ZOE (Zimbabwe Orphans through Extended hands) is training volunteers from local churches across Zimbabwe to help care for thousands of children orphaned because of AIDS.

Tearfund is a UK-based Christian relief and development agency with over twenty years experience working with churches and faith-based partner organisations in the response to HIV. Tearfund invested US $5.5 million in HIV work in 2006–7 and currently supports over 130 HIV projects, spanning prevention, treatment, care and support. Tearfund’s vision is that by 2015, in the communities where Tearfund and its partners work, the spread of HIV will be halted and the impact reversed.

This ambitious vision is based on the potential of the local church to play a distinctive role in the response to HIV.1 Tearfund seeks to mobilise and invest in the local church to realise this potential. It aims to link local churches and civil society worldwide to work together with international agencies and governments to enable a more effective response to the pandemic.

1 Working Together? Challenges and opportunities for international development agencies and the church in the response to AIDS in Africa
Taylor N (2006) Tearfund
www.tearfund.org/tilz
Introduction

There is a growing recognition among international development agencies and governments that faith-based organisations can play a critical role in poverty reduction, particularly in the response to HIV. Local churches across the world are already responding to HIV in their communities but their contribution often goes unrecognised and unrecorded.

These three case studies document church-based responses to the AIDS pandemic in three different countries – Zimbabwe, India and Ethiopia. They illustrate different approaches to working with and through the local church to effectively impact local communities, and examine both the challenges and the advantages of such responses. They aim to share learning, to provide examples of good practice, and to encourage churches and other organisations to work together to scale up their responses to the pandemic.

Zimbabwe

In Zimbabwe, ZOE (Zimbabwe Orphans through Extended hands), a small Christian organisation, has been mobilising and training volunteers from local churches to support children orphaned by AIDS in their communities. As the situation in Zimbabwe is rapidly deteriorating, ZOE is working with local churches to respond to the political, social and economic crisis, such as by distributing food to the most vulnerable through its network of churches and volunteers.

India

In Mumbai, India, local churches and faith-based organisations such as IMCARES (Inter-Mission Care And Rehabilitation Society) work together in an effective network, sharing learning, good practice, and coordinating responses across the city. Volunteers for IMCARES’ HIV work in the community come from local churches.

Ethiopia

The Kale Heywet Church (KHC) is a large and well-established national church denomination in Ethiopia. It is responding to HIV through its Medan ACTS programme, which operates as a registered non-governmental organisation (NGO), delivering services such as voluntary counselling and testing (VCT) and prevention of mother-to-child transmission (PMTCT). It involves local KHC churches in raising awareness and providing services.

Tearfund seeks to facilitate greater understanding of the significant contribution of the church in response to HIV. These case studies show how international funding agencies, governments, local faith-based organisations (whether Christian NGOs or large church denominations) and local churches are already working together to respond to the pandemic.

2 DFID, faith and AIDS

a review for the update of Taking Action, Taylor N (2007) UK Consortium on AIDS & International Development

'It is widely recognised that faith organisations are at the forefront of providing health services, particularly to marginalised communities that otherwise would be unreached.'

DFID, faith and AIDS

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These case studies highlight the unique potential of the local church to respond effectively to HIV within the community, and some of the diverse ways that local churches in Zimbabwe, Ethiopia and India are already responding. They also show the challenges and limitations of these responses, and how they can be addressed.

**Reaching communities**

The Christian church represents an independent civil society network already established at both grassroots and international levels. It has the potential to mobilise large numbers of volunteers and coordinate responses to HIV across local and national networks. Tearfund partner organisations connect with more than 15 million Christians in the South. Local churches are already involved in communities that governments and development agencies find hard to reach such as remote rural areas and slum communities.

**Sustainable responses**

Local churches are already responding to the needs of their own communities, often without much external financial support. NGO projects are usually short-term interventions, but the local church remains in the community for the long term. This sustainability is particularly important when responding to children orphaned because of AIDS, who need holistic long-term care and support. Many local churches face challenges around lack of resources, but giving (both time and money) is seen as a practical outworking of faith. Individual church volunteers are motivated by faith rather than financial incentive, which means they tend to persevere despite few resources and difficult circumstances. The church also provides a ready-made support network and encouragement for care-givers.

**Providing care**

The strength of local churches is not simply as a service delivery mechanism or a replacement for government health service provision. Although some large church denominations such as Kale Heywet Church in Ethiopia do have the capacity and infrastructure to provide professional health care services, this is beyond the capacity of most local churches, and is not the best response to the long-term health needs of communities.

Local churches can play a critical role in raising awareness and mobilising people to access services. Church congregations are a vital source of volunteers for providing long-term care and support in the community to people living with or affected by HIV.

In Ethiopia, Kale Heywet Church is raising awareness of HIV through youth clubs.
Speaking out

The authority that local churches and church leaders often have locally, and the national influence of large established denominations which represent thousands of member churches, mean that the church has an important role to play in local or national advocacy. ZOE’s work in Zimbabwe has seen local churches involved in advocacy around issues such as inheritance rights, addressing stigma and discrimination and protecting vulnerable children. In cases of child abuse, local church volunteers who are regularly visiting orphans are best placed to recognise and respond to the problems.

Transforming attitudes

Churches are often reluctant to openly discuss issues of sexual health or comprehensive prevention methods including condom use and needle exchange. It must be acknowledged that the church has often contributed to stigma and discrimination through harmful messages around gender and judgemental attitudes towards those living with or affected by HIV.

However, the church’s position of respect within communities, and its voice in shaping behaviours and attitudes, means that where churches are actively responding to HIV, they have the potential to transform attitudes within the community. Tearfund is working with churches and partner organisations to raise awareness and provide theologically-based understanding of issues of gender and evidence-based methods of prevention.3

Hope

Church-based responses do not just focus on beneficiary numbers or an individual’s medical needs, but provide a more holistic response. Local churches care for families, not just individual beneficiaries, and crucially this care and support continues through death and bereavement.

