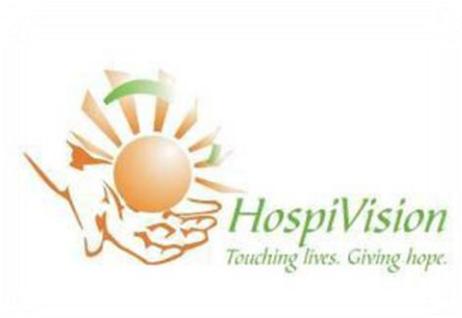


Called to Care

Supporting HospiVision's Volunteers

Final research project for the fulltime
study of practical theology at the
Christelijke Hogeschool Ede
(University of Applied Sciences)



June 2013
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091241

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1 Introduction

As a fourth year student of Practical Theology at the Christelijke Hogeschool Ede (Christian University of Applied Sciences), I came in contact with HospiVision, a South African non-profit Christian Faith-Based organization with a holistic approach to care for the sick while looking for a place to do my final research project. During my studies, I had come to realize that pastoral care was something I would like to specialize and work in. When HospiVision offered me the opportunity to do my final research project for my bachelors with them, I realized this would be a wonderful opportunity. Not only would I be exposed to a specialized form of pastoral care, I would also have the experience of doing my research abroad, something which has proved to be a learning experience in itself.

1.1 Incentive

HospiVision works with some 200 volunteers across 18 hospitals. During the past year, the organization's board discussed the important role which volunteers play in the HospiVision ministry, along with how to recruit, support and empower them. They asked that research be done about their volunteer programme, what role it plays, how the volunteers experience their work, how the medical staff feel about them, what procedures need to be put in place, and how HospiVision can further support, develop en empower the volunteers.

1.2 Broader framework

This research would become part of a long term research program "Religion, Health and Wellbeing in South Africa," conducted by the Department of Practical Theology at UNISA.

- The main research question: *What is the contribution of spirituality, pastoral work and the faith-based community to whole person health care in the South African context?*
- The main goal is: *To describe, evaluate and enhance the nature and extent of the contribution of spirituality, pastoral work and the faith-based community to whole person health care in the South African context.*

This project would contribute to the following objective of this larger research: *To describe, evaluate and enhance the role of volunteers as part of a spiritual care and counselling programme in South African public and private hospitals.*

1.3 Research question and objectives

Main question

How do the volunteers of the pastoral care and counselling programme at the Steve Biko Academic and Tshwane District Hospitals value their involvement in the programme and what can be done by the HospiVision staff to raise a greater awareness of the value of the volunteers' involvement and to further support them?

Main goal

To make recommendations as to what more can be done by HospiVision staff for the volunteers in the pastoral care and counselling programme at the Steve Biko Academic and Tshwane District Hospitals, as well as by the volunteers themselves (self-care), so that they experience their involvement as meaningful and make a long term commitment.

Objectives

- Describing and analysing the current volunteer programme
- Understanding the experience of volunteers
- Assessing the effectiveness and impact of the programme
- Making recommendations for improving the programme

1.4 Set up of the report

On the following pages you will find my literature study, a report of my methodology, the analysis of the interviews conducted, as well as the conclusions and recommendations drawn from this data. My prayer is that this will be of value to HospiVision as she continues to offer her volunteers the support that they need.

2 Project and organization

2.1 HospiVision

HospiVision is a South African non-profit Christian Faith-Based organization with a holistic approach to caring for the sick. HospiVision was 'established in 1997 to provide psycho-social and spiritual care, counselling and training, as well as physical support in the health care environment.' From the very start, she made use of volunteers to increase her man-power. Today, HospiVision is present in 18 different hospitals throughout South Africa and works with some 200 volunteers.

Vision: Touching lives. Giving hope.

HospiVision touches the lives of sick people and those around them and gives them hope through counselling, spiritual care and physical support.

Mission

HospiVision facilitates the establishment of sustainable integrated support systems that reach out to and are in service of the sick, the vulnerable and the disadvantaged, their families and those who care for them.

2.2 The Pastoral Care and Counselling Volunteer Programme

One of HospiVision's main activities is offering 'emotional, spiritual care and physical support to patients and their families.' Key to seeing this realized is 'a valuable volunteer services programme through which patients and personnel are visited and supported.' In this research I have focused on this aspect of the organization.

The volunteers of this programme are people who have chosen out of personal initiative to give of their time to care for patients in hospitals. They are not paid and receive no reimbursements. In this sense, they fit the definitions of 'volunteers' discussed in the literature study. A common factor that binds them together and distinguishes them from many other volunteers is a sense of calling from God.

I have limited myself to the volunteers working in Steve Biko Academic Hospital and Tshwane District Hospital, HospiVision's main departments.

2.2.1 Steve Biko Academic Hospital

With 900 beds, Steve Biko Academic Hospital admits around 54 000 patients a year. 4 500 staff are employed. As an academic hospital, it is linked to the University of Pretoria. HospiVision's office is well established in this hospital. Ten permanent staff members and ± 60 volunteers make up the team. The Head of Department is Dr Ilse Gravett.

The volunteer team consists of three distinguishable groups: the volunteers who server coffee and tea in the trauma unit to patients' families and to staff, the psychology students who do visitations in the wards, and the lay volunteers who also visit patients in the wards. In this research, I limited myself to the lay volunteers.

2.2.2 Tshwane District Hospital

Tshwane District Hospital is smaller than SBAH. With 200 beds, she admits around 24 000 patients a year. The HospiVision team is somewhat smaller as well, with seven permanent staff members and ±

25 volunteers. The Head of Department is Rita Potgieter (Secretary). The volunteers at TDH are all lay volunteers doing visitation in the wards.

2.3 Set up of the Programme

Hospivision has been given the responsibility to supervise the spiritual care offered in these hospitals. Individuals or groups who wish to come minister to patients must go via Hospivision. Hospivision facilitates the work of these people and guides the manner in which the ministry is carried out. A hospital setting is a specific context requiring a specialized approach, different from pastoral care within a congregation.

2.3.1 Weekly outreach

A large portion of the ward visitation is done by the lay volunteers. Every Tuesday morning there is an organized outreach to the wards with the volunteers.

The volunteers gather at 9:00 for a time of teaching and fellowship. At 10:00, the volunteers disperse to different wards to visit the patients, some going to the same wards each week. If Hospivision has received any calls from medical personnel, requesting that specific patients be visited, the staff will ask a volunteer specifically to go see each of these patients.

After the visitation, the volunteers return to the office. The staff make themselves available to listen to the volunteers, to hear their experiences and answer any questions they may have. The volunteers also share with each other, sharing not just their experiences in the wards but also things from their personal lives.

Most volunteers come once a week; a few come more often.

2.3.2 Selection

To become part of the Hospivision volunteering programme, one must go through a screening procedure and attend a training course.

The screening process consists of two interviews, the filling in of a form and the completion of the basic training course. A candidate will be interviewed by Pieter Barnard. If he finds the candidate suitable, he will fill in a form and direct him/her to Ilse Gravett. If Ilse Gravett finds the candidate suitable and if the candidate attends the course and completes the assignments, he/she can then become part of the volunteer team.

At times volunteers will come to the weekly outreach, without having completed the course yet. In such cases, they must accompany an experienced volunteer to the wards.

2.3.3 Training and Courses

Hospivision offers courses and weekly trainings.

Every Tuesday morning from 9:00-10:00, one of the permanent staff or sometimes a guest speaker meets with the volunteers for a time of training and encouragement. There is no planning for the topics to be addressed, but each leader picks the topic as he/she feels led. The topics relate to visiting patients. Often they draw from the material taught in Hospivision's courses or refer to incidents that have occurred.

Volunteers are expected to attend this training regularly; if not, they are to be taken off the volunteer list.

Hospivision offers nine UNISA accredited training courses for volunteer and professional caregivers and community and faith based leaders. After having attended the basic course 'Short course in Spiritual care and counselling for the sick: Apply basic skills of pastoral care,' one can attend any of the other courses. All volunteers are required to attend the basic course before they can work as a volunteer. They are encouraged to attend the other courses as well.

2.3.4 Supervision

Hospivision offers her volunteers supervision, debriefing and counselling as necessary. Most of the supervision takes place during the weekly meetings. There is ample opportunity for volunteer to share their experiences and receive feedback from staff and each other. If volunteers feel the need, they can request a personal debriefing or counselling session with a staff member. The staff regularly encourage this.

2.3.5 Other Aspects

Apart from the regular meetings, the staff at SBAH organize a social event for the volunteers from time to time. They will organize a breakfast as a way to show their appreciation for the volunteer.

Some of the regular volunteers become involved beyond the regular Tuesday morning outreach. For example, one volunteer was invited to give a series of devotions for the staff of the ward he visits. Another women comes daily, able to visit her patient much more regularly.

2.3.6 Volunteer's role

The volunteer's role is to offer emotional and spiritual support to the patients, their families and medical personnel.

Most of the volunteers who are part of the Tuesday morning outreach are lay counsellor and pastoral caregivers. Due to the time of day and week, most are pensioners, unemployed people, pastors, or house wives.

The volunteers are not expected to offer the care of a professional counsellor. They come to show love and offer hope. They do this in a variety of ways:

- Being present
- Listening, asking questions
- Praying
- Scripture reading
- Chatting
- Practical help
- Signalling problems, referring to professional help

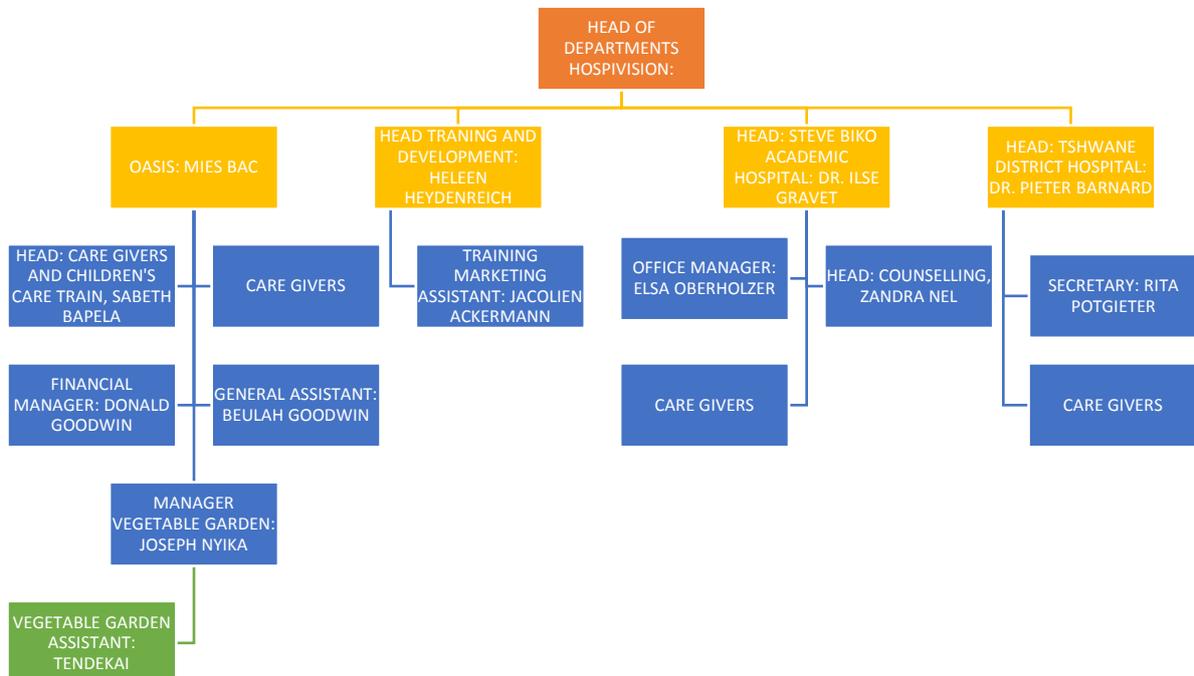
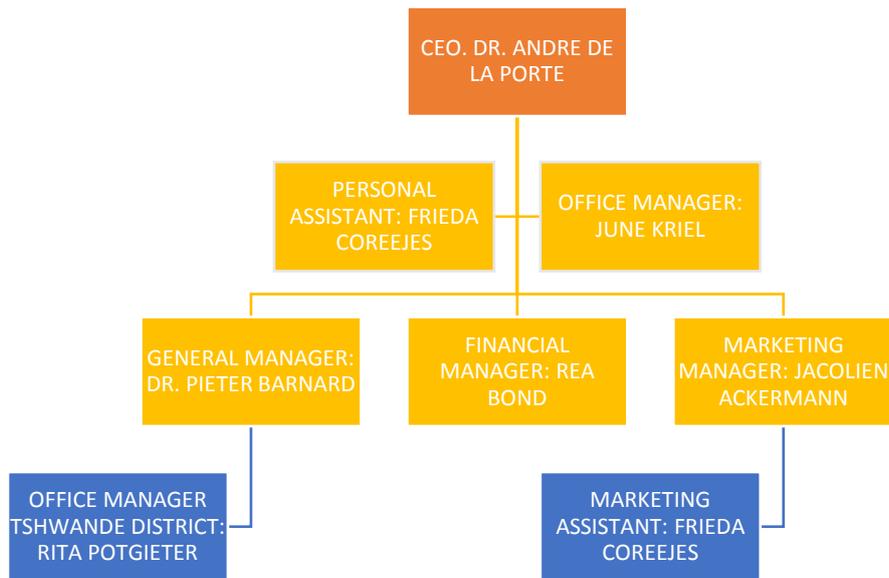
2.4 Other Activities

Hospivision's other activities are:

- 24 hour trauma counselling
- Radio Pulpit, a national Christian Broadcaster

- Physical support for patients and families
- Children's train, support for sick, vulnerable and orphaned children
- HIV and AIDS prevention and care
 - Oasis: support for people living with AIDS and on Anti-Retroviral Therapy
 - Hopeful Compassion programme: support for those infected or affected by HIV
 - Choose Life: Value based HIV prevention programme
- Nine UNISA Accredited training courses for supporting the sick
- Marketing, communication and resource mobilization

2.5 Structure



3 Literature study

3.1 Practical Theology

Practical theology always finds its starting point in a particular incident, situation or context that calls for interpretation and a response. This same is true for this research project. HospiVision identified the need to evaluate their volunteer pastoral care and counselling programme and make needed adjustments.

3.1.1 Osmer's questions

Richard R. Osmer has introduced an important model for conducting practical theology. He asks four questions:

- What is going on?
- Why is this going on?
- What ought to be going on?
- How might we respond?

These questions form a guide to interpret situations, so as to come to an appropriate response.

Osmer further developed these questions into four tasks:

- The descriptive-empirical task: What is going on? Information must be gathered to discover the patterns and dynamics that play a role in the happenings of a particular situation.
- The interpretive task: Why is this going on? One then sets out to discover the reason why these patterns and dynamics are presenting themselves.
- The normative task: What ought to be going on? After determining what is going on and what are the causes behind this, one then is faced with task of assessing what *should* be going on. Ones conclusions will guide how one determines to respond to the situation he is faced with.
- Pragmatic task: How might we respond? One must now see how one can influence the situation for good, weighing the probable outcomes of the different options.

(Osmer 2008, 4)

In this project, the different tasks described by Osmer, are applied at different points in this research.

3.1.2 Volunteering and practical theology

In this project, the focus is on volunteers who offer pastoral care and on the support they receive. Much of the work done within the Church is done by volunteers. All the members of the Body of Christ have been called to love, care for, comfort, and build up those around them. All are called to priesthood. In that sense, lay men and women are not so much there to support the clergy as to be supported by clergy.

The same is true for the HospiVision volunteers offering pastoral care. HospiVision facilitates their work. Their work of pastoral care is very much a topic related to theology. This research takes the situation of the volunteers, looking at how things are functioning and why, comparing it to literature and an understanding of how things should be, to finally make recommendation as to how HospiVision might respond.

3.2 Pastoral Care and counselling

This research focuses on how HospiVision can improve the support of her volunteers who offer pastoral care and counselling to patients, their families and medical staff. HospiVision as an organization has a clear understanding of pastoral care, the different streams, and the uniqueness of pastoral care in the hospital setting. Below follows a summary of my research on the topic of pastoral care and counselling and its value to those who are ill. A more extensive review is found in annexures 1 and 2.

3.1.1 Pastoral Care

The word ‘pastor’ comes from the Latin word ‘pāstor’ meaning ‘shepherd’ or literally ‘feeder.’ (Random House Dictionary 2013) Shepherding is a beautiful metaphor to describe the work of pastoral caregivers, as they follow in the steps of Our Great Shepherd. As shepherds, they care for God’s flock.

The essence of care is love: to love the other as we love ourselves. And love acts. It is a practical application of the Gospel of Hope which comes out in so-called ‘works of mercy’ (Matt. 25):

- Feeding the hungry
- Giving drink to the thirsty
- Clothing the naked
- Sheltering the homeless
- Visiting the sick
- and imprisoned
- Burying the dead

Added from Paul’s letters:

- Instructing the ignorant
- Counselling doubtful
- Admonishing the sinner
- Suffering injustice patiently
- Forgiving offenses willingly
- Comforting the afflicted (Hoek, et al. 2012, 73)

Relating stories

Pastoral care is in essence caring for the story of another person as it stands in relation to the story of God. (Ganzevoort and Visser 2009, 26) Perspectives differ on how these stories relate.

A means of proclamation	Therapeutic	Hermeneutic
God’s Word takes a prominent role.	God’s Word and prayer are but a means to an end.	The caregiver must come to an understanding of both Scripture and the confidant.
The confidant is seen in terms of his sinful nature - the core problem which needs to be addressed.	The confidant takes centre stage here.	
Gospel is ‘preached’ and must lead to a change.	The caregiver helps the confidant to help himself by providing a relationship characterized by empathy	The confidant’s particular context and unique personality are taken into account when the caregiver helps him to understand his

	and acceptance.	experiences in light of Scripture. Hope rises as the victory of the resurrection is integrated into the life of the confidant
	This stream of thought has been particularly influenced by psychology.	This approach seeks to combine the two streams listed to the left.
(Louw 2008, 217-219); (Hoek, et al. 2012, 74-75)	(Louw 2008, 219-220); (Hoek, et al. 2012, 74-75)	(Louw 2008, 219-220); (Hoek, et al. 2012, 74-75)

Pastoral care versus Pastoral counselling

Besides the varying perspectives on pastoral, there are also degrees of intensity found in pastoral care. However, in general, 'pastoral care' is used for the intentional care given by members of the body of Christ to each other, while more professional, specialized care is mostly termed 'pastoral counselling.' (Ganzevoort and Visser 2009, 26)

Thus, pastoral care is generally more spontaneous and encompasses more than just conversational care. In contrast, counselling is structured, conversational care. Appointments are made. Time is set aside to address (an) identified concern(s). The meetings are often more therapeutic of nature than in pastoral care. Sessions tend to be longer as well. Depending on the arrangements, fees may even be charged. (Ashely 2013, 125-126)

One of the distinguishing marks of both pastoral care is that their starting point is found in the Christian faith. The pastor is expected to be a specialist in regards to personal and existential problems as well as questions relating to faith and theology. He can make use of Scripture, prayer, sacrament and other rituals, not available in other forms of counselling. (Ganzevoort and Visser 2009, 30-33, 36-40)

The goal of Pastoral care

Pastoral care has many functions: support, confrontation, edification, counselling. According to Gary R. Collins, the ultimate goal of pastoral care is seeing the other grow as a disciple of Jesus (Collins and de Vriese 2009, 16-18, 52-60). Moreover, Professor Daniel Louw describes it as 'to foster change and promote human and spiritual health and maturity.' (Louw 2008, 77) In all instances, it is to build each other up.

Pastoral care in a multi-cultural setting

South Africa is a country characterized by cultural diversity. Thus, the pastoral caregiver's culture cannot be seen as the normative. He must be able to learn from, be sensitive to, understand, accept, judge, and make correct use of the patient's cultural background and its rituals and symbols in order to give the best care. In a hospital setting, the culture's view of sickness and healing is especially important to understand. (Ganzevoort and Visser 2009, 59-60) (Louw 2008, 169-170)

3.1.2 The added value of pastoral care in hospitals

The uniqueness of a hospital setting calls for specific pastoral care. Coping well with illness goes beyond the physical. It takes a team to make a patient well. Both the doctor and the pastor have their specialization and complement each other on the team. (Louw 2008, 213)

Holistic Health Care

An ill person's first concern is often his body; sickness however affects the entire person. The physical, psychological and spiritual aspects of a person interact and influence each other. Therefore, healthcare must approach the person in its entirety. (Louw 2008, 116-117) (Veltkamp 2006, 38) In the medical team, that pastor focuses on the soul, that is, that whole person in his or her entirety, in *relationship* to the living God.' (Cole 2010, 718)

Conflict of illness

Health is often defined as the 'absence of disease.' It is more. According to the World Health Organization, health is also 'a state of complete physical, mental and social well-being.' (World Health Organization 1964) In contrast, the sick are considered "different" because of the limitations that usually come with illnesses. In a culture where one's value is dependent on one's health, an ill person can feel inferior to those who are well. (Veltkamp 2006, 22-26) (Louw 2008, 107)

Illness leads to conflicts in all areas of a person's existence and consequently to emotional strain. Fear and anxiety often increase because of loneliness, uncertainty, loss of social security, loss of bodily functions, loss of certain freedoms, identity crisis, increased dependence, or impending death. (Louw 2008, 107, 120-121) Hospitalization can be a threatening and frightening experience and brings many discomforts. (Louw 2008, 210-212) The necessary changes trigger stress, which adds emotional as well as spiritual and physical discomforts. (Collins and de Vriese 2009, 74-76) A person must learn to accept and deal with the illness, especially if he will not (completely) recover. (Veltkamp 2006, 29-30)

Pastor's role

This is where pastoral care is of great value. How one copes with one's illness is dependent on one's ability to identify the illness and integrate it into one's life. Spiritual and emotional support can play an important role in this integration process. A pastoral caregiver can point the patient to God's steadfast promises and His assistance, assuring the patient that there is still meaning to life and that he can draw from a Source of comfort, encouragement and support outside himself. One can have hope even in the midst of illness - a hope found in communion with God. (Louw 2008, 109-110, 123, 128, 201, 205-208) (Veltkamp 2006, 44-45)

Part of coping well, is finding meaning in suffering and understanding God's role within trauma and suffering. A pastoral caregiver should help the ill person to come to a understanding of Who God is and what He is like, an understanding which is meaningful, fostering hope and empowering him to cope with his suffering. (Louw 2008, 194-196)

Practical implementation

In the hospital, a pastoral caregiver has the ministries of

- Presence: to be there with the other
- Compassion and hope: spiritual healing and a soul friend
- Interpreter and networker: helping the patient, family and medical staff to understand each other
- Counselling: co-partner in moral decision making. (Louw 2008, 241-242)

Practically, the caregiver's role is

- Empathizing
- Loving unconditionally

- Guidance in question's concerning suffering, meaning and dignity
- Comforting
- Encouragement
- Prayer
- Scripture reading
- Listening as patients speak about their feelings and emotions
- Facilitating communication with others
- Ensuring patients have (and understand) appropriate information
- Guidance in decision making, in light of God's Word by asking the right questions.

Care may extend to the family members as well. (Louw 2008, 193-196) (Collins and de Vriese 2009, 131-133)

Daniel Louw sums up the functions of pastoral care as follows, functions that are all part of the care to the ill:

- Facilitating-art of listening
- Sustaining-art of understanding
- Guiding-art of directing/diagnosing
- Healing-art of consoling/changing
- Nurturing-art of caring
- Reconciling-art of witnessing
- Confronting-art of admonishing (Louw 2008, 253)

Indeed, it is not that farfetched that pastoral caregivers are also often called guides, helpers, or travelling companions. (Hoek, et al. 2012, 73)

3.2.1 Conclusion

Pastoral care is an act of love. It is caring for the story of another person as it stands in relation to the story of God. Pastoral care is expressed in many ways, though mostly applied to intentional care given by members of the Body of Christ to each other. The goal is to see the other built up and supported. The background of both the caregiver and the confidant, as well as the context, play in influential role. Pastoral care in an ethnically diverse hospital calls for specialized care.

Pastoral care to the ill is important. Illness affects the whole person, physically, as well as, emotionally and spiritually. To cope well, a person must learn to accept or deal with his illness. This is where the pastoral plays his role as part of the medial tem. Of all his functions, the most important is the ministry of presence.

3.3 Volunteers and volunteering

A significant portion of pastoral care is carried out by volunteers. This is not so much a matter of finances as it is of responsibility. Christ commanded His followers to love one another. He appointed each to priesthood. In this, He gave each one the responsibility to care for those around him. In this sense, clergy are not so much supported by lay pastors as they are there to support these volunteers. To ensure the quality of pastoral care, volunteers need supervision. They must be equipped for service (Eph. 4:12) and receive care themselves. (Ganzevoort en Visser 2009, 155-156)
This chapter will address what is understood as 'volunteering', what motivates volunteers and what it takes to work with volunteers.

3.3.1 Volunteering defined

Various definitions exist concerning volunteer work. A comparison shows that, while similar, each has its own emphasis.

- Work done within an organized context, without obligation and unpaid, for the benefit of others and society. (Vrijwilligerscentrale Helmond n.d.)
- Any activity that involves spending time, unpaid, doing something that aims to benefit the environment or someone (individuals or groups) other than, or in addition to, close relatives. (Volunteering England 2013)
- Services for a non-profit organization, a non-profit corporation, a hospital, or a governmental entity without compensation, other than reimbursement for actual expenses incurred. (USLegal 2001-2013)

Movisie (the Dutch national institute and consultancy dealing with social issues), recognizing the great variety that characterizes volunteer work, designed a tool kit that allows organizations to formulate their own definitions suited to fit the work of their volunteers. The eight aspects to consider are:

- Motives
- Initial incentive
- Degree of free choice
- Reimbursements offered
- Who benefits
- Type of organizational context
- How formally tasks are divided
- The infinite variety that makes volunteer work unique. (Movisie 2013)

Concluding, variety exists but all volunteers freely choose (to some extent, at least) to make a commitment (join an organization, however developed) to serve others without seeking personal profit (excluding possible reimbursements). This service is to the benefit of others and society, but the benefit often carries over to the volunteer himself.

3.3.2 Value of volunteer work

Volunteer work benefits society by building social capital. The concept 'social capital' defines the networks people have. The three forms commonly defined are:

- Bonding capital: relationships inside one's own community, for example, family, friends, church.
- Bridging capital: relationships with people outside one's own community.
- Linking capital: relationships between organizations. (Stone 2003)

These networks are characterized by trust, reciprocity, information, and cooperation. They allow people to gather information, aid each other, act together, and form community. (Stone 2003) (The President and Fellow of Harvard College 2012) (Claridge 2004)

Volunteer work facilitates for individuals to participate in and improve their society. People from different communities are brought together, increasing the social capital of all groups involved. (Plemper, Wentink en Broenink 2005, 6) As social capital increases, so does a sense of community and trust.

3.3.3 Motives

Volunteers are driven by various motives. A comparison is given below.

Movie toolkit	Functional approach	Common motives
To acquire experience	Career (to gain experience, skills and contacts which open up opportunities in the paid sector)	Personal growth; developing skills and gaining experience
To increase influence/status	Learning (for personal development and increased value in the paid sector)	
		Related to past experiences or personal interests
		Social networking; make new friends
To do something meaningful		For results
Necessity	Quality of life (personal development and improved living conditions)	
Felt obligation (social, religious, political)	Norms (to put into practice norms and values)	Moral, normative, religious or political conviction
To return a favour		
	Social (to deepen or strengthen bond; to invest in what others find important)	Invited by family, friends, colleges
		Relaxation; distraction
	Protection (safe environment; avoiding or reducing negative situations or experiences)	
(Movisie 2013)	(vrijwilligerswerk.nl n.d.)	(Plemper, Wentink en Broenink 2005, 19-23)

A review of these lists shows the variety in motivations among volunteers. Clearly, volunteers work also offers the volunteer benefits himself. Increasingly volunteers are becoming more critical about the work they do. More than before, volunteer work must offer the opportunity for personal development. This means volunteers will generally be looking at what an organization has to offer in this. (Hoek, et al. 2012, 150-151)

3.3.4 Working with volunteers

Working with volunteers requires accepting uncertainty. Paid employee must meet certain standards or forfeit privileges or salary. Volunteers, when dissatisfied, can easily terminate their involvement. Commitment is largely dependent on the personal investment volunteer receive. (Meijs 1997) Personal investment must be integrated into all stages of working with volunteers: recruiting, coaching, retaining, appreciating and saying farewell.

