassroots ecclesiology.

This systemic and holistic approach, in turn, has two major implications:

a. The *being* of a person is more important than the *function* of his/her bodily parts. Human beings are moral and spiritual social beings within a dynamic process of generating meaning. Morality, spirituality/religiosity and giving meaning cannot be limited to analytical rational categories.
b. In order for the person to be healed, the structures in society as well as the dynamics within relationships should be healed as well.

The proposal made by Louw is important to note as the argument of this chapter is for an ecclesiology that will enable the church to play its role as part of such a systemic and holistic approach to home-based care. Sadly, however, this chapter also highlighted the divisions and structural difficulties that make it very difficult for the South African church to play its part in such an approach and the challenge of a paradigm shift with regard to our ecclesiology.

This chapter has argued that it is necessary for local church-communities to break through the denominational silos and hierarchical structures that make it problematic for the church in South Africa to combat HIV and AIDS collectively. The manner in which we choose to deal with HIV and AIDS as the church in South Africa, may lead us to new ways of being true to the Gospel of Jesus Christ and the true role and purpose of the church. We must recognise that HIV and AIDS do not respect historical church boundaries or traditional ecclesiological structures. HIV and AIDS are not bothered about what synods and high level councils decide or the public statements they make about the epidemic. The pain, humiliation, stigma and

discrimination that HIV and AIDS brings with it, can only be combatted by the church through the collective action of congregations of every village, township, suburb, or city practicing *diakonia* and *koinonia* in unity on the streets and in the homes of each community.

We are in agreement with Moltmann (1978) that it is only in becoming church from the base up that we will meaningfully address the giants of our time. A theology of affirmation then becomes the tool through which persons living with HIV and AIDS can find and practice their new identity and be included in the faith community. The church in South Africa must therefore confront that which divides the church and, like the Apostle Paul in Philippians 1:9-10 said "are able to distinguish what really matters." Local congregations must learn to find the meaning for their existence not in the existence of the denomination, but within the community they are called to practice the *missio Dei*. This may lead to the establishment of what Margaret Hebblethwaite (1993) calls "base communities".

Added to this challenge of replacing historical, hierarchical ecclesiology with "grassroots ecclesiology" is the call to mainstream churches in South Africa to become involve with African Indigenous Churches in a sensitive, equally beneficial way. In so doing both can learn from each other and assist one another in gaining theological insight or pastoral care and counselling skills for the sake of the Kingdom. The new commandment that Jesus gave to his disciples to love one another as He loves us as this shall be the manner through which the world will know that we are His disciples (John 13: 34-35) will indeed come into being if the church can commit itself to return to humility.

The next chapter will deal with how those who administer home-based care can assist those living with HIV and AIDS to identity-affirmation. The argument of this thesis is that in order to address the needs and fears of people, those who administer care must have the courage (*parrhēsia*) to guide people to find their highest purpose and ultimate meaning of life. This requires a theological understanding of anthropology as we will deal with understanding human beings in terms of our consciousness (*sinsbewussyn*), destiny, and normative framework in the process of our *diakonia*.

4. Chapter Four

Identity Formation: *Parrhēsia* within the parameters of a pastoral anthropology

4.1 Introduction

In the previous chapter, we highlighted the challenges that HIV and AIDS poses to the ecclesial structures of the church in South Africa. We recognised the diverse and complicated situation that makes it difficult for the church in South Africa to respond adequately and appropriately to the needs of people living with HIV and AIDS. We also pointed out the need to equip the ordinary members of the church with the necessary tools to affirm people living with HIV and AIDS in their personhood and quest for identity. We then concluded that a new understanding of ecclesiology and *diakonia* is needed in the light of HIV and AIDS in order to answer meaningfully the quest for dignity and identity formation through a theology of affirmation.

Chapter 4 deals with identity formation and investigates*parrhēsia* within the parameters of a pastoral anthropology.This chapter will deal with the need to equip the ordinary members of the church with the necessary tools to affirm people living with HIV and AIDS in their personhood and quest for identity. A new understanding of *diakonia* is needed in the light of HIV and AIDS in order to answermeaningfully the quest for dignity and identity formation. Home-based *diakonia* requires *parrhēsia*from the caregiver who must become aware of the intimate space he/she enters when they administer care. This requires some understanding ofthe person, his/her context, culture, God-image, thus: knowledge of pastoral anthropology. As a result, the chapter will investigate the notion of healing within an African context, *Ubuntu*, community care and *diakonia;* an African perspective on healing and wholeness. The chapter will then return to *diakonia* and the church in the light of HIV and AIDS to investigate if a paradigm shift is needed. The make-up of a diaconal church based on a practical ethics of love, how to implement change and guidelines on the training of home-based caregivers will form the last part of this chapter.

4.2 *Parrhēsia* within Pastoral anthropology

As noted earlier in chapter one, *parrhēsia* is the freedom and courage that is required from those practicing home-based care to those within the community living with HIV and AIDS. To be able to practice this fortology of hope, it is necessary for the caregiver to understand the people of his/her community, its culture and worldview with regard to illness and healing as well as its God-image. It is here that the AIC's (African Indigenous Churches) is leading the way, according to Hendriks (1995:29), in that they have moved to a small-group orientated church that meets the basic needs of the people on grass-roots level, addressing their needs, helping them to face and handle the realities confronting them. Hendriks (1995: 30) calls these faith communities "the church at grass-roots level where people learn by helping each other and by sharing their gifts." He points out (ibid: 31) that the dynamic point of church growth is in the local congregation (the local faith community) where primary socialization occurs—where believers are living with one another and faith values are embedded in virtue—where people learn how to face the future and that this implies an end to denominationalism.

Such a view connects well with Stevens (1999: 5) who calls for "a comprehensive biblical foundation for the Christian's life in the world as well as the church, a theology for homemakers, nurses and doctors, plumbers, stockbrokers, politicians and farmers" or as he states it: a theology *of* the people, *for* the people and *by* the people a sound and sufficient theology of the laity that is a "total ecclesiology". He then points out how there is no theology of the laity in the New Testament as the New Testament knows no difference between laypersons nor clergy.

