

Chapter 1

Masangane in Context

1.1 Introduction

This study is both an evaluation of Masangane, a faith-based integrated response to HIV and AIDS, and through it, a study aimed at deepening our understanding of the role of religious health assets in the face of HIV and AIDS, with implications for public health.

To achieve this aim, the report:

- Provides an overview of Masangane
- Explores the ways and extent to which Masangane can be considered to be a religious health asset
- Evaluates the role that the project plays and the value added by its being a faith-based organisation/initiative (FBO/I), and
- Explores lessons that can be drawn from the evaluation to inform ART roll out and the role of FBO/Is in responding to HIV and AIDS.

1.2 Aim of Masangane

In his introduction to *Buckling: The impact of AIDS in South Africa*, Hein Marais writes:

[W]hat emerges is a horrifying picture of a society that is being ruptured and buckled into an antithesis of the humane, just and dignifying society millions struggled for and continue to strive toward.¹

Masangane (isiXhosa for 'embrace one another') developed as a faith based response to the devastating impact of HIV and AIDS on communities in the Eastern Cape that were being served by

pastors of the Moravian Church. Now Masangane provides an integrated response to HIV and AIDS by addressing needs for prevention, treatment, treatment literacy, orphans and vulnerable children. Masangane is considered to be a religious health asset (RHA) in itself, and a repository of varying religious health assets at another level. This concept, a significant shift in terminology from the standard "faith-based organisation", will be explained in Sect 1.6.6 below.

In order to provide the context within which Masangane has developed it is important to trace the national and provincial public health response to the HIV epidemic. These provide the backdrop to the Masangane initiative.

1.3 South African HIV, AIDS and poverty context

1.3.1 HIV/AIDS policy, context and response

South Africa, having emerged out of the darkness of apartheid, is overwhelmed by the HIV/AIDS epidemic. The political freedom of democracy and the growing confidence it has brought at some levels is dampened by high levels of poverty and inequality, increasing deaths from AIDS, and despair at the country's capacity to respond to the pandemic. Reasons for despair range from personal tragedies experienced at family and community level through to the seemingly ongoing political intransigence as well as limited capacity nationally to respond to the scale of the epidemic.

The HIV/AIDS epidemic is concentrated in sub-Saharan Africa where UNAIDS estimated in 2006

that more than 60% of the total number of infected persons are located.² Within this region, South Africa's national prevalence is one of the highest and it certainly is home to the majority of those infected, with current estimates varying between 4.5 and 5.6 million South Africans infected with HIV.³

The HIV epidemic in South Africa is predominantly in the heterosexual population. There has been a rapid rise in infected antenatal attendees from an estimated 24.5% infected in 2000 to 29.5% in 2004.⁴ The increase varies between the provinces. Across the country, certain provinces have a more advanced epidemic and thus a higher percentage of those infected (see Figure 1 below).

Across the spatial divide, certain types of settlement are being highlighted as having higher HIV prevalence. The highest is in urban areas, and there people living in informal settlements have a HIV prevalence rate double that of those living in formal housing areas. By contrast, studies show the prevalence in typical rural areas to be lower.

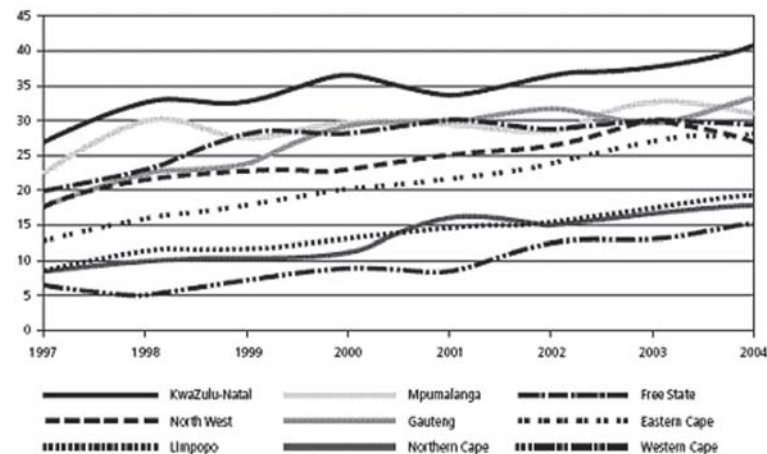


Figure 1: HIV prevalence among antenatal clinic attendees in South Africa by province 1997-2004. (Department of Health data). Source: Marais (2005) *Buckling*, p30 (see Endnote 1).

