Enabling Congregations: Church-based networks and resilience to the impacts of high morbidity and mortality in North-East Namibia

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Abstract

It has been suggested that participation in the 'right' kinds of social networks can contribute to reduced susceptibility to HIV infection and increased resilience to the impacts of high chronic morbidity and mortality by facilitating access to important material and symbolic resources. This hypothesised connection is being empirically explored through a case study in North-East Namibia, set in a location that typifies what has come to be seen as an environment of risk in the HIV & AIDS literature: a peri-urban area with high unemployment and high levels of migration. Churches from a range of denominations have emerged as the most common contexts for forming extra-familial relationships and have been described as important elements in social support networks by many, although by no means all, research participants.

This research suggests however that a nuanced understanding is required of the possible role of churches and church membership in building resilience to the impacts of chronic morbidity and mortality. Narratives of participation in and utilisation of church-based networks interweave with notions of social status, self-esteem, role fulfilment and explicit or implicit recognitions of the broader social milieu. Individuals that are marginalised in the community are more likely to remain at the periphery of church-based networks, either as they find it more difficult to become 'a somebody' in the church, or as they choose to avoid exposing themselves to gossip and identification with an undesired label: sick, dirty or poor. This presents a considerable challenge to church-based initiatives that target support at people living with HIV. Furthermore, the conceptualisation of HIV is changing in Namibia. With the availability of free ART, it is now possible for many people to manage their medical condition in private, reducing reliance on support groups and de-necessitising sero-status disclosure, further complicating attempts by churches to effectively target people living with HIV for support. Finally, it is suggested that the availability of human and economic resources within congregations is a significant dimension of the capacity of local churches to respond to the challenges being posed by HIV & AIDS, and that this should be taken into consideration when forming expectations about the role that local churches may play in the response to HIV & AIDS.

Background

From narratives of support networks by thirty-four participants, churches emerged, alongside the hospital, as one of the primary, and in many cases sole, contexts for obtaining extra-familial support, including counselling, advice and information, friendship and in some cases financial support. In order to describe and interpret patterns of resilience to the impacts of AIDS-related high level chronic morbidity and mortality, it is therefore important to understand how people engage in and utilize church-based

networks to access key forms of support. These may include short term credit, emotional support, help with making funeral arrangements, health information and so forth. The core research question is: 'To what extent are churches in the research sites able to enable community members to respond to the impacts of HIV & AIDS?' This paper will focus on some of the challenges facing efforts by churches to provide support to members of their congregations and the wider community that are affected by HIV & AIDS.

The starting point has been to generate narratives of (non-)participation in and (non-)utilization of church-run services relating to HIV prevention and impact mitigation. Three areas have emerged that will be discussed: the relationship between social status and participation in and utilization of available services; the emergence of new discourses around living with HIV resulting from the availability of free ART; and the capacity of local churches to deliver services in response to high levels of chronic morbidity and mortality in the community.

The research is set in Rundu, Namibia, on the North-Eastern border with Angola. Rundu, capital of Kavango, one of Namibia's poorest regions, has had adult HIV prevalence estimated to be around 15-20% for the past decade (MoHSS, 2004[1]). Rundu fulfils the archetypal high risk environment of much HIV & AIDS literature: situated on one of Namibia's major transport routes, despite areas of rapid economic growth the town boasts unenviable levels of income inequality and unemployment (UNAIDS 2006), and a young and mobile population including a large military base and an abundance of people working formally and informally in transport and entertainment industries. The research site is at the periphery of Rundu in a peri-urban area. The majority of participants are primarily dependent on subsistence agriculture, livestock, small-scale fisheries and support from the World Food Programme.

Exploring social networks

The enthusiastic application of a Putnam-inspired concept of social capital in public health literature (Moore, Haines, Hawe, & Shiell, 2006; Moore, Shiell, Hawe et al., 2005) has promoted interest in a particular kind of social relationship believed to somehow harbour health-promoting qualities: voluntary participation in groups (Hawe & Shiell, 2000; Putnam, 2000). In doing so, alternative approaches to the concept have been marginalised, notably that of Bourdieu, which focus more on the mechanisms through which participation in groups enables individuals to access material and symbolic resources (Bourdieu, 1986; Portes, 1998). Material resources may include items like money, credit, food, clothing and labour, whilst symbolic resources may include things like qualifications, social status and reputation. It is particularly this approach, with its emphasis on the qualitative aspects of relationships within groups and the availability of resources within the networks that constitute and are constituted by those groups, which provides the theoretical point of departure for this research.