For Stevens a theology *for* the so-called laity is communicating to the 'ordinary' Christian, untrained in academic theology, how the great truths of the faith impinge on his or her life. Thus it is the continuing and dynamic task of translating the word of God into the situations where people live and work (Stevens 1999: 9) thus: faith in action. A theology *by* the people would then mean the realization that everyday life bristles with the need for theological reflection and must face the existential questions faced by most people. The theological task (Stevens 1999: 17) is therefore not only to exegete Scripture but also to exegete life, and to do these together. This theology

being done by ordinary people is being done 'from the bottom up' requiring the academy to work with the congregation, the home, the marketplace (Stevens 1999: 17-18).

According to Louw (1999: 151), pastoral anthropology from a pneumatological perspective with its starting point in inhabitational theology (Louw 2008: 16), has to do with the result and consequences of a Christian anthropology with regard to one's life. This Christological perspective is not just a doctrine on being human, but is about the grace of God towards human beings and reconciliation in terms of Christ's role as mediator. The implications of Christ's cross and resurrection have implications for us being human and can only be understood in anthropological terms: God dwelling in humans—the pneumatological perspective or people as new beings through the indwelling of the Holy Spirit.

Diakonia-care as it is practiced and received by the caregiver and the person living with HIV and AIDS requires a faith response. The main purpose of a pastoral anthropology is the development of mature faith. By this Louw (1999: 152) implies the quality of the new person's status before God. The new man, as a redeemed person and creation has a new hope for the future. Anticipation thus plays an important role in pastoral anthropology. The faith-potential of the believer is directly determined and influenced by his/her God-image. It is therefore important in pastoral anthropology to determine precisely people's view, understanding and image of God (Louw 1999: 152) in order to bring about identity affirmation or renewal.

In pastoral anthropology it is about more than 'meaning' and 'therapy'; it is about the quality of life—thus the qualitative understanding of human-beings in terms of the nature of life. Louw (1999: 157) states it as follows: "*Daarsoudusgesêkon word datdit in 'n pastoraleantropologieom 'n verstaan van die mensgaan, met die oog op die normatiewegerigtheid van sy/haarbestaan en toekomsdimensie. Ditgaandusom 'n nuwebegronding van menslikebestaan, met die oog op die ontplooiing van ditwat die Bybelnoem: geestelikegeloofsvolwassenheid.*"

In his design of a theological anthropology to use in a pastoral model, Louw (1999: 174-175) points out that a phenomenological description of man may give important

information about man's biological, physiological, and psychological functions as well as an overall view of human behaviour. However, a theological anthropology goes further than the description of behaviour. The uniqueness of a theological anthropology, for Louw (ibid: 175), lies therein that it describe man as a moral agent in terms of God-consciousness and his/her final standing (*bestemmingsfunksie*) before God: "*die fenomenologiekonsentreer op 'mens-kennis' in terme van funksie, behoefte, emosie, denke en gedrag; die teologiekonsentreer op 'mens-verstaan' in terme van sinsbewussyn, lewensbestemming en normatieweraamwerk.*" Thus, pastoral anthropology is the quest to find the highest purpose and ultimate meaning of life (*summumbonum*). Pastoral anthropology then is to understand human beings within their relationship with and directedness towards God as they live their lives within their life-situations (*coramDeo).*

Louw (1999: 192-195) provides the following theological perspectives for a pastoral anthropology:

a. The Biblical view on human beings goes out from the central presupposition that he/she is dependent upon God and must therefore be understood from his/her relationship with God.
b. Scripture does not in the first place address humans on the grounds of sin and guilt, but on the grounds of his/her inclination as creation of God toward God and his grace. The new person within pastoral care is therefore not addressed in terms of his/her negative, destructive components (guilt and death), but in terms of the positive, transforming powers of an eschatological redemptive-reality (reconciliation, resurrection-victory, new life).
c. When the Bible speaks about humans, the Bible neither has a pessimistic nor an optimistic, but a realistic outlook on humans in order to bring about the glory of God or: a faith-realism with a doxological outlook or end-goal in view ("I am miserable—I am guilty—I believe—Praise God!").
d. The Bible see humans as a being/creature that is capable of reacting upon God's loving and gracious approach. Acceptance of our status as creatures of God implies a responsibility and dependence upon God. This responsibility is 'toward' God but also 'for' people: *respondeo ergo sum* thus making human beings both moral and charismatic beings.
e. The effect of a theological anthropology that works with man's creational

structure as responsible liability and motivated life-purpose is faith. Faith-realization is fundamental for a theological anthropology as it is the means through which the pastorate, anthropologically speaking, works. The effect of a theological anthropology that works with the Christological to determine human being as new creature/being is love and gratitude. A further effect is hope that opens up a future and places the new man/woman within the eschatological presupposition of the now and yet to be.

f. To be able to "measure" the five basic pastoral elements (faith, love, hope, gratitude and joy) in a theological anthropology, one can make use of the gratitude-factor as criterion. The measure of praise, thanksgiving and patience points to the wellness (*gesondheidskarakterofgeestelikewelsyn*) of the person.

The new person as pneumatic being plays an important role in pastoral anthropology. Faith-knowledge about God is a pneumatic experience within which the *pneumatic* is the most important factor in the understanding of God (Louw 1999: 206) as it refers to the spiritual-dimension of our Christian existence: our communion with God through his Spirit and our faith-knowledge about God within our daily life-experience. An outstanding characteristic according to Louw (ibid: 207) of the pneumatic person's spirituality is humility (*humilitas)* that give rise to sacrificial *koinonia* where the gifts of the Spirit is used for the good of others.

Louw (2008: 220) argues that pastoral care "reflects and represents the inhabitational reality of grace and unconditional love, and therefore intends to enhance the quality of life and to address our human quest for meaning within the realm of suffering." Thus, pastoral care for the sick envisages the fostering of mature faith (2008: 221). For Louw (ibid: 222) the goal of pastoral care is more than providing solutions to the sick person's questions and problems as it is care based on victory in the resurrection (*theologiaresurrectionis*). It is a victory that involves struggle, with a view to growth and maturity in faith. Louw calls this kind of care "faith care" (2008: 223).

Instead of admonition and encouragement to be brave, faith care equips the sick person to be obedient to God's fulfilled promises in order to strengthen the person's courage to be which Louw (ibid: 223) sees as the fortigenesis and fortology of hope. This fortology of hope (courage and strength that emanate from the eschatological

affirmation in Christ), is for Louw (ibid: 223) the *parrhēsia* that is not a human quality, but comes from God (1 Thessalonians 2:2) and Christ (Philemon 8).