The psychosocial benefits of the sense of belonging and individual worth, and the hope that the faith community can provide to those living with or affected by HIV result in clear improvements in mental, physical and emotional well-being.

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3 Footsteps 69: Sexual health, Tearfund, (December 2006). Tearfund’s publications are all available to download from www.tearfund.org/tilz

4 African Network of Religious Leaders Living with or affected by HIV and AIDS. www.anerela.org

‘Church leaders have a position of influence in the community, so can help to change judgemental attitudes. We have a chance to speak out against stigma, to try to save lives and to give people hope.’

Rev Ayano Chule Deyabo, of ANERELA+®
ZOE, Zimbabwe

ZOE (Zimbabwe Orphans through Extended hands) works through the local church, mobilising and training volunteers to care for and support children in their communities who have been orphaned by AIDS. In Zimbabwe, HIV prevalence in adults is over 20%, and malnutrition, lack of access to antiretrovirals and other medicines are now contributing to a rising death toll. There are currently an estimated 1.1 million orphans, out of a population of 13 million.

Recognising that the scale of the orphan crisis is beyond the scope of individual NGO projects to adequately address, ZOE seeks to mobilise local church congregations across the country to respond to orphans in their own communities.

ZOE envisions church pastors who take the vision back to their local churches. The focus is on building relationships that provide love and care for the orphans. Some material needs are also met. This approach aims for grassroots mobilisation which means a wide reaching and sustainable response which does not require many external resources. ZOE encourages church leaders and provides training for volunteers and support in sustainable livelihoods for carers. Where there is outstanding need, ZOE will provide some extra financial support, but the aim is that local churches are self-sustaining.

The economic collapse in Zimbabwe means that local churches are now increasingly stretched beyond their capacity. ZOE is responding to the escalating humanitarian crisis by distributing food through its network of local churches. In such a difficult and highly politicised situation, working through the local church is one of the main ways to ensure that the food reaches the most vulnerable people.

Budget (2007): US $216,000 not including feeding programme

Achievements

- 3,800 volunteers are regularly visiting and providing support for 75,000 orphans and vulnerable children in the community.
- 1,200 churches have an active programme for visiting and supporting children orphaned because of AIDS and a further 800 churches are involved in giving out food and providing school fees.
- In 2006, 230 churches requested envisioning and training to better care for orphans.
- 284 families received livelihoods support in 2006 to help them become self-sustaining.
- Crisis response: feeding programme for 36,000 people over six months in 2006 and, due to reduced resources and increasing prices, for 9,500 people for six months in 2007. From December 2007, this will provide for 35,000 people for six months.


UN Department of Economic and Social Affairs (DESA) Population Division (2006)
Sustainability

ZOE is a small organisation with minimal structure, a small staff team and low financial input. This is intentional as ZOE believes that its role is not to implement projects but to be a catalyst – to mobilise, train and strengthen local churches to respond to the needs of the orphans within their communities. The aim is to ensure local ownership and long-term sustainability by encouraging local churches to take the initiative and raise resources.

From the beginning of the process of church mobilisation, ZOE makes it clear that it will not provide any substantial resources other than training. The local churches are expected to take responsibility for their volunteers and for supporting families. As the work has grown, rather than take on new staff, ZOE has trained some of the volunteer area coordinators (usually the local church leader who initially invited ZOE into the area) so that they can deliver the volunteer training in their local area.

Local response

The focus is on building relationships of love and care for the orphans, rather than providing financial support. Within the context of this relationship, the volunteers and the church will try to meet the needs they see. Wherever possible, the resources come from the local churches themselves although where there is still outstanding need, ZOE will try to help.

Churches raise money from church members to pay the orphan’s school fees and provide for their needs, often by having a separate collection basket at the back of church specifically for the orphans in the community, or by requesting members of the congregation to donate food and clothes. The volunteers are not paid anything and visit in their own time. Church members are encouraged to offer their skills to repair a roof or to prepare land for families who are in need.

In this way, the programme is not reliant on outside inputs, but mobilises the potential of the community to respond to its needs and is therefore sustainable and empowering. Because the volunteers come from within the community – they are generally neighbours – they are best placed to know the actual needs as they arise.

Process: Mobilising the church

ZOE’s model for church mobilisation is simple, easy to replicate and can take only three to six months from the church leader’s initial request for help, to volunteers visiting orphans.

1 Envisioning workshop for local church leaders

This consists of a one-day workshop offered to all church leaders in a local area after an initial request from a few. The workshop uses Bible studies and participatory training approaches to look at the role and responsibility of the church and the needs of local orphans. Most church leaders are already motivated to care for orphans but feel they cannot because they lack the financial resources. The workshop communicates the message that the first need of orphans is not physical resources such as food or housing, but love, care, support and nurture. These needs do not require financial inputs, but can be met by local, caring
people. This breaks attitudes of dependency and empowers the local community. Pastors return to their churches and share the vision with their congregations, and then draw up a list of volunteers.

2 Volunteer training workshop

The workshop is facilitated by ZOE staff or a volunteer area coordinator, with the venue and logistics organised by the local church. Issues covered include identifying orphans, making visits, keeping records, identifying needs, HIV awareness, and involving existing community structures.

3 Identifying orphans in the local area

The pastor and volunteers draw up a list of orphans in their local area who are most in need of support. The nature of the AIDS pandemic, and the current situation in Zimbabwe, with little access to adequate nutrition, antiretrovirals (ARVs) or other medicines, mean that when one parent dies the other often follows, or at least is sick or struggling. Many orphans are being cared for by elderly grandparents who may not be able to provide for them. The orphans range from 0–18 and include child-headed households. The families are not limited to those that belong to the church but come from across the community.