I broadly adopt Latkin and Knowlton's definition of social networks as "constellations of personal networks" (Latkin & Knowlton, 2005: S103). Personal networks are ego-centric, they belong to individuals and can be utilised by them to gain access to material and symbolic resources. Social networks are like a map of the configuration of relationships in a given social space. They are not seen to belong to one individual; rather individuals

[1] MoHSS is the Ministry of Health and Social Services, Namibia

participate in and identify with a number of social networks. Social networks 'constellate' in different geographical and social spaces, such as the home, a church, a sports club, the workplace, an informal hangout, and internet chat-room and so forth (Kipke & Unger, 1997; Madhavan, Adams & Simon, 2003; Nardi, Whittaker & Shwarz, 2000).

Individuals negotiate the meaning of a social network through their interactions with members of their reference group, so each person may have a different definition and experience of a nominally identical network; different vantage points within a network offer different views of it. The chairperson of a church committee may include other churches and inter-church conferences in their description of a church network. A socially marginalised young person might only experience the church network as the youth group, and even then they might be excluded if, for example, they are unable to host youth group meetings at their house because they are unable to provide refreshments.

Stack suggested that social networks are an important means of accessing material and symbolic resources beyond household and kinship networks, particularly for individuals of low socio-economic status (Stack, 1974). However, the characteristics of social networks are also driven by the characteristics of the households and individuals that constitute them, and by the institutions in which they are embedded. Church-based networks are affected by the wealth of the individuals in the congregation and to some extent by the wealth of the denomination to which the church belongs. So, congregations dominated by unemployed people from predominantly poor households are unlikely to be rich in economic capital, making it more difficult to respond to some of the needs of the congregation that require inputs of economic capital.

Perceived participation or non-participation in social networks is also an important element in the formation of self-concept and of what Kleinman calls "local moral worlds" (Kleinman, 1992); the "contexts of shared experience" (Meinert, 2004: 13), integral to the demarcation of communities of identity and their formation of social norms and expectations. Being part of a church is an important identity co-ordinate in the research sites with 'being a Christian' broadly seen as a positive attribute (Health Communications Partnership, 2005). Being part of a congregation enables individuals to claim membership of a local moral world that is rich in what Bourdieu would call cultural capital (Bourdieu, 1986), associated with a set of 'admirable' aspirations: to do something in the community; to help others; to live according to God's commandments.

Church-based networks may extend beyond the bounds of congregations, for example through the priest who is based at the mission or through contact between deacons at different churches belonging to the same denomination. However, it is the congregation that, for most of the participants in this research, constitutes the church-based network. As such, I take the congregation as the core unit in church-based social networks for the purposes of this paper.

Methodology

Interviews were conducted in one of eight administrative blocks in the location[2]. About half of the participants were randomly selected through households. The other

[2] This research makes up part of a broader project that includes another research site on the other side of the town. The particular administrative block was chosen in order to provide a contrast with that other site.

participants were recruited either through the local clinic's TB programmes or due to their occupation as fishers[3]. A total of thirty-four participants have been interviewed. It is not possible to say how many of these are living with HIV as some do not know their status and participants are not asked to disclose their status unless they feel comfortable doing so.

First conversations with the participants were through semi-structured interviews about perceived meanings of 'a happy life', hopes and aspirations for themselves and their families, perceptions of health problems in the community and concerns about their and their family's health. This provided organising themes for the second round of conversations, oriented around an egocentric support-network drawing exercise.

The egocentric network drawing exercise was adapted from a training exercise used by Voluntary Service Overseas (VSO), utilising work on networks of intra-venous drug users (Trotter II, Rothenburg, & Coyle, 1995; Schensul, LeCompte, Trotter II et al., 1999). The participant is asked a series of questions, clustered around themes that emerged from the first conversations: emotional support and companionship, finance, nutrition, work, and personal and family health. As participants respond they build up a network map with more important sources of support represented with larger circles and the frequency of support or contact symbolised by the proximity of the circle to the ego. This is followed by a conversation about the diagram: what kinds of support are missing, who are the most important people or institutions, why people have been included or omitted. Whilst recognising that the diagrams themselves provide very thin descriptions of participants' support networks, they provide a focus for reflection and for teasing out narratives of participants' relationships with other people in their communities.