The difference in prevalence between metropolitan areas, smaller towns, the 'apartheid style' resettlement areas, and deep rural areas has not been assessed specifically. However, Lurie et al. have shown HIV prevalence to be associated with mobility,⁵ and recent work by Singh has highlighted the migratory patterns of those no longer able to work due to ill health.⁶ Poor urban households have been shown to use multiple strategies to address the impact of chronic illness of an income earner,⁷ including 'repatriating' those who are chronically ill to rural family homes to die. Singh also stresses the potential role of faith based organisations in prevention, and in supporting the roll out of treatment.⁸

Certain groups show much higher levels of infection than others. Young sexually active women under 30 have the highest prevalence rate; this can be seen in the trends in the age profiles in the national antenatal data, collected at public health clinics nation-wide, as well as in numerous other surveys.⁹

Trends appear to indicate that the rate of new infections in young women is levelling off, especially in the under 25 age group (see Figure 2).

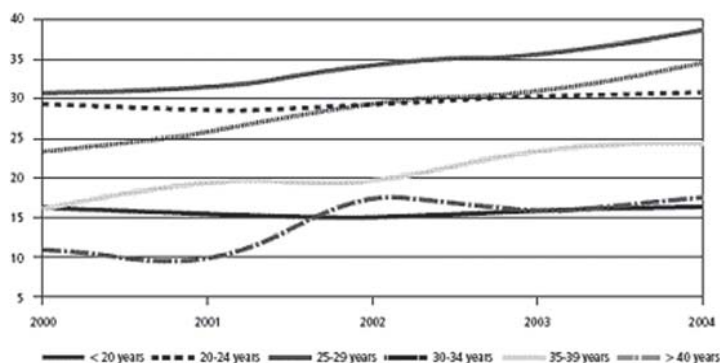


Figure 2: HIV prevalence by age group among antenatal clinic attendees in South Africa (Department of Health data 2000-2004). Source: Marais (2005) Buckling, p31 (see Endnote 1).

A national ARV roll out plan was developed in 2003, and by September 2005, 85 000 people needing ARVs had access to these life saving drugs through the public sector.¹⁰ At the end of 2005, it was estimated that ARV treatment was available in 62% of the local authorities in the country, through 199 public health facilities.¹¹ In addition, estimates are that a further 70 000 people had accessed ARVs by August 2005 via the private sector, their employers or other programmes.¹² However, due to the scale of the need and the limited capacity of the state health system, estimates are that by mid 2005 less than 20% of those needing ARVs as measured by their CD4 count have been able to gain access to these drugs.¹³

Although the capacity of the health service has been a constraint in enabling access to ARV treatment country-wide, certain areas have had the benefit of a quicker roll out programme. Concern is being raised about inequity in access to the drugs as well as the barriers to being able to receive treatment, especially among the very poor.

In the context of Masangane, key issues regarding inequity in access, the limited scale of the roll out, and the capacity of the health system, revolve around:

- Lack of staff, especially trained staff, to be able to implement the programme
- The long distances and high costs for those needing to get access to ARVs in more remote areas
- Long waiting lists with an estimated 20% of those needing ARVs being able to access the drugs through the state health system
- The impact that the high profile, vertical ARV programme (with a lack of adequate horizontal integration)

has had on the morale and capacity of the staff of the public health system at a primary care level¹⁴

- Concern regarding the integration, sustainability and scaling up of the programme and its potential to undermine the health system.