4.3 The notion of Healing within an African context:*Ubuntu* and community care

As stated in chapter one, this thesis will argue that from an African perspective there must be a holistic approach to healing "hence the important role of community and basic communal institutions, for example, the extended family and the dynamics of the social groups, in the healing of life" (Louw, 2008:171). However, this confronts not just the basic communal institutions in society, but the church too. The traditional African concept of "*Ubuntu*": a person is a person because of other people/persons" comes into play here. Louw (2008:452) sees the church as strategically located and recognised by the community so as to use its networks, mobilise resources and at the same time stay close to the community as it practices *Ubuntu*.

Emeritus archbishop Desmond Tutu, in *On the way to Fuller Koinonia*(1994: 101), describes *Ubuntu* as the essence of being human as it "*declares that my humanity is caught up and inextricably bound up in yours—the Old Testament spoke of the "bundle" of life. I am because I belong. My humanity does not depend on extraneous things. It is intrinsic to who I am. I have value because I am a person and I am judged not so much on the basis of material possessions but on spiritual attributes such as compassion, hospitality, warmth, caring about others."* Thus the church, in its practice of *diakonia*, must be aware of our African context and all the factors and principles that play a role in healing and restoration of the sick person.

Alta Van Dyk (2008: 201) argues that it is important for health care professionals who work in Africa to understand what health, sickness and sexuality mean in the African context, and to incorporate these beliefs into their HIV and AIDS programmes. She also stresses the importance of appreciating the importance of community life in African societies and to understand how this viewpoint impacts on the prevention of AIDS and on counselling in the traditional African context. The same principle or requirement will also be applicable to the church in South Africa as we take up the responsibility of *koinonia* within an African context. Those involved in home-based

care will need to familiarise themselves with and respect the African understanding of illness and health.

According to Van Dyk (2008: 321), many African people adhere to traditional beliefs, often combining these with other religious systems such as Christianity or Judaism. Therefore, it is important to recognise such systems and include traditional beliefs in spiritual perspectives on HIV and AIDS. Pastoral ministry in Africa should, according to AmonKasambala (Doctoral thesis, Stellenbosch 2004: 186), reckon with notions of African spirituality and cosmology that works with 'cause' and 'effect' when it comes to matters of healing. Louw (2008: 146-169) points out that for the African, health means the correct relationship to one's environment. Illness is the disruption of the societal order and the destabilisation of the equilibrium that spoils the harmony thereby making it a sociological phenomenon that affects the interests of the family, clan or society. Thus illness is a systemic and a relational issue associated with life's systemic, spiritual and religious dimension (Louw 2008: 170).

Illness implies that the harmony of societal order has been disrupted therefore healing is only possible if relationships have been repaired and if the community is healthy. Healing cannot take place in isolation from the community, family system and tribal system (Saayman and Kriel 1992 as cited by Louw 2008: 171). Mbiti (1969: 108) points out the importance of the community to the individual:
"When *he* (sic) *suffers, he does not suffer alone but with the corporate group; when he rejoices, he rejoices not alone but with his kinsmen, his neighbour and his relatives whether dead or living. Whatever happens to the individual happens to the whole group, and whatever happens to the whole group happens to the individual. The individual can only say: I am, because we are; and since we are therefore I am."*

In order to achieve spiritual healing of the person living with HIV and AIDS the caregiver also needs to take the following praxis principles (as related to the praxis of understanding/interpretation; communication/verbalising; acting; hoping; imagining and seeing) into account as people search in and through their faith for that which will restore and heal them (Louw 2008: 73-74):

- Pastoral care is that field that tries to describe and identify appropriate categories of understanding the comfort and compassion of God in order to

portray meaningful images of God within the realm of human suffering and pain: *fides quaerensintellectum.*

- Pastoral care represents the counselling procedures and counselling skills that try to communicate and verbalise the meaning dimension and the comfort of the gospel in such a way that people can be consoled: *fides quaerens verbum.*

- Pastoral care is about the enfleshment and embodiment of the engagement of God with life issues in such a way that concrete actions of comfort, change, liberation and transformation take place as an expression of the vivid and actual presence of God: *fides quaerensactum.*

- Pastoral care fosters hope and instils anticipatory experiences of eschatology in such a way that our being functions are comforted. Comfort in this regard implies being empowered in one's being functions and discovering significance and meaning in such a way that the result is the courage to be: *fides quaerensspem.*

- Pastoral care inspires people for the ensoulment of life by stimulating creativity and imagination in such a way that human souls can be illuminated and opened up for the aesthetic dimension of life through symbol, metaphor and liturgical rituals; faith seeking beauty, aesthetic and creative expression of the content of faith: *fides quaerensimaginem.* The concept of beauty in practical theology and pastoral care refers to the dimension of healing and reconstruction of life; it represents the urge for constructive change and the expression of meaning in life in such a way that it instils hope.

- Pastoral care opens the eyes of people to traces of God's presence (seeing the unseen) in life through the spiritual dimension incorporated within drama, storytelling, narratives, symbols, metaphors and virtual reality: *fides quaerensvisum.*

As caregivers meet the needs of people where they are—in their homes—with deep concern and sincere empathy, the space of their life (being functions) becomes the

office of the caregiver (Louw 2008: 75) and not so much the counselling room of a clinical profession in an office building. As they are busy with *curaanimarum*, they are busy with a holistic and comprehensive approach to healing closely related to the notion of salvation. Through sustaining, they provide a support system to help the person with HIV and AIDS to survive or to take courage to proceed with life. As a guide, they act as co-interpreters of life through empowerment and enabling of the one living with HIV and AIDS. Through guiding the person overcoming issues such as discrimination and stigma, estrangement, isolation and hatred, forgiveness, unconditional love and the peace of salvation may be experienced and reconciliation achieved. Caregivers will nurture the person living with HIV and AIDS to grow into maturity by developing the potential of the person to foster and facilitate growth through the different stages of life or the different stages/progression of the illness in such a way that the person can come to mature faith and a new identity. Thus, the caregiver assists in liberating the person from a victim mentality and the domination of structures and circumstances that rob them of human dignity and freedom to be free to accept their new status in Christ and to live as overcomers before God and in their communities.

It is therefore, indeed as noted before, by entering the intimate and sacred space and place of the sufferer that identity and dignity is restored and we arrive at affirming the new person in Christ. For this to happen we need a relevant and appropriate *diakonia*.