The accuracy of this initial list of families is very important. ZOE provides a basic assessment form for recording the families. The headings are:

- Family name:
- Family carer:
- Number of orphans:
- Mother or father or both died:
- Age: 0–1 / 1–5 / 5–18:
- Other relatives helping:

CASE STUDY

Releasing local potential

ZOE mobilises and encourages local people to support orphans in their community by emphasising that the most important resources are human capacity and not only financial input. At ZOE’s training workshops, volunteers are encouraged to see how they can contribute:

**HEART**: to love and care for orphans and families in need.

**EYES**: to observe needs, to see the soft brown hair and swollen hands and feet that indicate malnutrition, to see the hole in the thatch, lack of pots and pans in the home, to see signs of abuse.

**MOUTH**: to speak up on behalf of the orphans, to speak out against abuse and protect inheritance rights, to share learning and give advice, to ask people how they are, and to comfort them and pray for them.

**EARS**: to listen, to give orphans or elderly carers the chance to talk to someone and share their concerns.

**HANDS**: for providing practical help such as mending thatch, preparing ground for planting, cooking, cleaning, and teaching skills such as sewing or carpentry.

**FEET**: for taking messages, bringing provision, accompanying children to the clinic, and for playing sport or games with them.

The workshops make sure people understand that although these things cost nothing financially, there is still a price in terms of time and effort, and – particularly for those involved in advocacy – sometimes reputation.
It is essential that wherever possible, the extended family takes responsibility for their own orphans, so if relatives are already helping and providing care then the family will probably not be on the list. Volunteers ask the family and check with neighbours to find out the real situation. ZOE recommends that the number of families taken on should be appropriate to the size and resources of the local church, and no more than 30 families initially.

4 Visit programmes implemented by volunteers

Each volunteer should care for no more than five orphan families (fewer if that includes a child-headed household). ZOE recommends that they should live no more than 5km away, to ensure they are able to visit regularly. The volunteers aim to visit each family at least once a month and many visit more frequently. The fact that volunteers continue to visit regularly helps to reassure families of their commitment and care, which is psychologically very beneficial, especially if the household has been abandoned by the extended family.

The relationship is based on care, so is not dependent on financial resources, but the volunteers will also help practically where possible. When they visit, the volunteers seek to identify the needs, look for signs of abuse, listen, help practically, share resources, give advice on nutrition or accessing medical help, and pray with the families.

Volunteers are given a notebook and pen so they can keep simple records of each visit. Each time they note down the family name, the date of the visit, what they observed, what they did, and any needs. If the volunteer cannot write, there will usually be a child or family member who can.

5 Care for care-givers

Each month local church leaders and volunteers meet to share experiences, learning and problems, and coordinate local responses to needs. The volunteers bring their records to these meetings and report back and share any problems. This helps to ensure local church ownership of the work, and provides a support network for the volunteers. Other people from the community such as teachers and magistrates also attend and help to address any problems.

Developing local capacity

ZOE provides on-going training to equip volunteers to care for orphans and to encourage and strengthen local church responses. Training covers:

- **HIV** – basic facts about the virus, methods of transmission, how to address stigma, positive living, prevention of mother-to-child transmission and practical care such as planning a nutritional diet for someone living with HIV.

- **ABUSE** – aspects of physical, mental and verbal abuse, how to recognise it and how to effectively help the children to safety.

- **ADVOCACY** – speaking up to prevent abuse, and to defend the inheritance rights of orphans.

- **PSYCHOSOCIAL SUPPORT AND COUNSELLING** – counselling children and helping family carers to cope with bereavement and the issues they face.
FAMILY STRENGTHENING WORKSHOPS – covering issues such as parenthood, baby care and the importance of play.

TRAINING OF TRAINERS’ workshops for volunteer area coordinators, who go on to facilitate envisioning workshops and train volunteers. ZOE’s work has been so successful that there is now high demand from other local church leaders for training. Rather than take on new staff, ZOE trains selected volunteers to meet these needs.

Sustainable livelihoods

To enable orphan families to become self-sustaining, ZOE is investing in livelihood support. This includes training in conservation farming methods in rural areas, and providing funding for 227 orphans in urban areas to attend college courses.

ZOE also encourages micro-enterprise. Sixty orphan families have been trained in soap making, candle making and basic business management. Thirteen coordinators have received training in small business management so that they can now train families in their area in basic money management and marketing skills. ZOE has also distributed 251 goats and 2,500 chickens to selected families in 36 areas, and trained them in care of livestock.

Advocacy

Local churches are an integral part of the community and therefore are well placed to know the real needs on the ground and to speak up on behalf of the vulnerable. ZOE trains church leaders and volunteers to recognise and respond to orphans who are suffering abuse, and to raise awareness in the community about child rights. Volunteers are trained to check the physical condition of the children when they visit. Often children are too frightened to tell anyone, and those close to them may be either the perpetrators of the abuse, or dependent on the perpetrators, so the abuse continues. The church volunteer who visits regularly may therefore be the only one who is close enough to observe the effects of the abuse, and free enough to speak out on behalf of the child. Local church leaders, who have a position of respect and authority in the community, are able to intercede, to ensure the child receives medical attention, is placed with alternative carers, and to take legal action where necessary.

Birth certificates are needed to register children for school and for taking exams. When their parents die, and children go to stay with relatives, these documents are often lost. One church leader regularly goes into schools as a representative for these children, and persuades the schools to enrol them temporarily. He then works with the relatives to access birth records and replacement certificates from the local registry office.

Another problem is inheritance rights for property. The person who holds the parent’s death certificates can take ownership of their property, and many children who have been orphaned because of AIDS are left vulnerable to property theft by relatives. One church leader is currently looking after these documents for a child-headed household in his community, to prevent relatives taking away their home.

CASE STUDY

Child protection

A member of one local church alerted the pastor to a thirteen-year old girl who was being abused by her uncle, who was her care-giver. The family was reluctant to act, because it could damage the family’s reputation, and their neighbours were too afraid to help against the family’s wishes, but the church was able to speak out. The pastor took the girl to the doctor, and pursued the case, and the perpetrator was arrested. The family bribed the police to change the charges but the pastor, who had received training in advocacy, was able to lodge a complaint, and, supported by ZOE, took the case to court. He is now helping to look after the girl.