Recruiting

Recruiting is the first step as well as a continual process. In a well-functioning programme, new volunteers will be sought before lost capacity creates an urgent need.

Recruitment begins with publicity. Well-known and well-spoken of organization have an easier time recruiting volunteers than those with less publicity.

Then an organisation must ask which type of people she wants to recruit and choose the most effective means of communication. Personally approaching people remains the most effective and should be incorporated.

Two important questions are:

- What does the organization have to offer?
- What is she looking for in her volunteers?

Both the organization and the candidate have criteria the other must meet. Not every 'match' is a 'good match.' Screening is necessary. An organization needs to create a job description, a minimum list of the qualities, knowledge and skills a volunteer must have, and a selection procedure.

Screening can be done through interviews, during which both the organization and the candidate have the opportunity to share what they offer and expect. Both need to evaluate whether the match will be wise. (Veldman, Hegenman and Hinsberg 2005, 15-17) (Steunpunt vrijwilligerswerk en informele zorg n.d., 6-8)

For HospiVision this means, she must have a policy on recruiting and screening volunteers. She will have to ask herself the questions: What do we offer? What are we looking for? Her volunteers have a great responsibility, relating the unique stories of patients to God's story. This requires skill, spiritual gifts and sensitivity. Volunteers will look at what HospiVision offers and how flexible she is to accommodate their desires. When people sense an organization invests in her volunteers, they will more likely want to become involved.

Coaching

Once volunteers have been recruited, the real work begins. New volunteers need a time of adjustment. The organization helps create a smooth transition by discussing with them what activities to start with and evaluating together how things are going. Adjustments or training may be needed. Volunteers commit to helping an organization achieve her goal and deserve the best support she can give.

Volunteers need someone they can approach with questions, experiences and complaints, who will take them seriously. The insights of new volunteers can even be very eye-opening.

The organization needs to ensure volunteers do the right things, the right way. Authority can be an issue, as volunteers are not under obligation. This is why an organization must involve the volunteer in the processes described here and invest in personal relationships with them. When volunteers endorse the goals, mission and vision of the organization and have a healthy respect and trust in the leadership, a lot less 'controlling' will be needed. (Veldman, Hegenman and Hinsberg 2005, 25-27) (Meijs 1997)

For HospiVision, this means a lot of personal investment in volunteers, right from the start. It means clear and regular communication about her goals, mission and vision and why she does things certain ways.

Retaining

Coaching remains necessary if volunteers are to make a long term commitment. Coaching means coming alongside the volunteers, to help them excel in their work. The focus is firstly, not the work, but the well-being of the individual volunteers and getting to know them. (Steunpunt vrijwilligerswerk en informele zorg n.d., 16)

Communication is key from start to finish. It is the only way to know what motivates the volunteers and what will bind them. Someone needs to periodically meet with the volunteers individually to evaluate, motivate, signal, resolve and optimize. Both parties should be able to bring topics to discussion. Especially if an organization wants to see long term commitment, she must continue asking questions about the desires and motives of her volunteers. As volunteers change and develop, the organization may need to offer more training or adapt to remain interesting for the volunteer. The ability to 'let go' and change can be the key to retaining volunteers. Adapting can be as simple as adding or removing a responsibility. Involving volunteers in project fosters ownership and long term commitment. (Steunpunt vrijwilligerswerk en informele zorg n.d., 18-20)

For HospiVision this could mean scheduling meetings periodically with each volunteers. For these meetings to be effective, there should also be the openness to make changes in line with the feedback volunteers give.

Appreciation

Everyone longs to be respected and appreciated. Appreciation is an important factor which affects the commitment of a volunteer. It can be very helpful to sign one person to oversee that appreciation is adequately expressed, as it can easily be 'forgotten.' Appreciation begins with building awareness of the volunteers and their work, then acknowledging the value of it, being intentional about expressing it and in some cases offering rewards. . (Plemper, Wentink and Broenink 2005, 13-15, 28-37) (Steunpunt vrijwilligerswerk en informele zorg n.d., 14-15) The possibilities are endless. In annexure 2, practical suggestions are described. HospiVision will have to determine what fits her organization and her volunteers.

Saying farewell

Coaching does not end abruptly, when a volunteer or organization decides the time has come for the volunteer to move on. Asking a volunteer why he is leaving can provide valuable insights; with some adjustments a volunteer may even be able to stay.

When a volunteer leaves, a replacement is needed. But also the volunteer still needs care. A 'goodbye moment' is important (small party, gift, etc.). Some could be helped with networking or references. Ending well has a positive impact on the organizations imago and leaves open the possibility for the volunteer to return or occasionally help out. (Veldman, Hegenman and Hinsberg 2005, 43-44)

For HospiVision this means being intentional about making sure volunteers do not just 'disappear.' An interview and a moment of 'thanks' are essential.

3.3.5 Conclusions

Volunteers are motivated by various reasons. Their jobs may look radically different. However, all have made a commitment of their own free choice, to serve others and society without personal financial profit.

There are many aspects to working with volunteers, but the most important is personal investment in each individual volunteer. From recruiting to saying farewell, volunteers need to know they are seen, heard, appreciated and valued. Communication and the willingness to adjust and let go of old ways, are key to keeping volunteers committed and involved. For all the support they give an organization, they deserve good support in return.

3.4 Support

An organisation is responsible for the care and support of her personnel, her most valuable resource. HospiVision recognizes this responsibility and desires to give the best possible support. This section will look at the necessity of caring for the caregivers and the sources where they can find this care. The section ends with a model for fostering and providing for the care for personnel.

3.4.1 The capable caregiver

To give her personnel appropriate care, an organization must know what they need to function well. The capable caregiver must have certain characteristics and skills to function successfully within his specific role and function. Some are distinctive for pastoral care, others for one's particular organization and others for the individual. For example, as a pastoral caregiver, a volunteer needs to be empathetic. As part of HospiVision, he must value open relationship with his colleagues, according to the values and vision of the organization. His individual values, motives and skills make him dedicated. (Elizabeth 2009-2013)

A comparison of characteristics as described by different sources—the Academic Center for Practical Theology (K.U.Leuven), Zorgnet Vlaanderen, an organization supporting initiatives in (among others) spiritual health care, and Andre de la Porte, managing director of HospiVision—is given in annexure 4. These lists give the standards for professional caregivers. HospiVision works with volunteers, most of whom are lay counsellors and pastoral caregivers. She cannot expect them to perform on a professional level. In determining the characteristics and skills her volunteers should display, she will have to distinguish between beginners, those with experience, and professionals. Their skill level determines the complexity of situations they can adequately deal with. In the end, a 'competent' pastoral caregiver is not one who has arrived, but who is constantly growing and developing his skills.

3.4.2 The necessity of caring for the caregiver

Pastoral care brings with it both joy and stress factors. The stress factors include:

- Witnessing suffering
- Unresponsive or stubborn confidants
- (Unrealistic) expectations from others and self
- Personal challenges (Collins en de Vriese 2009, 74-76) (Louw 2008, 135-136)

How one copes, is largely dependent on the support one receives from one's community, colleagues and organization. (Elizabeth 2009-2013)

3.4.3 The care for the caregiver

Sources of care

Caregivers should take the initiative to ensure they receive care themselves. Indispensable are:

- Time with God, in prayer and in the Word.
- Time alone, to rest and be refreshed emotionally and physically.
- Time with others, fellowshiping with other Christians.

They must have a correct understanding of who they are in Christ: loved, accepted, valued, gifted. (Collins en de Vriese 2009, 76-79)

An article, published on the website 'Elizabeth' (an interactive website for pastoral caregivers), lists various sources of care. While focused on professionals in fulltime ministry, aspects can be applicable for HospiVision's volunteers.

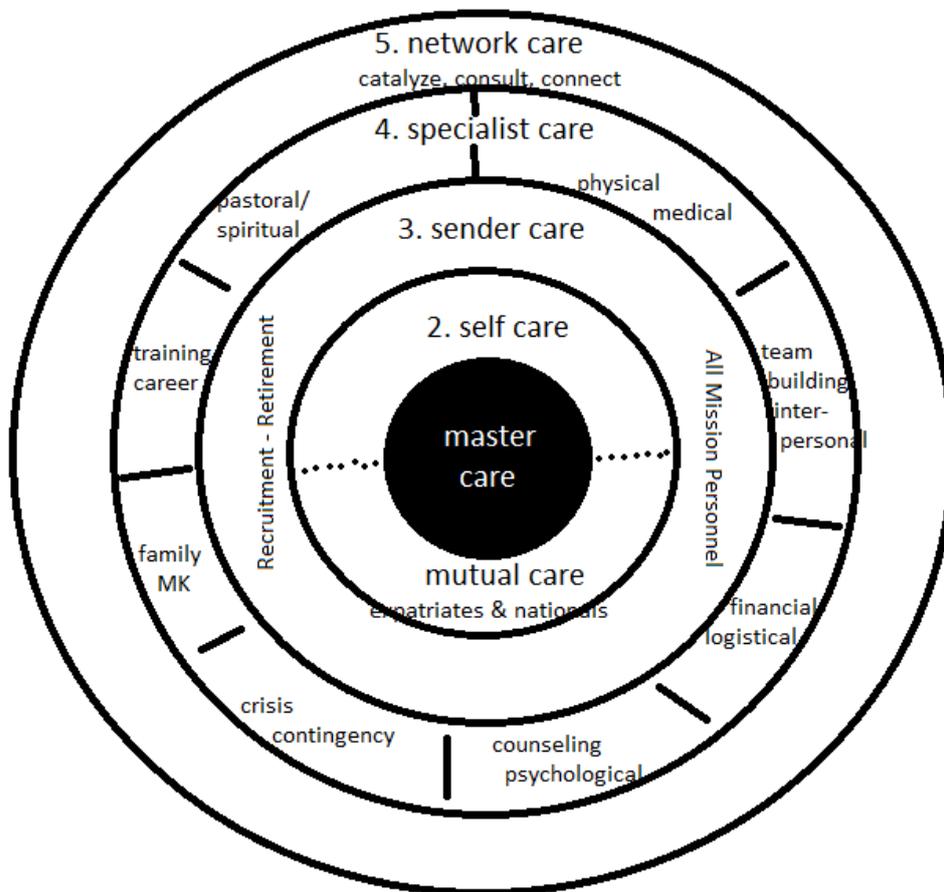
- *The organization:* evaluations, debriefing, coaching, supervision.

- *Colleagues*: encouragement, appreciation, positive and honest feedback, accountability, loving care, sharing joys and sorrows.
- *A defined and recognized role*: appropriate distance, clarity, authority. The volunteers are not professionals, but they do have a place in the medical team.
- *The pastor himself*: knowledge of personal strengths, weaknesses and limits and continued personal development. God works through broken en hurt people; one’s weakness does not have to hinder.
- *God*: spiritual nourishment and dependence.

Understanding that one cannot do every, that one is not the owner of the vineyard but a partner with God in what He is doing in people, brings freedom and refreshment. (Elizabeth 2009-2013)

A model

A useful model to understand the different aspects of care for those in ministry, is the best practice model for those in ministry, designed by Kelly O’Donnell, Dave Pollock and Marjory Foyle. This model has intentionally been kept general enough to be applied in different cultural and organizational settings. Different aspects are well suited for HospiVision as well. (O’Donnell 2002, 13-15)



Master care

Fundamental to all in ministry is their relationship with their Master. One must live out of the knowledge that one is His beloved Child. Only then can one love others. One must continually renew this relationship through spiritual discipline,

privately and together with fellow believers.

Best practice principle ‘Flow of Christ’: supplying resources that foster this relationship.

Examples: Facilitating times of worship, prayers and Bibles teaching for the volunteers; encouraging personal investment in one’s relationship with Christ.

Self and mutual care

Self-care and mutual care are essential. One's first responsibility is oneself, to see to one's needs, work on personal development and enlist help where necessary. Mutual care takes place in relationships with family, friends and colleagues. It includes support encouragement, correction, accountability.

Best practice principle 'Flow of community': encouragement and support in caring for self and in developing healthy relationships.

Examples: Awareness building of symptoms of potential problems (such as compassion fatigue) and how to deal with them; training for personal development; teambuilding events.

Sender care

Sending churches and agencies have the responsibility to care for their most valuable resource, personnel, from start to finish.

Best practice principle 'Flow of commitment': the commitment of a church or agency to support and help those in ministry by providing resources and means for development.

Example: Trainings, investing in organizational development.

Specialist care

Sometimes people need care from specialists to remain healthy and capable to do their work. The models list eight domains. Those applicable to HospiVision volunteers are mentioned below.

Best practice principle 'Flow of caregivers': special care by capable and qualified individuals.

Empowerment is the objective. Prevention, development, support and restoration are all part of it.

Examples: Pastoral/spiritual care (dealing with personal issues, spiritual refreshment); training (refresh and develop knowledge and skills); team building/interpersonal care (fostering relationships of trust, resolving conflicts); counselling (debriefing).

Network care

Networking opens avenues to resources and care from other groups and organizations involved in similar ministries of those offering specialized care.

Best practice principle 'Flow of connections': staying up to date to developments in the field of work and member care; striving to work together with others and build each other up.

Examples: Providing or pointing out relevant, up to date literature; staying up to date on developments in one's field of specialization and the impact they make on personnel.

(O'Donnell 2002, 17-19)

3.4.4 Conclusion

Certain things can be expected of a pastoral caregiver. A caregiver, however, cannot stand on his own. His work brings much joy, as well as stress. This means he must care for himself. His foundation is his relationship with God. Essential are times of rest and refreshment and a community to build up and support. Organization can be involved in various areas. The member care model provides a clear overview of how they can foster and supply care.

In the conclusions and recommendations, a comparison will be made between the member care model and the care HospiVision offers her volunteers.

4 Methodology and Results

4.1 Methodology

4.1.1 Introduction

In discussion with Dr Andre de la Porte, managing director of HospiVision, I determined the research question and objectives and drew up a project plan. The activities of my research would include literature study, participatory observations and interviews. In conducting my research, I used the techniques I learned at my university, largely based on the book *‘Wat is onderzoek? Praktijkboek methoden en technieken voor het hoger onderwijs’* by Nel Verhoeven.

4.1.2 Literature research

For the literature study, I choose four subjects related to the main research question:

- Pastoral care and counselling: Defining pastoral care and counselling
- Volunteers and volunteering; Defining volunteerism and the responsibilities an organization has toward her volunteers
- Support: The support pastoral caregivers need
- Practical value: The value of pastoral care for the ill

For each of these subjects, I formulated a set of questions based the objectives of the research plan. Taking into account that this research would be taking place in the South African context, I selected literature from Dutch and South African authors, as well as those more internationally known. I did not find a significant difference between my South African sources and the Western sources.

In my sources I included: books used as text books by my academy, writings from authoritative figures in the field of pastoral care and counselling, recent academic articles, and up to date literature from the internet.

I also looked at the 2011 Annual Report of HospiVision and her policies concerning the volunteer programme. They can be found in annexure 5-8.

4.1.3 Participatory observations

Upon my arrival in South Africa, I began my participatory observations. The first several weeks I spent getting to know the organization HospiVision and the different branches she has in Steve Biko Academic Hospital and Tshwane District Hospital. My participatory observations included:

- Joining the volunteers during the Tuesday morning outreach: Joining in the weekly training and accompanying volunteers to the wards.
- Participating in the HospiVision Short course in Spiritual care and counselling for the sick: Apply basic skills of pastoral care.

I joined the volunteers at TDH a couple times before going to SBAH several times. I then joined the volunteers at TDH again. Each week I accompanied a different volunteer, observing how each worked in the wards. This way I got a good idea of what the volunteers do and an impression of how the different volunteers do their work in their own unique styles.

Joining the short course gave me a good impression of what HospiVision trains her volunteers to do and what she expects of them.

While HospiVision works in 18 different hospitals, I limited my research to SBAH and TDH. These are two of HospiVision’s main establishments. Her head office is located in this hospital complex. The HospiVision branches in these hospitals are among the better established branches and they form a pattern for the branches in other hospitals.

4.1.4 Interviews

After several weeks of participatory observations, I began with the interviews. In agreement with Dr Andre de la Porte, I choose for a semi-structured interview schedule with open questions. In this way I could direct the conversation enough to ensure that I was able to gather the information I needed without just seeking to confirm my suspicions.

Set up of the questionnaire

The literature study served as background for the questionnaire. For example, literature on volunteers stresses the importance of coaching, training and supervising volunteers. The interviews ask questions about the training and support HospiVision gives. Or, in pastoral care, one's own faith plays a significant role. In the interviews, the volunteers are asked about the impact on their faith. I also took into account the specific questions of my research and what HospiVision indicated was important for her to know. The questionnaires are found in annexure 9.

Groups interviewed

In discussion with HospiVision, I choose to interview three stakeholders:

- HospiVision staff
- HospiVision volunteers
- Medical staff
-

HospiVision staff

I interviewed five permanent HospiVision staff members who are directly involved with the volunteers. Three from SBAH and two from TDH.

Volunteers

With the interviews with the staff in mind, I then wrote up an interview schedule for the volunteers. I interviewed eight volunteers, six from SBAH and two from TDH, taking into account number of volunteers working at each hospital. The volunteer programme at SBAH has quite a few more volunteers and is much better established than at TDH. We choose to interviews more volunteers from SBAH than from TDH.

To select the volunteers for the interviews, I used purposeful sampling. Because approximately half of the volunteers are male, and half female, half of the interviewed volunteers from both hospitals were also male and other half female. The same holds true for ethnicity. Half of those interviewed where black, the other half white. I found it important to interview both black and white volunteers because of the cultural differences between the groups, especially those beliefs regarding illness. I began selecting the volunteers by writing down their names in alphabetical order in two lists (male/female) and phoning every third person on the list. However, I soon discovered that with most volunteers making appointments via the phone does not work. After several cancelations and a misunderstanding, I made arrangements with the HospiVision staff at the hospitals to select volunteers randomly from those who came in on Tuesday the following week.

Medical staff

Lastly I wrote up the interview schedule for the medical staff. I had four short (10 min) interviews with medical staff. The HospiVision staff at SBAH arranged appointments for me with the nurses, choosing them from wards where HospiVision volunteers work. The original plan was to interview three staff from SBAH and one from TDH. However, to secure an interview at TDH proved to be

difficult. HospiVision is much better known at SBAH. In the end we settled for four interviews at SBAH.

Patients

A key group of stakeholders who I did not interview were the patients. While we realised the value of interviewing patients, it would not have been feasible to secure permission to interview the patients within the time frame we had. Also we were limited by the scope of this research project. Having done in depth interviews with HospiVision staff and volunteers, I would have had time for only a few short interviews with patients. The information I would have been able to glean would have been limited and not representative enough.

Processing

All the interviews were recorded. From the recordings I took thorough notes, placing the answers under the questions they answered from my interview schedules. I further processed these notes, coding the answers the participants had given. From these notes, I then chose themes from the interviews and rearranged the answers to discover recurring themes and group similar answers together. I colour coded the answers of the different interviews in this third document, so that one can see how often a particular answer was given and which answers belong to the same respondent. An example is included in annexure 11.

4.1.5 Report writing

Having completed gathering the information for this qualitative research, I then proceeded to look at all the data gathered and to draw conclusions and recommendations useful for HospiVision to improve her volunteer programme.

4.2 Results of the interviews

4.2.1 Themes

With approximately 13 hours of conversation, the interviews gave me a large amount of data. Not all the data was relevant for this research or could be further developed in this report. In my discussion of the results of the interviews and the conclusions and recommendations I made, I focused on what I felt was most relevant and useful. However, also the themes which were not further addressed are valuable information for HospiVision. It will be up to her to further unpack this data. My complete analysis of the interviews will be made available to HospiVision in a separate document.

An overview of all the themes that came up during the interviews is found in Annexure 12. The themes that were relevant for the specific goal of this report are developed below.

4.2.2 Understanding the experience of volunteers

To gain a better understanding of how the volunteers experience their participation in the volunteer programme, I joined the volunteers during their weekly training sessions, accompanied different volunteers to the wards, and interviewed eight volunteers. Following are results of the data I gathered.

Motives

Initial motivation

Most of the volunteers I spoke to (in the interviews and during the weekly outreaches), seemed to have been motivated to join HospiVision because of normative and religious convictions. The most common reasons were:

- A desire to reach out/help others
- A calling/obligation
- (Personal) invitation

Several of the interviewed volunteers shared that they had extra time, being unemployed or pensioners. They were looking for a way to help others.

Several others shared that they saw it as a calling, or as one woman put it 'a holy obligation.' When still a child, another woman had told the Lord 'Here I am, send me.' She waited for years; when she heard about pastoral services, she knew what her calling was. Still another volunteer had experienced the value of spiritual care as a patient himself. Knowing the need from first-hand experience, he made a commitment to God. One woman had experienced God's saving power and came to the hospital with a passion to testify to others in need.

Personal invitation played a role for several of the volunteers. One woman was approached by her church. Another joined because her future husband was involved. One couple became involved because Elsa Oberholzer came to their Bible study recruiting new volunteers.

A portion of the volunteers heard about HospiVision and decided to become involved in pastoral care in hospitals. Others had a desire to do pastoral care and were directed to HospiVision by the hospital personnel.

Motives to continue

The motivation of the volunteers to do this work seems to be strengthened through their involvement. The most common motivations to continue are:

- Calling
- Seeing the impact
- Awareness of the need
- Fellowship with other volunteers and HospiVision staff
- Tuesday training

Many of the volunteers see their involvement as a calling. This is one of the main factors which keeps them coming back, despite discouragements.

All the volunteers I spoke with, had a testimony of how they had seen lives impacted and changed. Patients accepted Christ. Patients changed, as they received love. Patients could smile again at the end of a visit. God was a reality in the lives of patients. Their trust in Him had a positive impact on how the patients dealt with their illness. Seeing lives change and God at work, gives the volunteers the encouragement they need to continue coming. Especially important is the appreciation and thanks which the patients express.

A few of the volunteers said it was the awareness of needs that brings them back. They realize how important it is for a patient to receive visitors, to know someone cares. But many do not. One woman said, she felt pity for those who do not know Christ. Another woman spoke of how the contact with others, reminds her of her social responsibility to help others.

One of the biggest motivational factors to continue is the fellowship the volunteers share together. Several times, I heard volunteers mention that the HospiVision personnel feels like family. They look forward to seeing each other each week. While some of the volunteers said that they work for the Lord and not for people or an organization, the appreciation the HospiVision staff expresses for her volunteers does seem to be one of the key motivating factors.

Along with fellowship, the weekly trainings are an important motivating factor. One volunteer put it this way: 'The times of Bible reading and prayer are a motivation to go out and do whatever you can.'

Discouragements

While the patients mostly spoke about what encouraged them, a few discouraging or frustrating factors were mentioned as well. The main ones mentioned were:

- Seeing suffering
- Rejection by patients
- Finances (for transportation)

Two of the volunteers gave examples of patients who rejected them. The one said he felt so angry and discouraged, that he could not continue further visits that day. He needed some rest. The other volunteer was determined not to give up. When rejected, she chooses for a different approach. In one case she clarified to the patient that she did not come as a pastor but as a caring mother. For several days, she would bring the patient some food, sitting by his bed but not speaking. With time, her love changed the patient's attitude toward her.

Other frustration or challenges that were mentioned:

- Trying to live up to his personal standard
- Patients screaming/causing violence (spiritual causes)
- Knowing how to respond to the beliefs of the black folks (lack adequate knowledge)
- Narrow mindedness of patients
- Seeing the needs and not being able to do more
- Beginner's challenges

Two of the volunteers interviewed had only been with HospiVision for three months.

The first expressed frustration about the application procedure. In her words, she felt 'toss from pillar to post.'

The second expressed frustration about her experiences with needing to accompany an experienced volunteer because she had not yet done the course. Her frustration lay, not in the fact that she must go with someone, but in the way the other volunteer acted. She did not feel wanted. She also felt an experienced volunteer was not acting properly, taking phone calls during visits or interjecting in the middle of conversations.

Impact on the volunteers personally

Faith

In general, participation in the volunteer programme seems to impact the faith of the volunteers in a very positive way, causing their faith to grow and strengthen. Each is impacted in his or her unique way.

Ways in which their faith has grown:

- Ability to help others better
- Increased love and patience for patients

- Seeing that God is a reality in the lives of the patients (not 'just theology')
- Seeing the miracles in people's lives
- Praying more for the patients
- Increased realization, that she is her brother's keeper
- Realization of her blessing
- Realization that suffering is part of the Christian life; that reliance on God in those circumstances makes a difference
- Realization that life is in the hands of God
- Fulfilment for a hunger for more of God and His love

Thinking

In general, involvement in the programme has an impact on the thinking of the volunteers as well. Some said their thinking changed; others that their thinking was not so much changed, as broadened and deepened.

Ways in which the thinking of volunteers changes or deepens:

- Contact with others makes her aware of the needs of others
- Coming to better understand the ill and how to approach them
- Valuing health more

Interestingly, while the volunteers come with the intention to help and encourage others, more than once a volunteer told me, that he/she was the one who was encouraged by a patient.

Impact on patients

The volunteers mainly spoke about the positive impact they are able to make in the lives of the patients.

- Patients get hope, cheer up
- Patients are comforted, feel cared about
- Patients accept Christ
- Patients change as they are shown love
- Patients thank volunteers, express their appreciation

The positive responses of patients appear to be important motivators for the volunteers. They encourage them to come back and make them realize the value of what they are doing.

Not every patient responds positively. Some reject the care the volunteers offer. One of the volunteers told about two such incidences. One patient started yelling 'Soul winner. You are not allowed to come here.' As a result, only one patient in that ward welcomed his visit. Another patient simply said 'Go!' when the volunteer came to his bed.

These negative responses do not discourage the volunteers to completely stop coming. One volunteer said that he takes the circumstances of the patient into account. He tries to always respond positively, as others have responded positively to him. Another volunteer pointed out that each patient is different. One may reject you; the other will welcome you.

Evaluation of the support offered

In general, the volunteers were very positive about the support Hospivision offers them. The Tuesday morning trainings were referred to most. They apparently play an important role for the volunteers.

What helps the volunteers most

The volunteers said they were most helped by the following:

- The fellowship with other volunteers
- The training sessions on Tuesdays

- Pastoral care for the volunteers
- The availability of the HospiVision staff
- The example the HospiVision staff set
- The basic course
- HospiVision facilitating their work

The training sessions and the fellowship with other volunteers were important themes that came up often. The volunteer spoke highly of the training session. Several volunteers said the other volunteers felt like family or good friends, with whom they can share their life experiences.

Training

The volunteers I spoke with, were very positive about the Tuesday morning trainings. One volunteer said, '[The staff] prepare beforehand. We can pick up that they really invest.' Another said, 'I always learn something.'

Three things stood out as important:

- Opportunity to share experiences
- The Bible reading and prayer
- The topics are relevant

One of the theme's that was mentioned in every interview with the volunteers, sometimes several times, was the support the volunteers received from each other. The volunteers say they learn a lot from each other as they share experiences and discuss with each other during the training sessions.

The volunteers also greatly value the prayer and Bible reading. They find motivation, encouragement and guidance.

The topics are relevant and useful, helping them to relate better to the patients. One volunteer mentioned the simple practical guidelines as being especially helpful. Volunteers are saying they are learning new things as well as being reminded of or confirmed in what they already know.

Courses

While HospiVision would like to see her volunteers do additional courses on a regular basis, most are not. The top three reasons mentioned are:

- Finances
- Time
- Age

Many of the volunteers are unemployed or pensioners. They cannot afford 800R for a course. This seems to be the number one obstacle to doing more courses.