4.4 *Diakonia* in the light of HIV and AIDS from a grassroots perspective: The need for a paradigm shift.

The Medieval notion that ministry (diaconate) is clerical, a gift of ordination, not of Baptism, and that ministry is for most intents and purposes exercised in and for the church (Barnett 1995: 207) is challenged and turned on its head by the HIV and AIDS epidemic. HIV and AIDS laid bare the deficiencies in the traditional model of pastoral care. The epidemic challenges our traditional ecclesiology as well as the diaconate of the church.

Just as we need a new grassroots ecclesiology, so we need a new model of diaconal ministry as the use of the traditional model of the diaconate is out-dated and irrelevant

and needs to change in character and nature (Barnett 1995: 208). Barnett (1995:217) still calls for the restoration of the integrity of the diaconate and see the implications of it as far-reaching and profound as no less than the nature of the church and its wholeness is involved. However, this study has shown thus far that we need to go further than mere restoration that Barnett suggests. HIV and AIDS has proven to us that we need more than just the "restoration of the office of deacon", we need an entirely new way of being the channels of hope if the church wants to remain relevant and involved in meaningful ways to assist communities and persons living with HIV and AIDS in their daily existential crisis.

Even though Barnett is writing on the ordained ministry of deacons as a full and equal order in the ministry of the Episcopal Church (something this thesis is disagreeing with), his closing remarks with regard to its diaconate fits well into the hypothesis of this thesis when he argues as follows on the wholeness of the church (1995: 217):
"The restoration of the diaconate as a full and equal order would go a long way toward recovery of a truly organic conception of the Church and its ministry as is found in the New Testament. Probably no single step could do more to bring about expansion of lay ministry in the Church today than making deacons of those who will in the minds of most remain "lay people." Perhaps we shall begin to recover the original and total ministry of the apostolic and pre-Nicene Church in which all are "laity." Perhaps we shall find again the essential oneness of creation seen in Jesus' incarnation as the "sacred" and the "secular" are united in the deacon of today."

However, this thesis would argue that the "deacon of today" or the diaconate of the church that must be practiced in the struggle against this epidemic lies not in the hands of a chosen few who see the diaconate as a first step in becoming an elder or a priest in the church but as a calling, as a gift and work of the Spirit in all of the members as part of the Body of Christ at work in the world to fulfil the *missio Dei* and in doing so affirm the personhood and dignity of those living with HIV and AIDS.

An effective diaconate will indeed be practiced by those in the church and community with an insight and understanding of HIV and AIDS on grassroots-level; those with empathy towards the existential fears of people; those who are present in the homes and provide support; those with the right attitude that makes it possible for the person

living with HIV and AIDS to cope because there is a systemic network of relationships and support structures made possible in the community by the involvement of the caregivers equipped for this task by the church (Louw 2008: 443-444).

Stevens (1999: 62-64) calls in this regard for a perichoretic church-community that has leadership and rich diversity without hierarchy. He argues that such a church can be a community without laity or clergy; without superiors and subordinates. In such a community there is no such thing as an individual member: the believer's identity is corporate as well as individual (in Christ we can say: "I am us!"); there is no hierarchy of ministries as members have in principle the same calling, responsibility and dignity and play their part in the apostolic and ministerial nature and calling of the church. Lastly, all members of the church belong to one another, minister to one another, need one another and contribute to the rich unity and ministry of the whole. Therefore "the church is not composed of those who minister and those who are ministered 'unto'."

Earlier it was noted that Elsie Anne McKee (1989: 36) pointed out that when Protestant reformers rejected the idea that the church is the necessary mediator of grace, the idea of the ministry also had to be redefined. The ordained ministry were no longer believed to be the only necessary channel of grace and the priesthood of all believers meant that the ecclesiastical is not intrinsically more than the civil. McKee (ibid: 37) quotes Calvin's remark in the *Institutes* (1: 724, 725) to illustrate that lay persons in the church has as important a place in the church as the clergy: "*The Lord bids each one of us in all life's actions to look to his calling….It is enough if we know that the Lord's calling is in everything the beginning and foundation of well-doing….No task will be so sordid and base, provided you obey your calling in it, that it will not shine and be reckoned very precious in God's sight.*"

Thus the Calvinist understanding of the church's diaconate made it possible to accept and appreciate the possibility of cooperation with a civil welfare program in a context where the church was recognised or established by civil law (McKee 1989: 39). The home-based care that is practiced by the women of the community with low academic training and against the milieu of patriarchy will, if accepted with such a view,

receives the respect and support it desperately needs in the fight against HIV and AIDS and positions the church as empowerment agent.

McKee (1989: 91) makes it clear that the church's *diakonia* cannot be relegated to specialists while ordinary members go their own way without further personal concern. In pointing out the fundamental unity of the church as Christ's Body (the ecumenical movement) and its implications for *diakonia*, McKee (ibid: 93) argues that no Christian, no church member, can escape the obligation to be faithful to Christ and the church while escaping the obligation to *diakonia*. If one accepts this argument then it should follow that the church is obligated to search for ways to practice ways to apply visibly and practically *diakonia* concerning HIV and AIDS ministry. Louw (2008: 443) suggests that a pastoral ethics of love must then come into action as we are coping with HIV and AIDS within a systemic network of relationships and structures.

4.5 On being a diaconal Church: A Practical example of a pastoral ethics of love based on Scripture.

The following components will have to be dealt with when dealing with a pastoral ethics of love in the case of HIV and AIDS (Louw 2008: 443):

1. A realistic insight and understanding that acknowledge reality and does not play games.
2. Empathy that accepts the person living with HIV unconditionally.
3. An attitude of complete support and the provision of a supportive network.
4. Imparting meaning through adapting and or changing of attitude.

One such practical example of a pastoral ethics of love is CABSA's "Churches channels of hope programme" that calls upon those that they train as facilitators to understand the unique nature of their involvement by discovering old truths (for example the passage of Matthew 5: 13-16 or: the call upon the church to be salt of the earth and light of the world) and then apply this ethics of love within the context of HIV and AIDS (CABSA "Churches Channels of Hope" Facilitator's Manual, January 2009 edition, 4.1/1). The conclusion made after a study of Matthew 5: 13-16 is that Christians have valuable and varied roles to play in society (2009: 4.1/2) and that

Christians cannot but be involved in the AIDS epidemic (ibid: 4.1/3).