As the Health Systems Trust notes, "Improving the efficiency and effectiveness of existing services is the first step to meeting the health needs of rural people."¹⁵

1.3.2 Eastern Cape policy, context and response

Having considered the role of the public health system in ARV roll out in 2005, it is important to highlight the disparities between urban and rural areas with respect to poverty, especially given the endemic poverty in the country. On a national level, 48.5.% of the South African population would be classified as in poverty; the figure is much higher in the Eastern Cape, as much as 68.3% according to UNDP. This also varies across the province with 61.2% of the population being classified as living in rural areas, where poverty is more extreme.¹⁶

As a result of deep poverty, it is not surprising that rural people bear the greatest burden of disease. Further, rural people in South Africa have less access to health care, and they often cannot travel to urban areas to access public health services there, nor can they access private health care owing to its costs. For the same reasons, the infant mortality rate is much higher across the country in rural areas when compared to urban areas (52.2 versus 32.6 in 1998), and in the Eastern Cape the overall infant mortality rate was 72 compared to the national average of 59/1000 in 2002.¹⁷

Turning to HIV prevalence, the Eastern Cape would appear to be lagging behind the national epidemic according to the ASSA model (2005).¹⁸ It

is thus likely that the epidemic has not as yet reached its peak in the region. A number of studies suggest a provincial overall HIV prevalence of 10%.¹⁹

The prevalence for those in the sexually active age group is much higher, especially among younger women. The provincial HIV prevalence rates of women ranged from 20.4% in the HSRC Nelson Mandela 2005 study for 15-49 age group, compared to 28% in the 2004 antenatal survey by the Department of Health.²⁰ A consequence of the high HIV prevalence rate amongst women is the very high rate of orphanhood found in the Eastern Cape province, second only to KwaZulu Natal; in 2005, the HSRC found that 18.1% of children in the Eastern Cape were orphans compared to 19.8% in KwaZulu Natal.



Driving conditions in the area

Another factor impacting on HIV prevalence in the region is the role that the Eastern Cape continues to play as a base from which people migrate to other provinces for work. At the same time, there is an increasing trend of indigent

people to return home to rural areas in the Eastern Cape when sick, but it is unclear to what extent this alters the provincial HIV prevalence rate. In this study there is anecdotal evidence of some of those now on Masangane's ARV programme having returned home to the region from workplaces elsewhere in the country because they were too ill to continue to work.

A number of ARV sites have now been set up by the state in the Eastern Cape. Indications are that as at February 2006 just over 15 000 people were on ARV treatment provided by the provincial Government. Its health department hopes to nearly double this to 27 000 people by the end of 2006.²¹

This is an ambitious plan given the fact that the Eastern Cape has long been identified as a province of limited capacity that struggles to provide the necessary basic health care. With the province's lack of resources, with a limited economic base and capacity, with structures constructed on the back of a number of previously separate administrative areas from apartheid history, and with its largely rural population, the challenges to the Eastern Cape Government of expanding the provision of ARVs are immense. At the same time, a study in 2004 has shown that in the province, 90.3% of the population is dependent on the public health system, compared to 85 % nationally.²²

1.4 Role of faith based community in responding to HIV and AIDS in a context of poverty

Faith based communities from differing religions have very often responded to human need as a fundamental imperative arising from their tradition and beliefs. This was evident during the apartheid era as well, when many Christian

churches, for example, played a key role in social justice issues. But the same churches have struggled to respond adequately to the HIV/AIDS pandemic, which has proved in some respects to be different due to the sexual stigma and connotations of sinfulness often associated with HIV infection.²³ Nevertheless, various religious groupings have played a role in helping to reduce stigma and to promote prevention, access to treatment, care and support.

In the Eastern Cape, a province that is predominantly Christian and strongly Methodist, there have been a range of responses. These have included broad initiatives through the SA Council of Churches in its Eastern Cape office, as well as denominationally specific initiatives. Some of these have been driven by local faith community groups, perhaps the best known kinds of engagement being through hospices and orphan care programmes. Other initiatives have come from national level, such as the broad-based Anglican programme.

Of these many initiatives, very few faith-based organisations have responded to HIV with the aim of providing treatment. The most publicised and largest in scale is the Roman Catholic Church which, at the initiative of the SA Catholic Bishops Conference, is using PEPFAR funds to make ARVs available to over 2 000 people across the country through 24 individual programmes. These were originally set in place to meet the needs of the dying, and are already part of a Catholic Church local home based care and hospice network of projects. As it happens, they have no initiatives in the Eastern Cape, though there is an ARV site providing drugs at Umzimkulu in Southern KwaZulu Natal just north of the province. No other denominations are known to have provided ARVs except the Moravians through Masangane.