Some, even if they had the finances, do not have time. They are involved in other ministries or studies.

A lot of the volunteers are elderly people. While not all elderly would feel this way, a few of the volunteers I spoke with felt that doing an additional course would be too much. As one also said: 'Life experiences have taught us a lot.'

One of the volunteers interviewed, had just completed the basic course. She had had opportunity to visit the wards before doing the course. Looking back after having done the course, she recognizes several mistakes on her part and now takes a much different approach. These experiences have really show her the value of the basic course.

Improvements

The volunteers are mostly content with the support they are receiving. Several points for improvement were mentioned throughout the interviews, the most common one being:

- Financial support for transportation

A lot of the volunteers have limited financial resources, especially the pensioners and unemployed. They struggle to find the money to come to the hospital.

Other points which were mentioned were:

- Volunteers want to know they are wanted, or missed when they do not come
- More clarity on the approach HospiVision expects
- More information on the wards
- Conduct in the wards must be better managed
- The application procedure
- Arrangement of new volunteers accompanying experienced volunteers

One volunteer was disappointed when she called to say she could not come in. She was told, 'You don't need to let us know if you don't come.' Another volunteer said he would like staff to check up on him, when he does not come in, to see if everything is alright.

One of the volunteers felt uncertain about the approach HospiVision expected. Is HospiVision happy with the Christian approach of the volunteers? Or does she expect a secular approach? While happy to follow HospiVision's leading, she expressed: 'It is hard for [us] to take a secular approach because it is so different from [our] thinking.'

This volunteer also wanted more information about the wards. Are certain wards off limits? Are some wards more infectious? This will help her know what wards to avoid under certain circumstances.

One volunteer noticed some incorrect conduct by other volunteers in the wards lately.

One of the newer volunteer struggled to get an appointment for her interview. It gave her the impression that she was not welcome. She was eager to start but frustrated by all the procedures.

Another volunteer, who has not done the course struggle had a negative experience with how the experienced volunteer she was accompanying was behaving. This caused stress each time she came on Tuesday. Would the person she went with welcome her along? How would the visits go?

4.2.3 Assessing the effectiveness and impact of the programme

Goals

The main goals

The goals for the volunteering programme, as described by the HospiVision staff, could be broadly categorized into three categories.

- To increase HospiVision's capacity
- To support the volunteers
- To support the patients

Through the volunteer programme, HospiVision endeavours to enlist as many people as possible to reach as many people as possible. The volunteers increase the capacity HospiVision already has. The volunteer programme also plays a role in expanding HospiVision to as many hospitals as possible, as volunteers move on to other ministries beyond the central area of TDH and SBAH.

The volunteer programme is geared toward supporting the volunteers. This includes:

- Encouraging and motivating volunteers
- Training and equipping them to function well in the hospital context
- Helping the volunteers to grow spiritually and emotionally

Touching lives. Giving hope. The volunteer programme helps to reach this goal, as the volunteers give emotional and spiritual support to patients.

Extent to which the goals are met

'To a large extent HospiVision meets the goals. The volunteers do a fabulous job.'

The general impression the staff gave was: the goals are being met to a certain extent, but there is room for improvement.

- Capacity

People are involved. The capacity of lay volunteers is significantly increased by student volunteers. However, more people are needed.

- Support to volunteers

Long term volunteers are building up skills and expertise. The hospital context always has an impact and volunteers are growing through their experiences. Many are healing and helping others heal. However, energy is being invested in volunteers who then are unable to continue. While some grow rapidly, others stagnate. In addition, not all volunteers are adhering to the behavioural code of the hospital setting, even though this code is often repeated.

- Support to patients

Patients are being reached, but nearly as many as HospiVision would like. According to the statistics, 20,000 to 30,000 patients are being reached per year; that is <10% of all the patients.

Reasons the goals are not being met

There could be numerous reasons the goals are not being met. Two limiting factors that seem to have an impact on various aspects of the programme are

- Finances
- Time

Finances are a challenge for many volunteers.

Time is a challenge for the staff.

- Capacity

Two factors which greatly eliminate potential candidates are:

- Finances
- Time of outreach

Many of the volunteers struggle to pay for transport many each week. Candidates are also eliminated is they are unable to pay for the required basic course.

The organized outreach and weekly training take place on Tuesday mornings, a time when many people are at work. This makes HospiVision largely reliant on pensioners and housewives (and unemployed people and pastors).

For a variety of reasons, volunteers may also stop coming. Some of those mentioned were:

- Volunteers have taken offense when they felt HospiVision was compromising her beliefs.
- The job turned out harder than expected.
- They use their certificates for other purposes.

- Support to volunteers

The main challenge here is:

- Time

Care requires time. The staff are often overloaded.

Other factors which hinder or make support ineffective are:

- Finances
- Attitude of the volunteers

Volunteers lack the finances to pay for additional courses.

Some volunteers are un-teachable. They refuse to comply with the rules, saying: 'The Holy Spirit told me to...'

- Support to patients

The extent to which this goal is met, is largely dependent on the extent to which the two above mentioned goals are met.

- Capacity
- Skill/understanding

Some volunteers are not open to receiving. They fail to understand both patient and caregiver are both student and teacher. They think own lessons are the answers to others circumstances as well, not understanding each person's journey is different. Their own need for healing can be a hindrance. Limited training limits their skills and abilities.

Another reason comes from outside the organization:

- Medical staff

Not all medical staff are willing to have HospiVision volunteers. They block the entrance to their wards, or make volunteers feel uncomfortable and inadequate to deal well with situations, affecting the support they give.

Effects of the programme

Feedback from volunteers

During the training sessions and through personal conversations, the staff are regularly receiving feedback from the volunteers.

Positive feedback

A good portion of the feedback is very positive. Volunteers are saying

- They experience their involvement as meaningful and valuable.
- Patients and their families are expressing their appreciation.
- Patients are being reached.

Despite frustrations, patients experience their work as worthwhile. They feel blessed, finding fulfilment for their calling.

Volunteers report that patients have really been comforted and given hope. They also report patients coming to faith in Christ. They are able to build a relationship with patients, to reach them.

Negative feedback

While the negative feedback is more limited, the most common sources of frustration are:

- Finances
- Rejection by patients

Many volunteers struggle to make ends meet, making it difficult to find the money for transportation.

Rejection by patients can be cold, indifferent attitudes to aggressive behaviour. Often just the extreme cases of rejection are reported. Some patients ask difficult questions concerning God and suffering.

Other sources are:

- Uncooperative staff
- Seeing so much suffering
- Personal standards and insecurities.
- Challenge of exposing oneself to reach out to strangers.

Some volunteers feel they have failed if they have not prayed and shared the Word with patients. Many feel insecure, uncertain how to handle certain situations.

Feedback from the medical staff

From time to time, HospiVision receives feedback from the medical staff. In general, the staff would say the medical staff appreciate the work the volunteers are doing.

Positive feedback

- Appreciation for HospiVision's availability
- Referrals

The medical staff appreciates the way HospiVision works and especially her availability. In THD, HospiVision has a very good relationship with the CEO, who is supportive of her. The volunteers are welcome guests.

HospiVision gets a lot of phone calls from medical staff, asking HospiVision to visit particular patients. The volunteers are among those who then go visit.

Negative feedback

Despite the general appreciation, HospiVision also receives complaints concerning:

- The behaviour of volunteers.

This behaviour includes loud praying, having an attitude, upsetting of patients, touching patients in the face, etc. People have zeal and want to help, but do so in an intrusive and insensitive manner, not according to the behavioural code.

Some complaints are grounded. Others, when investigated, concern people other than HospiVision volunteers.

Feedback from medical staff themselves

Four sisters who have volunteers come to their wards regularly gave feedback on their experiences with HospiVision. One must keep in mind that the nurses do not distinguish between the lay volunteers, the student volunteers and the permanent HospiVision staff who do visitations. While their feedback relates to all HospiVision personnel, it also includes the lay volunteers.

The evaluation of the sisters was:

- Volunteers are doing an excellent job.

The other sisters in their wards seemed satisfied with HospiVision as well.

The sisters see that patients respond positively. Examples of the responses they see:

- Children open up, starting to talk and smile, after having been visited by HospiVision volunteers. They are comforted and feel loved.
- Patients come to terms with their diagnosis after counselling. They then become easier to nurse.
- Patients say, 'Thank you for sending that person to me.'
- The conditions of patients improve when they receive visits.

The sisters appreciate:

- Accessibility
- Spiritual support: pray and Bibles
- Listening
- Referrals
- Practical help
- Skill
- Follow ups

HospiVision comes, even when not phoned. HospiVision is often easier to contact than other services and they come quickly.

The nurses appreciate the prayer that volunteers offer to the patients. The nurses who made mention of this were born again believers themselves. Patients can feel lonely and forget God is there. They also appreciate the Bibles HospiVision supplies at times.

Many patients are lonely. By mere talking to the patients, HospiVision's volunteers comfort and reassure the patients, letting them know they are loved. The staff do not always have time to listen.

HospiVision is good with her referrals to psychologists, further counselling, etc. Through these referrals, patients are able to receive follow up care after being discharged.

In one of the wards, when the nurses were short staffed, volunteers helped feed spinal patients.

The HospiVision visitors understand the nature of the patients' diagnosis and how to deal with the consequences of the nature of their diagnosis. They help the patients a lot.

Some volunteers come regularly (daily) to check how patients are improving.

One sister pointed out: 'It takes a team for a patient to heal.' These sisters would refer patients to HospiVision because:

- They offer spiritual support and prayer.
- They offer counselling (psychological help).
- They are very easily accessible and have a variety of help resources.
- They have time to listen and a patient can tell them everything, also things they cannot tell the sisters.

Recommendations from the medical staff

The main recommendation the sisters gave was:

- Keep up the good work. [HospiVision] is meeting a need.

The sisters had the following recommendations and questions:

- Who are the volunteers?
- Does HospiVision see patients after they have been discharged?
- HospiVision should not forget to bring Bibles.
- Who supplies the Bibles?
- Can volunteers also talk to staff?

Are the volunteers psychologists, social workers, or pastors? Professional or students? Knowing this helps the sisters know whom to refer to whom.

Following up is important but difficult to do, especially with patients with low education, family problems and social economic problems. In the hospital they receive support, but at home they can feel they must do it all alone.

Patients appreciate having a Bible to read when the volunteers leave. Some do not have one or they cannot have theirs brought because they live too far away or do not get visitors. Bibles are needed in all languages. Maybe HospiVision can sell them.

The volunteers always come for the *patients*, but the staff also need spiritual support. They need prayer for encouragement and the reminder that they are not alone, God is there. Practically, this could mean, that sometimes the volunteers come specifically for the staff. They could gather the staff for prayer and a word of encouragement, even for just 10 minutes.

Needed improvements

The volunteer programme is functioning well in many ways. However, the possibility for improvement always remains. The HospiVision staff are aware of aspects that are going well, but also recognized different areas needing improvement.

What is going well

According to the staff, the following is going well:

- Relationships
- Work is valued
- Availability
- Training and development
- Bridging of the cultural gap
- Administration

Relationships are important to HospiVision and play an essential role in the volunteer programme.

- The relationship between the HospiVision staff and the volunteers

Volunteers are open to share with and receive input from staff. They share a closeness because of their common goal.

- The relationship between the volunteers

The volunteers form a small community. They develop friendships. They share with and support each other. Long term volunteers positively influence new comers.

- The relationships with patients

Volunteers are building up relationships with long term patients.

Volunteers are understanding the value of their work and finding fulfilment in it.

Volunteers are readily available. They don't shy away from helping and are available to come when called. The few regular volunteers have a real desire to come.

Volunteers are developing and growing personally. The long term volunteers are discovering and developing skills. They enjoy the training and find it useful.

Volunteers come from a variety cultural backgrounds, which has been very valuable for reaching the patients who also come from culturally diverse backgrounds.

The people responsible from bringing the volunteers together, sending them to the wards, and getting feedback from them are doing this well.

What needs improvement

Three areas in which the staff feel there could be improvement are:

- Screening

- Training
- Supervision

The main challenge for the staff in this is:

- Time, to give the needed attention.

Screening

Hospivision has a good set up for the screening, but the implementation is not always there.

The staff feel the screening procedure could be improved in the following aspects:

- Implementation
- Clarity

The policy is not always implemented. Not every volunteer is interviewed, mainly because of time limitations. The course alone does not offer enough opportunity to assess if a volunteer will fit in; the interviews are necessary.

The process is not communicated clearly enough. Just because one passes the course, does not mean one is suitable for the team.

There seems to be some disagreement concerning whether a candidate is suitable. One staff member felt the criteria were too strict. This person felt no one should be screened out. Everyone should get a chance. If they do not want to adhere to Hospivision's policy, they will leave of their own will.

Training

In general terms, the training is going well. The volunteers are being built up developing skills en expertise. The teaching is relevant, addressing the challenges they encounter. There is room for questions and to learn from each other. The training could be improved in these areas:

- Structure
- Attendance

The training lack coordination and long term planning in regards to the topics addressed. More structure would give more continuity in the teaching and ensure topics are not repeated in a row or missed completely.

Not all volunteers are able or willing to come to the weekly trainings. Some regularly come in late, missing the fellowship.

An additional concern of one of the staff was that while the behavioural code expected of the volunteers is repeated often during the training, not all the volunteers are following it. They rather let themselves be led by the teaching they receive at their churches, instead of from Hospivision.

Courses

The staff agree that the courses Hospivision offers are excellent courses which really equip those who attend. The major challenge concerning the courses as relating to the volunteer programme is:

- Attendance

The courses give more opportunity for continuity (3 days in a row) than the weekly sessions. Ideally volunteers should attend one extra course a year. Right now attendance is too low.

The main reason for this low attendance rate seems to be:

- Finances

The courses are (too) expensive. One staff estimates that 80% of the volunteers have difficulty paying the 800R course fee. This is especially true of the black folks.

Other reasons are:

- Time constraints
- Unwillingness to undergo three day training with assignments.

One man was unwilling to do that training, claiming the Holy Spirit trained him.

Supervision

Supervision is one area in which the staff felt there are some major challenges. Aspects of the supervision are going well. The relationship between staff and volunteers is such that the volunteers are open to share with and receive input from the staff. There is the opportunity to share (during training and after the ward visits). Also the statistics are monitored well. The major challenge lies in:

- Giving adequate attention
- Qualitative evaluation

Nothing takes the place of personal contact. Volunteers need to know they are loved and cared for. Because the staff each have multiple task and many demands on their time, aspects of the care fall through the cracks. More tokens of appreciation need to be given throughout the year.

The staff have very little insight into what the volunteers do in the wards or the quality of their work. The staff primarily get their insights indirectly, from the feedback of medical staff or others. To accompany the volunteers to the wards is too labour intensive. At this point, checking up on a volunteer's work is done mainly when there is a complaint or a problem has been signalled, not as a precaution. However, the staff feel it is an important to ensure the volunteers understand and comply with what HospiVision teaches.

Again, time (that is, a lack thereof) is the main reason the supervision is not what it should be. The staff struggle to prioritize the demands made on them.

Other challenges are:

- Debriefing and individual care
- Discipline

The staff feel that more debriefing of volunteers on a personal level, to hear how things really are, would be beneficial. One of the staff suggested the guideline should be two individual session per year. When given the opportunity, volunteers are not always making use of it. For example, the volunteers were offered debriefing by the psychology students, and they are encouraged to come share their stories after their ward rounds.

Discipline concerning volunteers coming late, missing training, and causing trouble was mentioned in one interview as being lacking. Also more consistency is needed. For example, a person who is no longer permitted to work in one hospital should not be allowed in another hospital either.

4.2.4 Conclusions

Looking at these results, we can conclude that HospiVision's pastoral care and counselling volunteer programme is a well-functioning programme with some important strengths. One of her greatest strengths is the positive relationships that the staff and volunteers share. Knowing one is loved, valued and appreciated forms the basis for stepping out to serve, love and accept others, for getting up after one blunders, for personal development and growth. We see these things happening through the volunteer programme. Volunteers are reaching others. Their stories testify that patients are impacted, being encouraged and given hope. Volunteers are also impacted personally, developing skills and expertise as well as growing in their faith, healing and maturing.

Another strength is the accessibility of HospiVision. At least a portion of the staff are aware of the services HospiVision offers and know how to contact them. HospiVision is able to respond quickly.

A healthy organization is always looking for ways to continue growing and developing. There is always room for improvement. The same is true for HospiVision. There is room for improvement in several areas: screening, training and supervision. The greatest hindering factors are a lack of finances and time/capacity. These precious commodities are not easily increased. HospiVision will need to look at what resources she does have and how these can be more efficiently used.

5 Conclusions and Recommendations

Based on my literature research, my participatory observations and my analysis of the interviews with the HospiVision staff, volunteers and medical staff, I have come to the following conclusions and recommendations.

I have looked at what the strengths and weaknesses of the volunteer programme are. Then, comparing these to the literature study, I have made some recommendations. In this, I have sought to focus on the main points that came up during my research.

I have subdivided my recommendations into four sections: the programme in general, the screening, the training, and the supervision. I conclude with the recommendations the volunteers gave and the questions the medical staff had.

5.1 General

5.1.1 Strengths

- Love and unity

Perhaps HospiVision's greatest strength lies in the love and unity her staff and volunteers share. In Jesus' farewell speech to his disciples shortly before his death, he spoke on the importance of unity and love. His desire was for his followers to share in the unity and love He shared with the Father. This is the foundation for a fruitful and joyous life and ministry. From knowing we are loved, we can love others.

- Passionate volunteers

HospiVision's volunteers are involved because they truly have a passion for what they are doing and many of them have a calling. HospiVision has a core group of volunteers who will not easily let themselves be discouraged from the work they are doing.

- Appreciation

HospiVision is intentional about letting her volunteers know they are valued. During the training sessions, the staff often repeat their appreciation for the volunteers. The programme at SBAH is more structured and developed in this regard, than at TDH. For example, the volunteers at SBAH are invited to a breakfast several times a year. They also received a small package on their birthdays. The volunteers from both hospitals are invited to the yearly functions in November, a time when HospiVision expresses her appreciation for their work.

- Personal attention

The programme not only focuses on the work that must be done. There is a lot of focus on the volunteers themselves, on their well-being and their spiritual and personal growth. Each one counts and is valued for who he/she is.

- Accessibility

HospiVision is accessible. The medical staff can easily call HospiVision to come support a patient, without needing any referral from a doctor, and HospiVision responds quickly.

- Diversity

The volunteers are a diverse group, coming from a variety of church and cultural backgrounds. In a hospital, where one finds people from all backgrounds, this is a great asset. In HospiVision, there is a place for volunteers from many cultural and denominational backgrounds.

5.1.2 Weaknesses

- Dealing with diversity

The cultural diversity among the volunteers is a strength. In the hospital, it can also be a challenge. Some of the volunteers struggle to cross the cultural gap between them and patients. For example, one white volunteer indicated she struggled to know how to support a black patient who was being threatened with witchcraft. During the training sessions, I heard little mentioned about how to deal with cultural diversity.

- Preferred approach

One volunteer pointed out: 'I would like some more clarity on the approach HospiVision expects us to take.' Meaning, does HospiVision expect a secular approach or a Christian approach? This is a topic that came up during interviews with the HospiVision staff as well. HospiVision and the volunteers (and their congregations) at times seem to have different understandings of what it means to offer spiritual support. While this is not the case for all the volunteers, a good many of them seem to favour a more explicitly Christian approach than HospiVision favours. There seems to be a gap between how HospiVision envisions 'spiritual care' and how many of the volunteers do.

- Recruiting new volunteers

One thing everyone seems to agree on is that HospiVision seems to need more volunteers. Working with volunteers often means working with a constantly changing group. Yes, HospiVision has a core group of long term volunteers but also a high rate of change. I have not discovered a clear policy on how HospiVision goes about recruiting new volunteers. Recruitment is being done to some extent (for example, through radio pulpit), but to a limited degree. A good portion of the volunteers I spoke with, became involved after they had already come to the hospital, wanting to minister to the ill but unacquainted with HospiVision.

- Fragmentation

HospiVision is established in 18 different hospitals. I only looked at the branches in SBAH and TDH. While these two hospitals form a complex, the two branches are clearly separate. This is fine. However, I noticed that the office in SBAH is better established than in TDH. This includes that the policies of HospiVision are implemented better at SBAH than at TDH. While I cannot say much about the branches in other hospitals, I would suspect that the HospiVision office is even less established there than at TDH. They have less contact with the head office and are smaller. Now the task of ensuring the policies of HospiVision are implemented is divided among those staff directly involved with the volunteers, staff who also have many other tasks to attend to.

5.1.3 Literature study

During my literature study, I came across a model for those in ministry (designed by Kelly O'Donnell, Dave Pollock and Marjory Foyle). It was initially developed for those serving in fulltime ministry in a cross-cultural setting but was intentionally kept general enough to be applicable within a variety of cultural and organizational settings. This model for member care is composed of five spheres of ministry: Master care, self-care, sender care, specialist care and network care. (Figure 5.1.)

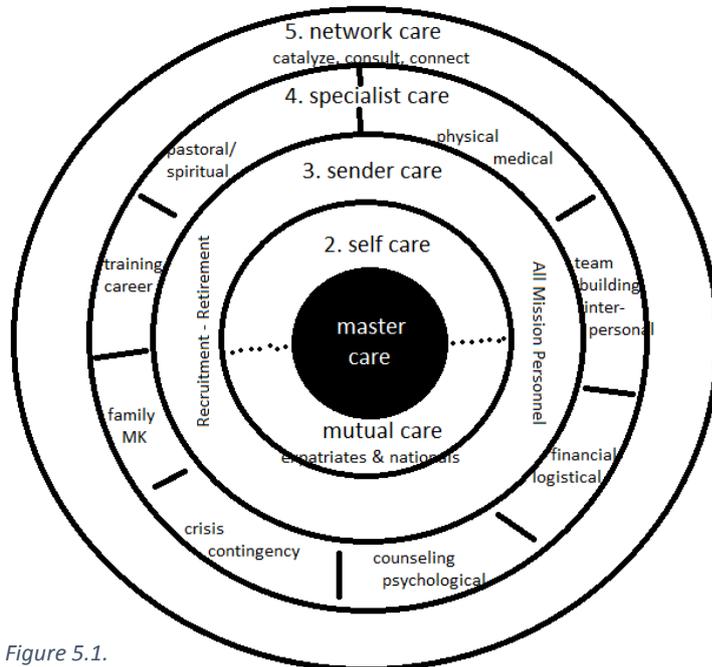


Figure 5.1.

Looking at HospiVision, care pertaining to each of these levels is offered or fostered. Master care is fostered during the trainings, through Bible teaching and prayer. Self-care is fostered through the focus on personal growth and development of the volunteers. Mutual care among the volunteers is strong. Sender care is present in HospiVision's commitment to support her volunteers. Specialist care is offered mainly through the counselling available to the volunteers themselves. (Network care is not some much directly available to the volunteers themselves, but HospiVision does greatly invest in staying up to date with the developments in the field of pastoral care and counselling to the ill.)

The core, the two inner spheres of master care and self-care, are strong. Within these spheres, love and unity are fostered, which we see reflected in the way HospiVision's personnel interact together.

A lot has been written on volunteers and volunteering. Essential to working with volunteers is letting them know they are appreciated. Appreciation is a key motivator. It can be expressed in many ways:

- Creating a greater awareness of their work, through publicity or by making the volunteers 'visible' (clothing, badges, etc.)
- Acknowledging the importance of their work by taking them seriously and doing what one can to make their work as pleasant and effective as possible (ex.: flexible working hours, reimbursements, pleasant atmosphere in the work place, trainings, etc.)
- Expressing appreciation through affirmative words, social gatherings, or small gifts
- Rewarding their service through a small gift, certain privileges, awards, etc.

The possibilities are endless. HospiVision is very appreciative of her volunteers and is already making uses of some of these possibilities. Of course, she could look at what other forms would fit her organization.

A second key motivator is personal contact. Nothing can be as motivating or up building as positive personal investment in people. It is part of the whole process of working with volunteers, from recruiting to coaching to saying farewell. This calls for much time and energy. HospiVision is aware of this and does give the volunteers much personal attention. However, she struggles with the time factor.

One of the recommendations is concerning reimbursements of travel expenses. Volunteers do their work voluntarily, for free. However, many organizations will reimburse costs volunteers must make to do their work, considering that the volunteers already give a lot (time, energy). It is one way of showing that the work they do is very valuable.

One of the weaknesses is the gap between the explicitly Christian approach some volunteers prefer and the more implicit approach HospiVision prefers. Pastoral care could be defined as 'caring for the story of the other, as it stands in relation to the story of God.' Various perspectives exist on how these two stories relate in pastoral care. Some emphasise the Word, others the therapeutic side. Others look for a balance somewhere between these extremes.

Of course the context plays an important role. The ministry of pastoral care in a hospital setting has been described as

- A ministry of presence
- A ministry of compassion and hope
- A ministry of an interpreter and networker
- A ministry of wisdom counselling.

These characteristics are descriptive of what the volunteers are offering.

The differences lie in that some volunteers feel strongly that the Word of God and prayer *must* always be part of a visit. Some patients really appreciate this and even expect this from a visiting pastor; but not all are ready for this. HospiVision envisions a broader approach, focusing on emotional support not just spiritual support.

One's understanding of what pastoral care is influenced by one's understanding of how the other person's story and God's story relate. Another influential factor is culture. It is in culture that people are able to relate to the world and where words, symbols and stories take on meaning. A pastoral caregiver must be sensitive to the culture the other is coming from as well as to how his culture influences his own attitudes and dispositions. HospiVision's volunteers are confronted with a diversity of cultural backgrounds. And some do struggle to reach across the differences to understand, be understood and offer support.

One can invest considerable time and energy into coaching and supporting volunteers. However, one cannot overlook the first step of recruiting volunteers. Recruiting new volunteers should be a continual process. In a well-functioning programme, new volunteers will be sought before one begins to experience shortage through lost capacity. Recruitment begins with publicity. Organizations that are well-known and well-spoken of have an easier time recruiting volunteers than those with less publicity. Secondly, an organization must ask herself what type of people she is looking for, that is, her target group. Then, what would be the best means of communication to reach this target group? And what does HospiVision offer what would appeal most to this group? Finally, the best and most effective approach remains to approach people in person. Whatever strategy an organization chooses, that should always be a part of their approach. HospiVision invests considerably in the support of her volunteers and has come up with good policies. A structured approach for recruitment is missing however.

5.1.4 Recommendations

- Dealing with diversity:

Hospivision could consider asking volunteers from various cultural and denominational backgrounds to share about their backgrounds during training sessions. They can help each other to better understand and support patients who are coming from backgrounds different from their own.

- Additional forms of support

Hospivision makes an effort to let her volunteers know they are appreciated and valued. The possibilities of what one can do are endless. Below are a few suggestions of some additional forms:

- Reimbursements for travel expenses

Since covering transportation fees is a challenge for many volunteers, Hospivision could look at what possibilities she has to help them. Some examples:

- Setting up a fund supporters of Hospivision could donate to. Even if Hospivision is unable to completely cover the costs for her volunteers, she could cover at least part of their travel expenses.
- Helping volunteers to find sponsors. Perhaps the volunteer's church or someone from their church would be interested in partnering with the volunteer through helping pay for transportation fees. Hospivision could help her volunteers approach their churches, to see if they would be willing to partner with them in this way.

- TDH

The volunteer programme better established at SBAH than at TDH. Some good practices already in place at SBAH could also be put in place at TDH. Some examples:

- Biscuits with the tea

A small token of appreciation, is to have something to serve the volunteers with their tea. Especially since some volunteers struggle to make ends meet, having something to eat (biscuits, sandwiches, etc.) can be an encouragement. It does not have to cost much.

- Small gift or card on special days (holiday, birthday, etc.)

A small gift or card on ones birthday can really make one feel seen and valued.