‘We need to strengthen the church in the short term, so that it can do the work in the long term.’
Pastor Promise Manceda
Responding to crisis

ZOE’s programme of church mobilisation has been very successful. However, Zimbabwe is a country in crisis. Malnutrition and lack of medicines are contributing to a rising death toll, and increasing numbers of children orphaned. Economic collapse means that people cannot afford basic commodities or school fees. Increasing national tension and 80% unemployment contribute to rising crime rates. Orphans are particularly vulnerable to abuse and property theft by relatives. Bad harvests and the escalating economic crisis now mean that many are facing starvation.

ZOE’s aim is that local churches are self-reliant and able to provide sustainable care for the orphans in their community. However, increasing external resources are now required. The level of need and the number of orphans is so overwhelming that local churches are now struggling to offer the most basic care through their own contributions. The escalating crisis in Zimbabwe has meant that ZOE has had to begin food distributions. This is the reality of working in an unstable environment; ZOE has found itself increasingly responding to crisis rather than facilitating the long-term development that is its primary aim.

Food distribution

The need for food distributions is increasingly urgent in both urban and rural areas. This was not part of ZOE’s original plan, but has increasingly dominated their work. The majority of beneficiaries are extremely vulnerable as they are too young, and their guardians too old or weak, to produce food or work for money, and so cannot sustain their livelihoods without external help. Bad harvests, closure of informal markets in urban areas, and the economic collapse make it increasingly difficult to survive as traditional coping mechanisms are breaking down. Many people feel that they would be facing starvation without these food distributions.

The benefits of food distribution are shared by communities through the informal social networks that often support communities in times of crisis. Without food distributions, many orphans were surviving on donations and handouts from relatives, volunteers and other community members. The food distribution means that these people no longer have to share their limited food supplies, and the orphans are ensured good nutrition.

CASE STUDY

Saving lives

Esinah Ndlovu is a widow caring for eight grandchildren. The oldest is 14 years old and the youngest just learning to walk. They harvested nothing this year, and as the economy collapses, the food distributions organised and administered by volunteers from the local church have become essential. Esinah says, ‘There have been many deaths and people are starving, without this food we would probably be dead by now. Only God knows what will happen.’

Esinah signing for her food distribution.
Food distributions also keep orphaned families together, as in times of food shortages siblings are often split between different households, or elder children are forced to leave home to find casual work in neighbouring countries to support their younger siblings. This inevitably has a negative psychological impact on children who have already experienced the loss of their parents.

Food distribution increases the demand on coordinators’ and volunteers’ time but it is appreciated because it enables them to address the children’s most urgent needs. Volunteers report that providing food strengthens relationships as it gives the children confidence that the volunteers really care about their welfare. However, as the crisis deepens, the volunteers themselves are increasingly strained, and are themselves in need of food.

As there are now many restrictions on NGOs operating in Zimbabwe and food distribution is intensely politicised, working with the local church is one of the main ways to ensure that support reaches vulnerable and marginalised people.

**GOOD PRACTICE**

**HAP-I’ beneficiary accountability**

Seeking to improve its monitoring and evaluation processes, ZOE has been implementing a pilot programme of beneficiary accountability according to HAP-I standards into its feeding programme activities. The one-year pilot has focused on three distribution sites. Before distributions, communities are informed through posters and community meetings about:

- criteria for selection of beneficiaries
- ration quantities allocated for each beneficiary
- timescale for distributions.

Beneficiaries involved in this pilot were empowered to decide on distribution sites and manage the food distribution themselves. There was also a ‘suggestion box’ provided at each distribution site for feedback. This was widely welcomed and used by communities. Community members reported that where they could not write down the feedback themselves, this was not a problem as they could find someone who could write their complaints for them.

Results so far have been positive and the pilot has since been extended to other sites and to cover issues beyond simply food distributions. Communities involved have valued the opportunity to take control of their own distributions, and to have a mechanism for feeding back complaints. This program has helped to address concerns and ensure that pastors are not using food distributions to encourage church attendance. It has improved the self-esteem of beneficiaries who no longer feel helpless and dependant, but are now actively involved in the decisions and distribution of the food. One child who is the head of her household reported that ‘it feels like they respect us now that they let us handle the food.’

Monitoring and evaluation

Monitoring and evaluation of the care for orphans has been difficult, as ZOE relies on reports from local coordinators. Coordinators are often church leaders who have many other commitments. Responsibility for monitoring and evaluation should be delegated to a volunteer who is good at record keeping and follow-up. Transport problems because of fuel shortages mean that it is increasingly difficult to collect data from rural areas. ZOE has now appointed a member of staff to support and strengthen monitoring and evaluation of the programmes.

7 Humanitarian Accountability Project – International
KEY LEARNING

Mobilising the church

ZOE’s work with orphans has led many local churches to recognise and accept the importance of responding to HIV, and to realise that even with limited resources they can make a difference in their communities. Seeing the vision carried out successfully at the local level has encouraged other local churches, who were initially reluctant, to get involved.

Local response

ZOE mobilises local churches to respond to the needs of orphans and vulnerable children within their communities. Because the church volunteers are local, they know the needs, are trusted, and can visit regularly. However, it also means they are affected by the same problems. As the situation in Zimbabwe becomes more difficult, local churches are no longer able to support the work and ZOE has had to increase its financial help and begin food distributions.

Changing attitudes

Where children cannot stay with relatives, either because there are none, or because there is abuse, some are being taken in by volunteers and coordinators. This is done after much discussion with neighbours and local leadership. It is unusual, as it has been a taboo in many areas to adopt someone who is not a family relation, and demonstrates how the local church is helping to transform attitudes.

Advocacy

The worsening situation in Zimbabwe has meant an increased emphasis on local lobbying and advocacy around birth certificates, need for ARVs, inheritance laws, school attendance, abuse. In cases of abuse, the children are often too frightened to tell anyone, and those close to them are often either the perpetrators, or dependent on the perpetrators, so the abuse continues. The church volunteer who visits regularly is often therefore the only one who is close enough to observe the effects of the abuse and free enough to advocate on behalf of the child.