1.5 Aims of the report

1.5.1 Aim of the study:

To understand the role of the religious health assets of the Masangane integrated AIDS programme for public health as a model for a replicable response to HIV and AIDS.

1.5.2 Objectives

- To describe the Masangane programme in its context
- To assess the strengths and weaknesses of the initiative as viewed by multiple stakeholders
- To assess the impact of ARV treatment on health seekers (and their family/ community) and the other activities of the programme (education, treatment literacy and mentoring, home based care, orphans and vulnerable children)
- To identify the 'value added' by the involvement of a faith based community in a HIV and AIDS programme
- To understand the impact of plural health systems on health seeking behaviour and choices
- To evaluate the Masangane project as a faith based organisation's integrated response to HIV and AIDS in a rural area, and
- To assess the potential replicability and scaling up of the programme by other FBO/Is and community based organisations (CBOs).

1.6 Association with ARHAP and its research framework

1.6.1 Association with the ARHAP programme

The evaluation of the Masangane programme forms part of an international cross-disciplinary research

initiative, with a multi-country collaborative structure, aimed at exploring the religious assets that are and can be mobilised to promote health. This is the African Religious Health Assets Programme (ARHAP),²⁴ which coined the term 'religious health assets' used throughout this report.

The primary assumption of the research undertaken by ARHAP is that religion in its own right is important to the health of individuals and communities. This basic assumption lies in direct contrast to the secularisation thesis that has ruled the social sciences and academia in general for so long.

The research on Masangane forms one of ARHAP's case studies, each designed to explore different aspects of initiatives, programmes and organisations that rest on faith-based or religious origins and structures. Other current studies that dovetail with the Masangane work include research being carried out at district, regional and national level in Lesotho and Zambia as part of a World Health Organization contract to map religious health assets (quantitatively and qualitatively).²⁵

Some of the concepts utilised in this study are drawn from work in ARHAP. Here we clarify some of them as relevant to understanding the focus of this study:

1.6.2 Religious health assets and agency

The ARHAP model builds on the assumption that human communities have assets of various kinds, not just material, that are critical to their capacity to survive and grow. These assets take effect through the agency of individuals and groups acting to deal with their situation.²⁶ It is simply wrong to make the assumption that poor people are 'not able to do'. In fact, they are always engaged in strategies and struggles for survival, adaptation and freedom. What is still unclear is how agency is formed around faith

or through faith-forming entities and religious organisation as it impacts on health, that is, just how religious health assets come into play. The critical issue in this context is how this relates to the work of FBO/Is in engaging HIV.

The term 'religious health assets' (RHAs) is related to the more common use of the idea of 'faith-based organisations' or FBOs. It is not the same, however. It captures two theoretical points: That the interface between religion and health can be understood in terms of both tangible and intangible assets; and that an asset-based developmental logic is the most useful approach to understanding the way in which religious or faith based interventions and activities engage with matters of health. These notions may be defined as follows:

1.6.3 An asset-based logic and approach

'Assets' carry value and may be leveraged to create greater value. 'Needs', by contrast, imply that we are seeking to identify and overcome what is found to be lacking. 'Assets' points to human agency in the local context, and prompts us to identify what is already there to work with, rather than beginning with lack or need - concepts that emphasise outside agency, or even undermine local agency. External resources remain important, but policy, usually driven 'from above', and therefore inherently oriented toward prioritising external resources, might be better served by an approach that mobilises existing internal assets, strengths and capabilities.²⁷

1.6.4 Tangible and intangible RHAs

Religion may be an asset in a variety of ways. One tangible example is missionary involvement in setting up hospitals and clinics in Africa that are still relied on today and in more rural parts of Africa

are often the only healthcare facilities available. Here we may speak of tangible religious health assets.