- Social gatherings

The volunteers at SBAH are invited to a breakfast several times a year. The volunteers who go, are greatly encouraged through it. Something like this could be done for the TDH volunteers as well.

- Checking up when volunteers don't come

Some volunteers do not come in regularly. To call them every time they do not show up, would be too much. But the staff could look at the attendance list on a monthly basis. If volunteers have missed two or more Tuesdays, they could contact them, just to see how they are and if the staff can offer assistance to help them come more regularly.

- Writing down their stories

The volunteers all have stories to tell of how they have seen God as work in the lives of patients, stories they have had the privilege of being part of. Hospivision could ask a different volunteer to write down one of their stories for her regular newsletter. She could post a new testimony on the website each month. This tells the volunteers that their work is important. Also personal stories are often the best motivators; they can become a means through which others are challenged to join the volunteering programme.

- Recruitment

The need for more volunteers is evident. Hospivision will need to become more proactive in her recruitment if she wants to really see an increase in her capacity for an extended period of time.

- Publicity

She could begin by making her organization more well-known in churches. During my time her, I met few people who had heard about HospiVision and what she does. But they listened with interest. HospiVision could consider ways to make her organization better known in the congregations in Pretoria. Different means could be used, depending on what is appropriate for each church setting: a short presentation during the Sunday service, visiting mid-week Bible studies, writing in the church newsletter, organizing an evening. This would be an opportunity to ask for more volunteers as well as to make people aware of the care HospiVision offers, should they or a loved one ever end up in the hospital.

- Approaches

People are coming to the hospital, wanting to minister to patients without even knowing about HospiVision. There is potential to recruit more volunteers.

HospiVision needs to consider who her target groups are and what she has to offer them. She should not just consider the need for more volunteers but also needs potential candidates may have (for example, the need for social contacts and a support group). She should also consider possible hindrances and what changes she can make to accommodate more volunteers. For example, the outreach is during a time when many people work. Is there a possibility to schedule a second outreach in the evenings? Is someone available to facilitate this? HospiVision could start with an evening outreach every other week. Perhaps some experienced volunteers would be available to help. This would make volunteering possible for those with regular jobs.

HospiVision can elicit the help from her volunteers to create publicity as well as to recruit people. Volunteers can represent HospiVision at their own churches. HospiVision can give them so folders and letters to hand out. Volunteers who are excited about their work are the best advertisements. They could be encouraged to share testimonies to excite others as well. Stories often make a stronger impression than abstract information.

HospiVision could place 'business cards' in the wards. People who come to visit the patients who have not gone through HospiVision will be able to find her easily.

Finally, the personal approach works best. HospiVision and her volunteers should continue to approach people personally, asking them to consider joining the volunteer team.

- Coordination

The HospiVision staff involved with the volunteers have many responsibilities apart from their involvement in the volunteer programme. They are short on time to really implement some of the policies HospiVision has drawn up. The extent of the implementation of these policies also differs from branch to branch. HospiVision could consider the possibility of appointing someone who can focus completely on the coordination of the different branches and ensure that HospiVision's policies concerning the recruitment, screening, training and supervision of the volunteers are being implemented. Of course, more staff would be involved in the actual implementation but he would be responsible to oversee what is happening in the different hospitals and where certain things are falling between the cracks.

5.2 Screening

5.2.1 Strengths

- Quality

Hospivision does not let the need for more volunteers blind her for the fact that not everyone is suited for the volunteer programme. She will not exchange quality for quantity. She is concerned that both the candidate will be able to operate well within the organization and that the patients receive the correct treatment.

- Good set up

Hospivision has a good set up for her screening process. Candidates are clearly explained how Hospivision works and are well trained to do this ministry. Hospivision takes the time to personally get to know the candidates, giving Hospivision the opportunity to assess if the candidate is a good match. The Hospivision staff seem to have a good picture of the criteria required for a volunteer, while allowing for the individuality of each person.

5.2.2 Weaknesses

- Implementation

The main weaknesses of the screening process lie in the implementation. Volunteers are either not being interviewed or they are struggling to get an appointment. A candidate who is frustrated in this way, can get the impression that he is not welcomed or even decide to not to join Hospivision.

Time is the big challenge here. Staff are very busy or work part time.

5.2.3 Literature study

Literature concerning volunteering indicates the importance of a selection procedure. Not every candidate will be a 'good match.' Two questions must be asked: Does the organization have offer what the volunteer is looking for? Does the volunteer meet the criteria of the organization? Volunteer jobs require certain skills and knowledge. And a volunteer must be able to endorse the vision and mission of the organization and her manner of working. In this sense, Hospivision is on the right track.

5.2.4 Recommendations

First impressions have an impact. How volunteers are welcomed into Hospivision will impact how they adjust and if they will stay. Hospivision's has a good set-up for her screening procedure, but implementation could be better. Time limitations is the main challenge. If one cannot make more time available, one will have to look at how one can do things more efficiently.

- Train more staff

At present, only two of the staff are conducting the interviews. Hospivision could consider training more staff to conduct these interviews. Hospivision will have to make a more thorough description of what she is looking for in a candidate. But with more people who can conduct interviews, volunteers will be able get an interview more readily and be less likely to get overlooked.

Much has been written on the skills and characteristics of a competent pastoral and what is needed for the specialized context of the hospital setting. In writing up the criteria potential candidate, Hospivision will have to take into account the difference between professionals and lay care givers. She could consider describing different levels of competence: beginner, experiences, professional.

5.3 Training and Courses

One of HospiVision's strengths is the training she offers to her volunteers as well as to leaders and caregivers outside of her organization. I have considered the training and courses as they relate to the volunteer programme.

5.3.1 Strengths

- Tuesday training sessions

HospiVision understands the importance of equipping her volunteers for the job, if both the volunteers and the patients they reach are to thrive. The goal of the Tuesday training is being met in that the volunteers are being equipped and built up and the community spirit is fostered.

- Interactive

The training sessions are interactive, giving much freedom for the volunteers to raise the questions or to share their experiences. Through the training, HospiVision creates an opportunity for the volunteers to teach and build each other up.

- Spiritual care

An important aspect of the training is the teaching from the Bible and prayer. Not only does HospiVision invest in the practical skills for the work, she ministers to the volunteers spiritually. The volunteers are encouraged and motivated.

- Relevant topics

The topics address are relevant. HospiVision is clearly aware of what it take to do hospital ministry and what the volunteers struggle with. The volunteers can really use what HospiVision teaches them.

- Courses

- High standard

The courses are professionally put together and accredited by UNISA. They are open to anyone, not just for HospiVision personnel. The topics are relevant and practical. People enjoy them and find them very useful.

5.3.2 Weaknesses

- Tuesday training

- Structure and planning

The topics are relevant, but the not structured. A variety of people take turns leading the sessions. This is a great opportunity. Each person has his unique contribution and strengths, complementing the others. However, topics are not planned; each individual chooses as he is led. In this ways, topics can easily be repeated in a row while other important topics are overlooked. Also, one cannot really build on what has been taught the previous weeks, so as to work toward a goal.

- Attendance

HospiVision would also like to see the attendance improve. Not all the volunteers come regularly, or they regularly come late. They miss out on the teaching, but also on the fellowship with the other volunteers.

- Courses

- Attendance

While ideally HospiVision would like to see the volunteers attend at least one additional course a year, these courses are poorly attended. The main reason seems to be finances. Quite a few volunteers struggle to pay transport, let alone pay 800R for a course. Of course, finances is not the only obstacle. The age of the volunteers (feeling too old) and time (jobs, other studies) are obstacles as well. However, finances is a major one.

5.3.3 Literature study

Training is an important part of coaching volunteers. Research has shown a shift in motivating factors among volunteers. While volunteers used to make long term commitments and do things because it was expected of them, they are now looking to see what volunteering benefits them in their personal development. Courses and training offer possibilities to grow and develop. Among the volunteers I spoke with, I did not so much sense this need for opportunities to work on personal development. Perhaps because many of the volunteers are elderly people and because many have a strong sense of calling.

Literature emphasises the importance of training, not just to keep a volunteer's interest, but also as part of making the work of a volunteer pleasurable and effective. Along with training, it is important that volunteers have someone they can approach with questions and concerns, advice and unloading stories. The training sessions allow for this type of input.

5.3.4 Recommendations

- Scheduled topics

The topics of the training could be more structured. A list could be made of all the topics HospiVision and the volunteers find important. A planning could be made per year or half year. Leaders could be chosen according to the topics. Volunteers with experiences or skill related to certain topic could even be asked to lead (part of) a training session

- Rewards

Because volunteers do their work voluntarily, obligating them to come regularly or to participate in certain activities can be difficult. However, one can motivate a volunteer by offering rewards for desired behaviour. For examples, volunteers who have attended the training a set amount of times in a year (for example, 45 out of 52 times) received a certain benefit.

- Reduced fees

HospiVision could consider linking this benefit to the courses. Many volunteers do not have the means to pay for the courses. HospiVision could encourage attendance by offering the courses at a reduced price to regular volunteers. For example, HospiVision could offer one course of their choice per year at reduced rate (or for free) to volunteers who have not missed the Tuesday training for more than 10 weeks in the past year. This helps to motivate regular attendance and makes the courses more accessible to volunteers without reducing the value of the courses. The volunteers can do the course at reduced rate but must work for it. It also minimizes people making abuse of the reduction offered to volunteers by becoming a volunteer only to receive a reduction but not showing up for the outreach regularly.

Other forms of rewards could be offered to those who do not have the time to attend a three day course.

5.4 Supervision

5.4.1 Strengths

- It is taking place

Hospivision recognizes the need for supervision. Supervision is taking place during the training and through personal contact after the volunteers return from the wards. If volunteers have questions, the staff make time to speak with them.

- The statistics are monitored well.

5.4.2 Weaknesses

- Little direct insight

The weakness of Hospivision's supervision is that she has very little insight into what the volunteers are doing in the wards. Her only insight is gained through indirect means: what volunteers share and what medical personnel report. To go with the volunteers is too labour intensive.

- Time constraints

The staff have more work than time. This has consequences for the time the staff have to directly invest in the volunteers. This is especially true for the staff in SBAH, where the office is always busy. Although the staff feel like they are not giving enough attention to the volunteers, I have found that despite their busy schedules they do regularly make time to really listen and speak with volunteers. It is hard for me to assess to what extent the staff are not giving enough attention to the volunteers. In general, the volunteers seemed to be very appreciative of the way the staff invest in them. It is important, that the staff also feel like they do enough.

5.4.3 Literature study

Coaching of volunteers is not only important in the initial stage of working together. It remains important aspect of the interaction between the volunteer and the organization during the entire time they work together. Coaching volunteers means coming alongside the volunteers, to help them excel in their work. This means, not just focusing on the work done, but in the first place focusing on the well-being of the volunteers, investing in individuals and finding out what motivates them and what their job experiences are.

Focusing on the volunteers' well-being necessitates personal contact with them. Through contact relationships are build, which is again important to be respected as authority. Volunteers are not bound by a salary or 'obligated' beyond the commitments they choose to make. The extent to which one can then manage them, has a lot to do with the relationship one shares with them and to what extent they respect and trust the leadership. Their understanding of why an organization sets certain guidelines and how this contributes to meeting the goals, mission and vision of the organization also determine to what extent the volunteers will want to comply.

5.4.4 Recommendations

Hospivision could look into how she can gain some more insight into what is happening in the wards. During this research, I had the opportunity to accompany volunteers to the wards. From the interviews and training sessions, it sounds like the staff have a good feel for what goes on there.

- Students

Hospivision could consider asking the students to accompany the lay volunteers to the ward to observe. They could write a report about their observations: What went well? What should have been done differently? Why? This will both give Hospivision more insight and be a great learning experience for the students.

Volunteers themselves could also write up short reports on a case of their choice. What did they do? What went well? What could have been better? However, this may be asking a lot for some volunteers. These could be questions to ask the volunteers during a personal meeting with them. Some may be willing to share during the training sessions.

- Additional research: Interviewing patients

For reasons described in chapter 4, I was not able to interview any patients. Patients are a valuable source for assessing the effectiveness and quality of the work. This is something that future student interning with Hospivision could look at. Not only would it be valuable in assessing the effectiveness of Hospivision's volunteer programme, it would also be very interesting for the larger research on Spirituality and Health.

- Setting goals

The staff are saying they feel as though they do not give the volunteers enough attention. It could be good for the staff write down some goals for themselves, based on realistic expectations for the time they have available. One can always do more; setting some goals can help to not feel as though one is failing in this area. In this process, if the staff discover that they really cannot give adequate attention to the volunteers within the time they have available, they could look at delegating some of the supervision to experienced volunteers who can help coach newer volunteers. The volunteers already seem to be supporting each other in this way. By matching up volunteers, one avoids volunteers from being overlooked.

5.5 Recommendations from the interviews

Some of the recommendations the volunteers and medical staff gave have been incorporated in the recommendations given above. Here I have listed them again, as something for Hospivision to take into consideration as she looks to develop her volunteer programme further.

5.5.1 Volunteers

- Volunteers want to know they are wanted, or missed when they do not come. This has a lot to do with how the staff respond to them missing a week.
- One volunteer suggested there be more prayer for the patients and medical staff, as well as for the volunteers. The volunteers need protection (spiritually) as they speak to patients, whose backgrounds they do not know.
- One volunteer sensed a need for more clarity on the approach Hospivision expects. How explicitly Christian can the volunteers be in their approach? What exactly is Hospivision looking for?
- One volunteer wanted some more information about the wards. What wards can the volunteers visit? What wards are more infectious? Etc.
- One volunteer finds that conduct in the wards must be better managed. He had seen some incorrect conduct in the wards by other volunteers.
- A recently new volunteer was frustrated by the long process of becoming a volunteer and the difficulty of getting an appointment for an interview.

- Another recent volunteer was frustrated by her experience with an experienced volunteer, whom she had to accompany.

(The staff do look at whom they send newcomers with. The volunteers differ in their ability and willingness to let a new volunteer accompany them to the wards. HospiVision could consider training some experienced volunteers in how they can best teach newcomers who accompany them to the wards.)

5.5.2 Medical staff

- Additional research: More interviews with medical staff:

With just four 10 minute interviews, the data I was able to collect from the medical staff was limited. In addition, the sisters I interviewed were all acquainted with HospiVision and had positive experiences with her volunteers. HospiVision had not done interviews with the medical staff before. Their understanding of how the medical staff view the volunteers is largely based on the feedback the medical staff offer of themselves. It would be worthwhile to interview more medical staff, including those who have had negative experiences with the volunteers. The medical staff and the spiritual caregivers form a team. The better they understand each other, the better they can work together.

- Pamphlets:

HospiVision could make herself better known among the medical staff by creating a small pamphlet for the medical staff, explaining how HospiVision works, who her personnel are (professionals, volunteers and students) and how they can support patients and staff. These pamphlets could be placed in every ward.

The sisters I interviewed asked the following questions:

- Who are the volunteers? Are they psychologists, social workers, or pastors? Professional or students? What patients can they refer to whom?
- Does HospiVision see patients after they have been discharged?
- Who supplies the Bibles? Perhaps HospiVision can sell Bibles.
- Can volunteers also talk to staff?

These questions could be answered in the proposed pamphlet.

- Support to medical staff:

The medical staff also need support. Most of the focus during the courses and training sessions is on support for the patients. A topic that could be addressed more is the stresses and frustration of medical personnel and the support they need. HospiVision could also consider asking certain volunteers to specifically focus on the medical staff.

6 Summary

The project 'Called to Care' was given in assignment by HospiVision. After her board discussed the importance of the role which volunteers play in the HospiVision ministry, they asked that a research be done about their volunteer programme and recommendations be made concerning recruitment, supervision and empowerment of the volunteers.

The main question of the research was:

How do the volunteers of the pastoral care and counselling programme at the Steve Biko Academic and Tshwane District Hospitals value their involvement in the programme and what can be done by the HospiVision staff to raise a greater awareness of the value of the volunteers' involvement and to further support them?

The main goal was:

To make recommendations as to what more can be done by HospiVision staff for the volunteers in the pastoral care and counselling programme at the Steve Biko Academic and Tshwane District Hospitals, as well as by the volunteers themselves (self-care), so that they experience their involvement as meaningful and make a long term commitment.

The objectives were

- To describe and analyse the current volunteer programme,
- To understand the experience of volunteers,
- To assess the effectiveness and impact of the programme, and
- To make recommendations for improving the programme.

Being a qualitative research, research was done through participatory observation and semi structured interviews.

Christians, as members of Christ's body, all have received the responsibility to care for each other and those around them. Pastoral care is an important aspect of this care, through which one cares for the story of another person, as it stands in relation to the story of God. The hospital context calls for a specialized form of pastoral care. While some prefer an implicit approach (such as HospiVision) and others a more explicit approach (such as many of the volunteers), the most important function of pastoral care for the ill is the ministry of presence. Many volunteers are picking this up.

A large portion of pastoral care is done by volunteers. HospiVision facilitates for her volunteers to minister emotionally and spiritually to hospitalized patients. Volunteers are an invaluable resource; working with volunteers calls for investment, the most important forms being personal contact and expressed appreciation. HospiVision recognizes her responsibility toward her volunteers and desires to offer her volunteers the best possible care and support.

Important aspects of the programmes which were discussed were the screening, training and supervision of the volunteers. Much is done to support the volunteers once they are in; recruitment receives less attention. Themes which surfaced often, in relation to various aspects of the programme were: time, finances and capacity. The staff struggles with limited time. Many of the volunteers struggle financially. Everyone agreed that more people were needed. These factors affect each other and impact the training and supervision.

Hospivision's strongest characteristic is the unity and love her personnel share. Her policies are put together well. The care she gives her volunteers is well up to standard. Her greatest stumbling block is the implementation of her policies in relation to the volunteers. A recommendation in this area is to appoint someone to oversee and coordinate the volunteers programme for all the hospitals.

The volunteers were very positive about their experiences in the wards and as Hospivision volunteers. Their sense of calling, the positive responses of the patients, and the friendships they share with their colleagues are primary motivators. The volunteers are seeing positive results and are personally impacted as well, as they are built up and grow in their faith through serving. The stories of the volunteers were an important contribution to this research. Hospivision would do well to continue listening and acknowledging these inspiring stories.

Recommendations were made for the various aspects of the volunteers programme. Various additional forms of support could be easily implemented, one being a form of financial support through traveling reimbursements or fee reductions on the courses. SBAH has various support forms in place, which can serve as a model for her other branches. The training could be improved by structuring the topics into a planned schedule. The courses could be made more accessible, by offering them at reduced fees (or for free) in exchange for regular attendance of the trainings and outreaches. Supervision could become more proactive, instead of reactive to signalled problems, by enlisting others in the process. Delegation may be the answer to the time shortage the staff experience. Recruitment could receive additional attention and a clear policy could be drawn up. These suggestions briefly summarize the recommendations made to Hospivision.

Hospivision's desire is to offer hope to the ill and their families. The fact that many patients come alone, their families too far away or too poor to visit, in addition to the usual stresses and challenges of hospitalization, only reemphasises the importance of the work the volunteers do. Hospivision and her volunteers understand this importance, as do some of the medical staff. In general the medical staff speak positively about Hospivision's volunteers and some have seen the positive results as well. Hospivision is reaching her goals and is well on her way in offering the volunteers the support they need.

Final statement

Looking back over this report as well as my time with HospiVision, I can see that HospiVision is a well-structured organization with many strengths. Her strongest quality is the love and care her personnel have for each other. It has been a privilege and pleasure to work with HospiVision for the past four months. I have felt very welcomed and supported, and have learned a lot. I want to thank Dr Andre de la Porte for inviting me to come do a research project for HospiVision as well as coaching me in the process. I also want to thank all the other permanent staff as well as the volunteers for welcoming me, teaching me and supporting me in this research. My hope is that this report will contribute to the excellent care HospiVision offers her volunteers. May God bless her and all who work with her to continue to reach out and bless those in need of Hope.

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ANNEXURES

Annexure 1: Pastoral care and counselling

Pastoral Care and Counselling

The goal of this research is to see how HospiVision can improve her pastoral care and counselling programme by better supporting her volunteers. In order to make recommendations concerning the improvement of the pastoral care and counselling programme, we must first look at what pastoral care and counselling is and what should be its goal. This is what I want to do in this chapter. I realize that there are differing views concerning what pastor care entails. I want to begin by looking at some definitions which I have found in my literature research and then look at how HospiVision defines it.

Pastoral care and counselling defined

Shepherding

The word 'pastor' comes from the Latin *pāstor* meaning 'shepherd' or literally 'feeder.' The root of this word *pās-* is also the root of *pāscere*, meaning 'to pasture, feed.' As 'pastor' is one who feeds. (Random House Dictionary 2013) Considering the origin of the word 'pastor,' it is not surprising that a common metaphor for the pastor is a shepherd. The Bible often uses this metaphor to describe the leaders of God's flock. Israel's leaders are described as bad shepherds who do not look after the flock of God, to feed them, clothe them, strengthen the weak ones, heal the sick, bind up the wounded and seek the lost ones. Instead they looked after themselves and fed themselves at the expense of the flock. (Ez. 34:1-10) Several of Israel's great leaders are described as shepherds of God's flock: Abraham, Moses, David,...God Himself is called the Shepherd. (Ps. 23) Jesus says: I am the Good Shepherd. A metaphor emphasizes the similarities between two different concepts. A pastor is as a shepherd in that he is sent (by God) to take care of and have mercy on the sheep (God's people). He is to tend them, to keep watch over them. A good shepherd will know his sheep; he'll have a personal relationship with them. He will gather them together, to lead them to pastures for feeding and to shelter and protect them. He offers the sheep perspective...hope. This metaphor beautifully describes how pastors are to care for those entrusted to them, following in the steps of their great Shepherd in doing so. Apart from the metaphor 'shepherd,' pastoral caregivers are also often called guides, helpers, travelling companions. (Hoek, et al. 2012, 73)

Various perspectives

Pastoral care is not easily defined. Nor can pastoral care be confined to specific activities done by certain people who have been specifically appointed for the task. Pastoral care is the responsibility of the Church as a whole, by means of which all the members care for each other. Still, in order to speak about pastoral care, we must have a definition. Pastoral care always entails the story of people and the story of God. In a way, we could say, pastoral care is caring for the story of another as it stands in relation to the story of God. (Ganzevoort and Visser 2009, 26) Here we see two important aspects of pastoral care: the story of the other person and God's story. While most will agree that both these stories are essential components of pastoral care, exactly how these two relate to each other remains a topic of discussion. This can be seen in the different streams of pastoral care.

Pastoral care as a means of proclamation: In this approach to pastoral care, the Word of God takes a prominent role. Faith and the communication of the Gospel are the characterizing factors of a pastoral care. The underlying assumption is that there is a problem to be addressed. A person is seen in terms of his sinful nature, the core problem of mankind. As the Word is preached in the presence

of God, both the pastor and the confidant are called to respond. In the proclamation of the Word, God Himself speaks through the intermediation of the pastor. The message proclaimed is one of sin, admonition and forgiveness. Pastoral care must lead to a change, that is, to conversion, as the gospel message is personally applied. The danger of this approach is that pastoral care becomes 'preaching' and the unique story of the confidant in his unique circumstances is lost sight of. The Gospel does play an essential role in pastoral care, but God's message is more than that of sin and forgiveness. In Christ, the believer is a new person. This redemption must become integrated into the life of a believer, who learns to walk in the resurrection life. Resurrection life gives freedom to live in hope. (Hoek, et al. 2012, 74-75); (Louw 2008, 217-219)

Pastoral care as therapeutic: In this approach, not God's Word but the confidant takes the centre stage. This stream of thought has been particularly influenced by psychology. The underlying assumption is each individual is unique. The particular situation of the confidant and his emotions receive much attention. The care giver is there to help the confidant help himself, within a relationship characterized by empathy and acceptance. God's Word and prayer are but a means to this end.

The danger in this approach is that psychology takes the overhand. Yet the added value of pastoral care in relation to psychology, is that a person's story is viewed in its relation to God's story. A pastoral caregiver must not lose sight of the content of the faith. Pastoral care takes place in the presence of God, by means of His Holy Spirit. The caregiver has the privilege of showing the meaning of grace and love and of helping the confidant find purpose and meaning in life, despite suffering. Healing is found as the promises of God are reckoned on. These promises are to be found in God's Word and embodied in the sacraments, prayer, rituals and fellowship with fellow believers. (Louw 2008, 219-220); (Hoek, et al. 2012, 74-75)

Pastoral care as hermeneutic: This third approach seeks to combine the two streams mentioned above. The pastor must come to an understanding of both Scripture and the confidant. As caregiver, he seeks to understand the confidant, taking into account his particular context and unique personality. He then seeks to understand the experiences of the confidant in light of Scripture. Hope rises as the victory of the resurrection is integrated into the life of the confidant. This hope rests on the reality of who the confidant is, as one justified before God; and who he can become, one sanctified by God. This approach seeks to do justice to both the Word and the unique individual, although in practice a good balance is hard to keep. (Louw 2008, 220); (Hoek, et al. 2012, 74-75)

The goal of pastoral care and counselling

'Care'

Much can be said about the methods of pastoral counselling. In the end, we must remember that pastoral care and counselling is about *caring*. The essence of pastoral care lies in the responsibility the Church has to care for all her members and her fellowman. In this, pastoral care is a practical application of the Gospel of Hope.

The early church formulated the so-called 'works of mercy.' These 'works of mercy,' which take Jesus' teaching as starting point (Matt. 25), describe what caring for each other looks in practice.

- To feed the hungry
- To give drink to the thirsty
- To clothe the naked
- To shelter the homeless
- To visit the sick

- To visit the imprisoned
- To bury the dead

Another seven have been added to the list, based on the teachings found in the Pauline letters.

- To instruct the ignorant
- To give counsel doubtful
- To admonish the sinner
- To suffer injustice patiently
- To forgive offenses willingly
- To comfort the afflicted
- pray for all (Hoek, et al. 2012, 73)

All of these works of mercy can be understood as aspects of pastoral care and *diakonia* (care for the poor).

Caring for the other, is loving the other as we love ourselves. It is more than comforting and showing interest in the other. Truly caring means seeking to understand the other. It means one respects the other and does not try to manipulate, criticize, gossip, etc. It means taking a risk, because the other may not accept your care. Truly caring also means being ready to not only give, but also to gratefully receive. For care becomes care when it is not only given but also received. All healthy relationships must have a good balance of giving and receiving by both ends. In a 'care-relationship,' the caregiver is not the only one with something to offer. The one receiving help can offer the caregiver recognition, by acknowledging and accepting the help offered.

'Care' happens in four phases. The first phase, *caring about* is about realizing the need for care and taking sincere interest in the other person. The second phase, *taking care of* is about ensuring that what needs to be done gets done as well as acknowledging the need for care and accepting the responsibility for it. The third phase, *care giving* is the act of giving the needed care, something that requires knowledge and skill. One must be capable. The final phase is *care receiving*. Only when care is experienced as such, does it become care. This means that the caregiver must wait to see how someone responds to that which is offered and act accordingly. (Collins and de Vriese 2009, 83); (Veltkamp 2006, 102-106)

Pastoral care and counselling takes place in a relationship between at least two people, of whom one receives care and the other is the caregiver. The caregiver strives to care for the other person (the confidant) by helping him deal with the challenges of life. Within Christian counselling, the caregiver draws from the wisdom found in God's Word, to see it applied in the life of the confidant. Pastoral care and counselling is not limited to the working hours of professionals, but is often happen in informal settings, when members of the Body of Christ invest in each other.

Functions

Different forms of counselling exist. It is the confidant's personal situation which determines the type of counselling given.

- *Support*: At times, especially in times of crisis, the caregiver will seek to support the confidant, encouraging him to acknowledge and face his challenges or to talk about his feeling in order to acquire a more realistic perspective. This may be especially important when the confidant has difficulty acknowledging and expressing his feelings (of, for example, worry, fear, loneliness, anger, etc.). Sometimes the confidant may need help to accept

support or encouragement. Or perhaps the confidant needs to be encouraged to step out and help someone himself.