Interviews with eight church leaders were conducted to better understand the contexts of the churches frequented by participants. Four areas were discussed: demographics and management structures of the church; services delivered to the community; the church's response to HIV & AIDS and other perceived health challenges; and personal experiences of receiving support from the church.

All interviews were carried out and discussed with local research assistants to facilitate authentification of the data and my interpretation of them. Themes have been revisited through informal conversations with inhabitants of the research site and through participation in church and community activities.

The research has some limitations. This paper is based on research carried out in the first four months of a fourteen month fieldwork period, and is based only on experiences of people in one atypical location in Rundu. Most parts of Rundu are at the opposite end of the rural-urban shift.

Results and discussion

After the hospital, churches were described as the most important form of extra-familial support by nearly all participants. Having a relationship with God was often cited as the primary reason for church attendance and high perceived importance of the church as a

[3] This interest in fishers as an occupational group ties in with a broader research interest of the AIDS and Development Group (ADG) at the University of East Anglia into the occupational identities and risk behaviours of fishers.

source of support. Consolation, emotional support and material support during funerals and memorials were also prominent forms of perceived support.

In the location there are thirteen churches serving a population of approximately 8,000 people. These churches include Catholic, Gospel, Apostolic, Interdenominational, Evangelical, Baptist, United Reform and Independent Churches. Of the thirteen churches, eight have participated in the research, the others lie at the opposite end of the location to the research sites and no participants have mentioned them during interviews or informal discussions.

Church leaders report more or less stable congregation sizes. All the congregations are female dominated, with every church leader estimating between 60% and 80% of the congregation are female. This is corroborated by patterns of church attendance reported by participants. Men of working age are largely absent. This may be a reflection of widespread migration of young men towards nearby Rundu town and other towns in search of employment, however informal discussions with members of churches in town suggest similar patterns of attendance there. Further exploration of the causes of such a clear gendered disparity in attendance is required, but is beyond the scope of this paper.

All church leaders reported activities aimed at reducing the impacts of HIV & AIDS among their congregations, with 'providing information about illness and testing', 'giving emotional support through prayer and counselling' and 'material assistance during funerals' the most common forms of support. Most churches also expressed a desire to extend services in response to the perceived challenges of HIV & AIDS, with some churches having already begun working towards establishing kindergartens for orphans and vulnerable children and vegetable gardens for people living with HIV. None of the churches made claims to cure HIV[4].

In all cases, church affairs are almost entirely managed by people drawn from the community. It is also the local church that runs most HIV & AIDS related activities, even in the case of the Catholic Church and ELCIN (Evangelical Lutheran Church in Namibia) that have established national charities to respond to the HIV & AIDS epidemic.

Three main points for discussion emerge from the data: the interaction of social status and participation in and utilisation of church-based networks; changing discourses about HIV & AIDS in the context of wide-scale availability of free ART; and the differential capacity of congregations to manage their affairs and the vulnerability of local leadership to the impacts of high chronic morbidity and mortality. The first two points relate to the question of who participates in and effectively utilises church-based networks. The third relates to the strength and resilience of the network itself.

Social status and utilization of church-based networks

Comments about social status are prominent in the narratives of participation in church activities. Unsurprisingly, higher social status is associated with holding prominent positions in church-based networks and high perceived availability of church support. However, this appears to be a two-directional association with high social status

[4] Some participants mentioned 'healing' churches in town, although they were referring primarily to healing of spirit-related conditions, rather than the elimination of HIV from the body. Attendance at healing churches was in addition to and not instead of taking ART.

facilitating centrality in networks and centrality in church networks being seen as a means to gain status. Furthermore, narratives of participation in church activities contain accounts of losses as well as gains in social status.

Social status in the community is a strong predictor of position within the church. For example, all the teachers in this study occupy prestigious positions within church committees. On the other hand, some socially marginalised participants described difficulties in 'becoming a somebody' in the church. This might not be due to intentional exclusion, but to subtle processes that see people drift to the periphery of church-based social networks, from where they are less likely to access the resources available through those networks. Social networks structure and are structured by macro-social environments, they become aligned with the socio-political environment, reproducing existing social, political and economic structures (Bourdieu, 1990). As such, patterns of marginalisation may be, often unintentionally, reproduced through networks that are socially embedded. One former street youth described how this might happen.