The following nine guiding principles for a Christian response (*diakonia*) are then set forward in CABSA's training manual to assist those who become involve in HIV and AIDS care (2009: 4.1/4-8):

1. Our motivation: **Compelled by the Love of Christ** (2 Corinthians 5:14). Christian compassion that flows from the love of Christ crosses barriers in society and embraces those who are stigmatised, ostracised or oppressed. It advocates in society on behalf of the silenced voices, creating awareness of their needs.
2. Our attitude towards people: **To accept as Christ accepted** (Romans 15: 7). The unconditional acceptance of Christ should compel those who minister to HIV positive people to mediate and facilitate reconciliation, forgiveness and new life. The mistaken idea that sickness is the result of sin needs to be countered in order to remove judgement and a lack of love and acceptance.
3. Our service: **To serve God in practical acts of love and compassion** (James 1: 27; Matthew 25: 34-40). The rich history of Christian service to those in need must complement secular bodies involved in charity. The holistic value placed on human life does not separate "body" and "soul" thus leading to a rejection of dualistic attitudes. Living the Gospel daily means that service to those who are in need is not an alternative to, or a preparation for preaching the Gospel but a daily devotion to it in practical acts of love and compassion.
4. Our search for answers and solutions: **With wisdom from heaven** (James 3: 17). Drawing from Scripture and our traditions through the ages, we search continually for answers with the wisdom that comes from the Holy Spirit in order to go beyond simplistic solutions to creative ways of living in the midst of HIV and AIDS. In this way the church can find ways of dealing with issues of human sexuality and death in a mature and responsible manner. Prevention programmes grounded in Scripture and a countering of the epidemic should not be with moralistic and prescriptive preaching, but rather by emphasising the dignity and worth of the human person that derives from biblical teaching.
5. Our responsibility: **To break the silence by speaking the truth in love** (Ephesians 4: 15). Christian communities should break the silence surrounding

the HIV and AIDS epidemic by overcoming our own fear. Christians should break the stigma that surrounds HIV and AIDS that results from disinformation, discrimination, judgmentalism and lack of love, which often go hand in hand with a superficial and uninformed reading of Scripture. Truth can only be liberating and empowering when it is spoken in a sensitive, empathetic and caring way. Christians must be in dialogue across denominational boundaries in order to inform one another, and to prevent perpetuating wrong perceptions concerning HIV and AIDS.

6. Our Hope: **To believe is to have hope** (1 Peter 1:3). The Christian message of hope is a living hope confirmed in the resurrection of Christ and the life-giving power of the Holy Spirit. Hope in Christ empowers Christians to give hope to the hopeless. Christians believe that we serve a living God, that Christ is alive, and that our hope is nurtured by the Holy Spirit—even in the midst of suffering (Romans 5: 3-5). Christians know that all of life has great worth, measured by the dignity and value accorded to all people. The respect of all life calls us to live our live in such a way that our actions will disclose that which we hope for in concrete and practical ways.
7. Our identity: **We are the body of Christ** (1 Corinthians 12: 12). Christians must know that HIV and AIDS are not "out there" but "in here". The church is an infected body, therefore no one dare say "This is not my problem." Those living with, or otherwise affected by the virus, all form part of the body of Christ. When one suffers, all suffer. As the body of Christ we are committed to help one another and to reach out to those outside the church. The divisions created by stigma, secrecy, silence and judgmentalism divide the Body of Christ. This requires special emphasis on our unity in Christ in order to equip and empower the Body of Christ to deal compassionately and constructively with HIV and AIDS. Christians are connected and supported by a network of human resources and communications within structured communities throughout the churches. This enables the church to strengthen and support those who are at the forefront of delivering services to people in need.
8. Our task: **To be Christ's ambassadors** (2 Corinthians 5: 20). Christians are called to be ambassadors for Christ and therefore to practice living according to the disposition of Christ by demonstrating loving care, forgiveness and acceptance in order that God's mission in the world can be accomplished. God

is the source of our being and strength for this task.

9. Our relationships: **To uphold the dignity and worth of every human being** (Luke 8: 43-48; Genesis 1: 26-31; Galatians 3: 28). God, as the author and creator of the cosmos and all that is in it, is also author of all that we are, in all our diversity. We are all image-bearers of the one God, the Creator of all. This means that all human beings are of inestimable worth, and no one is more important than another is. We are bound together in our common humanity, despite our differences of race, gender, class, ethnicity, sexual orientation or whatever other differences we may have. While we share our human brokenness we also share a common longing for God's love that renews and transforms our lives. We do this within the context of different cultures that hold certain beliefs and traditions as "normative". The consequence is that people may have strong views they may experience as authoritative, but are not necessarily in agreement with Scripture. The expectations and burdens caused by such views can result in gender relations that are dysfunctional, oppressive and inappropriate and may contribute to stigma and discrimination, stigma and the spread of HIV. It is the will of God that our relationships transcend all our prejudices, and our cultural and gender stereotypes. Nowhere is it more clearly demonstrated than in the way Jesus socialised with those people society looked down on. One such example is how Jesus reacted to the woman who had suffered for twelve years with constant bleeding and touched Him from behind to be healed (Luke 8: 43-48). Jesus stopped on his way to a dying girl to first pay attention to her. Jesus brought her from "secrecy" to an open confession of her faith as well as her healing. Thus Jesus restored her as a "clean" member of her Jewish community. She was not only healed—Jesus gave back her God-created dignity that was taken away through her sickness and society's perception thereof. Restored relationships in Christ are now the new principle as Paul states in Galatians 3 verse 28.

4.6 Activating, implementing, and managing this change

Brain Germond (1995: 173-181), when he discusses the involvement of the laity for ministry and of restructuring the church to make this possible, notes that "*no matter how much a minister may talk about 'the ministry of all believers' and actively*

promotes an 'every member ministry', as long as the unconscious cultural norms of the whole maintain that 'ministers minister and congregations congregate,' all efforts at developing that ministry will be subtly (and sometimes not so subtly) undermined." He therefore identifies four stages (ibid: 175) in the process of preparing for and managing effective change:

- Self-awareness,
- Involving the congregation,
- Implementing change, and
- Evaluation.