- *Confrontation*: At other times, sin must be acknowledged and confessed. Or the confidant might need to take responsibility for his behaviour or habits. In this case, the caregiver may need to confront the confidant.
- *Edification*: The caregiver may have the task of helping the confidant learn new or better methods of dealing with stress or other emotions. Habits, behaviour or thought patterns may need to change. Or the confidant may wish to acquire certain skills (for example pertaining to communication, prayer, dealing with emotions, etc.). Sometimes counsel and guidance are needed to take wise decisions. At other times, a caregiver can help the confidant to understand the root of certain problems and learn how to deal with them at the root.
- *Spiritual counselling*: The confidant may have questions concerning his faith.
- *Group counselling*: Pastoral care and counselling is not limited to a one-on-one relationship. Within a group setting, confidants have the opportunity to encourage and learn from each other.
- *Prevention counselling*: Sometimes counselling is given to prevent problems from arising (for example, marriage counselling). Pastoral caregivers can help by recognizing potential challenges and helping the confidant deal with these issues before they develop further.

While these different categories help to understand how pastoral care can be used, the different types of counselling should not be kept strictly separated. During a single meeting, elements from multiple categories may be present. Pastoral care and counselling is also not something which is limited to the working hours of professionals. Often it happens in informal settings, when members of the Body of Christ invest in each other. (Collins and de Vriese 2009, 16-18, 52-60)

Gary R. Collins, a well-known Christian psychologist in the U.S., known for his books and seminars on pastoral counselling, describes the ultimate goal of pastoral care as seeing the other grow as a disciple of Jesus Christ. As Christians we are called love our neighbour as well as to make disciples. (Matt. 28:28-20) Pastoral care, he says, has a place within this calling. The caregiver's aim should be like that of Paul: "Him we proclaim, warning everyone and teaching everyone with all wisdom, that we may present everyone mature in Christ. For this I toil, struggling with all his energy that he powerfully works within me." (Col. 1:28-29) (Collins and de Vriese 2009, 17-18)

Professor Daniel Louw sums up the basic functions of the pastoral care givers as follows:

- Facilitating-art of listening
- Sustaining-art of understanding
- Guiding-art of directing/diagnosing
- Healing-art of consoling/changing
- Nurturing-art of caring
- Reconciling-art of witnessing
- Confronting-art of admonishing (Louw 2008, 253)

Elsewhere, Professor Louw also mentions liberating, empowering and interpreting as functions of pastoral care and counselling.

- Liberating: enabling people to overcome bondage and victimhood to regain their human dignity and freedom.
- Empowering: revealing abuse, as well as equipping people with skills and knowledge to overcome or face crises.
- Interpreting: making the connection between the confidant's story and God's Story.

All these functions, Louw says, are intended 'to foster change and to promote human and spiritual health and maturity.' (Louw 2008, 77)

We may safely conclude that pastoral care and counselling have a variety of functions. Each individual and each particular situation calls tailored care. What is needed in one situation, can be damaging in another. The caregiver must therefore listen carefully and closely to understand the care required. Collins described the ultimate goal of pastoral care and counselling as seeing others grow as disciples of Christ. Professor Louw offers a more general perspective, describing the goal of pastoral care and counselling as 'human and spiritual health and maturity.' For the believer this includes growth in discipleship. In either case, the well-being and growth of the confidant is in view.

The distinguishing marks of pastoral care and counselling

Care verse counselling

Up until now, we have used the terms 'pastoral care' and 'counselling' interchangeably. But are they the same? 'Pastoral care' can be divided into varying degrees of intensity. There is the spontaneous care of the members of the Body of Christ for each other through fellowship (*koinonia*). Then there are the pastoral aspects present in services, liturgies, church structures...whenever attention is given to the personal stories of people. Pastoral care is, in a way, interwoven into the all aspects of a well-functioning church. However, the term 'pastoral care' most often refers to the intentional care given to the members of the Body, most often by volunteers who have been commissioned to take leadership positions in visiting church members. The goal of these meetings is to support fellow believers, especially those in difficult circumstances. 'Pastoral counselling' is often used for more professional, specialized care for those persons with specific questions concerning faith related themes. (Ganzevoort and Visser 2009, 26)

Counselling is structured, conversational care. Appointments are made. Time is set aside to address (an) identified concern(s). The meetings are often more therapeutic of nature than in pastoral care. Sessions tend to be longer as well. Depending on the arrangements, fees may be charged. In contrast, pastoral care is generally more spontaneous and encompasses more than just conversational care. (Ashely 2013, 125-126)

Pastoral care and counselling verse other forms of care

The more structured forms of pastoral care, as well as pastoral counselling, remind of other forms of care, such as the counselling offered by therapists or psychologists. These differing forms of care do overlap each other to some degree. We must not, however, confuse them.

Pastoral care of course does touch other fields of study. Aspects of anthropology play a role in how the pastor views mankind in relation to creation, sin, redemption and eschatological hope. His views concerning soteriology will determine his understanding of how people reach their fulfilment in life and if and how their relationship with God must be restored. His views concerning ecclesiology will

determine his perspective on the role the church can play in pastoral care. While a pastor is not a psychologist, their fields of study do overlap. Exactly how these relate to each other, whether they oppose each other, are subjected one to the other or support each other, is a topic of discussion. Most pastors however are not psychologist or therapist and should not try to take on the roles of psychologists or therapists.

One of the distinguishing marks of pastoral care, is that the pastor is expected to be a specialist in regards to personal and existential problems and questions relating to faith and theology. These can be faith questions concerning doubt, suffering, forgiveness, etc. or theological questions concerning afterlife, ethics, etc. Pastoral caregivers must therefore also be theologians.

Pastoral care distinguishes itself further from other forms of counselling in several aspects. The pastoral care is embedded in a community, the Church. A pastor has the opportunity for informal contact outside of scheduled appointments. A pastor also has the opportunity to enlist the support of other church members. For many people, pastoral caregivers represent God, Christianity or the church. A pastor is therefore also often expected to connect the story of the confidant with the story of God. Apart from the communication techniques commonly used by caregivers, pastoral caregivers have additional resources they can make use of: Scripture, prayer, sacraments and other rituals. (Ganzevoort and Visser 2009, 30-33, 36-40)

The most distinguishing marks of pastoral care is that it is *soul-care* which is embedded in the *Christian story*. The 'soul' in soul-care refers to the whole person, who can engage in a relationship with God. The 'Christian story' is the story of how God created, redeems and transforms mankind and the world. These acts of God can be seen in Israel's history, in the life, death and resurrection of Jesus Christ, in the work of the Holy Spirit. This story is found in Scripture, but this story is not limited to Scripture. The Holy Spirit continues the outworking of this story in lives up until the present time. This story gives meaning to life, evaluates and ranks according to importance the various aspects of life, and gives a standard for what is moral, ethical and just. This story teaches how we are to act and interact with other persons, with creation, with God. It calls us to align our lives according to its principles, setting boundaries, guiding and shaping our lives. (Cole 2010, 715-719)

Pastoral counselling has a lot in common with other forms of professional counselling. Still pastoral counselling, like pastoral care distinguishes itself from other forms of care because her starting point is found in the Christian faith. Christian counsellors then have several unique *presuppositions* about life and the universe (Ex: believe in a personal God who communicates with us, who is the Creator and Sustainer; man is created to live in freedom; through Christ we have forgiveness of sins; Christ is our Intercessor; each individual is known and loved by God). They maintain several unique *aims*, differing from non-Christian counsellors. These include communicating the Gospel message, encouraging the confidant to live as a disciple of Christ, helping the confident to acknowledge and confess his sins and to receive forgiveness, encouraging spiritual growth, encouraging the confident to live out the Biblical principles in a secular world, as well as being an example of what it looks like to be a disciple of Christ "in speech, in conduct, in love, in faith, in purity" (1 Tim. 4:12) A Christian counsellor has some unique *methods*, most of which have been mentioned above in discussing the unique character of pastoral care, such as Scripture reading and prayer. Christian counsellors will also refuse to use methods that are 'immoral' or that go against biblical principles. (Collins and de Vriese 2009, 17-18)

Pastoral care is sometimes also called spiritual care. In a recent book on spiritual and pastoral care, one of the co-authors, Rev. George Handzo distinguishes between spiritual and pastoral care.

Spiritual care is an overarching category of care, aspects of which should be part of the care offered by every health care professional. Pastoral care is one aspect of spiritual care. Spiritual care is “interventions, individual or communal, that facilitate the ability to express the integration of the body, mind, and spirit to achieve wholeness, health, and a sense of connection to self, others, and [/or] a higher power.” Pastoral care is spiritual care flowing from and shaped by a religious tradition. It is more specific form of spiritual care. (Handzo 2013, 24-25) Pastoral care and counselling distinguish themselves from secular forms of counselling in several different ways. In addition one must also understand that pastoral care is care shaped by a particular religious tradition.

Pastoral care in hospitals

Up until now, we have spoken about pastoral care and counselling in general terms. The distinguishing characteristic of the work done by the volunteers participating in HospiVision’s pastoral care and counselling programme is the context of the hospital setting.

Suffering and stress are common to the hospital experience. Patients often have to deal with pain. The need to adjust to the changes of new surroundings and limitations due to illness, along with anxiety due to an uncertain future, all lead to stress. Stress is the physical or mental pressure that rises in situations in which we are forced to adjust. (Collins and de Vriese 2009, 61) Suffering and stress can give cause for negative feelings of fear, anxiety, worry, irritation, etc. They can raise questions concerning the meaning of life and impact one’s relationship with God in a positive as well as a negative manner. Pastoral caregivers can play an important role in helping patients deal the challenges that illness and a hospital stay bring with it.

Pastoral care is caring for another person’s story as it stands in relation to God’s story. The pastoral caregiver will seek to understand the patient and his struggles and questions, in order to help him discover the wealth of God’s grace and compassion.

The pastor is part of the team that assists the patient in the hospital bed. Within this team, he has a unique role. In his book on illness and the healing of life, Professor Louw describes the ministry of the pastor in terms of a ministry of presence, of compassion and hope, of interpreting and networking and of wisdom counselling. (Louw 2008, 241-242)

- *A ministry of presence*: to be there with the other.

In a setting where time is precious, where efficiency is the norm and where medical staff are trained to look objectively at the human body to treat the illness, the pastor is someone who has (made) time to be with the patient. He is someone who accepts the patient, with his pain and suffering, who sees him as a unique individual, as a person. By his presence, he creates space for intimacy. Sometimes he will create a space within which the patient can be silent, can meditate and pray, aware of God’s embrace. At other times the pastor creates space to talk, to put into words the experiences pertaining to the other person’s illness. The pastor’s role may also be, to simply be with the other, to say nothing and by his presence to let the other know that he is accepted and cared for. A pastor does not stand on his own; he is a representative of God and of the community of faith to the patient. (Louw 2008, 221, 235-236, 241)

- *A ministry of compassion and hope*: spiritual healing and being a soul friend

The uncertainty and suffering of illness can raise questions concerning God and His dealings with man. The pastor can play a role in helping the ill person wrestle with his faith. The pastor has the task of discovering how the patient views God. This is not to label the other person’s view of God as ‘right’ or ‘wrong,’ but to discover how one’s concept of God functions and to help one come to an appropriate understanding of God, so that one can grow even in the midst of suffering.

A pastor seeks to foster and sustain the patient's hope. He will strive to help the ill person to see and embrace the faithfulness of God and to discover the promises found in Scripture. As the ill person takes hold of God's promises and compassion through faith, learning to integrate them into his life, he will be able to accept his illness and live in the victory that is his in Christ, full of faith, hope, love and joy. Embracing the victory we have in Christ does not mean denying the pain of suffering. In fact, awareness of our victory makes us more keenly aware of pain and suffering as they stand in sharp contrast to our position in Christ. However, our victory in Christ does take the sting out of death. Anxiety can be replaced with hope. Though outwardly we may wear away, inwardly we are renewed day by day. We have a meaningful and hopeful future.

Often times, suffering and pain will raise theological questions. They cause people to struggle with the meaning of life. God often will not tell us 'why?/wherefore?' we suffer. Perhaps because these are not the right question. It is not about what happens to us, but what God desires to do in and through us, by means of our experiences, including illness and suffering. God is concerned about how we respond, if we will walk in obedience to his promises. The questions then become 'where to?/to what purpose?' God does not offer logical solutions for suffering. Instead He points us to the Cross, where God in Christ suffered. God does not dismiss suffering as of no consequence. He knows the struggle we go through. But He wants to be there in our suffering. His faithfulness causes hope to rise and gives life meaning.

A pastor's role then is to discover how a patient sees God and how his expectations of God relate to the patient's personal needs. A pastor can then help his confidant to come to an appropriate understanding of God.

Besides helping the patient with questions concerning one's existence and the role of God in one's life, he can help the ill person to still reach out to others in love. Such an act testifies of God's presence in the life of the ill. (Louw 2008, 226, 235-236, 241-242)

- *A ministry as an interpreter and networker*

To most patients, the hospital setting and the medical world are completely new to them. Medical care tends to be fragmented. Pastors can be of great help to an ill person, by helping the patient, family and medical staff to understand each other. He can help the patient to understand the different aspects that come into play with illness. He can help him to contact the right people at the right time and to learn how to relate to one's illness, to other people and to the medical professionals. (Louw 2008, 236, 242)

- *A ministry of wisdom counselling: being a co-partner in the moral decision making*

The pastoral caregiver can assist an ill person in decision making especially when moral questions arise. The pastor is not an advisor but a guide. He helps the patient to ask the right questions and to look into the possibilities. In doing so, he also gives insight from God's Word, concerning the issues at hand. (Louw 2008, 242)

The uniqueness of the hospital setting calls for specialized care. Professor Louw has defined four aspects of this specialized care. Sometimes this entails practical help (interpreting and networking); sometimes it calls for conversing, thinking through issues together (wisdom counselling). But most importantly, the pastor has a ministry of presence: making time for and giving one's attention to the patient. To know that there is someone there beside you is of immeasurable value.

Cross-culturally care

South Africa is a country characterized by cultural diversity. This necessarily has an impact on the pastoral care given by HospiVision volunteers. Illness makes no distinction between cultures. In the hospitals where the volunteers work, culturally diversity among the patients prevails.

Culture not only plays a role when the caregiver and the confidant come from differing cultural backgrounds, but also with partners from the same context. A pastor must always be sensitive to the meaning of culture in the story of the confidant, as well as to what extent culture determines his own attitude and disposition. Only then can he come to a correct understanding of the other's story. (Ganzevoort and Visser 2009, 59-60)

Culture is a 'way of life.' Culture is what a community in a certain place and time shares together: truths, norms and values, ideas, attitudes, habits, symbols, rituals, meaning, language. One generation carries these products of human interaction over to the next generation. Culture is constantly changing, as communities learn to adapt to changing circumstance. Culture is needed for the survival of human community especially in difficult circumstances. It is also within culture that life happens and where life is given meaning.

Often religion and culture blend. Cultural rituals often carry religious significance. Religious rituals originate within cultures. (Jones 2013, 114-115) Pastoral caregivers working in intercultural settings, must be sensitive to the role culture places in the life of his confidant and in his own life.

An important question to ask, when considering the impact of culture on pastoral care is how culture and Christ relate. For it is within culture that the church, as representative of Christ, meets the world. It is also within culture the mankind meets God. In his work *Christ and Culture* (1952), Neibuhr has suggested five different models to describe the relationship between Christ and culture.

- *Christ against culture*: the rejection of culture.

Culture is seen as inherently sinful. However, this approach forgets that as people we are shaped by our culture.

- *Christ of culture*: accommodation.

Christ is the fulfilment of cultural ideals. However, this approach ignores negative aspects of culture and diminishes the uniqueness of religion.

In between these two extremes we find the three other models.

- *Christ above culture*: Christ is related to yet distinct from culture.

Culture has valuable things to offer but it will never be a match for what Christ offers.

- *Christ and the cultural paradox*: tension.

We are in the world, yet not of the world. We must not become estranged to the world, yet also not embrace it.

- *Christ the transformer of culture*: culture must be renewed.

Christ comes, not to do away with culture, but to transform it, to redeem it.

Neibuhr comes to the conclusion that Christ is above (different, distinct from) culture, yet he works in culture to transform it. (Louw 2008, 152-154); (Ganzevoort and Visser 2009, 60-61)

What does this mean for pastoral care? For pastoral care to happen between partners coming from differing cultural backgrounds, intercultural communication must take place. This requires an intercultural hermeneutic. The caregiver must not see his own culture as normative. He must be ready to learn to understand the culture of the confidant to be able to understand the meaning and significance of certain experiences of the confidant. To make use of rituals and symbols he must know what rituals and symbols already exist in the other's culture and their significance. He must be able to judge what practices of the other culture can become part of the church's practice and what practices must be transformed. The pastor's responsibility is not to shy away from diversity, but to

accept and include is. Diversity is of great values, something that is inherent to the Christian faith. (Ganzevoort and Visser 2009, 65-66)

An example of cultural diversity, that requires sensitivity in pastoral care, is how different cultures view sickness and healing. In the Western thinking, illness is strictly due to natural causes within the body which science can explain. In African thinking, illness is the result of a purposeful intervention, by a human or supernatural agent. This does not deny natural causes, but healing will also require restoring the upset relationships. Forgiveness and reconciliation with the social environment or the ancestor world may be needed.

Another example is the emphasis cultures place on family relations. In Africa, the role of the extended family is of much greater importance than in the West. This of course impacts the involvement of the family in times of illness. (Louw 2008, 169-170); (Ganzevoort and Visser 2009, 62-63)

Conclusion

'Pastor' comes from 'shepherd' or 'feeder.' Pastoral caregivers follow in the steps of the Great Shepherd to care for His own. There are different perspectives where the emphasis must be placed in regards to the confidant and the use of Scripture. Both have a place within pastoral care, since pastoral care is all about caring for the story of the individual as it stands in relation to God's story. Pastoral care and counselling are all about *care*, signalling a need, taking responsibility to see the need met, and taking action. Care becomes care when it is received.

Pastoral care and counselling lie close together in their practice. Counselling could be defined as more professional, specialized care and other forms of pastoral care as more informal and interwoven in all aspects of the functioning of the Body. Both distinguish themselves from other forms of counselling by certain presumptions based on Scripture, the role of faith and the use of Christian sacraments and rituals.

Pastoral care and counselling have a broad range of functions, dependent on the situation of the confidant. The uniqueness of the hospital setting calls for specialized care. The functions of the pastoral caregiver in the hospital setting are to be present with the ill person, to show compassion and hope, to help interpret information and help network, and to give wisdom counselling.

Pastoral care to each individual is unique, tailored to the needs and circumstances of the individual. In this, the setting (ex. Hospital) as well as the backgrounds and cultures of both parties are of great significance. The pastor must learn to listen carefully, to hear who the confidant is.

Above I have discussed my literature findings on what pastoral care entails. I have used it in understanding and evaluating the pastoral care given by the volunteers of HospiVision. I found that most of my findings were close to the understanding HospiVision has of pastoral care and counselling.

Interestingly, HospiVision as an organization preferred a much less explicitly Christian approach than the volunteers and also less explicit than the picture of pastoral care I had formed in my thinking when writing this chapter.

Annexure 2: Practical Value

The added value of pastoral care and counselling in hospitals

To understand the value of the HospiVision pastoral care and counselling volunteers programme, we must understand the value of pastoral care to the ill. In this chapter we will look at why care must go beyond physical care and what the needs are that pastoral care and counselling strive to meet.

Holistic Health Care

The entire man

The first concern of a person, who is ill, is his immediate pain and physical disorder. The pain and physical disorder are the motive for approaching medical personnel for healthcare. An ill person seeks care for his body. But one's physical body cannot be considered apart from who one is. One not only *has* a body, one *is* a body. One's physical body allows one to live and function in the world we live in. When the body is affected, the whole person is affected. Healthcare must approach the ill person in his entirety, because sickness affects the entire person. (Louw 2008, 116-117)

Man can be described as being a body, mind and soul. These three distinct components are undeniably intertwined, a unified whole. Perhaps we could better speak of the physical, psychological and spiritual aspects of a person. The physical aspects of a person include the body and all that pertains to it: breathing and heartbeat, muscles and nerves, bones and organs, neurological and biochemical processes. A person's psychological aspects are his consciousness, behaviour, thought processes, emotions, choices, etc. The spiritual aspects are those of sense and meaning, religion, worldview, etc. These different aspects of a person interact and influence each other. (Veltkamp 2006, 38)

Because a person is a unified whole of body, mind and soul, healthcare must deal with all three aspects of an ill person. In the healthcare sector, the pastoral care distinguishes itself from other forms of care, in that it focuses on the soul. Again, the soul is not then seen as 'part of' the person, but as the whole person. The soul is 'the whole person, in his or her entirety, in *relationship* to the living God.' (Cole 2010, 718)

The human being is a unified whole; therefore sickness affects the person as a whole. To understand what sickness and illness do to a person, we must first understand what sickness and illness are.

Illness and health

To understand illness we must understand health. Often times, health is defined as the absence of disease; and disease as the absence of health. Every person finds himself somewhere between these two extremes. However, health is more than the absence of disease. According to the World Health Organization, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (World Health Organization 1964) Health is a highly valued quality, for some even their most prized possession. Sickness brings limitations. The sick are 'different,' they cannot participate in society to the same degree as those who are healthy. The implication can be that our value depends on our state of health. Such thinking is detrimental for the emotional and spiritual well-being of both the ill and the healthy. (Veltkamp 2006, 22-26)

Disease goes beyond the physical and affects more than just the body. Louw makes a distinction between the physical dimension of a disease and a patient's response to the disease. Sickness then, is 'the biological and physiological dimension of medical pathology and the total predicament of

being a patient or being hospitalised.' Illness is 'the patient's awareness of the illness and his/her responsive behaviour, perceptions and emotional experience of pain.' (Louw 2008, 105) Sickness refers to the physical aspects, including the limitations and changes that accompany a disease or infirmity. Illness is the person's response and perception, something that goes beyond the physical that touches the mind and the soul. It has to do with how a person interprets what is happening, his experience of pain and suffering, his search for meaning.

Our understanding of illness and health are not limited to medical facts. Our cultures play a huge role in how we perceive illness and health. In a culture where health is greatly valued, to the extent that one's value is linked to one's state of well-being, an ill person can feel of less significance than a well person. In certain cultures, some diseases are stigmatised, even to the point that a person with such a disease is rejected by society. For example, tuberculosis or HIV, both common in South Africa, are diseases which are often stigmatized.

Illness affects a person as a whole: physiologically, biologically, psychologically, existentially, socially, and religiously. In each of these areas, illness leads to conflicts. At the physical level, the part of the body affected by the disease or infirmity poses a threat to the existence of the ill person. Sickness reminds one that we are fragile human beings, susceptible to death and decay. Existentially, an ill person can come in conflict with himself. He can raise questions concerning his identity. He cannot do as he wishes, limited by his illness. In his reasoning, he weighs his chances of recovery and searches for an explanation for his illness. Different emotions cause conflict within himself. Illness not only raises concerns in regards to self but also to one's family, and how the illness will affect them. Questions concerning one's profession and financial position arise. Illness influences the basic choices a patient makes and his purpose and direction in life. Illness often raises questions concerning the future and meaning of life. Also God's role is questioned, extending illness even to the religious dimension. (Louw 2008, 107, 116-119)

Emotional strain

All sorts of emotions come into play, when one is faced with illness. As illness threatens life, one's desire to live is challenged by despair. As illness exposes the fragility and insignificance of life, one's need for security is threatened by the anxiety concerning rejection. While with fear, we can identify what scares us, anxiety is the state of being, or feeling, threatened. Loneliness, uncertainty, loss of social security, loss of bodily functions, loss of certain freedoms, identity crisis, increased dependence, impending death are all factors that can be cause for anxiety. As illness confronts one with one's life and what one has done or left undone, the need for wholeness, for forgiveness, reconciliation and peace are challenged by feelings of guilt. As illness brings with it limitations, one's freedom and normal daily activities are challenged by feelings of failure. (Louw 2008, 107, 120-121)

Hospitalization gives cause to a variety of emotions as well. To some, hospitalization is a threatening and frightening experience, to others a sign of hope. Industrialization of hospitals is a threat to human dignity and individuality, when patients are then seen as a number, an object of research. Being exposed, needing to share a room with strangers, being unable to participate in the daily activities one was accustomed to, now placed in a very small and sterile environment where one must wait to be helped and be ready to undergo research and treatment when others find this convenient, are all discomforts that come with being hospitalized. (Louw 2008, 210-212)

The conflict that illness brings with it, all the changes that the ill must endure and learn to deal with, bring with them stress. Stress can be triggered by the context one lives in. Conflict within a

community one takes part of, or the instability of one's country can be causes for stress. Stress can be triggered by experiences, such as losing one's job, having to say good bye to a loved one, illness, etc. Stress is not only externally triggered but can also come from within oneself. Anxiety, perfectionism, and self-criticism can be causes of stress. And stress always has an effect on a person, on their entire being. In small amounts stress can be good, but too much stress is damaging. We have said that a person is a body, mind and soul. Physically, stress can lead to heart failure, stomach ulcers, headaches, etc. Stress can worsen, or even cause illness. A body weighed down by stress, requires more time to recover and heal. Psychologically, stress can lead to forgetfulness, inefficiency, irritability, impatience. Spiritually, stress can causes one to draw away from God, as one's mind is occupied with that which is causing the stress, or stress can causes one to draw closer to God. (Collins and de Vriese 2009, 74-76) And this is where pastoral care can be of great value.

Problems, conflicts, tension, stress, anxiety, feelings of insignificance, consciousness of guilt, redundancy, feeling useless, isolation, rejection, pain, meaninglessness, questions concerning God's role, torment, distress, doubt, despair,...the suffering with suffering are all part of being ill. Holistic health not only has eye for the physical ailments but also for the suffering within suffering. The pastor plays an important role in this, as he reaches out to the ill, offering support in their predicament. He knows that one can have hope even in the midst of illness, a hope found in communion with God. The pastor's desire is to lead the ill to this place of hope. (Louw 2008, 110, 123, 128)

The process

Before looking at the role of the pastor within the hospital setting, we must consider one more aspect of illness. An ill person must go through a process in which he comes to accept and deal with the illness, especially if he will not recover. Those who will not recover or completely regain their health, must go through a process in which they say goodbye to their health and accept their disease, realizing that their sickness will now be a part of who they are. (Veltkamp 2006, 29-30)

An ill person commonly goes through several stages in learning to deal with illness. The first is a period of transition from health to illness. Often this stage begins with denial. One needs time to acknowledge one is ill and in need of care. When one has come to acknowledge the illness, one enters into a period of treatment. Medical treatment brings with it much discomfort, as well as anxieties. Do the doctors know what they are doing? Will I recover? etc. The patient will possibly become more dependent on support from others. He may not be able to fulfil all his responsibilities anymore, which will necessarily need to be pick up by others, often family members. When all goes well, a patient will in time transition from treatment to recovery. Again he enters a time of changes. Adjustments need to be made in who picks up what responsibilities. The patient may prefer not to again take on certain responsibilities that he had to lay down for a time. Or perhaps family members have come to enjoy the responsibilities which they took over from the ill person. (Collins and de Vriese 2009, 131-133)

Not all patients will enter into the period of recovery. Sickness may lead to death. A person facing death will commonly go through several stages. These stages may run through each other, and each patient will follow his unique path.

As with sickness, a person approaching death, will first go through a period of denial and isolation. The hope that things will get better, the disbelief concerning what is happening, is strong. As reality sets in, anger rises. Out of frustration, patients dealing with anger will often direct their anger irrationally at people who can do nothing about their illness, doctors or family members for example.

As the anger subsides, the bargaining begins. 'Lord if I live then I'll...' In time depression may set in, as the patient becomes discouraged and begins to miss certain people or particular activities or is faced with loss of physical functions of the body. Finally comes acceptance. In time the resistance subsides; interest in the world diminish. The patient accepts his lot, and now chiefly desires to be loved and cared for. At last, when hope to continue living ends, death comes quickly. (Collins and de Vriese 2009, 134-136)

Whether a patient has a good chance of full recovery, whether death is impending or whether the patient will continue to live but with limitations, he must go through a process in which he learns to accept and deal with his new situation in life. This will not be an easy process. But it can be a process in which the pastor can offer help, to both the patient as to the family.