Contact details

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Email: enquiry@tearfund.org

‘The church is the key agency for care, counselling, advocacy, in response to HIV. Support groups within the church can provide emotional, practical and spiritual care for people living with or affected by HIV, and for care givers.’

Jean Webster, founder of ZOE

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IMCARES, India

IMCARES (Inter-Mission Care And Rehabilitation Society) is a Christian NGO working with local churches in the poorest communities in Mumbai, India. There are an estimated 2.5 million people living with HIV in India.8

Mumbai is the economic capital of India, but more than 60% of its 20 million population live in the slums or on the streets. Mumbai is the capital of Maharashtra state, where HIV prevalence is amongst the highest in India. HIV prevalence for female sex workers in Maharashtra is reported to exceed 20%.9 Stigma remains high and those living with HIV are often abandoned by family and unable to access treatment in hospitals.

Since 1992, IMCARES has been running the IMPACT (Inter-Mission Prevention of AIDS Through Care and Training) project, responding to HIV in the slums of Mumbai. IMCARES aims to raise awareness and transform community attitudes towards people living with HIV, from stigma to acceptance. It is working to advocate for access to treatment and to enable the local church to help provide care for people living with or affected by HIV. Through working with local churches IMCARES is reaching hidden and marginalised populations such as slum communities, sex workers and eunuchs.

A distinctive feature of the church-based response to HIV in Mumbai is the way that local churches and Christian NGOs in the city have networked together and cooperate with each other to share learning, expertise and support, and ensure a more effective response to the HIV epidemic.

Budget (2007): US $186,000

Achievements

■ IMCARES staff and volunteers work with more than 1,200 children and adults every day, and reach around 15,000 indirect beneficiaries.
■ Clinics in slum communities provide primary health care for 6,500 patients.
■ Advocacy to uphold the rights of people living with HIV and combat discrimination to ensure access to treatment.
■ Awareness-raising about HIV, reaching more than 100,000 people every year through media and other campaigns.
■ IMCARES facilitates the CORINTH network in Mumbai (Christian Organisations’ Response in Networking to HIV/AIDS).

9 Ibid

IMCARES works among marginalised communities in Dharavi slum in Mumbai, India.
Working with the church

IMCARES is committed to working with local churches, particularly the small churches of the slums. IMCARES begins by meeting with the local pastors. If the pastors are interested, they must write a letter requesting IMCARES to come and work with their church. This activity ensures that the church committee has discussed and agreed to work with IMCARES, so that the church takes ownership of the work.

IMCARES provides training and advice to pastors and church volunteers, to enable them to respond more effectively to HIV. The response is therefore led by people who live in the community, who know and understand the local needs. One young mother who was receiving support did not want IMCARES staff to visit her home in case it raised community suspicion over her HIV status, but volunteers from the church were able to visit, because they were neighbours. Usually local church leaders already have an established and trusted voice among their community, and people will often come to the local church for help with problems. The churches can help to provide information and to link their communities with local NGO services.

IMCARES runs a one-year full-time Community Training Course (CTC) for church volunteers, to sensitise and equip the church to respond to HIV. The volunteers spend two months learning theory and attending training about HIV work and ten months gaining practical experience on the streets. Many of the staff of IMCARES and other local NGOs are former CTC students.

Many of those who were initially receiving care, such as those living on the streets, people living with HIV, or orphans and vulnerable children who have grown up in the IMCARES Agape Family homes are now actively involved and taking up leadership positions within local churches.

To help with monitoring and evaluation, IMCARES has adopted a diary system, where volunteers and staff keep a diary, briefly recording key events and learning from each day. The diaries help with writing reports and are kept to form a reference library of IMCARES’ work.

Networking

A distinctive feature of the church-based response to HIV in Mumbai is the cohesive, networked nature of the response. Rather than just isolated churches with an individual vision, or NGOs implementing separate projects, churches and NGOs are working together. The CORINTH (Christian Organisations’ Response in Networking to HIV/AIDS) network, focusing on HIV work, is part of the wider Mumbai Transformational Network which links together churches and Christian organisations across Mumbai.
focused on addressing poverty in the city. IMCARES is one of the founding members and currently coordinates the CORINTH network.

The network is largely informal and is made up of individuals, small local churches and larger organisations all working to respond to HIV. Members meet four times each year to share concerns, resources, learning. They update each other on their work and pray together. In many cases the directors of NGOs are themselves leaders of local churches, and most of the volunteers and staff are members of local churches so the relationships are personal, not simply professional, and based on shared values.

Groups are formed within the network to coordinate joint activities such as media events or awareness-raising programmes. At one meeting, IMCARES facilitated a mapping exercise of the city, to identify where the local churches are and what work they are doing. This has helped reduce duplication and encouraged a more strategic, cooperative

Raising awareness
IMCARES raises awareness around HIV through various means. These clocks, which feature the message ‘HIV? Do not fear, I am with you’ and contact details for IMCARES, were distributed to police stations and prisons.

Other strategies include sending SMS messages to local pastors, writing articles in a local weekly paper, and producing popular music videos with HIV messages. These Bollywood-style films are made in consultation with people living with HIV, and shown at churches, schools, street showings and broadcast on cable TV.
response rather than isolated interventions. Sharing learning, expertise and opportunities, and providing mutual help and support through this network ensures a more effective and comprehensive response to HIV in Mumbai.

Reaching the marginalised

IMCARES’ ‘Pavement Ministry’ involves volunteers spending regular time with people living on the streets. They sit with and talk to them in order to get to know them individually. The volunteers document each ‘contact’ and go back to visit regularly, providing food such as soup, cleaning and dressing wounds, or taking people to hospital where necessary.