CABSA (CABSA Manual 2009 edition 6/18-20) follows a similar route in their proposal for effective change in the congregation to enable the church to become actively involve in the fight against the epidemic. It suggests that the congregation starts an "AIDS Action Team" that will take the congregation through the following steps:

1. Step One: A situational analysis that will take into account the situation of the congregation and the broader community; become aware of existing projects and programmes and identify relevant role-players; become aware of the needs and gaps.
2. Step Two: Identify issues, solutions and options to attend to both within the ministry and the broader community; list them; explore how these issues impact on the broader community; gather more information; investigate solutions and provide training on possible ways in which the church could intervene to support those who are living with or otherwise directly affected by HIV and AIDS.
3. The Third Step: Making Strategic choices. Here the various course of action that were identified in step 2 are weighed against each other and decisions are made about what represents the most appropriate area for future church HIV and AIDS activities.
4. Step Four: Developing objectives and activities. Detailed planning on what the congregation wants to achieve and the possible activities that will lead to the accomplishment of each objective is explored in detail.
5. Step Five: Monitoring and evaluation of the process.

The ultimate goal is the defrosting of the congregation so that those with the spiritual gift of caring will become involve in HIV and AIDS care and counselling thus forming the congregation's volunteer home-based caregivers. These caregivers can then be trained to care for people in the community in their different stages of illness. They can be made aware to be sensitive for the needs and existential fears of persons living with HIV and AIDS by knowing the emotional and spiritual needs of the person and to provide the appropriate pastoral care in the appropriate stage of the illness.

Thus it implies that because of the priesthood of all believers, everyone in the congregation that lives under guidance of the Holy Spirit is a minister. Those who have received the gift of caring will practice their gift with much more freedom (*parrhēsia*) as they are empowered and enabled by the congregation to do so. This will mean an incorporation of pastoral care (*diakonia*) into the training of home-based caregivers.

4.6.1 Training of home-based caregivers

Alta van Dyk (2008: 340) points out that it is important for home-based caregivers to be trained properly and thoroughly in order to provide a high standard of holistic care. Van Dyk (2008: 340-341) includes the following as necessary in a training programme:

- Background to home-based care (definition, purpose, team members and the health care system).
- Ethical principles of home-based care: confidentiality at all times; respect for the patient's wishes about disclosure; the autonomy of the patient to agree or disagree with treatment; and respect for the patient's choice on issues such as abortion.
- Basic facts about HIV and AIDS and other sexually transmitted infections.
- Knowledge of the signs and symptoms of TB as well as an understanding of DOTS.
- Teaching and facilitating skills, especially adult education.
- Communication skills, including communication with children.
- Basic counselling skills (attending, listening, emotional support, how to deal

with feelings, and problem solving skills).

- Promotion of positive living.
- Spiritual and religious issues.
- Bereavement counselling.
- Gender and cultural issues.
- Infection control in the home-based care situation.
- Basic nursing care principles and the management of common illnesses.
- Practical procedures to help the patient, for example lifting, wound dressing, mouth care, feeding, bathing in bed, shaving, and using a bed pan.
- Nutrition and problems influencing nutrition.
- Incorporating palliative care principles into basic nursing care in the home.
- Social support, community support and referral possibilities.
- Care of the caregiver to cope with a very demanding task.

If the objective of the hypothesis of this thesis is to be achieved, those involved in voluntary home-based care must also be equipped in spiritual/pastoral care as pointed out by Van Dyk in her list (basic counselling skills; spiritual and religious issues). When members start to be ministers/servants who want to fulfil their calling as part of the Body of Christ, they will naturally also want to better themselves and improve their counselling skills. This will entail counselling from a pastoral perspective and the praxis of a theology of affirmation (Louw 2008: 446-447) and includes:

- The establishment of a helping relationship of trust (to be with somebody);
- Ensuring a caring system (empathetic space)
- Defining the problem, in order to articulate the issue at stake, telling the story;
- Engaging in constructive or structured conversation (interview, group discussion, dialogue, verbalisation);
- Teaching how to cope in a more "meaningful" way with different life issues or problems;
- Connecting possible problems to more constructive attitudes, alternative options and preferred scenarios;
- Exploring sources for appropriate and effective coping skills or management strategies;
- Empowering the person to take responsible decisions as well as to set goals,

taking action, and

- Assessing and utilising appropriate God-images in the establishment of a mature spiritual stance in life in order to promote hope and growth.

This may see the churches of a specific area coming together to find within themselves the necessary resources needed and available within their community (grassroots ecclesiology) in order to provide the best possible care (*diakonia*) to those living with HIV and AIDS within the community. The combined *koinonia* in faith, love and witness will then indeed, as emeritus Archbishop Desmond Tutu argued at the 5th World Conference on Faith and Order in 1993, reflect the unity of the Triune God. In this time of flux, when the old order is replaced by the new, there may be times of turmoil, Tutu warns (1994: 94), but these 'combined churches' could become the trailblazers in all their "ecclesiastical untidiness" (D. Tutu in *On the way to Fuller Koinonia,* 1994:98) and lead the way to a grassroots ecclesiology.

4.7 Conclusion

This chapter showed that HIV and AIDS do not only pose a challenge to the Church with regard to ecclesiology in the South African context, but also to the practice of *diakonia* by the South African church in the face of the epidemic. In order to practice a relevant *diakonia* we need to know and understand who we are caring for, where they come from, what is important to them, their cultural background, how they understand illness and healing, the importance of family and other people in the process of healing, their understanding and view/image of God (Father, Son and Spirit), their state of spiritual maturity, their understanding of their ultimate destiny, their norms, their understanding of the meaning of life, their relationship with God, if they understand the presence and effect, working and gifts of the Holy Spirit in their lives (pneumatology), the worldviews of the community and its culture. This will require spiritual fortigenesis (*parrhēsia*) and fortology, according to Louw (2008: 32), a pneumatic function as part of the fruit of the Holy Spirit.

This chapter also showed that a theology of affirmation, that has as its outcome the establishment and affirmation of the identity of people as new beings in Christ/new creation in Christ through the working, gifts and fruit of the Spirit, can be practiced

within the parameters of a pastoral anthropology that takes into account the issues raised in the previous paragraph and throughout this study. In pastoral anthropology it is about more than 'meaning' and 'therapy'; it is about the qualitative understanding of human beings in terms of the nature of life (*die normatiewegerigtheid van sy/haarbestaan en toekomsdimensie*) in order to implement/bring about spiritual faith-maturity that will enable a person to find the highest purpose and ultimate meaning in life before people and before God. Louw (2008: 425) rightly points out that HIV and AIDS is fundamentally an issue of human dignity and integrity.