Role of the pastor within the medical team

We have spoken about what illness is and the impact it has on a patient. We will now look at the role of the pastor within the medical team and how the pastor contributes to the recovery and healing of patients.

Man has the need to interpret that which happens to him, to find meaning within his experiences. Only when he is able to interpret events, can he order these events and integrate them into his life story. Integrating these events into his life story, will enable him to accept his lot in life, or even live a better life because of it. Spirituality helps one to understand that the meaning of life is not tied up to our state of health. Illness does not detract from the value of one's life. (Veltkamp 2006, 44-45) How one copes with one's illness, then, is dependent on one's ability to identify the illness and integrate it into one's life. (Louw 2008, 201)

We have said that illness threatens our very existence. Physically we are limited, but also our identity, our 'self,' is touched. Learning to speak about our illness is essential in the healing process. This speaking cannot be limited to the medical terms used by doctors. One needs to learn to verbalize what the illness means for oneself and one's life. Often illness will cause one to re-evaluate one's convictions. Prominent among these are those convictions concerning the presence of a higher Being. Some may wonder where He is. Others may be surprised by the presence of Another. (Veltkamp 2006, 81, 96)

Integrating illness into one's existence

To cope well with illness, one must learn to accept the illness and integrate it into one's life, accepting that one will now be limited in a particular manner. Several factors influence how one copes with illness. They include the following:

- the information one receives
- the possibility to verbalize both the pleasant and unpleasant emotions rather than having to crop these up inside
- the use of defence mechanisms
- the degree to which one is willing to seek help and to co-operate with care-givers
- what one does with one's knowledge of illness
- to what extent one can and will acknowledge one's inner disorganization and exhaustion
- one's willingness adapt to the necessary changes
- one's sense of identity and the degree of one's maturity
- the extent to which one trusts medical personnel and the care they offer

- the amount support one receives from family and friends and one's community
- one's readiness and ability to set short and long term goals which have been adapted to one's new limitations
- one's faith in God and one's use of Scripture and prayer, as a source of comfort outside oneself.

(Louw 2008, 202-204)

A pastor can help and support that patient in each of these areas, so that instead of responding with denial, resignation, apathy or a minimizing of his suffering, the patient will learn to integrate his illness into his life and to interpret his illness in the light of God's presence. As pastoral caregiver, one can point the patient to God's steadfast promises and His assistance, assuring the patient that there is still meaning to life and that he can draw from a source of comfort, encouragement en support outside himself. (Louw 2008, 205-208)

Theological reflection

In order to be able to assist an ill person in coping with his illness, especially in understanding his illness in the light of God's presence, a pastor must be able to offer theological reflection. In theological reflection one must be able to build a picture of how a personal story fits into the greater story of culture and of the cosmos and of God's dealings with mankind. How one understands the hardships of life, is tied up with how one views God. One must also be able to find meaning in suffering. Where a patient suffers from anxiety, fearing rejections and longing for intimacy, the pastor has the task of pointing the patient to God's unconditional love and grace which can replace anxiety. Guilt, the awareness that one has done wrong and has acted contrary to one's values, can be replaced by forgiveness and reconciliation. Despair, caused by depression and hopelessness concerning the future, can be turned into a living hope of a future resurrection. Helplessness, due to an awareness of one's vulnerability and fragility and the need for support, can be met through fellowship with fellow believers and support for the Body of Christ. Anger, due to frustration and unfulfilled expectations and hope and to the need for possibilities to grow and develop, can be soothed by the knowledge of God faithfulness and His promises. Theological reflection then also involves God's role within trauma and suffering. How is He part of the suffering? And what is His will concerning suffering? A pastor can help an ill person wrestle with these essential questions by helping him to communicate with God, offering prayer and at times also sacraments. Even the presence of the pastor can communicate something of the presence of Christ. In helping the patient to wrestle with questions concerning God's involvement, a pastor must help the ill person to come to a helpful understanding of Who God is and what He is like. The question then for the pastor to ask is not so much: 'Does this person have a right or wrong God-image?' Rather the question is: 'Is this person's understanding of God meaningful, fostering hope and empowering him to cope with his suffering?' (Louw 2008, 194-196)

What this looks like practically

We have seen that a pastor has the privilege of assisting an ill person in giving sickness a place and finding healing in learning to live in hope despite limitations and suffering. We will now look at what this means very practically.

A pastoral caregiver comes not to visit 'the patient' or 'the sickness' but the soul. He comes to empathize, to give unconditional love—a love that is not conditioned by the sickness, to help a person understand God's will concerning suffering, and to help this person to find meaning and dignity in life. This counselling may even extend to the families of the ill. The caregiver counsels, comforts, and encourages. He prays for and with the ill and their families, reads Scripture with them

and encourages them to speak about their feelings and emotions. He offers help to take care of practical things such as arranging finances and the redistribution of responsibilities in the family. The caregiver also facilitates the communication between the ill person, his family and the doctor and other medical staff. He seeks to ensure that the patient has and understands the appropriate information and helps coordinate the contacts among the right people at the right time. Often times an ill person must make important decisions. The caregiver can help the patient think through his options, not so much as an advisor but as a guide to ask the right question and to find answers in light of God's Word. (Louw 2008, 193-196) (Collins and de Vriese 2009, 131-133)

The doctor and the pastor

The position of the doctor in the medical team is unquestioned. A sick person must be assisted in dealing with physical ailments in order to recover. However, illness goes beyond the physical and affects our entire being. The pastor plays an important role in assisting the patient to find emotional and spiritual recovery and healing. While they are both part of the same team, they have very distinct roles. Coming from such difficult backgrounds, they could easily see the other as a threat. Doctors are taught to focus on the illness. They work under high pressure and cannot permit themselves to make mistakes. A pastor may become uneasy about the drive of medical staff to keep patients alive at all cost, by the manner in which patients are viewed in terms of their biological and physiological functions, by experimentation or by the way they foster optimism despite the weakening and decay of the body. On the other hand, the doctor may feel uneasy concerning the pastor. The pastor's ignorance and his unprofessional behaviour, the danger that he may reveal confidential information, the possibility that the caregiver may cause patients to become upset emotionally, the clumsiness of some caregivers when counselling or the possibility that the pastor communicates medical information that is incorrect all can be causes of concern for doctors in regards to the pastor. (Louw 2008, 213) However, when both doctor and pastor do what they are specialized in, they complement each other and together have more to offer than alone.

A personal impact on the caregiver

Caring for the suffering does not leave the caregiver untouched. Witnessing suffering and listening to the downcast comes with a cost. A pastoral caregiver must be aware of two things. The first is what Nouwen refers to as the wounded healer. In his understanding of ministry to the suffering, the caregiver is able to reach out to those suffering because they are weak and fragile themselves. Because one suffers, one can care for those who suffer and extend the compassion and encouragement one has received oneself. In this understanding, God is also a suffering God. In Christ He suffered for us and is able to identify with us. The second thing a caregiver must understand is that caring comes with a cost, but also with positive 'payments.' The caregiver must learn to also see the positive aspects of trauma, not only the unavoidable negative aspects. Like with humour, one must develop the ability to see the same events from a different perspective and the relativity of the events. (Louw 2008, 136-137)

Demands

Those offering pastoral care can experience stress and be confronted with their own personal problems. Common sources of stress for pastoral caregivers are social isolation, exaggerated expectations, financial pressures and inner psychological pressures. Pastors are called to listen to the stories of others, but may not have someone to listen to their story. If they are leaders in their communities, they may feel that they are closely watched at all times, finding it then hard to relax. Sometimes they are expected to do too much, or to be more than they can be. Sometimes the

struggles come from within. They are discouraged because the work is too much, or they see little response. They may feel the need to compete with fellow caregivers, leading to jealousy, criticism and frustration. Others place unrealistic expectations on themselves and carry with them feelings of guilt or anger. (Collins and de Vriese 2009, 74-76)

Caregivers are said at times to suffer from compassion fatigue. Compassion fatigue is 'stress (on the attitude of counsellor) from (wanting to) help a traumatised person; over exposure to trauma.' To certain extent compassion fatigue resembles burn-out, but must be distinguished as something different. Not a build-up of stress, but witnessing too much suffering and investing more than one ought is the cause for compassion fatigue. This results when caregivers give so much they become exhausted themselves, finding it difficult to maintain a healthy balance between empathizing and connecting with the one suffering and retaining objectivity. Like burn-out, compassion fatigue is a response, a certain attitude to a particular pressure. The result for the caregiver is that he becomes stressed, vulnerable and exhausted. (Louw 2008, 135-136)

In order to deal well with these demands, caregivers must also care for themselves. They must continually remind themselves of who they are in Christ: loved, accepted, cared for. Instead of focusing on what they lack, they ought to acknowledge and develop the gifts God has given them. They must care for their bodies. They need to support of others, friends with whom they can share their hearts. Above all, they need to continually make time with God, in His Word and in prayer. (Collins and de Vriese 2009, 76-79)

Rewards

Not only is caring taxing, it can be refreshing as well. Often times joy comes when we do not focus on ourselves, but on others (1 Cor. 12:25), as well as share our own struggles with others. The joy God promises us is a joy that rises above circumstances (not a joy contingent on circumstance). This joy is a fruit of the Spirit (Gal. 5:22), it flows from a relationship with Christ (Jn. 15:10, 11). (Collins and de Vriese 2009, 31)

A caregiver may not always see the effects of his investment. But at other times he will. And he can trust that what he does for God, will not be in vain. Pastoral care is an answer of obedience to God's call to love one another, to care for one another and to bear each other's burdens. And He rewards obedience.

Conclusion

Man does not just 'have' a body, man is a body. But man is more; man is also mind and spirit, three facets of our humanity that are intertwined and that necessarily influence each other. Illness not only affects the body, but also one's mind and soul. Care should not simply remain physical health care, but the mind and soul need care as well. Pastoral care compliments the medical care given to the ill in hospitals, as the pastor makes time to be with an ill person, to offer love, acceptance, encouragement, a listening ear. The pastor becomes a temporary travelling companion, to help the other find meaning and direction and to set his eyes on Who God is, in the midst of life's circumstances.

Just like the pastor gives care and support, he also needs care and support. Giving pastoral care can be taxing and one cannot do that on one's own. However, giving pastoral care is rewarding as well. While it is demanding, it also brings joy and fulfilment.

Annexure 3: Appreciation and acknowledgment

A basic need

Every volunteer has his own motives to commit to a job. But to stay motivated, they need to know that they are appreciated, even considering that volunteer work often brings with it benefits for the volunteer themselves. An often heard complaint from volunteers is that they are not shown much appreciation for the work they do. This leads to frustration and is often a reason given for terminating one's involvement in volunteer work. (Steunpunt vrijwilligerswerk en informele zorg n.d., 27) Volunteers need and deserve to know that their services are appreciated.

The need for appreciation is one of the basic human needs. Maslow identified five basic needs which all humans share, esteem being one of them. (Figure A3.1) According to Maslow, all humans share the following needs:

- Physiological needs: health, food, sleep, etc.
- Safety: shelter, removal from danger, etc.
- A sense of belonging: to know one is loved, to feel affection, to be part of a group.
- Esteem: from others as well as self-esteem.
- A means to self-actualization: to achieve his individual potential.

While Maslow developed his theory from a very humanistic point of view and certain aspects of his theory are not compatible with a Biblical worldview, it does contain some truth. In identifying the basic human needs, Maslow recognized that as humans we need more than to just have our physical needs met. One of these needs, the need for esteem, can be seen as a longing to be respected and acknowledged by others based on their qualities and achievements. Volunteers are no different from other people in this. While they offer their services free of charge, the desire to be acknowledged and appreciated for what they do remains. (Plemper, Wentink en Broenink 2005, 13-14)

Appreciating and acknowledging

Some very practical steps can be taken to ensure that volunteers are shown their well-deserved appreciation. Appreciation begins with awareness building, followed by acknowledging the value of the work offered. Appreciation can be expressed in a variety of ways, and at times distributing rewards may be appropriate. (Plemper, Wentink en Broenink 2005, 14-15)

Awareness building

A greater awareness concerning volunteer work can be attained through publicity, promoting volunteer work, informing potential volunteers, setting an example, having young people engage in some form of volunteer work, conducting research about volunteer work, making volunteers visible by means of badges, clothes, etc.

Acknowledgment

Acknowledging the importance of volunteer work can also be done in a number of ways. The volunteers must know that their work is valued and that they are taken seriously. An organization working with volunteers should therefore have a clear policy concerning her volunteers (how to

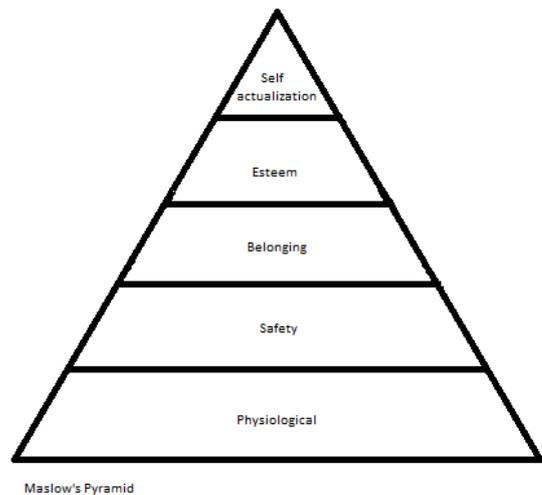


Figure A3.1

recruit and retain them, etc.). Volunteers give of their time and resources help to an organization and her target group. In return an organization working with volunteers should strive to help them in what ways she can. It may be that she creates a pleasant work environment, with good facilities and a work atmosphere in which the volunteers can feel at home. Flexible working hours, reimbursement for costs made, regulations concerning insurance, the availability of a confidant, certification and the possibility to increase personal skills are all ways in which an organization can help make the volunteer's work as pleasant and effective as possible. Training courses for volunteers is another possibility, from which both the volunteer and the organization will benefit.

Appreciation

An organization can express her appreciation for her volunteers in a variety of ways. This can be as simple as giving volunteers a 'pat on the back,' especially effective if person in a leading position with the organization does this. Small gifts of appreciation (cards, flowers, etc.); choosing a volunteer of the week/month/year; organizing an outing, party or coffee/lunch meeting; or having public figures visit the volunteer work are also possibilities. As organization should look to see what suits her situation the best.

Reward

A reward goes a step further than the more general gestures of appreciation. Rewards could be gifts or some money for special events like birthdays, farewells or holidays; discount cards; the use of certain facilities; awards for outstanding achievements; a wall of fame. (Plemper, Wentink and Broenink 2005, 28-37)

Conclusion

The possibilities for showing appreciation and recognition are endless but will require time and personal investment. And this is what volunteer work requires: time and investment. This is true from start to finish, from recruiting volunteers to coaching, retaining and rewarding volunteers, even to saying farewell. In fact showing appreciation and recognition is but a part of a larger process of working with volunteers.

Annexure 4: Characteristics of a pastoral caregiver

The capable caregiver

A capable caregiver displays a certain level of competence. The characteristics that define the competent caregiver are those characteristics which contribute to his successful functioning within his specific role or function. Elizabeth (pastoralezorg.be), an interactive website for pastoral care, differentiates three different areas of competence. First of all, there are those distinctive for the particular function of pastoral care. For example, a pastoral caregiver must be able to empathize well. Then there are those qualities and skills necessary to function according to the values and vision of the organization for which one works. Personnel in all functions are expected to have these qualities and skills. For example, an organization may value working professionally or openness among colleagues. Finally there are the individual's skills and qualities which are fed by one's personal values, motives and skills. (Elizabeth 2009-2013)

When considering the characteristics that describe a competent caregiver, we must leave room for varying levels of competence. One cannot expect the same skills from lay volunteers just beginning with pastoral care as we can from professional counsellors. When considering the characteristics of caregivers, we could distinguish different levels of competence: the beginning lay volunteers (capable of managing simple cases), experienced lay volunteers (able to handle more complex cases) and professionals (able to handle complex, demanding cases).

We will look at what three different authors have to say concerning the necessary skills and characteristics of pastoral caregivers. We will consider the criteria suggested by the Academic Center for Practical Theology (K.U.Leuven), Zorgnet Vlaanderen, an organization supporting initiatives in (among others) spiritual health care, and Andre de la Porte, managing director of HospiVision.

Academic Center for Practical Theology: Seven areas of competence

Considering all these different aspects, the Academic Centre for Practical Theology (K.U.Leuven) has suggested seven areas of competence for the pastoral caregiver. Each of these aspects influence each other and build on each other. Although these areas of competence give us a sketch of what the profile of a pastoral caregiver could look like, we must bear in mind that pastoral caregivers work in a variety of different settings and certain settings require unique skills. Hospital care, for example, requires additional knowledge and skills which may be less relevant in a school or church setting. (Elizabeth 2009-2013)



Figure A4.1

The seven areas of competence are pastoral service, professionalism, communication, partnership, reflection, prophetic service and organization. (See figure A4.1) The earlier mentioned website Elizabeth lists several indicators for each of these seven areas, not as a comprehensive list, but to help one to think through what it means to be a pastoral caregiver. Below are listed the indicators that make these areas practical.

Pastoral service:

To render pastoral service effectively, one must possess certain skills distinctive for the function of the pastor. Indicators of proficiency in this area include the following:

- A pastor finds his inspiration in his faith.

- He understands the liturgical practices and rituals associated with the faith.
- He is able to prepare and facilitate these practices for his confidants.
- He is able place the story of his confidant in the perspective of the Christian story.
- He is able to recognize and use faith related language and symbolism.
- He is able to create a climate in which the existential questions of life can be discussed.

Professionalism:

This area of competence can be described by skills distinctive for the function of pastoral caregiver as well as by interdisciplinary skills.

- The pastor is able to appropriately minister to the (acute) needs of patients, family members, caregivers and personnel.
- He operates according to the values and guidelines of the organization he is involved with.
- The care he renders is of excellent quality, offered in integrity, with honesty and sincerity.
- He knows the limits of his capacities and restricts himself to these boundaries.

Communication:

While communication skills are not unique to the function of pastoral care, they are indispensable for the pastoral caregiver. A few indicators of adequate skill in this are the following:

- The pastor is able to build up relationships quickly and spontaneously with patients, caregivers, families and personnel.
- He is able to create a climate of trust through verbal and nonverbal communication.
- He is able to make use of a variety of communication technics.

Partnership:

Pastoral caregivers are not the sole caretakers of their confidants. They are part of an interdisciplinary team. They must also have the skills to work alongside others and be prepared to make use of the specialization of their colleagues.

- The pastor confers with colleagues and other caregivers.
- He refers confidants on to other caregivers in a suitable manner.
- He is intentional to contribute to the interdisciplinary partnership.
- He is able to work alongside others in setting up projects related to the organization he is involved with.

Reflection:

We all are able to learn and grow, when we reflect on our experiences. The same is true for the pastor. A competent pastor is not someone who has reached the ideal state, but who is prepared to learn from his experiences; someone who is intentional about further developing his skills.

- The pastor is disposed to learn from his experiences.
- He intentionally continues to refresh and build on his knowledge and experiences.
- He is able to recognize his own learning process.
- He is aware of his own spirituality and capable to put this into words. (Elizabeth 2009-2013)

Prophetic service:

The pastoral caregiver is concerned about the well-being of his confidants. This is evidenced in the care directed toward the confidant, as well as in the manner in which the pastor advocates the case of the confidant.

- The pastor is able to purposefully bring the needs of the patient to the attention of those responsible for those areas.
- He is continuously alert for possibilities to optimize the care offered.

Organization:

Lastly the way a pastoral caregiver functions in regards to the organization he is involved with is of importance. The pastoral caregiver must ask himself two questions:

- How can I contribute to the organization? The pastoral caregiver has something to offer the organization.
- What does the organization expect of me? The organization has certain expectations.
- The pastor also possess IT skills, so as to make care optimal.

Again, these indicators do not tell us when a person has ‘arrived,’ fully ‘competent’ with no further need to learn and grow. In fact, an important quality of a pastoral caregiver is the desire to continue developing oneself. This will require courses and training sessions, as well as supervision moments. (Elizabeth 2009-2013)

[Zorgnet Vlaanderen: Six points to consider](#)

Zorgnet Vlaanderen made a list of areas of competence for the pastoral caregiver. Below are the six areas mentioned, along with some of the indicators for these areas of competence.

- Expertise: professional knowledge

Aware of the developments within pastoral care, able to apply the Bible to daily life, aware of the different God-images people may have, able to value his own faith traditions,...

- Expertise: spiritual empathy and communication skills

Able to listen, speak and act intentionally and empathetically, so that one’s confident will be able to express his own existential and spiritual experiences. This requires creating an atmosphere within which this is possible. It requires active listen and confirming if one hears correctly.

- Expertise: solidarity

Has eye for the marginalized, accepts differences, seeks to work together with others in the organization.

- Expertise: community building

Intentional about working together with others, about to handle conflicts as well as refer confidants to others, works according to the vision and identity of the organization

- Person: faith inspired

Has a personal faith, seeks fellowship with fellow believers, speaks/acts in accordance with own spiritual emotions/convictions...

- Office: Church ties

Feels affiliation with the Church

(Zorgnet Vlaanderen 2011)

[Andre de la Porte: Criteria for spiritual care in the healthcare sector](#)

In an article on spirituality and health, Andre de la Porte, gives the following criteria for those supplying spiritual care in the healthcare sector.

- ‘Sensitivity to multi-cultural and multi-faith realities
- Respect for patients' spiritual or religious preferences
- Understanding of the impact of illness on individuals and their caregivers

- Knowledge of healthcare organizational structure and dynamics
- Accountability as part of a professional patient care team
- Accountability to their faith groups' (de la Porte 2013)

He goes on to also describe the key elements of spiritual care as identified by Culliford, (2002)

- 'An environment for purposeful activity such as creative art, structured work, enjoying nature
- Feeling safe and secure; being treated with respect and dignity and allowed to develop
- a feeling of belonging, of being valued and trusted
- Having time to express feelings to staff members with a sympathetic, listening ear
- Opportunities and encouragement to make sense of and derive meaning from experiences, including illness
- Receiving permission and encouragement to develop a relationship with God or the Absolute (however the person conceives of what is sacred), thus a time, place and privacy in which to pray and worship, education in spiritual (and sometimes religious) matters, encouragement in deepening faith, feeling universally connected and perhaps also forgiven.' (de la Porte 2013)

The pastoral caregiver must be able to foster and provide these elements.

Concluding the competence expected of pastoral caregivers

Looking at these lists, we can conclude that competence in different areas is required. The pastoral caregiver must be able to work professionally and able to work together with those of other disciplines and in accordance to the vision and values of the organization he is part of. Personally he must be committed to further growth and development, in his profession and personal faith. He must be able to accept differences in others. He must also possess communications skills, including the very important skills of listening and interpreting.

The challenge now is to look at these areas and determine to what extent they apply to the lay volunteers working for HospiVision. When considering the volunteers working with HospiVision, we must remember that they are volunteers and many are lay counsellors and pastoral care givers. One cannot expect them to perform on the same level as professionals.

One could consider these criteria to be the standard for professional counsellors and pastoral care givers. Professionals should be capable of dealing with complex and difficult cases. The criteria for volunteers should not be held up to the same level. Even among the volunteers distinction can be made: beginners and advanced. Beginners need a certain level of competence to begin, but cannot be expected to have the skills that come through experience. The criteria for more experienced volunteers should be their goals to grow toward.

We have first looked at the required areas of competence for a caregiver. It is in these areas that he will need support, so as to excel in these areas. One of the characteristics of a competent pastoral caregiver is that he is disposed to learn and continue developing skills. This is one of the reasons pastoral caregivers need support. We will look at some more.

Annexure 5: Annual Report 1 March 2011 – 28 February 2012



ANNUAL REPORT 1 MARCH 2011 – 28 FEBRUARY 2012



1. Introduction

Jesus said in Matthew 28:19 "Go therefore and make disciples of all the nations... ". In the hospitals of our country "all the nations" have come to us. The Steve Biko Academic Hospital, for example, provides services to patients not only from Gauteng, but also from Mpumalanga, Limpopo, North-West as well as specialised treatment to people from neighbouring nations like Namibia, Botswana, Zambia and Mozambique and going to the north as far as Nigeria and the DRC. Francis Grim, the founder of the Health Care Christian Fellowship is indeed correct when he said that more people go through the doors of hospitals in a year, than through the doors of the church.

Hospitals are places of hope and healing, but also of pain, uncertainty and loss. At HospiVision we are not only provided with various opportunities to expand the Kingdom, but there are numerous occasions where a child of God needs encouragement and reinforcement of his faith and of God's love. We deal with situations where questions arise which cannot always be answered but where people could experience Jesus through the presence of another human being. HospiVision is therefore a natural and indispensable part of the hospital landscape.

2. HospiVision's core activities

2.1 Vision: *Touching lives. Giving hope.*

HospiVision touches the lives of sick people and those around them and gives them hope through counseling, spiritual care and physical support.

2.2 Mission

HospiVision facilitates the establishment of sustainable integrated support systems that reach out to and are in service of the sick, the vulnerable and the disadvantaged, their families and those who care for them.

2.3 Values

HospiVision is committed to *spiritual values* such as respect, responsibility, integrity, love, fairness and service. *Ownership* by the community, church, family and individual involved, is encouraged. HospiVision promotes a culture of *lifelong learning* and the provision of the highest quality, most cost effective accredited education and training.

2.4 Objectives

- To provide emotional and spiritual care and physical support to patients, their families and caregivers.
- To provide care and support to sick, orphaned and vulnerable children, in particular those infected or affected by HIV & AIDS in the family and/or living with a life-threatening illness (e.g. cancer)
- To provide care and support to people living with AIDS and who are on Anti-Retroviral Therapy.
- To provide a value-based HIV prevention training programme for faith and community based leadership.
- To provide UNISA accredited training for volunteer and professional caregivers as well as community and faith based leaders.

- To mobilize the necessary resources for our programmes.

2.5 Main activities

2.5.1 Emotional, spiritual care and physical support to patients and their families.

- Plan, implement and manage care programmes
- A valuable volunteer services programme through which patients and personnel are visited and supported.
- 24 hour trauma counseling to patients, their families and staff.
- Support medical personnel and care-givers through special programmes and Employee Assistance Programme services.
- Present HospiVision Time - a weekly programme on Radio Pulpit, a national Christian Broadcaster.

2.5.2 Children's Care Train

- Provide care and support to sick, orphaned and vulnerable children, in particular those infected or affected by HIV & AIDS in the family and/or living with a life-threatening illness (e.g. cancer)
- Educational and early childhood development programmes
- Nutritional support: meals and food parcels
- Physical support: clothes, toiletries, educational material

2.5.3 HIV and AIDS care

- The Oasis: Support for people living with AIDS and on Anti-Retroviral Therapy.
- Nutritional support: meals and food parcels
- Income generation
- Vegetable garden
- Hopeful Compassion programme: Support, care and counseling for people infected or affected by HIV and AIDS and their families, as well as training for their caregivers.

2.5.4 HIV Prevention

- Choose Life: A Value Based HIV prevention programme for church, community and youth leaders.