> "There is the youth group that has people visiting each other when they have problems – but if they come to your house and you don't give them anything to eat then they won't come again." [Paulus[5]]

Churches were described by several participants as a forum in which one can build up status in the community. Becoming somebody in the church enables you to become 'a somebody' in the community, with the associated benefits that this brings.

> "I wanted to be a reader there so that I could do something for my community… If I do that for my community then I become a somebody in the community, like a famous person. Then if I have a problem it cannot be so bad." [Eddie]

Being a reader at church or singing in the choir is described as an effective means to becoming a recognised person in the community (or to meet girls). This is in turn associated with being more able access help and support when problems are encountered. In the absence of other opportunities for individuals to acquire social status in the community, it is important to seize those presented through the church. This is alluded to through Nicolette's comments that identify one of the bi-products of this process: jealousy.

> "One of the problems at that church is the jealousy. Like I am running the kindergarten, but the other one is jealous of me because she wants her daughter to run it." [Nicolette]

The possibility of gaining status is a powerful motivator for involvement in church life, above and beyond the spiritual motivations and personal satisfaction that can be derived from it.

However, a counter-discourse related to social status highlights potential costs of participation. Gossip is a strong theme in many interviews, with 'not being a person to gossip' often cited as a reason for friendship. The local church, with its focus on moral correctness and confession, is a place where personal life may come under even greater

[5] All names used in this paper are pseudonyms, mainly chosen by the participants

scrutiny than it does in the normal cauldron of community life. The theme of gossip is especially relevant in relation to HIV & AIDS as it continues to be the subject of much speculation and moral evaluation.

> "The thing is at church they will be gossiping you. 'That one was so thin and now she is coming fat again, she must be on the tablets'" [Maria]

> "I wouldn't go there to talk about my problems … to be honest I don't trust those people, they would be talking about you. It's not the church leaders, it's those people that go there. That's why I just go and pray to my God." [Daz]

There are two broad categories of response to such concerns about being or becoming the subject of gossip among co-religionists. The first is disengagement with aspects of church life. This may include an unwillingness to attend confession, non-participation in church groups or not actively forming friendships with other members of the congregation. Maria and Daz still attend church regularly and describe the church as an important part of their lives, however, neither would use church resources to cope with the challenges associated with chronic morbidity. The second is disengagement with the church, which may include moving to another church, less regular church attendance or ceasing to attend any church.

> "It's a long time since I'm going to church … My clothes are dirty, I don't have soap and water to take a shower so I don't go … because there they are talking about hygiene – they might not let me in and they will ask me why I don't take a shower." [Mapeu]

> "You should have a special thing to go to church. If I go like this they will say "Is he going fishing?!" … so I don't go." [Mondaha]

This second response is particularly significant when viewed through a social networks lens. Withdrawal from a church-based network reduces that individual's access to the resources available through the network, and may weaken the network itself if sufficient numbers of people withdraw partially or entirely from the activities around which the network is oriented.

Church attendance and participation in church activities offers potential gains and losses in terms of social status. Being a Christian and being a church-goer may be desirable identity coordinates and associated with high self-esteem however, people of low social status tend to be at the periphery of the church-based networks and perceive less church-based support. The recognition and reaffirmation of their low social position at church may further disincentivise participation in church activities. When considering the extent to which churches can build resilience to the impacts of HIV & AIDS it is therefore relevant to ask: 'if churches are renowned as hotbeds of gossip, how likely are they to successfully deliver services for people living with a medical condition that is still strongly stigmatised?' Furthermore, the context of living with HIV is changing in Namibia with the growing availability of ART; a change that is providing individuals with more choice about how they approach living with HIV and changing the dynamics of the relationship between people living with HIV and the many service providers.

New discourses of HIV & AIDS: a manageable medical condition

> ‘Like it can be that I’m taking these ARV and your father is taking these tablets for high blood pressure. He doesn’t need to be in a support group, it’s just up to him. Then it’s the same for me to take these ARV, I don’t need a support group’. [Eddie]

Another emergent theme of significance to the utilization of church-based support is an apparently new discourse around HIV & AIDS, emanating from health professionals and organisations delivering health services as a result of the growing availability of free ART. Being diagnosed as HIV positive is ceasing to mean the beginning of a slow or not so slow decline, it is no longer the signal to run to church to receive your last rites. Instead, people are being encouraged to think of HIV as a medical condition to be managed, rather like high blood pressure. This is being done to help promote voluntary counselling and testing (VCT), and it is being successful. Staff at the New Start VCT centre in Rundu are sometimes unable to cope with demand, a change from previous years.