However, religion can also have more intangible effects that could have great potential for impacting health in Africa if they were more clearly understood. From volunteerism and education to behaviour change and social capital building - little is known for instance, about how religious involvement can engender hope or resilience. Yet, ARHAP believes that what often makes RHAs different from other health associations, institutions or structures lies in what is not visible - the volitional, motivational and mobilizing capacities that are rooted in vital affective and symbolic dimensions of religious faith, belief and behaviour. This is one key focus of the present study.

1.6.5 Religion

Exactly how to define religion, what to include and what not, is central to the academic study of religion, and multiple definitions are available. Here, in relation to our purposes, we take religion to include a wide variety of comprehensive systems of beliefs and practices held to be sacred, usually (but not always) issuing in religious institutions, groups or organisations that range from fluid to codified, popular to formal, centralised to decentralised, communal to institutional. In Africa, this includes particularly African traditional religions, Islam and Christianity.

Technically, this is a pragmatic definition of religion, therefore, rather than a substantive one. Its relevance and usefulness lies not in describing some essential object - a "thing" given in reality

to which we attach the name religion - but rather in acting as a significant focusing lens for reflection on human identity and difference in relation to a field of relations that includes person, culture and society. It functions as an analytical category, in our case, to speak of certain forms of Christianity and of African traditional life as expressed by Masangane clients, which shape their self-understanding in general and their response to health interventions in particular.

1.6.6 Faith-based organisations or initiatives (FBO/Is)

Religion or religious entities are not always construed in terms of visible institutions, let alone representative ones. In the field of health, faith-based interventions are often expressed through clearly defined, structured organisations. But equally often they are rather expressions of a movement or an informal but enduring group, which may at some point turn into an organisation, or may not do so. Hence, in order that such activities are not declared or treated as invisible, when they are clearly important to faith-based interventions in health, we have throughout this study preferred to use the double acronym "FBO/I" to encompass both faith-based organisations (FBOs) and faith-based initiatives (FBIs) that are not organisations in any standard sense.

Thus, it is the case that Masangane began as a faith-based initiative, in this case of a pastor (Rev Mgcoyi), a field worker (Ms Magoloza), and a fundraiser and catalytic mediator (Rev Cochrane), with



Field researcher in interviewee's home

Rev Matinisi joining early on. Typical of what happens in the church, they simply began with an initiative that was a response to a pastoral crisis. Over time - for reasons that are obvious in the history we give of Masangane - and again typically, the success of this initiative required an increasingly formal organisational framework and a move away from a loose or ad hoc intervention. Yet Masangane was doing crucial work for a long time before this point was reached. It is this kind of reality that we wish to foreground in using the acronym FBO/I.

1.7 Methodology

1.7.1 Research design

A mixed method case study design was used. This involved key informant interviews, in depth interviews and participant observation and focus group discussions. While the study primarily made use of qualitative methods, a questionnaire was also developed and administered specifically to quantify and understand in detail the views and circumstances of the beneficiaries of the project.

1.7.2 Methods used

Tools

The range of instruments were prepared, piloted and revised before being used in the field.

The objectives of the study outlined in Sect 1.5.2 informed the development of the tools as did the most suitable research methods given the wide range of actors involved in Masangane activities. For each objective, there was careful assessment of who would be the appropriate sources of information and the best research methods to use.

The tools developed included:

<i>Tools</i>	<i>No.</i>	<i>Interviewees</i>
Key informant interviews, semi-structured	16	Funders, doctors, decision makers in Masangane as well as health seekers
Additional unstructured interviews	6	Traditional healers and family members of clients
Health seeker ("client") questionnaires	77	Includes 59 Masangane clients on ARVs and 18 not on ARVs
Focus groups	2	One support group in Matatiele and one in Shiloh
Participant observation		Support group meetings and households identified from the health seeker questionnaires

Table 1: Tools used in the Masangane evaluation study

Qualitative data: Key informant interviews, focus groups, participatory observation

The primary source of data collected was from a range of qualitative instruments.

Data was collected making use of key informant interviews,²⁸ in depth interviews, participant observation, and focus groups.