2.5.5 UNISA Accredited Training for volunteer and professional caregivers as well as community and faith based leaders.

The following courses are presented

Course	Unit standard	SAQA Reg Nr
Short course in Spiritual care and counseling for the sick	Apply basic skills of pastoral care	115913
Short course in Spiritual care and counselling for sick and vulnerable children	Build relationships with children	116743
Short course in spiritual care and counseling for people living with AIDS	Engage with issues of death and life	115985

Short course in a narrative approach to journeying with Depression	Identify ways to manage anxiety and depression in own life situation	New: Unit standard 114944 upgraded
Short Course in a faith and value based approach to HIV prevention	Develop, facilitate and evaluate appropriate Christian responses to HIV/	115949
Short course in Narrative practices for spiritual care and counseling for the sick	Apply pastoral counselling skills	115921
Short course in Trauma counseling in an Accident and Emergency Unit	Provide trauma counselling support	243941
Short course in Memory Work and life maps in counseling for loss, death and bereavement	Practise and evaluate models of pastoral care	115999
Short course in Implementing a spiritual care and counseling programme in health care	Develop a community development intervention plan	377873

2.5.6 Marketing, communication and resource mobilization

- Newsletters and communication with donors
- Grant research and application
- Fundraising events

2.6 Statistics (March 2010 - February 2011)

ITEM	TOTAL	BLACK	%
Number of private sector hospitals where we work	10		
Number of hospitals where we work	11		
Permanent staff members	36	22	61.11
Volunteers in all ministries	320	250	78.13
Students attending courses	341	282	82.69
Practical assistance (clothes/toiletries/food parcels)	3510	3051	88.82
Meals served at the Oasis	31321	31321	100.00
People receiving spiritual care and counselling	30272	24562	82.84

Public sector hospitals:

Tshwane: Steve Biko Academic, Tshwane District, Mamelodi, Pretoria West, Kalafong, Dr. George Mukari, Tsepong TB hospital.
 Boksburg: Tambo Memorial hospital
 Johannesburg: Helen Joseph
 Brits General Hospital.

Private sector hospitals: Tshwane: Eugene Marais, Moot General, Curamed Heart, Med

Forum, Jacaranda, and Zuid-Afrikaanse Hospital. In co-operation with Moreleta Park and Hatfield Christian Church: Pretoria East, Kloof and Willows hospitals.

3. Governance

3.1 Hospivision board

The following Hospivision board members were elected at the AGM:

Name	Appointment	Expertise	Gender
Dr A de la Porte	Managing Director	Project Management	Male
Dr J P v d Walt	Founder	Business Consultant	Male
Dr I Gravett	Member	Care and Counselling	Female
Ms S Kgaka	Member	Entrepreneurship / Gender	Female
Prof D Louw	Member	Pastoral Counselling	Male
Rev C Mangayi	Member	FBOs & Development	Male

3.2 Staff composition

POSITION	NUMBER	REPRESENTIMTY		
		MALE	FEMALE	RACE (African, Asian, Coloured, Indian, White)
Managing Director	1	1		White
Financial Manager	1		1	White
Office Manager	1		1	White
Department Manager	4	1	3	Black
Department Manager	1		1	Coloured
Department Manager	2		2	White
General Manager	1	1		White
Fund Raiser	1		1	White
Counsellors	16	7	9	Black
Counsellors	6	4	2	White
Counsellors	1	1		Coloured
Personal Assistants	1		1	White
Secretary	2		2	White

Total number of staff members: 36

4. Registrations and Achievements

- Section 21 Non Profit organization (Reg. Nr 99 12761/08)
- Article 18(A) Public Benefit Organization with tax exemption (RG/0042/09/05)
- BBBEE compliant

- First faith-based organization to be accredited at the National Department of Health as HIV and Aids Lay Counselling Organization
- SAQA alignment and accreditation of our training
- Accreditation by the CP Powell Bible Centre at the University of South Africa as a training provider
- "Proudly South African" Organization
- SA Institute of Fundraisers –membership
- Member of the South African Association for Pastoral Work (SAAP)
- Nominated for the Gates Award for Global Health (2007)
- Invited to attend and do a presentation at the 53rd United Nations Convention on the Status of Women (2009)
- Performance excellence award Steve Biko Academic Hospital 2011

5. Membership of other organizations

- The Global Health Council (GHC)
- International Connections for Christian Health (ICCH)
- Recognized by the International Health Awareness Network (IHAN)
- South African Association for Pastoral Work (SAAP)

6. A brief overview of some of our departments

6.1 *Spiritual Care and Counselling*

6.1.1 Steve Biko Academic Hospital (SBAH)

There are 900 beds available in this academic hospital. Patients stay an average of 6 days and approximately 54 000 patients are admitted during a year. There are more than 30 intensive care units and 50 clinics. In total ± 750 000 patients are treated at this hospital. The hospital is linked to the University of Pretoria for the training of medical students. A total of 4 500 people work here. The Emergency Unit at PAH has treated ± 34 000 patients during the past year. The HospiVision team here consists of the Head of Department, Ms Ilse Gravett, 9 other permanent staff members and ± 60 volunteers.

Trauma support is provided on a Monday, Wednesday and Friday evening from 19:00-23:00 when volunteers serve coffee and tea to family of patients and the staff in the unit. These figures are not included in the statistics above.

Other activities include prayer meetings in certain wards as well as memorial services.

6.1.2 Tshwane District Hospital (TDH)

There are 200 beds available in this district hospital. Patients stay an average of three days and approximately 24 000 patients are admitted during a year. The team here consists of the Head of Department, Rita Potgieter (Secretary) and 6 other permanent staff members and ± 25 volunteers. The Chapel at TDH is used for church and memorial services and prayer meetings are conducted in some wards. One of the highlights is the weekly Sunday service in the Chapel.

6.1.3 Mamelodi Hospital

A new hospital has been built and commissioned and upgraded to a district hospital. There are 200 beds available. The team there consists of the coordinator, Pastor Stephen Ndada and a team of 30 volunteers. Pastor Ndada conducts a weekly morning devotional service attended by approximately 200 people at a time.

6.1.4 Kalafong Hospital (KH)

There are 900 beds available in Kalafong hospital. Ms Catherine Ledbwaba heads up the team of 25 volunteers. Apart from regular visitation in the wards various churches from the Atteridgeville area take turns to conduct services in the hospital on a Sunday.

6.1.7 Helen Joseph

Hospivision Helen Joseph became operational in 2010. There is a very positive attitude towards Hospivision from the management. Rev Japie Coetsee is the coordinator and a trauma counselling course has been presented. For now the focus is on providing trauma counselling and support

6.2 HIV and AIDS support and care

The Anti-Retroviral Therapy clinic at the Tshwane District Hospital is the largest in the Tshwane area. A total of 8000 patients are registered at the clinic of which 1500 are children and adolescents. Apart from the adult clinic there are also dedicated paediatric and adolescent clinics. Of the 1500 children at least 800 are below the age of 6 years. Approximately 60% of the adult patients are women with children (not all necessarily HIV +), which as a result are vulnerable. People attending the clinic do not necessarily come from the "official" catchment area. Research done at the Oasis has indicated that people come from the following areas: Mamelodi, Hammanskraal, Soshanguwe, Mabopane, Winterveld, Stinkwater, Pretoria Central, Moot, Marabastad, Pretoria East, Pretoria North and Centurion.

The Clinic primarily provides medical treatment which is supported by a social worker and nutritionist. Hospivision was approached by the management 7 years ago to provide additional psychosocial, spiritual and physical care and support. As a result the services of Hospivision's Children's Care Train were extended to provide more holistic care to orphaned and vulnerable children, in particular those on ART. The Oasis Community Centre was established to provide support to OVC's, their families and patients on ART.

The Oasis community centre is housed in an unused operating theatre adjacent to the clinic.

The Oasis provides the following services:

- Psychosocial and spiritual care and counselling for people on ART as well as OVCs and their families;
- Nutritional support: free meals are provided for everyone attending the clinic as well as a food parcel programme to supplement the food parcels provided at the clinic;
- Physical and material support;
- Developmental support for OVC;
- Support to access government grant programmes;
- Vegetable garden (supply of fresh vegetables as well as training in establishing a vegetable garden);
- Income generation (hand craft, sewing, computer literacy);

- HIV prevention education;
- Literature (Bible, spiritual literature, books, educational materials)

A 360 square meter vegetable garden has been established adjacent to the Oasis. This garden provides vegetables for the meals served at the Oasis. A training programme in establishing and maintaining a vegetable garden is presented for people attending the clinic. A home garden start-up package consisting of compost, seedlings and seeds are provided. Through a community outreach programme, on site assistance and monitoring will be provided in future for those who have been trained and have established their own gardens. The establishment of the garden was funded by the Dutch Koornzaaijer foundation and corporate social investment programmes.

6. Finances

Hospivision is back on a growth path after two very difficult years. Our revenue increased with 26% (from R1458666 to R1948309) during the past financial year.

7. Thank you

Hospivision wants to thank all the permanent staff and volunteers for faithful and diligent work during the past year. Also a word of thanks to all our sponsors and funders, from the individual who contribute through a monthly debit order, churches who support our work, businesses who support Hospivision's programs through corporate social investment programs, trusts and foundations, and international donors.

In closing we want to acknowledge that all the glory for Hospivision's work belongs to God our Father and our Lord Jesus Christ through the work of the Holy Spirit.



André de la Porte
(Managing Director)

Annexure 6: Annual Report for HospiVision (March 2011 – February 2012)



HospiVision
PO Box 12423
Queenswood, 0121
Tel/Fax: 012-329 9492
E-mail: friend@hospiVision.org.za
Web: www.hospiVision.org.za

June 2012

The Director
Non-profit Organisations
134 Pretorius Street,
HSRC Building,
Pretoria

ANNUAL REPORT FOR HOSPIVISION (MARCH 2011 – FEBRUARY 2012)

Please find attached the HospiVision Annual Report to the Directorate of Non-Profit Organisations.

Yours truly

A handwritten signature in black ink that reads 'Adella Porte'.

.....
Dr. A E de la Porte
(Managing Director)

1. Section A: Basic details about the Organisation

1.1 Organisations name: HospiVision

1.2 Registration Numbers

- Section 21 Non Profit organisation (Reg. Nr 99 12761/08)
- Article 18 (A) Public Benefit Organisation with tax exemption (RG/0042/09/05)
- NPO (071-706)

1.3 The twelve-month period this Report covers: March 2011-February 2012

1.4 Contact persons (Two office bearers nominated by the Organisation):

Contact person: Dr A E de la Porte

Contact person's title in your organisation: Managing Director

Telephone number: 012 329 9492.

Fax number: 012 329 9492

Cell phone number: 083 793 3537

E-mail address: andred@hospivision.org.za

Another contact person: Me. Frieda Coreejas

Contact person's title in your organisation: PA to the MD

Telephone number: 012-3299492

Fax number: 012:3299492

E-mail address: marketing@hospivision.org.za

1.5 Organisation's physical address:

Tshwane District Hospital

Dr Savage Road

Gezina

Pretoria

Gauteng

1.6. Organisation's postal address (if different to 1.5):

P O Box 12423

Queenswood

0121

1.7 Organisation's Office Bearers

Name	Office bearer title	Work or home address	Postal address	Telephone (including dialling code)	ID number
Dr A E de la Porte	Managing Director	110 Blakestr Riviera 0082	P O Box 26487 Gezina 0031	012 329 9492	5805105005083
Dr H v d Walt	Business Consultant	124 Kameelave Rietondale 0121	P O Box 12424 Queenswood 0121	012 420 2000	5404265072081
Dr I Gravett	Pastoral Therapist	9 Wag-'n- bietjie str Clubview 0014	P O Box 13652 Clubview 0014	012 6542113	6302080013083
Ms S Kgaka	Project Assistant Manager	Equistria Estate House 84 Witteberg. Pretoria	Same as physical	011 339 5214	213 921814 (Botswana)
Prof Daniel Louw	Professor Pastoral Theology	Nellmapius str 2, Stellenbosch 7600	Faculty of Theology, Dorpstr 171 Stellenbosch 7600	021 8871703	440808215081085
Rev. C Mangai	Director	22 Third avenue, Roodepoort North 1724	Private Bag x45, Wilro Park 1731	011 760 660	6412175325183

1.8 Organisational profile

Total number of personnel =

36

REPRESENTIVITY				
POSITION	NUMBER	MALE	FEMALE	RACE (African, Asian, Coloured, Indian, White)
Managing Director	1	1		White
Financial Manager	1		1	White
Office Manager	1		1	White
Department Manager	4	1	3	Black
Department Manager	1		1	Coloured
Department Manager	2		2	White
General Manager	1	1		White
Fund Raiser	1		1	White
Counsellors	16	7	9	Black
Counsellors	6	4	2	White
Counsellors	1	1		Coloured
Personal Assistants	1		1	White
Secretary	2		2	White

1.9 Basic skills or services of the Organisation: Broadly describe the service activities of the organisation (i.e.: nursing, counselling, monitoring, activism, managing fundraising or community development):

Hospivision is a non-profit (section 21 reg. nr: 99 12761-08 / NPO 071-706) Christian Faith-Based Organisation (FBO) established in 1997 to provide psycho-social and spiritual care, counseling and training, as well as physical support in the health care environment. Hospivision is a section 18(A) Public Benefit Organisation with tax exemption (RG/0042/09/05) and complies with Broad Based Black Economic Empowerment (BBBEE) criteria. Hospivision facilitates the establishment of sustainable integrated support systems that reach out to and are in service of the sick, the vulnerable and the disadvantaged, their families and those who care for them.

We render the following services

Hospivision Annual Report (March 2011 – February 2012)

Page 4 of 12

1. Emotional, spiritual care and physical support to patients and their families.
 - *Plan, implement and manage* care programmes
 - *A valuable volunteer services programme* through which patients and personnel are visited and supported.
 - *24 hour trauma counseling* to patients, their families and staff.
 - Support medical personnel and care-givers through special programmes and *Employee Assistance Programme services*.
 - Present *HospiVision Time* - a weekly programme on Radio Pulpit, a national Christian Broadcaster.
2. Children's Care Train
 - Support children in health crisis and those infected or affected by HIV & AIDS in the family.
3. Care and support to people living with HIV and AIDS
 - *The Oasis*: To provide care and support to people living with AIDS and who are on Anti-Retroviral Therapy.
 - *Hopeful Compassion programme*: Support, care and counseling for people infected or affected by HIV and AIDS and their families, as well as training for their caregivers.
4. HIV and AIDS prevention
 - *Choose Life: A Value Based HIV prevention programme* for church, community and youth leaders.
5. UNISA Accredited Training for volunteer and professional caregivers as well as community and faith based leaders and for those who would like to become involved in 'caring' and/or wish to start their own ministry.
6. Marketing, communication and resource mobilization to mobilize the necessary resources for our programmes.

2. Section B: The Organisation's major achievements over the past year:

2.1 List the Organisation's planned objectives set at the beginning of the past year (the measureable activities you planned to achieve.)

Objectives:

- To provide emotional and spiritual care and physical support to patients, their families and caregivers.
- To provide care and support to sick, orphaned and vulnerable children, in particular those infected or affected by HIV & AIDS in the family and/or living with a life-threatening illness (e.g. cancer)
- To provide care and support to people living with AIDS and who are on Anti-Retroviral Therapy.
- To provide a value-based HIV prevention training programme for faith and community based leadership.
- To provide UNISA accredited training for volunteer and professional caregivers as well as community and faith based leaders.
- To mobilize the necessary resources for our programmes.

2.2 Indicate which of the Objectives listed in 2.1 you achieved or partly achieved.

	<i>Initiative</i>	<i>IMPACT</i>
1	<i>Counselling and spiritual care for staff, patients and families accessing public health care</i>	<i>Building of skills and resiliency to cope with adversity. Anticipated reach</i>
2	<i>Trauma support and debriefing</i>	<i>Preventing the development of Post-Traumatic Stress Disorder (PTSD) significantly contributes toward general mental health and prevention of relationship and other social problems</i>
3	<i>Care and support for sick, Orphaned and Vulnerable Children</i>	<i>Identify OVC and OVC parents and guardians, Psycho-social support, Spiritual support, Food and nutrition, Education and vocational training, Economic strengthening, Shelter and care, Health (Referral), Child protection (Referral), Legal counseling (Referral).</i>
4	<i>Care and support for people living with AIDS and on Anti-retroviral therapy</i>	<i>Hospivision has developed a model to create a supportive and nurturing environment for people who are living with AIDS, are on ART (Anti-Retro-Viral Therapy) and therefore have to visit the clinic on a monthly basis. Spiritual and emotional support is provided through counselling, prayer and distribution of Christian literature and Bibles. Nutritional support, Economic strengthening and income generation are provided</i>
5	<i>Choose life – A HIV prevention program based on spiritual values: The target groups for the programs are faith, NGO, community and youth leaders.</i>	<i>The program focuses on creating behaviour change based on the Biblical framework of the golden rule and the cultural framework of Ubuntu, well as six central spiritual values (respect, responsibility, integrity, fairness, love and service). It strengthens the life-skills of decision-making, assertiveness and negotiation. The outcome of this program is to empower participants with knowledge, skills and attitudes to live powerful, spiritual, self-confident lives by making wise ethical decisions. Trained leaders initiate the community mobilization activities such as raising awareness about HIV and AIDS in faith communities, workshops for community members and youth as well as activities like congregational meetings and training for children and youth.</i>

5	<p><i>Training programmes: A large part of HospiVision's ongoing work is done by trained volunteers. The following programs are presented:</i></p> <ul style="list-style-type: none"> • <i>Counselling and Spiritual Care for the Sick (Basic and Advanced)</i> • <i>Hopeful Compassion (Basic and Advanced) – Training in spiritual care for people living with AIDS and their families</i> • <i>Choose Life: A value based and ethical response to HIV & AIDS (Funded by the United States Agency for International Development)</i> 	<p><i>Most of the trainees implement their training and skills in the wider community and in their churches</i></p>
5	<p><i>Service: Physical needs are also addressed. These include for example clothes, toiletries for poor patients, food parcels, free cafeteria (at the Oasis).</i></p>	<p><i>HospiVision has the opportunity to cooperate in many other activities within the health care field where we use the opportunity to witness. Services at health related "focus days" like World AIDS day, National Nurses Day, World TB Day etc.</i></p>

2.3 Explain how you achieved, or partly achieved, the Objectives indicated in 2.2. Try to keep your explanations to 100 words or less for each of the Objectives.

- To provide Emotional and spiritual care and physical support to patients, their families and caregivers.
 - o HospiVision rendered services in the following Hospitals:
Public sector hospitals: Tshwane: Steve Biko Academic, Tshwane District, Mamelodi, Pretoria West, Kalafong, Dr. George Mukari, Tsepong TB hospital. Boksburg: Tambo Memorial Hospital. Brits General Hospital. Johannesburg: Helen Joseph Hospital. Fishhoek (Western Capre) False Bay Hospital. KZN: Gray's Hospital.
Private sector hospitals: Tshwane: Eugene Marais, Moot General, Curamed Heart, Med Forum, Jacaranda. Zuid-Afrikaanse, Pretoria East, Kloof and Willows.
- To support children in health crisis and those infected or affected by HIV & AIDS in the family.
 - o Children reached:

- To provide care and support to people living with AIDS and who are on Anti-Retroviral Therapy.
 - o *People reached:*

- To provide a value-based HIV prevention training programme for faith and community based leadership.
 - o *People reached:*

- To provide UNISA accredited training for volunteer and professional caregivers as well as community and faith based leaders.
 - o *People trained:*

- To mobilize the necessary resources for our programmes.
 - o The tough economic circumstances of the past 12 months have negatively impacted on HospiVision's resources and our ability to reach all our targets.

- One of HospiVision's core purposes is the development of sustainable models for the provision of spiritual, emotional, social and physical support with a focus on public health care facilities (mainly hospitals). Our work at the Steve Biko Academic and Tshwane District Hospitals has always had this "pioneering" purpose.
- During the past year the following developments have taken place:
 - o Better definition and implementation of programmes at the Oasis for people on Anti-Retroviral Therapy (Tshwane District Hospital Clinic). Apart from the provision of food, food parcels and clothes, there are now established income generating programmes and a training centre for computer literacy.
 - o Development and implementation of an Orphaned and Vulnerable Children care and support programme at the above mentioned clinic
 - o Care and support programme at the Pediatric Oncology Department at the Steve Biko Academic Hospital
 - o Allocation of facilities in the newly commissioned Mamelodi Hospital
 - o Expansion of programmes at the Kalafong and Dr. George Mukari Hospitals

2.4 Planning for the year ahead

The HospiVision leadership had a day long strategic planning session at the end of February. We believe that our calling to bring hope and healing in health care and to touch the lives of those that are suffering has been confirmed. We are prayerfully adapting our priorities and strategies for the future. A couple of priorities are dear for us:

1. HospiVision is back on a growth path after two very difficult years. Our revenue increased with 26% (from R1458666 to R1948309) during the past financial year.
2. Within our broad objectives we have identified the following key areas for 2011-2012
 - o Developing and refining our approach to facility based care and support for sick, orphaned and vulnerable children;
 - o Increase our ability to respond quickly to ever increasing levels of trauma in accident and emergency units through the provision of 24 hour counselling and debriefing;
 - o Further develop income generating programmes for people living with AIDS and on anti-retroviral therapy (with a focus on women);
 - o Strengthen service delivery at our existing sites and in particular those initiated in 2010;
 - o Review all our UNISA accredited training programmes and increase accessibility to accredited training.

2.5 Give a general description of the ways in which beneficiaries (individuals/groups/communities/social or economic or environmental condition) benefited from your Organisation's programme, projects or services during the past year. Try to keep your description to 100 words or less.

HospiVision facilitates the establishment of sustainable integrated support systems that reach out to and are in service of the sick, the vulnerable and the disadvantaged, their families and those who care for them. This includes support orphaned and vulnerable children in health crisis, a Value-Based HIV prevention program for church, community and youth leaders, support for people living with AIDS and on Anti-Retroviral Therapy, the implementation and management of spiritual care programs, 24 hour trauma support and counselling for patients, family and staff at regional hospital emergency departments and a valuable volunteer services program.

3. Section C: List of important meetings held by the Organisation during the past year, and details of any changes to your Constitution.

NOTE: Responses to the headings below must be given on separate sheets of paper.

3.1 List the number of meetings your Organisation held during the past year. Use the following headings (if applicable).

What meetings of the kinds listed below (if applicable) did your organisation hold during the period of the report? And how many of each did you have?

Type of meeting	No of meetings held during the year	
Annual general meeting	1	
Special general meeting	None	
Management meeting	12	
Board meeting	3	
Executive meeting	4	
Others (specify)		

3.2 Give the date of your Annual General Meeting and indicate if this was held at the time stated in your Constitution or not. If not, give the reason for delay or advance.

As determined by the constitution the AGM was held on 9 July 2011.

3.3 If the Organisation held a Special General Meeting, or Meetings, during the past year, give a short explanation for this.

Not applicable

3.4 Did the Organisation make any change or changes to its constitution during the past year?

NO

Financial Report – income and expenditures:

1. Section A: The Organisation’s income and basic accounting details:

1.1 Accounting Office’s name: Snijder&Associates Inc

1.2 Accounting office’s address (an outside or accounting company or auditor):

699 Pierneef str
Deerness
Pretoria
0084

1.3 Organisation’s accounting policies (i.e. Are your accounts done monthly):

Accounts are done monthly and audited once a year.

1.4 Has the attached Accounting Officer’s report and annual statement of accounts been approved by your Organisation’s Office Bearers? YES/NO

NOTE: The Directorate will only accept a report and financial statement that has been approved by your office Bearers.

1.5 What % (percentage) of your total annual expenditure was spent on

administration costs (i.e. salaries, rental, travel, water/lights, maintenance, insurances, stationery etc) 60%

1.6 Indicate your sources of income under the headings below (with a tick):

Kind of funds	
Donations:	70%
Fees/membership:	
Sales of products or services:	5%
Gifts-in-kind (other than money):	10%
General income (i.e. fundraising events)	15%
Interest on investment:	

1.7 What % (percentage) of your annual income come from submitting project or grant proposals to corporate, foundations/trusts or foreign donors: 70%

1.8 Who did you use to raise your income during the past year? (you can tick more than one box if you used more than one method):

Our fundraising was done by:	
Full-time staff member/s	<input checked="" type="checkbox"/>
Part-time staff member/s	<input checked="" type="checkbox"/>
Volunteer/s	<input type="checkbox"/>
Outside person/company for a fee or commission	<input type="checkbox"/>
Other	<input type="checkbox"/>

Section B: A copy of your most recent Annual Financial statements, which include a Balance Sheet and an Income and Expenditure Report.

Attach your organisation's annual Balance sheet and Income and Expenditure Report.

Annexure 7: Volunteer screening, training and supervision procedure

Procedure for the Screening and Training and Supervision of Lay Pastoral Volunteers

1. Pre-screening of:
 - Completed application form (below).
 - Assessment of English or Afrikaans language capability for training purposes.
 - Shown valid ID, as well as proof of residence (make and keep copies).
2. Selection interview by an appropriate member of the permanent staff (possible questions appended).
3. Screening out candidates identified as unsuitable during the attendance of HospiVision Short Course for in Spiritual Care and Counselling for the Sick or if assignment and Volunteer Orientation not successfully completed. Screening out candidates identified as unsuitable during the practical training period, using their capability to independently:
 - Adhere to the Behavioural Code;
 - Apply basic listening and counselling skills
 - Be aware of and set aside their own needs and issues.
4. Sign-off of successful candidates and incorporation into the Volunteer Roll, with a welcoming ceremony.
5. Issuing of Hospital card. Control of all cards (must be picked up from Coordinator each time), except reliable evening or weekend volunteers.
6. On-going supervision by Pastoral Care Team Coordinator.
7. Sign-in and out at wards (spot checks by Coordinator).
8. Debriefing and personal counselling as needed.
9. Regular attendance of monthly Pastoral Care Team meetings and removal from Volunteer Roll if commitment not shown.
10. Annual review and renewal of agreement if appropriate and attendance of further formal HospiVision training courses.

Annexure 8: Volunteer Agreement

February 2012

Dear pastoral care volunteer,

Welcome at HospiVision Counselling and Spiritual Care. We think that the experience of meeting hope, pain, life, courage and death will broaden your understandings and knowledge. We believe you will learn about yourself and your caring capabilities, your innate wisdoms and strengths to serve and receive from others.

We wish to assure you of our appreciation of volunteering your services and will do the best we can to make your experience enjoyable and rewarding.

HospiVision expects you to honour the code of conduct and to honour the commitment to yourself to make the most of volunteering your services.

Our culture is one of friendliness, tolerance, flexibility, servitude, hard work and discipline.

By signing the attached contract you indicate that you understand what is required of you as a pastoral care volunteer.

Best regards

Ilse Gravett

Head: Counselling and Spiritual Care



AGREEMENT

between

Hospivision

(hereinafter referred to as "**HV**")

and

(hereinafter referred to as "**the volunteer**")

(ID number)

for the purpose of voluntary providing pastoral care services to HV under HV's supervision and in accordance with the guidelines and conditions laid down by HV.

1 The volunteer provides lay pastoral care as follows:

- 1.1 Providing lay pastoral care to patients and family members within the hospital context. This includes a range of practical emotional and spiritual supporting and helping acts like listening and being a friend, comforting the person, assisting the person with practical problems, providing for physical needs and praying with the person.
- 1.3 Using sound lay pastoral care skills as taught through HV training and accepting responsibility for further developing skills and knowledge in lay pastoral care.
- 1.4 Behaving ethically at all times in line with HV's Behavioral Code (Appendix 1) as well as Confidentiality Agreement (Appendix 2).
- 1.5 Behaving with understanding and support of the hospital context and hospital procedures and processes.
- 1.6 The volunteer is supervised by and reports to the Lay Pastoral Team Coordinator.

2 Place

The volunteer participates in lay pastoral care services only in Steve Biko Academic Hospital only in wards and at times as indicated by HV.

3 Competence and scope of practice

- 3.1 The volunteer has to successfully complete the HV Short Course in Spiritual Care and Counselling for the Sick, a Volunteer Orientation session and a period of practical training. The volunteer remains in training until signed off the practical training period by the Head of HV Steve Biko Hospital.
- 3.2 Before the volunteer starts his or her practical training period, he or she must review and sign the HV Behavioural Code, as well as the Confidentiality Agreement (Appendix 2).
- 3.3 After sign-off the volunteer is placed on HV's volunteer roll until the automatic lapsing of this agreement (as per Section 8).
- 3.4 The volunteer reports to and is under the supervision of the Lay Pastoral Care Team Coordinator.
- 3.5 The volunteer has to attend at least one volunteer team meeting per month for the purpose of review, debriefing, continuing education and team building. If the volunteer misses these sessions without pre-arranged permission for two months, or attends them irregularly, his or her name will be removed from the roll of volunteers.
- 3.6 Crisis debriefing and personal counselling is available to all volunteers as requested by the volunteer or the Coordinator.
- 3.7 Volunteers are strongly encouraged to attend at least one HV Short Course per year of volunteering.
- 3.8 Volunteers may not provide care beyond their level of competence and outside the scope of lay pastoral care.