Such a conceptualisation of HIV has a number of consequences for organisations seeking to provide support to people infected and affected by HIV & AIDS. One of the outcomes is a growing recognition by people diagnosed as living with HIV that they are able to choose how they wish to approach this challenge. As ART can be a matter of taking your tablets in accordance with the doctor’s instructions; joining a support group starts to become a matter of choice. Indeed some participants felt it unnecessary to disclose their sero-status to anyone other than a partner and some close relatives. Many people choose not to speak to church leaders or other congregation members about their HIV status. The opportunity to make choices is generating space for critical reflection about what it means to be part of an HIV support group or a home-based care group.

> “They say that in the group it is confidential, but already you are in the HIV group, so people know that you are positive!” [Eddie]

Despite the majority of churches in this study encouraging people to take HIV tests and having a rhetoric of openness, the church leaders all reported that they did not know approximate numbers of people at their churches on ART, and that they are only rarely approached by people that wish to discuss their status with them.
The attraction of managing your own health in private is easy to understand; HIV is still often associated with promiscuity and sin, and if it becomes public knowledge can have significant consequences for many aspects of life, including finding sexual partners, an important source of psychosocial support, self-esteem and social status for men and for women.

Yet this does not necessarily mean that churches may have less of a role to play as the ART role-out continues. Firstly, taking long-term medication for a potentially life-threatening condition can be stressful and participants with high blood pressure describe how important it has been for them to be able to discuss this with church elders. In addition to this, HIV & AIDS are by no means the only or even the main challenges perceived by people in the location: unemployment is high, many households rely on the meagre old-age pension of one or two members, there are growing concerns about falling yields and erratic rainfall, and basic services like sewage and drinking water are

either unavailable or unreliable. Many research participants still show a willingness to be involved in support groups of some form, there is still a 'market' for them, but there is a question to be asked about the way that these are labelled.

> Maria: "If there was a HIV support group or something like that there then I could join."
> Joel: "And what would you hope to gain from participating in that group?"
> Maria: "I don't know, just to be in it, then we will see what comes."

For the time being it may continue to be possible to corral people into support groups, regardless of the titles given to those groups. However, if free ART act as a catalysts for a shift in the way that living with HIV is perceived, then church programmes will have to adapt. One participant complained that he has been left alone to look after a vegetable plot for people living with HIV as the other group members are afraid to be seen working there. Not being able to get a girlfriend was seen as the main disincentive to working in the garden.

With an apparently increasing number of people able and wishing to deal with their medical condition in private, defining a group by the sero-status of its members, rather than simply calling them a 'community action group' or something to that effect, may discourage participation. Building supportive networks to promote individual, household and community resilience is important, but will have limited success if participation in those networks entails an undermined sense of social status and self esteem.

Institutional capacity and availability of support

A further disincentive to participation in HIV-related church activities is a concern about the inability of churches to respond effectively to the challenges being identified and experienced by congregation members. Several participants referred to the differential capacity of churches to provide support, associating this with the perceived availability of economic and human resources within congregations: somebody able to supply credit when the electricity needs to be paid; somebody with a pick up truck to transport people for a funeral; or somebody who knows how to apply for support from external donors. Participants expect that churches with more wealthy and educated people in their congregations, and particularly in their committees, will be more able to effectively manage church affairs and more effectively respond to the needs of their congregation.

> "You see that church, that maybe in the committee there are some teachers, and the business people, and you know that the things will happen there. Even if there is a problem they will be able to act fast. Then you would want to go to that church because you know it can help you" [Eddie]

> "When I was sick, there was nobody helping me from church, it was just the one, the church leader who would visit. I tried to go to the other church, the one in town, the Apostle Church. There we could go every day, for Bible reading or for prayers, there was a lot of support." [Nicolette]

Nicolette's church belongs to one of the wealthier denominations, however, it is not so much the wealth of the denomination that is important, but the congregation and the expectation that they should provide support. The majority of the congregation in this case are scratching a living from subsistence agriculture, and most of those that have

completed school have moved away to seek employment, making it more difficult to organise around and respond to challenges in the lives of members of the congregation.