We conducted 16 key informant semi-structured interviews and 6 additional unstructured interviews with traditional healers and family members of clients. These included all of the staff and key support personnel who instituted Masangane or maintain its work, some additional members of the management committee, two Moravian Bishops (one from the region and one from the Head Office of the church), the President of the Moravian church, the two medical doctors in private practice who are key to the treatment programme in Matatiele and Shiloh respectively, and the medical doctor from Médecin Sans Frontière (MSF) in Lusikisiki in the Eastern Cape, who has been a key

advisor to the programme.

Most of the interviews and the participant observation were conducted by two Xhosa-speaking field workers, while other team members spent five days in the area. The handwritten records of the interviews were typed up and the digitally recorded data was transcribed and translated. Together these sources provided a very rich electronic data set, which was analysed using *Atlas.ti* software. The coding approach was agreed upon by the research team and undertaken largely by those who undertook the data collection.

Besides the methods of collecting data noted above, we were given access to documentary records, annual reports, photographs and published pieces on Masangane, all of which were used to



Field researcher working on data

add to the description of the history and context of Masangane, and additional information on Masangane's work and operations. Photographs were also taken of key individuals and some of the religious practices and context of the study sites.

Qualitative analysis software requires the mechanical task of loading and coding the data, which in turn required judgements about appropriate coding categories made by the

researchers. While certain categories emerge from the data set itself, they are also governed in part by what the researchers are looking for. This is where the greatest leeway exists for different ways of viewing the data, even when using a standard coding list.

In our view, this is both a limitation and a strength of the data set: a limitation in that interpretive variations do occur; a strength in that it offers a rich set of interpretations, from different disciplinary traditions and frameworks of knowledge and accumulated wisdom, that display critical and necessary insights into the way in which a FBO/I such as Masangane works, and succeeds, in its integrated response to HIV and AIDS.

In short, the results are more likely to reflect the real complexity and ambiguities inherent in a programme such as Masangane and its context, even as it reflects the different perspectives one may bring to the data. At the same time, the controlled nature of the coding process, including ongoing discussions in the research team about codes and categories, allowed for a level of assurance about the results that ad hoc interpretations would not. Further, the multiple methods used in obtaining data helped to build up a complex picture for the research team, adding to the validity of the findings.

We provide for the readers of this report, in Appendix A, a critical perspective on the limitations, but also *the crucial value*, of qualitative research, as we have undertaken it in Masangane.

Quantitative data: Client survey

The client or health-seeker survey was carried out using a structured questionnaire, piloted initially at the Masiphumele clinic in Cape Town, and administered by ARHAP researchers in the field. Of some 100 clients at the time of the survey (88

on ART), 77 were interviewed (59 on ART, or 67%). Those included in the study were selected based on availability and thus do not represent a random sample however, given the finite population correction the standard errors are likely to be small. Given the small population size and the nature of the study, the data from the sample could be described as providing a reasonable reflection of the responses and experiences of Masangane clients.

The questionnaire²⁹ was developed to incorporate a number of themes. These included a socio-demographic profile of the respondents, self reported health and mental health, religious beliefs, health seeking behaviour and where appropriate experiences of using ARVs and Masangane's services.

Standard questions were used for as much of the data being collected as possible. These included validated measures for self reported health and mental health (using the WHO's SRQ20 questionnaire). New questions were developed for the ARHAP special areas of interest - notably those objectives of this study (see Sect 1.5.2) which explore the value added by Masangane's being a FBO, participants' plural health approaches and the impact of plural health systems on their health seeking behaviour. In the piloting of the whole questionnaire, responses to these questions were assessed very carefully with the added benefit of insights of specialists in religion and health seeking behaviour and anthropology who were part of both the piloting and pilot results assessment team.

Likewise the frequency data from the questionnaire was also the subject of much discussion by the research team, drawing on a multi disciplinary range of skills.

The data was entered into Excel and analysed using SPSS v13. Frequencies and cross tabulations were generated using SPSS.

1.7.3 Ethical issues

UCT Humanities Faculty Ethics Committee gave ethical approval for the study. The analysis of the quantitative and qualitative data has been undertaken and reported in a way to secure the confidentiality of the individuals interviewed through the use of code names. This applies to all individuals other than the key informants who need to be identified as they play specific roles, for example the doctors and nurses.