5. Identification

The volunteer has to identify him or herself as part of HV by:

- 5.1 Identifying him or herself as a Lay Pastoral Care Volunteer.
- 5.2 Wearing the required hospital ID.
- 5.3 Wearing a HV shirt.
- 5.4 Signing into and out of the HV register in wards.

Prices for the shirt and hospital ID vary and the volunteer is responsible for payment of both items.

6. Recording and reporting visits.

The volunteer has to record all visits at hospital and submit visit statistics on a monthly basis.

7. Status of volunteer

It is expressly understood and agreed that the volunteer is participating in HV’s lay counselling services on a volunteer basis; that he or she will not be remunerated and is not an employee of HV.

8 Indemnity and release

- 8.1 The volunteer assumes full responsibility for his or her own health and safety while participating in HV as a volunteer.
- 8.2 The volunteer hereby releases and forever discharges and agrees to indemnify and hold harmless HV and its employees, agents, officers, and trustees (individually and in their official capacities) from and against any and all liability whatsoever for any and all damages, losses, or injuries (including death) including but not limited to any claims, demands, judgments, damages, expenses, and costs which arise as a result of or connected in any manner to his or her participation in HV as a volunteer .

9 Termination of Agreement

All agreements with lay pastoral care volunteers lapse automatically at the end of each year and a new agreement has to be signed to continue with volunteer work.
HV may nevertheless terminate this agreement with immediate effect before the automatic lapsing takes place.

Date:

For HospiVision

Volunteer

Witnesses:

Appendix 1: BEHAVIOURAL CODE

As representative of the HospiVision I undertake to subject myself to the following code of behaviour whenever I minister to patients, their family and staff of the hospitals in which I minister:

1. I will at all times treat all people with whom I come into contact with courtesy, love and respect, irrespective of their attitude, race, religion, age, gender, national origin, physical handicap, or sexual orientation.
2. I undertake to be faithful in my obligations regarding the ministry and to submit an apology when I am unable to do so.
3. Should the situation dictate such that my presence is essential and I am unable to attend, I undertake to make the necessary alternative arrangements.
4. When working with patients, their families and staff, I undertake:
 - a) To be sensitive to the needs of the patients.
 - b) To be sensitive to and considerate of the personal opinions and convictions of the people to whom I am ministering.
 - c) To act as a representative of the Christian faith, rather than a specific Christian denomination or church.
 - d) When ministering to members of other Christian churches than my own, to avoid contentious subjects such as baptism, gifts of the Holy Spirit and Holy Communion.
 - e) When ministering to members of other faiths, to treat them and their beliefs with respect and sensitivity, to avoid contentious subjects and not to impose my religious convictions on them or try to convert them to my faith.
 - f) To be aware of the unique vulnerability of patients and family members during crisis and within the hospital context as well as of the power inherent in the pastoral care or counselling relationship and under no circumstances to intimidate or victimize people, or abuse this power.
 - g) Not to provide care beyond my level of competence, comfort and skill and to refer patients outside my level of competence and scope of practice. .
 - h) Not to touch patients physically. When a patient, family member or staff member of his or her own volition asks to hold hands, be touched on the forehead during prayer or to be hugged I will do so in an honest and open way.
 - i) To treat personal information with the utmost respect and confidentiality and not to read patient's medical files.
 - j) Not to sell anything to patients.
 - k) Not to accept or solicit gifts from patients and family members.
 - l) Not to present myself by any title other than a HospiVision Pastoral Care Volunteer.
- 5) To act with respect and awareness of the medical and hospital context:
 - a. Not to interfere with, advise on, oppose or comment on the quality and nature of medical treatment in any way.
 - b. To beware of the uniqueness of the medical and hospital context when addressing, or referring to, issues relating to laying of hands, salving with oil, praying for healing, using the concepts of "Healing", "Divine healing" and "Miracle healing".
 - c. Not to minister by laying on of hands or driving out of demons and when praying for healing, to do so without disturbing other patients and personnel.
 - d. To avoid spreading germs from patient to patients during bed visits by washing my hands regularly; not touching patient beds, not placing anything on beds.
 - e. To switch off my cell phone within the wards.

- 6) To keep every promise I make to the people with whom I am working as a testimony of God's love. Should I be unable to keep my promise, I undertake to follow it up with the person to whom the promise is made.
- 7) To treat other people's property with respect.
- 8) I undertake not to misappropriate any property or service of HospiVision or any hospital in which I am serving.
- 9) I will not remove any property from the premises unless I have received the express permission of the people in charge.
- 10) I will not misuse any property or service available to me (such as telephones or other facilities and supplies) for personal benefit, and will only use these facilities and supplies according to the purpose for which they are provided. I understand that this does not preclude the use of such in cases of personal emergency, in which case I will request permission from any permanent staff member on duty.
- 11) I undertake to report punctually for any duty I have accepted.
- 12) I undertake always to behave in an orderly manner and dress neatly and conservatively when I minister to people.
- 13) At no time will I make myself guilty of a breach of good manners.

.....
Signed

.....
Date

Appendix 2: Confidentiality Agreement

1. Each person will be treated as a unique individual with their own history and interpretation of the world they live in. This is respected by the counsellor.
2. All information given by a patient or family member will be kept confidential.
3. If discussed during training and supervision, the unique aspects of a person's story will be kept confidential. This includes, but is not limited to:
 - a. Name, physical address and any other identifying information.
 - b. Information not relevant to the discussion.
4. No information given by a patient or family member will be shared without the person's explicit informed consent, which includes discussing the reasons for, the extent and consequences of the sharing of information. .
5. Any written information on patients and family members will be kept under lock and key in such a way that no one has access to it.
6. Confidentiality may only be breached when:
 - a. A person threatens self-harm.
 - b. A person threatens to harm another.
 - c. There are indications of abuse.

When any of these possibilities emerge in a conversation, the HospiVision supervisor must be informed and further appropriate steps taken in consultation with the supervisor.

I have read, understood and agree to the content of this Confidentiality Agreement.

Signed:

Date:

Annexure 9: Interview schedules

9.1. Interviews with HV staff

1. Personal details

- 1.1. Name:
- 1.2. Function:
- 1.3. How long have you been working with HV?
- 1.4. What is your involvement with the volunteers?
- 1.5. How long have you been involved with the volunteers?
- 1.6. In one sentence, can you tell me what comes to mind when you think about the volunteers working within HV?

2. Purpose of the programme

How would you describe the goals of the volunteer programme?

- 2.1. To what extent are these goals being met?
- 2.2. What feedback do you receive from the volunteers themselves? From the medical staff?
- 2.3. What might be reasons why some of the goals are not being met?

3. Role of the volunteers

Can you describe for me the role of the volunteers in this programme?

- 3.1. What is the extent of their responsibility?
- 3.2. What is going well, in working with the volunteers?
- 3.3. How would you describe the competent volunteer?
Experience level, spiritual maturity, knowledge, skills, etc.
- 3.4. How does the programme impact the volunteers themselves?

4. Challenges

What do you perceive as the biggest challenges of the volunteer programme?

- 4.1. What are the challenges for you as staff working with the volunteers?
- 4.2. From the feedback you receive from the volunteers, what are their main challenges?

5. Role of the organization

How would you describe the role of HospiVision with the volunteer programme?

- 5.1. What are her responsibilities toward the volunteers? (What should and should not HV be doing?)
- 5.2. How do you feel about the current...
 - 5.2.1. Selection process of volunteers?
 - 5.2.2. Training of volunteers?
 - 5.2.3. Supervision of volunteers?

6. Final questions

Is there anything else you want to say or remark about the functioning of volunteers within HV?

9.2. Interviews with HospiVision volunteers

1. Personal details:

- 1.1. Name:
- 1.2. M/F:
- 1.3. Age:
- 1.4. Ethnicity:
- 1.5. Denomination:
- 1.6. How long have you been working with HV?
- 1.7. How often do you come in to the hospital for visits?

2. Cases:

Can you tell me about two of your volunteering experiences, one which went well and one which did not go so well?

- 2.1. What happened?
- 2.2. What role did you play?
- 2.3. What helped you deal with the situation? Or what did you lack to adequately deal with the situation?
- 2.4. What is it in this situation that motivates you to continue your volunteer work? Or what discourages you?

3. Motives

- 3.1. What motivated you to become involved the HV pastoral care and counselling volunteer programme?
- 3.2. What keeps you coming back to the hospital to visit with patients?
- 3.3. What would be a reason for you to stop coming?

4. Experiences of volunteer programme

How have you experienced working for as a volunteer for HV?

- 4.1. What is your intended goal in visiting patients?
- 4.2. What are some of the frustrations you encounter?
- 4.3. How has volunteering impacted your faith and changed how you think or do things?

5. Experiences of organization HV

How do you feel about the support and guidance offered to the volunteers by HV?

- 5.1.1. What helps you most?
- 5.1.2. In what ways would you like to see the support change/improve?
- 5.1.3. Training:
 - 5.1.3.1. Have you attended any additional courses? If so, which ones?
 - 5.1.3.2. If not, what would be reasons holding you back from attending additional courses
 - 5.1.3.3. How do you experience the weekly training?
- 5.1.4. At what moments do you feel valued as a volunteer?

6. Recommendations

Do you have any recommendations for improving the volunteer programme?

Is there anything else you would like to add?

9.3. Interviews with medical staff

Personal details:

- 1.1. Name:
- 1.2. Gender:
- 1.3. Ethnicity:
- 1.4. Function:

Questions:

2. Are you familiar with the work HV volunteers do?
 - 2.1. How did you hear about HV?
 - 2.2. Do you have HV volunteers which come to your ward?

3. How do you evaluate the work HV volunteers do?
 - 3.1. What have been your experiences with HV volunteers?

4. Would you refer patients to HV?
 - 4.1. Why or why not?

5. Do you have any recommendations for HV?

Annexure 10: Examples of the letters and consent forms for the interviews

The interviewed volunteers and medical staff received a letter and signed a consent form.

10.1. Consent letter volunteers

Dear HospiVision volunteer,

We are currently evaluating our volunteer programme. This is done by Hanna Snetselaar, a Dutch student, who is conducting a research project.

The evaluation consists of interviews with HospiVision staff, volunteers and medical staff. We are interested in how you experience the programme and what we can do to improve it.

Hanna will conduct an hour interview with each of you based on a specific set of questions.

No person details will be captured or used in any of the reports.

You will also receive a copy of the final report for you input.

Thank you for your co-operation.

You can contact me directly if you have any questions.

Kind regards

Dr. Andre de la Porte
Managing Director HospiVision
Tshwane District Hospital
012-3299492

10.2. Consent form volunteers

I (Full name).....

ID Number.....

Hereby consent to take part in the assessment of HospiVision’s volunteer programme.

I understand that no personal details will be captured or used in any of the reports.

I will also receive a copy of the final report for my input.

I have received a copy of the introductory letter explaining what the programme is about.

Signature

.....

Date

.....

I have received R30-00 travel reimbursement.

Signature

.....

Date

.....

10.3. Consent letter medical staff

Dear sister,

We are currently evaluating our volunteer programme. This is done by Hanna Snetselaar, a Dutch student, who is conducting a research project.

The evaluation consists of interviews with HospiVision staff, volunteers and medical staff. We are interested in how you experience the presence of HospiVision volunteers in your ward and what we can do to improve it.

Hanna will conduct an interview of approximately fifteen minutes with each of you based on a specific set of questions.

No person details will be captured or used in any of the reports.

You will also receive a copy of the final report for you input.

Thank you for your co-operation.

You can contact me directly if you have any questions.

Kind regards

Dr. Andre de la Porte
Managing Director HospiVision
Tshwane District Hospital
012-3299492

10.4. Consent form medical staff

I (Full name).....

ID Number.....

Hereby consent to take part in the assessment of HospiVision's volunteer programme.

I understand that no personal details will be captured or used in any of the reports.

I will also receive a copy of the final report for my input.

I have received a copy of the introductory letter explaining what the programme is about.

Signature

.....

Date

.....

Annexure 11: Examples of the analysis

A sample of the analysis process is given below.

During the first stage, notes were taken from the recordings and placed under the appropriate questions. They were then coded.

	How have you experience working as a volunteer for HV?	What is your intended goal in visiting with patients?
A1		<p>Motivate: To motivate the people, to say that is not the end, there is light at the end of the tunnel.</p> <p>How: <u>by speaking to the people</u>. (Says: 'No don't say that, ...don't stop now here. Carry on, carry on. I know, tomorrow it is a better day.')</p>
B2	<p>HV is a very good place to work.</p> <p>Unity and love: He sees the people in HV are <u>one</u>. They <u>work together</u> and have <u>love for one another</u>.</p> <p>Fellowship: Whenever the volunteers come together they <u>encourage</u> each other and <u>pray</u> for one another, enjoying a very good time of <u>fellowship</u>.</p>	<p>My intended goal is to pray for them, give them hope.' *Pray for the patients</p> <p>*Read the Scriptures: The Bible, God's Word, is the <u>tool</u> he uses. His own words won't make a difference, put input in their lives. So he comes to share God's Word, to encourage the patients.</p>
C3	<p>Community: The communion with other volunteers is special to him. The volunteers <u>share certain things</u>. In general, they see their work as a calling, the want to share hope with patients and encourage them, and they have compassion.</p> <p>The volunteers are <u>like a small family</u>. This means something to this volunteer. He looks forward to seeing the others on Tuesdays.</p> <p>Patients: Seeing patients <u>really have hope and trust God in their circumstances</u>, is also important to him.</p>	<p>Not one specific goal: He takes it on the day and see what happens. It's not always the same. You don't meet the same people, and that makes it interesting. <u>One just does not know what may be needed</u>.</p> <p>Ex of needs:</p> <p>Clothing: Patient that really needed clothing. Like one patient who was burned by fire and was worried what he would put on when discharged. HV has donations of second-hand clothing, which volunteers can help patients with.</p> <p>Food: Another patient had an operation. When he was permitted to eat and drink again, he really wanted to eat some chips or just drink a coke. As a volunteer, you then can go down to the cafeteria to get him something.</p> <p>Phoning: A patient may not have a cell phone, making it difficult for him to call his relatives. As a volunteer you can help him with that.</p> <p>Talking: Sometimes the volunteers just talk to people in general. They appreciate it. Sometimes they get so</p>

		<p>preoccupied with their illness and the hospital environment; talking to someone in general, helps distract their mind from their illness. Often you see they really appreciate that you were just there.</p> <p>Spiritual care: Sometimes you get deep spiritual conversations.</p>
D4	<p>She just enjoys it.</p>	<p>Presence: to <u>be there</u> for the patients and <u>help in whatever way</u>. Sometimes is <u>prayer</u>. Sometimes that is <u>just to listen</u>. Patients share a lot with the volunteers, including their problems.</p> <p>Practical support: Sometimes <u>practical help</u>, if they need anything. Like some bread, or to make a phone call.</p> <p>Witnessing: She feels she has a <u>responsibility to speak to patients about the Lord</u>. If they die, where will they go? She will not force anything on anybody, but to know you are there for them. She won't offend, but wants to give patients the opportunity to choose. She's not there to preach but if the opportunity is there she will witness.</p>
E5	<p>A very positive experience.</p> <p>Encouragement: They get a lot of encouragement <u>from the people in charge</u>.</p> <p>Weekly training: A real blessing and motivation are the times of <u>bible reading</u> and <u>prayer</u> together. It's always a motivation to go out and do whatever you can.</p> <p>Family: The volunteers of HV almost feel like family. (also motivates)</p>	<p>*Mere encouragement</p> <p>*Showing love</p> <p>*Showing sympathy: But <u>not too much sympathy</u>. You don't want to make people feel even more sorry for themselves. *Focus on the positive: Instead you try to take their minds <u>to another place where things are better/positive</u>, where things change for the better.</p>

<p>F6</p>	<p>Good. There are different aspects to the work (different experiences): wards, then tea at the office. *Learn from each other: She says they learn from each other as they <u>share many of their own life experiences</u> together after coming back from the wards. and we are hear, just from our own experiences. *Friendships: They build so many good friendships.</p>	<p>*Show God love: She thinks that normally most people who are sick, are angry, some even at God. She aims is to show that in their sickness, God loves them. How: <u>In different ways</u>, depending on the <u>situation</u> and the <u>Holy Spirit's guidance</u>. (Always guided by the HS; prays that whatever she says will touch the patient.) Ex. In Angeliek's case, she thought she must <u>deal with the unforgiveness</u> toward her mother. Ex. Some patients are too sick to talk to. But then the HS may tell her <u>just to be there and pray</u>. so i just stood there and prayed. so I'm just relying on the HS to guide me. Ex. Sometimes it's not even speaking, but <u>listening/letting the patient vent</u>.</p>
<p>G7</p>		<p>*Show God's love: If the patients can <u>only grasp the love of Christ</u>, even if they die, they are in safe hands. Our love for Christ is not dependent on answered prayers, but on knowing His love for us is enough. Despite circumstances, we can hold onto His love. If they fail to see Christ, she will not have met her goal. *See people mature in Christ: She sees it as her duty to make the patients <u>mature in Christ</u> so that they will be <u>able to deal with their problems</u>. <u>Patients tend to face a serious crisis, especially when facing life threatening diseases. They lose all hope, waiting for death.</u> *How: By her <u>mere presence</u>. Merely by her leaving her place, giving time she could have invested in her NPO, to sit with patients, <u>listen to their needs</u>, try to <u>encourage</u> them. She cannot give money/material things, but can give time to listen. She can help them with their <u>spiritual need</u> and is happy to help them <u>find sources</u> to help with other needs. (Refer to doctor, psychologist, etc.; not a superhuman able to meet every need.)</p>

<p>H8</p>	<p>It is a <u>blessing to me and to those who love the Lord.</u> <u>Many people, even the medical staff, appreciate HV's presence.</u></p>	<p><u>Presence:</u> For <u>patients not to feel alone</u>, as if nobody think about them. To let them know someone feels for them, is praying for them.</p> <p>Some patients come to hospital for couple days/weeks without their family members knowing and <u>without getting any visitors.</u> (Ex. Patients from SA's sister countries (Zimbabwe, Mozambique, Nigeria, etc.) The HV volunteer can be such a <u>blessing/make a big difference, bringing such a great healing to his soul.</u></p> <p><u>Illustration of a tree:</u> A tree may not look well. You can take medication and sprinkle that tree, trying to get it healed. But you must pour water on the ground. That tree will take that water, and immediately, within 2 hours, you will see that tree getting well, getting life. The problem was within, there were no food. Once the tree is feed, the outside will look beautiful. <u>A patient doesn't only need some medications but sometimes needs spiritual food. If you give spiritual food, you will see him come alive from within.</u></p>
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The next step was to categorize the answers and group together those answers which were similar. Colour coding was used to be able to distinguish which answers came from which interviews.

<p>Intended goal in visiting patients</p>	
<p>*To motivate (encourage); to bring hope *To give hope (encourage) *Mere encouragement</p>	<p>*By <u>speaking</u> to the patients, telling them this is not the end. Carry on. Tomorrow is a better day. (hope) *By <u>praying with the patients.</u> *By <u>reading from Scriptures with the patients.</u> Not his own words, but God's will encourage.</p>
<p>*To do what is needed (not one specific goal) *Presence *Presence</p>	<p>*<u>Supplying clothing, fetching snacks, helping with phone calls to relatives, chatting, or spiritual conversations.</u> *To be there; help in whatever way. Can be prayer, listening, or practical support (snacks, phone calls, etc.) *For patients <u>not to feel alone</u>, as if nobody think about them. To let them know someone feels for them, is <u>praying for them.</u></p>
<p>*Witness</p>	<p>*Feels it her responsibility to speak to patients about the Lord. Not giving offense, but giving the opportunity to choose.</p>

<p>*Showing love *Showing sympathy *To show God's love *To show God's love</p>	<p>*But <u>not too much sympathy</u>. You don't want to make people feel even more sorry for themselves *To show that God loves them, even in illness, through many different ways, depending on the situation and the Holy Spirit's guidance: just <u>being there, listening, praying, addressing issues</u> such as forgiveness. *A love not dependent on circumstances, by <u>presence</u> (giving time), <u>listening</u> to needs, <u>encouraging</u>, helping with <u>spiritual needs</u>, finding <u>resources</u> for them (referrals).</p>
<p>*Focus on the positive</p>	<p>*To <u>take their minds to another place</u> where things are better/positive, where things change for the better.</p>
<p>*To see people mature in Christ</p>	<p>*So that they will be able to deal with their problems</p>

Annexure 12: Interviews Themes

With approximately 13 hours of conversation, the interviews gave me a large amount of data. Not all the data was relevant for this research or could be further developed in this report. In my discussion of the results of the interviews and the conclusions and recommendations I make, I have focused on what I felt were the key points that needed to be addressed. However, also the themes which may not have been further developed in this report, valuable information for HospiVision. It will be up to her to further unpack this data. My analysis of the interviews will be made available to HospiVision in a separate document.

Below are a list of the themes the came up during the interviews.

12.1. HospiVision Staff

- Goals of the volunteer programme

The goals are to enlist more people to reach the patient as well as to support those people.

- Role and responsibilities of HospiVision toward her volunteers

The organization creates the platform for the volunteers to fulfil their calling. She is responsible for the screening, training and supervision of the volunteers. Her care includes spiritual and emotional care, the fostering of personal growth and development and helping people to connect as a community. Financial support was also mentioned.

- Screening

The setup is good. Improvements could be made concerning the clarity with which the process is communicated to candidates as well as the implementation itself. Staff differ in opinion on who strict the screening should be. One mentioned possibly adding personality tests to the procedure; another felt that everyone should be given a chance.

- Courses

The courses are excellent but expensive. Attendance by volunteers is low. Possible reasons include finances (main reason), time or unwillingness (Holy Spirit's training is enough). Others use the certificates to get jobs outside of HospiVision.

- Training

Volunteers are being equipped, built up and encouraged. They learn from each other. Improvements could be made in the areas of structure/coordination, continuity and attendance. Some volunteers do not comply to what is taught with the excuse: 'The Holy Spirit led me...'

- Supervision

The relationships among staff and volunteers are good; there is openness to share. The statistics are well monitored. Improvements are needed in the amount of attention the volunteers receive, the qualitative evaluation (more direct), individual care/debriefing, and discipline. The staff lack time. Volunteers do not always make use of the opportunities to receive supervision. Little negative feedback is given by volunteers; they rather focus on the good.

- Role and responsibilities of the volunteers

Relational support, practical support, loving, caring, encouraging, sympathizing, listening, signalling, bridging the cultural gap, and just being present. Some emphasised the emotional support, others the spiritual. Their conduct is important. They are not expected to give professional care. The spiritual care must be suited to the hospital setting, which is different from the congregational setting.

- Characteristics of a competent volunteers

Volunteers need a certain level of spiritual and emotional maturity. Various character qualities as well as skills were mentioned, both those that are a mark of competence and incompetence.

- Feedback from volunteers

In general, feedback is positive. They see the value of their work, as patients and their families are being encouraged and given hope. People are coming to know Christ as well. Frustrations include rejection by patients or staff and transportation.

- Feedback from medical staff

The medical staff generally appreciate the volunteers. They appreciate the availability of HospiVision and refer patients often. At TDH, HospiVision has a very good relationship with the CEO.

- Strengths

Good relationships between the staff and volunteers, the volunteers themselves and the volunteers and guests; volunteers feel valued and make themselves available; they are growing and developing; they bridge the cultural gap; and the administration of the volunteers is well done.

- Challenges for staff

Inflexibility and arrogance of volunteers, their turnover, their lack of commitment/consistency volunteers, irregular attendance of training, lack in numbers. Lack of time and staff affect the supervision. Sometimes complaints come; having to correct is not nice. Sometimes visitors not going through HospiVision are the trouble makers.

- Challenges for the volunteers

Finances, rejection by patients, feelings of failure if they do not read the Bible and pray, witnessing suffering and dealing with theological questions they cannot answer, wanting more attention, feelings of uncertainty, negative attitudes of medical staff, crossing cultural barriers, taking offense concerning decisions HospiVision makes.

Three themes that came up often in connection to various themes were:

- Time

Staff are too busy, to give adequate attention to the volunteers.

- Capacity

There are too few volunteers and staff.

- Finances

Volunteers struggle to pay transport, let alone additional courses.

12.2. Volunteers

- Motives

Volunteers shared their stories of who they became involved and what keeps them coming back. Motives were related to God, to HospiVision and the patients.

- Discouragements

Several claimed nothing discourages them or would stop them from coming. Others indicated that seeing suffering, being rejected by patients can be discouraging. They would stop coming due to personal health, negative treatment by HospiVision or emergencies.

- Frustrations and challenges

Narrow mindedness of patients, poor medical care, more needs than one can meet, feeling uncomfortable with the volunteer one must accompany, the application procedure, finances, putting in the extra effort, rejection by patients, cultural differences, and communication challenges.

- Intended goals in visiting

To motivate, encourage, be present, witness, show (God's) love, sympathize, distract from sickness, see people mature in Christ.

- Impact on faith and thinking

Growth and strengthening of faith, awareness of need, broader views of life, better understanding of patients, a change in approach.

- General working experiences

Very positive. Unity, love, fellowship, encouragement from staff and patients.

The volunteers related some of the experiences they had. They described the roles they played, what helped them and what they missed:

- Roles they fulfil

Read Scripture and pray, encourage, give perspective, be present, listen, share testimony, accept patient, intercession, informing and comforting family.

- What helped them

Past experiences, relationship with Christ and what He gives, the positive attitude of the patients, the support from HospiVision (training) and the other volunteers, volunteer badge (recognition of position).

- What they missed

Training (not done course yet), time/follow up opportunity, gift of healing, skills to speak about God without giving offense.

- Support

Positive: They mentioned the trainings, the good relationship with the staff, the personal support they can get, and the opportunity HospiVision gives them. In general, they were very positive about the support.

Most helpful: the pastoral care available for volunteers, the availability of staff, their example, the trainings session, the fellowship with other volunteers, the course and the platform HospiVision creates.

Negative: a lack of clarity on the approach HospiVision expects and a situation in which the volunteer felt her presence did not matter.

Improvements: Nothing in particular, financial support, commitment and practical involvement, more appreciation, more clarity, shadowing new volunteers must do, the application procedure.

- Tuesday training

Helpful, motivating, relevant, good reminder, learn a lot, guidance. They especially appreciate the Bible reading, the prayer, and the discussions/sharing experiences. They all spoke very well of the training.

- Courses

All were asked how many and which courses they did. Things that held them back from doing more include: finances, time, age/maturity level and personality.

- Feeling valued

When needed and recognized, through the fellowship, the training session and the expressed appreciation of the patients (smile, thank you), the staff (breakfast) and the medical staff (invitation to lead Bible study).

- Recommendations

More volunteers, more prayer, financial support, application procedure, management of dress code and conduct in wards, more information on the wards.

12.3. Medical Staff

- Familiarity with HospiVision

All four were familiar with HospiVision and had HospiVision personnel visiting their wards. They heard about HospiVision from the volunteers themselves, from the Hospital management or through studies.

- Evaluation

The volunteers are doing a good/excellent job and really do help the patients. HospiVision is well accessible.

Patients respond positively to the encouragement and support. Volunteers are helping out practically, by giving referrals, and through counselling.

- Referrals

They would refer patients to HospiVision because HospiVision helps the medical personnel, is easily accessible, has a variety of help resources, gives spiritual support and prayer, has time to listen and gives psychological help/counselling.

- Recommendations and questions

To keep up the good work. To continue praying with patients and bringing Bibles. The sisters asked: Who are the volunteers (background, experience)? Can they see out patients? Who supplies the Bibles? Can they support medical staff also?