This chapter further pointed out that affirmation is not an individual issue to be dealt with in isolation of the community the individual finds him/herself. It is rather a systemic issue where the individual is taken care of within his/her local context (community, culture, belief-system, level of faith-maturity, God-images). Failure to take context into consideration may lead to inappropriate and ineffective *diakonia*.

The church in South Africa needs to practice *Ubuntu* and community care within a grassroots ecclesiology thus becoming a church of the people for the people by the people. The church, if it wants to be effective against the epidemic needs to be aware of the African view on illness, healing and wholeness. Our *diakonia* in the light of HIV and AIDS will regard all aspects and everyone involved in care as important and every role as part of the whole. A pastoral ethics of love (Louw 2008: 443) must therefore come into action as we implement home-based *diakonia*.

CABSA's ten guiding principle for a Christian response to assist those who become involve in HIV and AIDS care was put forward as an example of a pastoral ethics of love. This was followed by a critical look at the diaconate of today. This chapter argues for the end of the official office of the deacon in the church on the ground of it being out-dated in character, function and nature. The reason for such a radical argument is because HIV and AIDS has proven to us how ineffective and ill-prepared the historical or traditional ecclesiology and diaconate of the church in South Africa was and still is to stem the tide of HIV and AIDS that washed over our country and is still ravaging our communities today. We argue that the whole of the church as the Body of Christ must learn again how to care for one another and to care for the community that it is in: that the responsibility to care cannot be transferred unto a few

ordained ones in ecclesial office but that the *diakonia* is the responsibility of all.

This chapter gave some ideas as to how a congregation can be activated into becoming a diaconal church before giving guidelines as to what would be important to implement in the training programme of home-based caregivers under the direction of the church in light of the hypothesis. The following chapter will provide the findings and conclusions to the thesis.

5. Chapter Five

FINDINGS AND CONCLUSIONS

5.1 Introduction

This study has addressed the role of pastoral care in HIV and AIDS care with specific reference to home-based care from a congregational perspective. It has offered a theology of affirmation based on the key verse of 2 Corinthians 5: 17: "So if anyone is in Christ, there is a new creation; everything old has passed away; see, everything has become new!" The study pointed out how, through the application of a theology of affirmation in home-based *diakonia* the person living with HIV and AIDS can change status: from being HIV positive to being a new man/woman in Christ through the transforming power of the Holy Spirit.

The study critically investigated the situation of the South African Church with regard to its ecclesiology, *diakonia* and *koinonia* as it enlightens the support for those who are HIV positive and those who care for them. The researcher agrees with Kieth Griffiths (2006) that it is time for confession for the church in South Africa on HIV and AIDS and the response of the church to the epidemic. Griffiths (2006: 47-49), in his M.Th. thesis titled *The Relationship between Pastoral Care and Worship in the context of HIV and AIDS,* is of the opinion that the Church must confess and repent of the following with regard to HIV and AIDS:

- Failures in teaching;
- Failures in the initial response to HIV and AIDS;
- Failure to locate concerns to local congregations, and
- The use of discriminatory language.

This study has also revealed the need for a paradigm shift with regard to the ecclesiology, *koinonia* and *diakonia* of the South African church if it wants to influence positively in the fight against the HIV and AIDS epidemic and enable its members to become active and effective as home-based caregivers.

5.2 Another Kairos moment

HIV and AIDS brought the church to yet another 'Kairos' moment in its existence (Ackermann 2003: 91). The HIV and AIDS epidemic has vividly brought to light the inability of historical and existing hierarchical ecclesiology to respondadequately to

modern times of crisis (UNAIDS, Framework, 2003: 16). HIV and AIDS further laid bare the out-dated, inefficient and inappropriate system of the ecclesial office of deacon in the church and is challenging the church to rediscover, fulfil and apply the priesthood of all believers.

This study has revealed that the diaconate of the church and its essential role in building and maintaining community calls for the brave step of abolishing the office of deacon and to replace it with small care-groups with different missions of care and outreach within the *missioDei*. To betruly of comfort to the people, the church needs to not only restructure its ecclesiology, but also know and understand the community that it is in in order to care in a sensitive empathic manner that will restore human dignity and affirm a person's new identity in Christ. The *diakonia* must become relevant again to addressadequately the needs of a post-modern society. Therefore we explored in this thesis how a theology of affirmation—that seeks to restore identity, human dignity and integrity—as well as the notion of *parrhēsia* and the application of pastoral anthropology may be used to enrich or make it possible to implement an ecclesiology of grassroots care and identity affirmation.

Is it therefore time to redefine our diaconate and our ecclesiology? This study has advocated for a holistic approach to healing that takes into account the African perspective on health and the healing of life. Such a holistic approach will lead us to a new and different understanding of the *diakonia* of the church. This will bring about a reinterpretation of hierarchical congregational management as it underpins the importance of *koinonial* life of the congregation and the participation of all members in the *paraklesis* and *diakonia* within the congregation.

The study also concluded that it is time for the South African Christian faith-community to restructure our ecclesiology in the light of lessons learnt from the epidemic. There is no doubt with the researcher that the time has come for the South African church to earnestly enter into discussion regarding ecclesiology within our South African context in the light of Scripture and the lessons learnt from the HIV and AIDS epidemic. It is a discussion that must take place in academic circles and the ecclesial structures of the different churches, but moreover a discussion that must take root within every village, town, and city of our country amongst the ordinary

members of the church where the painful reality of living with HIV and AIDS is experienced on a daily basis. The study has pointed out that those involved in home-based care are not interested in knowing about the doctrinal background, church affiliation or religion of the person living with HIV and AIDS and neither is the HI-virus.

The time has come to implement church-driven or church-assisted home-based *diakonia* in South Africa. The church must become actively involve in home-based *diakonia* on grassroots level. The care of those living with HIV and AIDS can no longer only be a part of the social responsibility of the state, NGOs or faith-based organisations linked to the church. The existential needs of persons in crisis and the need for mature faith to face these challenges when diagnosed as being HIV positive or having full-blown AIDS makes it impossible for the church to remain outside the care-continuum and uninvolved in home-based care. A holistic approach to combat the epidemic needs the input and involvement of the whole South African church. This study has argued that, through its involvement in home-based care, the church will fulfil the need for a functional, available and viable support system within the community of the person living with HIV and AIDS.