It is the personal care that has most impact, as one contact said: ‘Our own family don’t do this. You are so loving to us, you have become like family to us.’ Stigma and discrimination mean that people living with HIV may be rejected by family and friends. In India, this isolation is often increased by the caste system, which designates some of the poorest people as ‘untouchable’. So when IMCARES’ staff and volunteers tend to the people they meet on the streets, and care for them with their own hands, it can help restore people’s sense of worth, and transform community attitudes by example.

IMCARES’ focus is on the quality of personal care rather than maximising beneficiary numbers. Building relationships gives the volunteers the opportunity to talk about sensitive issues such as HIV. Often they will accompany a contact to the VCT clinic. A government doctor may only have limited time for counselling, but the volunteers can spend time with...
IMCARES, India

Providing medical services and care to marginalised communities: the clinic in Charkop slum.

people after the test, to answer their questions and provide emotional support.

Through its work with local churches, IMCARES is able to access marginalised communities within the slums who are rarely reached by government services. IMCARES also works with sex workers and a number of hijra (eunuch) communities in Mumbai. HIV prevalence among hijras is high, and they are surrounded by stigma. For marginalised groups like this, and particularly for those who are dying of AIDS-related illnesses, there is no support network. Because of widespread stigma and conservative social attitudes around sex, politicians and policy makers in India are often reluctant to engage with these ‘hidden’ populations. In working with commercial sex workers and hijras, IMCARES and the churches it works with are breaking down barriers and enabling marginalised communities to access services.

Medical care

IMCARES medical clinics operate from the IMCARES Agape Community Care Centres within Mahim, Dharavi, Bandra, Kandivali and Charkop slums. They provide voluntary HIV testing, pre- and post-test counselling, bereavement counselling and medicines. They charge a small fee for the medicine, as they have found that this means that people will value it and complete the course of treatment. Since the government has begun to provide affordable VCT, and ARVs are now available, IMCARES now focuses on advocacy and helping patients to access these government medical facilities. However, for many people in the slums, transport to government hospitals remains a problem, especially when they are sick, so these local clinics enable them to access medical help.

IMCARES provides home-based care and nutritious food where needed to people living with HIV.
are also support groups for people living with HIV that meet at the clinic. If they wish, clients at the clinic are linked into local churches to help provide long-term support, but there is no requirement to join a church.

The clinic in Charkop slum was begun in 1992 as a local church initiative, supported by IMCARES, to provide medical care and advice to the local community, many of whom have no means to travel from this area to the hospitals in the city centre.

The clinic offers basic health care, medicines, and testing and counselling for HIV. A local doctor holds free clinics on four afternoons each week. He also trains volunteers from local churches as counsellors and health educators. As well as volunteering at the clinic, they raise awareness about HIV and sexual health issues in the community where they live, in their church groups and among those they work with. Around 60 people living with HIV regularly attend the clinic. If someone misses a number of appointments, then a volunteer will visit their home to check they are well.
Addressing stigma

Much of IMCARES’ HIV work has focused on addressing stigma and discrimination against those living with HIV, particularly around access to treatment. Many hospitals were initially reluctant to admit patients with HIV. They would keep them in isolation and refuse to dress their wounds. Sometimes hospitals would even discharge patients with HIV, particularly those brought in from the streets or slum communities, who have no family to support them. Now, church leaders and IMCARES staff often accompany patients into the hospital, to ensure they are admitted and cared for.

It has been important to raise awareness and address fears and misconceptions within communities in order to ensure the rights of those living with HIV, such as access to communal water supplies. Widows often lose their homes to their husband’s family when he dies of AIDS-related illness. CORINTH network members include lawyers, so collectively there is the capacity to respond to legal issues such as those related to inheritance rights.

Attitudes within the church

Attitudes within the church have also needed to be transformed. Many church leaders were initially judgemental and reluctant to engage in the response to HIV. Although this has improved over time, and through increased awareness, there is often still a reluctance to speak about issues of sexual health and comprehensive prevention strategies including condom use. Tearfund is working with partners such as IMCARES to challenge and engage local churches on these issues.

Lack of resources

In many slum communities, levels of poverty and lack of access make an effective response to HIV difficult. Even when medicines are available, if people are sick and cannot work, then there is no money for food. It is important that people who are taking ARVs have adequate nutrition. The communities are isolated and so it is often difficult to access NGO or government health facilities, particularly for the sick.

However, IMCARES’ work has demonstrated that small churches in poor communities have the capacity to offer support to those living with or affected by HIV. In one slum community there was a widow who was living with HIV who attended the church clinic. The church leader took her to hospital and she was admitted, but she later died. Donations from church members helped pay for the funeral. Her daughters (aged 13 and 15) wanted to stay in their own home, so the local church is now providing some money and food each week to enable them to stay. A woman from the church has moved in to live with them. She helps to cook food and pays some rent to help support the family.
Sustainability

IMCARES works in partnership with local churches to ensure sustainability and local ownership of the work. The aim is to eventually hand over all of the work to the local church, so it always has a higher profile than IMCARES during the project life. In fact, a recent external evaluation of IMCARES’ community work found that people in the community had not heard of IMCARES – they only knew of the church related to the project.

Wherever possible, those identified through the clinics or Pavement Ministry are linked into local churches so that long-term support is available, but there is no requirement to join the church.

Reaching communities

IMCARES can respond more effectively to HIV in the community because it works through the local church, which is already an integral and long-term part of the community. This is particularly important for reaching marginalised communities, such as those who live on the streets or in the slums of Mumbai, who have little access to government services.

Changing attitudes

The church has the power to shape values and attitudes. Lack of awareness and judgmental attitudes within the church have often meant that people living with or affected by HIV have suffered discrimination and rejection. However, when the church welcomes and cares for people living with HIV among the congregation, it can dramatically influence local attitudes and combat stigma. In one slum community, the whole church came to the funeral of someone who had died from an AIDS-related illness. This public show of support helped to transform local attitudes.

Providing community

A distinctive benefit that local churches can provide is the sense of belonging to a community. This can restore hope and self-worth for people living with HIV, who may have experienced rejection from family and friends.