AIDS-related morbidity and mortality is further undermining local capacity for effective management of churches and their responses to HIV & AIDS. The loss of skilled and experienced individuals as a result of the HIV & AIDS epidemic has been already considered in relation to agriculture (Barnett & Blaikie, 1992), mining and fisheries (Allison, & Seeley, 2004). A similar process can be seen occurring here within churches.

> It has been very dangerous and we have lost a lot of people. In 2004 we lost our highest catechist, he was a principal. Up to now I'm alone; all my colleagues have passed away, all the ones with experience. From the group of 1981, I'm the only one remaining. [Michael]

The effects on church-based networks can be illustrated with an example. In a church-run home-help group, if somebody becomes chronically ill, they may be less able to contribute their labour to the group as their body is weaker, their time taken up by visits to the clinic and a greater portion of household income is spent on healthcare. If several people in the group become less able to contribute their time and resources to the group, that group becomes more dependent on a smaller number of individuals, more vulnerable to health shocks affecting those people and less able to fulfil its previous role.

As well as the direct loss of church members, pressure on the time of key figures within church networks may mean resources being drawn on and divided amongst a number of different networks.

> The pastor and deacons have already had some meetings [about an inter-denominational programme to initiate a home-based care scheme]. You know, the group wanted to start, to be active, but they themselves have a problem in their household, so they are unable to start. [Augusto]

The churches in this study are seeking to organise around responses to HIV & AIDS and seize some of the opportunities to engage in the daily lives of their congregations presented by the high chronic morbidity and mortality. These responses include efforts to provide emotional and spiritual support and attempts to generate and distribute limited material and financial resources. However, the capacity of most of the churches in this study is limited by the absence of different forms of capital among the people that comprise the congregation and the church leadership, the community itself. The churches, like other institutions in Rundu, are affected by the broader social context that includes chronic high unemployment, urban migration of younger and more educated people, and soaring morbidity and mortality rates related to HIV & AIDS that result in the loss of leadership and valuable experience.

Concluding thoughts

This paper set out to begin to explore the role of churches in the research sites in enabling community members to respond to the impacts of HIV & AIDS, highlighting some of the challenges facing church initiatives to provide support to people living with HIV.

Being known as a Christian or a church-goer is seen as a positive social identity by most participants, contributing to build self-esteem and social status, particularly if one holds a position within the church. However, potential loss of self-esteem and social status derived from gossip may also help us to understand disincentives for participation in church activities among some socially marginalised or excluded groups[6]. This reproduction of existing social hierarchies limits who feels able to access the resources that are available through the church-based networks. As such, church-run programmes for 'the poorest of the poor' or 'people living with HIV' face challenges in reaching their target groups as they resist being identified and classified.

The changing discourse around living with HIV in Namibia may provide a further disincentive to utilizing church-run services for some people. Church-based discourses of HIV occur within the context of Namibia's ongoing struggle with HIV & AIDS. That context has changed dramatically in the past three years with the rapid rollout of free ART. The social representation 'HIV' has been given a violent shaking, shedding core elements like 'incurable' and 'certain death'. Namibian people, government ministries, NGOs, FBOs, CBOs[7], and churches are searching for new ways to conceptualise HIV. With the growing possibility of managing HIV without having to go public about one's sero-status, it is likely that the way in which churches deliver counselling services will change. Identifying and grouping people together as people living with HIV may cease to be the most effective way to deliver support. Indeed, 'living with HIV' might cease to qualify somebody for the 'in need of support' category. Further research is required into the interaction between church discourses on HIV and the changing public perception of HIV in the context of free ART, and how this in turn affects the ways in which people living with HIV perceive the support available through their churches.

Finally, it is important to examine the availability of resources within church-based networks before forming expectations about the extent to which churches can deliver, or can supplement government delivery of, services for people living with and caring for people living with HIV. By focusing attention on the congregational level, one sees how limited the resources are within the social networks on which some local churches can draw. Yet, churches have a central role to play in delivering a range of services to people in Kavango, and are often the only or one of the only sources of what some might call social capital. As such, one might argue that serious consideration be given to ways in which the capacity of local churches to support their congregations can be strengthened. This may include intra- or inter-denominational skill-sharing and mentoring programmes, training in basic financial management and accounting structures that give local churches greater control over their budget, and more systematic consultation between the churches and the local and regional authorities.

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[6] It is not suggested that this is the case with the apparently low level of male attendance at church.

[7] Non-governmental organisations, faith-based organisations and community-based organisations

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