5.3 A return to the chapters in light of the hypothesis

As part of the introduction to the topic, the hypothesis of this study in chapter 1 stated that for effective home-based ministry within the HIV and AIDS epidemic, the church is challenged to apply a theology of affirmation in terms of addressing the impact of HIV and AIDS on our being human. A theology of affirmation has to do with the dimensions of space and place and being. We have pointed out that the *diakonia* of the church must take place within the space of a grassroots ecclesiology in order to bring about identity-affirmation. The hypothesis continued to propose that a theology of affirmation will compel us to reframe the *diakonia* dimension of ministry within the context of HIV and AIDS. The hypothesis further stated that this will also have a direct impact on our ecclesiology as it will challenge the church to a different approach: an ecclesiology of grassroots care. The implication would be that the home-based caregiver should be empowered by the church to focus on affirmation of human dignity, identity, and finding meaning in life and death. Through designing an

appropriate paradigm of care for the church in the midst of the HIV epidemic through home-based care, the church will move away from sophisticated counselling in private to a individual in an office or room removed from his/her daily context, to counselling in the homes of those infected and affected as part of a team or combined approach to home-based care.

Chapter 2 placed the study in context of the present statistics concerning HIV and AIDS and revealed that an audit of home/community care (HCBC) showed that out of a total of 892 HCBC-related projects around South Africa, only 31 were run by faith-based organisations. This chapter then investigated the obstacles that make it difficult for the church to become involve in an effective, meaningful and unified way in home-based care. However, the study pointed out that the pastoral responsibility of the church compels it to become involve in caring for people living with HIV and AIDS. The church has the responsibility to equip its members in order for members to become part of this paradigm shift of taking care of people where they are in their homes thereby taking pastoral care and counselling to the space of the community.

The third chapter investigated the existing ecclesiological structures of the church in South Africa and concluded that the many divisions make it impossible for the church to be a serious role-player in the struggle against HIV and AIDS. This chapter then called for the church as the Body of Christ to opt for a bottom-up approach to being church in the midst of the epidemic and in order to overcome traditional hierarchical ecclesiological with its ineffective top-down approach. A grassroots ecclesiology was proposed to replace traditional hierarchical and divisive ecclesiology. A theology of affirmation that affirms new identity and restores personhood and concentrate on being-functions in order to bring about attitudinal change was proposed for use in the home-based care ministry of the church within a grassroots ecclesiology.

Chapter 4 expounded on a theology of affirmation as an essential part of counselling people living with HIV and AIDS and sought to illustrate how the *diakonia* of the church is informed by pastoral anthropology, strengthened by the *parrhēsia* of its members and enlightened by their knowledge and appreciation of our African context. This chapter investigated how identity formation can be assisted through pastoral anthropology, as put forward by D. J. Louw (1999, 2008), that forms the foundation

for a theology of affirmation. The notion of *parrhēsia* within pastoral anthropology and how it operates within the African context was put forward to show how those involve in home-based care can be empowered to council those they come across in their ministry. This chapter also calls for the end of the official or ecclesiastical office/order of the deacon as the call to *diakonia* is a call upon the whole church as the members of the Body of Christ and as part of the Reformation principle of the priesthood of all believers.

5.4 The findings and conclusion

The researcher is convinced that the findings and conclusions made in the chapters that followed the hypothesis corroborate the hypothesis. This study therefore finds that the church does have an important role to play in the struggle against the HIV and AIDS epidemic in making home-based care part of its *diakonia*. Even though the epidemic has been with us for almost three decades, it is not too late to learn valuable lessons about how to combat it.

As there is still no cure for AIDS, there is a definite need for church-driven or church-assisted home-based *diakonia*. Home-based care under the authority of the church will have the added and essential component of spiritual care needed to bring about mature faith that can praise God despite and amidst our painful situation. The church can and must become part of a holistic inter-disciplinary approach to combat HIV and AIDS. It is part of the mission of the church; it is our calling to love and care with empathic understanding. The structures of the church, its traditions and history cannot and must not keep the church from fulfilling the vision Christ has for it.

This study is also a call for a paradigm shift with regard to ecclesiology and *diakonia* in the South African church that may have a profound effect on the church in South Africa. This shift must happen in three areas:

4. The church must become actively involve in home-based care as part of its ministry and calling to the world amidst the HIV and AIDS epidemic. The church can no longer be a bystander or advisor, or at best a supporter of government and civil actions. Every congregation needs to become active within the community they serve through joint/combined and innovative ways

with other churches in their areas in establishing an ecclesiology of grassroots care.

5. The *diakonia* of the church must change. Every member must realise their full potential of utilising their Holy Spirit gifts and fruit in order to serve/minister in the Kingdom of God. *Diakonia* can no longer be the responsibility of a few ordained or commissioned for the diaconate. The whole church must become active in service to their community and those living around the church. The church needs to break the chains of membership-*diakonia* and open the arms of Christian love to everyone in need, even those who hates us.
6. Perhaps the biggest challenge is the call to change our way of being church in South Africa: our ecclesiology. We must admit that we have come to love the church more than we love God and that we forgot that God so loved the ***world*** not the church! This realisation will make it possible to become open to the proposal of this thesis: that we become church from the bottom up, that we start to practice a grassroots ecclesiology.

The future of the *diakonia* and ecclesiology in the South African Church is tied to our response to the HI-virus. This small, weak virus may be successful in not only killing millions of people, but also severely damage and weaken the church unless we humble ourselves in service before God and each other.

This study has opened up the possibility of investigating how churches in the community can practice grassroots ecclesiology and still keep their ties with traditional churches. I would also like to investigate what kind of church would be able to minister to the post-modern or the post-post-modern era. Another possibility for future research might be to investigate the lessons that the Church in South Africa learnt through HIV and AIDS, the impact on the faith-community, and how these experiences can position the church to a more efficient reaction to similar situations in future. The researcher is also interested to investigate if and how the fifteen theological characteristics of a grassroots church of the so-called “base communities” of mainly Roman Catholic areas in South America put forward by Leonardo Boff (1981: 124-143) can be of use in establishing a grassroots ecclesiology in South Africa.

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