Personal care

The local church responses in Mumbai are characterised by the personal care provided. In India, this is highlighted by the realities of the caste system, which designate some of the poorest and most vulnerable as ‘untouchable’, but across the world, stigma and discrimination mean that people living with HIV are often rejected and uncared for. In this context, when church volunteers reach out and with their own hands care for the dying or the destitute, it can help transform community attitudes, as well as restoring dignity and identity to those they care for. IMCARES’ clinics and Pavement Ministry emphasise giving quality time to each person, and building relationships, even if that means taking on fewer cases.

Networking

The church-based response to HIV in Mumbai is made more effective by the way local churches and Christian NGOs in the city cooperate in a network to share learning and expertise, to avoid duplicating work and to support each other.

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The Kale Heywet Church (KHC) is a well-established denomination in Ethiopia, consisting of over 6,000 local churches and over five million members. This large church structure means that KHC has a voice and credibility at local and national level, and the ability to mobilise considerable human and financial resources.

KHC coordinates a wide range of development programmes including its response to HIV: Medan ACTS (AIDS Control, Treatment and psychosocial Support). Medan ACTS programmes function as registered local NGOs and deliver high quality medical services such as voluntary counselling and testing (VCT). KHC’s established network of local churches is a source of volunteers for the programmes and enables a wide dissemination of information at the grassroots level. It also provides the opportunity to replicate and scale up responses nationally. KHC involves local churches in delivering services such as home-based care, as well as raising awareness about HIV and encouraging access to VCT.

Although there has been an increase in funding available for responding to HIV in Ethiopia in recent years, there remain huge gaps in service delivery, particularly in rural areas. Only 7% of people living with HIV who require antiretrovirals (ARVs) receive them, and only 0.3% of pregnant women living with HIV are receiving the ARVs they need to prevent transmission of HIV to their child. Churches in Ethiopia have a history of providing help and care where there is no national government provision.

KHC has a high profile within Ethiopia and the respect of local government, and is known for its response to HIV, particularly through its work in preventing mother-to-child transmission (PMTCT). KHC has been granted a government contract to provide PMTCT services for the whole of Addis Ababa. KHC demonstrates how a large church denomination can play an important role in responding to HIV at both local and national levels.

Budget (Jimma Medan ACTS, 2004–8): US $550,000

KHC’s established church structure has enabled the Medan ACTS HIV programme which was piloted in Jimma to be replicated nationally. There are now eight Medan ACTS programmes across Ethiopia.

Medan ACTS projects provide services to over one million people.

Since 2004, 4,134 people have received voluntary counselling and testing at Jimma Medan ACTS VCT centre, and in 2006, a further 1,546 received VCT at the hospital-based centre.

Medan ACTS in Addis Ababa pioneered a PMTCT programme. In March 2005, the chief of the Health Bureau in Addis Ababa asked KHC to provide PMTCT services for the whole city. KHC now has 50 PMTCT sites across Ethiopia, including rural areas that are not reached by government services.

In 1999, KHC began piloting Medan ACTS, an eight-year community-based HIV programme which integrates prevention, treatment, care and support. The Medan ACTS programme was piloted in Jimma, a large commercial town in the south west, and has now been replicated in eight sites across Ethiopia. These sites are chosen according to HIV prevalence and the willingness of local authorities to work with KHC. KHC aims to ensure the sustainability and impact of its HIV response by networking with local partners and government, and by integrating the programme into local community structures such as the kebele (local government administration unit).

Medan ACTS programmes work with local KHC churches and the community to:

— build awareness of HIV
— provide access to services such as VCT and PMTCT
— provide care and support for people living with HIV and for children orphaned because of AIDS
— mobilise local resources and leadership towards HIV prevention.

This case study is based on Medan ACTS, Jimma. The approaches piloted here have been replicated by the other Medan ACTS projects.

**Education**

Medan ACTS focuses on education and behaviour change among young people. This involves training peer educators and establishing HIV response youth clubs in local churches, schools and for young people who do not go to school. Medan ACTS also produces educational materials.

In Jimma, 528 peer educators have been trained, and the education materials produced and distributed included 4,500 leaflets, 3,800 brochures, 120 posters, 2,900 hospital client cards. A film about HIV was shown to 20,000 school children. Out-of-school youth are encouraged to participate in the clubs through provision of sporting facilities such as table-tennis tables. The youth clubs provide young people with life skills and raise awareness about sexual health issues. However, particularly within the church groups, the focus is only on abstinence. Tearfund is working with KHC to ensure that more comprehensive prevention strategies, including condom use, provision of antiretroviral drugs, voluntary counselling and testing services, and provision of clean needles and syringes are discussed and incorporated.
**Voluntary counselling and testing (VCT)**

Increased awareness of HIV and reduced stigma has led to increased demand for HIV counselling and testing. Government provision of VCT remains incomplete and unreliable. Medan ACTS responded to this need by setting up VCT centres in its project sites to provide free VCT services. These have proved very popular. In 2006, the VCT centre of Jimma Medan ACTS tested 1,583 people.

There are two full-time qualified counsellors who provide counselling and advice before and after HIV testing. This includes providing information on living positively and how to avoid opportunistic infections. In a few cases, where needed, the counsellor will make further home visits to offer follow-up counselling and help identify other sources of support. Such support may include income-generating activities and identifying family and friends who can provide emotional support. This level of personal support and follow-up care is a distinctive benefit of the church response over the public health service.

To ensure the sustainability of VCT services, Medan ACTS has been working with the government to integrate their VCT programme into the local government hospital. A staff counsellor has been seconded by Medan ACTS, while the hospital provides test kits and facilities. However, people report that they prefer the Medan ACTS VCT centre to the government clinics because it is more private, test results are faster and more personal counselling is provided. Many government hospitals suffer from irregular supply of the chemical reagents necessary to carry out the tests, and the hospital nurses do not have as much time for counselling and follow up as the Medan ACTS counsellors.