The core Masangane project team agreed to the study taking place. Before being interviewed, all participants were asked if they were willing to participate in the study and were given an Information sheet which provided further details of the study and contact details should they have required further information. The information sheet also reaffirmed that they were not obliged to participate and could have withdrawn at any stage. Interviewers were responsible for ensuring that consent forms were filled in and signed before any interview actually took place. Permission was also requested to make use of a digital voice recorder where appropriate.

The consent forms and interview sheets, transcripts as well as other data sources (e.g. electronic data files) have been stored safely in the Department of Religious Studies at the University of Cape Town.

1.7.4 Translation

The research was undertaken wherever possible in the first language of the interviewee. The focus groups were undertaken in isiXhosa and led by an isiXhosa first language speaker. Likewise, interviews of key informants and in-depth interviews also took place in the mother tongue of the participant except where the participants were comfortable to speak in English. Prior to piloting,

the questionnaires were translated and back translated and were printed in English and isiXhosa.

Translations of transcripts were undertaken by the research team and in some cases by contracted researchers and checked for accuracy by a member of the research team.

1.7.5 Timing

The study largely took place during 2005. It has however also tracked the evolving changes which have taken place in Masangane during the period from May 2004 until February 2006. Following a preliminary workshop at Hout Bay in May 2004, the details of the research were planned at a follow up workshop in Morija in January 2005; and tools were developed during February and March with piloting and ethics approval following. Field work took place in April to August 2005. The data entry, translations and analysis took place over the subsequent 5 months. A preliminary presentation of the findings was presented at the ARHAP Colloquium in July 2005, at the 3rd SAHARA conference in Dakar, Senegal in October 2005 and to a DIFAEM workshop in Tübingen, Germany, February 2006.

1.7.6 Different needs - different products

The research has multiple objectives ranging from academic to practical project evaluation. The multiple objectives will result in multiple products being generated in addition to this report. These include:

- Evaluation report of the project
- Report back of findings to key role players including the Masangane ARV programme and Vesper Society who are funders of both the programme and this evaluation.
- Presentation at the annual ARHAP Colloquium in Gauteng, July 2005
- At least two peer reviewed journal articles which

would provide the appropriate opportunity to be able to make a contribution to the theory ARHAP is exploring at the interface of public health and religion

- Circulation of lessons learned to other FBOs potentially involved in integrated HIV and AIDS programmes

Further outcomes were also envisaged: These included the presentation of the findings to inform the Eastern Cape public health and religious leaders, FBOs offering HIV/AIDS responses and national policy makers (see Chap 7: 7.6) as well as capacity development of the research team.

Given the above wide diversity of objectives and products, this report merely provides a very limited comment on the potential theoretical contribution of the findings. From preliminary assessment, the theoretical contribution of the research to the health and religion interface is exciting for the research team and will be explored further as part of ARHAP.

1.7.7 Research team

The team was co-led by Liz Thomas (MRC's Health and Development Research Group and the Centre for Health Policy of WITS School of Public Health) and Barbara Schmid (Religious Studies, UCT). Together they provided experience in the setting up of the study, management of field work, data analysis, report writing and project management. Additional support and writing, especially in the field of religious assets and analysis, was provided by Prof. James Cochrane. Two post-graduate students were responsible for the field work. They are Mr Malibongwe Gwele (Religious Studies, UCT), and Ms Rosemond Ngubo, (Anthropology, UCT). Further technical assistance in the field was provided by Kgetheng Dlamini and Mary Bennett of Johannesburg as well as Mary Baich of the Vesper Society, USA. Jill Olivier (ARHAP, UCT) assisted with proofreading and publication preparation and layout.

The study provided an opportunity for capacity development for the two senior students to obtain further field work and analysis experience under the supervision of the two co-leaders. The whole team also benefited from Atlas training.

1.7.8 Funding

Masangane as an ARV programme depends on multiple sources of international aid. Funding for this study was made available by one of the US funders of the Masangane ARV programme, the Vesper Society. An amount of USD 25 000 was allocated for this purpose. In addition, substantial contributions were made in kind by Religious Studies, UCT and MRC in the form of time of the research team.