**Home-based care**

Medan ACTS trains volunteers from local churches in home-based care for people living with HIV. The

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**GOOD PRACTICE**

**Monitoring and evaluation**

- The medical lab at Medan ACTS’ VCT centre has obtained a government health department licence which has to be renewed every year.
- Government inspections regularly check standards and HIV test equipment. Medan ACTS VCT uses three HIV Rapid Tests: Screening (Determine® HIV), Confirmatory (Capillus™) and Tie Breaker (Uni-Gold™).
- Every quarter, Medan ACTS sends all positive samples, all discordant results and a random 10% of negative samples are sent to the regional government office for checking and approval.
- To ensure confidentiality, all clients are given a client number so all records are anonymous.

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Professional counsellors provide counselling and advice before and after HIV testing at the Medan ACTS VCT clinic.
Volunteers visit people in the community, providing care to people who are living with HIV when they are sick. Two or three volunteers usually work together and they visit eight or nine people a week. When someone is sick, the volunteers take them to the clinic. If the person is bedridden, they will help them by cleaning their home, washing the person, cutting their hair, or cooking for them. Jimma Medan ACTS has trained 24 church volunteers as carers and currently coordinates care for 58 people who are sick with HIV-related illness. These people were identified through the VCT programme. Providing care can be time-consuming and difficult, but the volunteers report that it is their Christian faith that motivates and sustains them through this work.

‘The local church is at the heart of the community, it really has an impact on people’s lives. If the local church is strong it can influence the whole community. The HIV situation is beyond what a health centre can address. The church is one place where you can reach so many men and women of all ages gathered together, where you can find volunteers willing to go out into the local community.’

Dr Teferi Fissehatsion, Medan Projects Coordinator

**CASE STUDY**

**Home-based care**

Fantai Abagerow is a family care-giver who has been trained by Medan ACTS. Before training she was already caring for her adult daughter Nuria, who is living with HIV. She helped to wash and clean and look after Nuria’s children when Nuria was ill. Now seven days of training have given her increased confidence and she says; ‘I’m satisfied my daughter is in better health and in good condition because I now know how best to care for her.’ Fantai also helps other people in the neighbourhood who are living with HIV to care for themselves, and advises their families on how to take care of them when they are sick.

Nuria initially came to Medan ACTS for VCT. They identified sources of support and gave her advice on income-generating activities. With a small loan from Medan ACTS she set up a vegetable stall in the market. The VCT counsellors visit regularly, providing nutritional support such as oil, sugar, flour, as well as relational support. This personal contact and relationship-building is an important part of Medan ACTS’ Christian ethos and service.

Nuria’s family is Muslim but when describing the Medan ACTS VCT counsellors, she says: ‘When they come I feel like a close relative is visiting. It makes me very happy.’
Income-generating activities

Medan ACTS provides training in income-generating activities for people living with HIV, and care-givers for children who have been orphaned because of AIDS. The aim is to enable them to provide a sustainable income. In Jimma, there are 43 families currently involved in income-generating activities such as polishing shoes or driving horse-carts. One orphan, who is head of the household, received support to purchase a horse cart. He is now able to support eight family members and is studying for a degree at Jimma University.

Mobilising the local church

Making use of the established leadership structure of KHC, Medan ACTS targets local church leaders for training and raising awareness about HIV. It then encourages these leaders to speak out in their churches about the issues. Church leaders recruit volunteers from the congregation for services such as home-based care for people living with HIV, and to form a committee to focus on HIV, which is integrated within the existing structure of the church. The committee has representatives from each of the areas of church ministry (Education, Children and Youth, Marriage and Counselling). They receive training to become peer educators on HIV. Training for the volunteers is given by Medan ACTS and consists of five days of initial training (general

‘HIV is a critical issue. The government must work in collaboration with other organisations to address the issue and broaden services. We have to work with everyone if we are going to tackle the problem. We work through the churches, and the mosques. People have to take responsibility in the community.’

Ismael Mohammed, Vice Mayor of Jimma

Medan ACTS produces resources to raise awareness in the community about HIV.
sensitisation, basic facts of HIV, counselling, home-based care) and a further two days of refresher training after six months.

The committee sets up a club for the church youth and supports church-based responses such as volunteers providing home-based care for people living with HIV. Some of the church budget or particular offerings may be used to support this work, or to provide for children orphaned because of AIDS. In this way the HIV work becomes an integral part of the church’s ministry.

Prevention of mother-to-child transmission (PMTCT)

In 2004, the Ethiopian government reported that 25,000 children had died of AIDS-related illnesses. The actual figure is likely to be higher as it is difficult to compile accurate birth records. Only 0.3% of pregnant women living with HIV are receiving the information and medical services they need to help prevent their children being born with the virus.11

KHC is providing PMTCT services through its Medan ACTS programme in Addis Ababa. This involves training healthcare providers involved in Mother and Child Health services as well as supplying ARVs. KHC receives Viramune in 200mg tablets from Boringer Engelheim and Abbot laboratories, and supplies government clinics. Although there are very strict monitoring and evaluation requirements for this supply, KHC has met the required standards each year since 2004. Since 2006, KHC has been the largest local supplier of PMTCT materials, supplying 50 out of 171 sites nationally. In 2005, the chief of the Health Bureau in Addis Ababa granted KHC a contract to provide PMTCT services for the whole of Addis Ababa.

CASE STUDY

Tackling stigma

Local churches are adapting and using local traditions to raise awareness of HIV and to address stigma. Most of the 200 young people within Jiren KHC church in Jimma belong to the ‘Anti-AIDS’ club. They regularly organise traditional coffee ceremonies, to which they invite the local community. Often these ceremonies are held in the homes of people living with HIV, which helps to break down barriers of stigma. They use this informal opportunity to talk about HIV-related issues and share information.

Stigma within the church

Medan ACTS invites local church leaders for training about HIV. Initially many were reluctant, as stigma was high and the prevalent attitude was ‘there is no HIV in the church’. Hundreds of church leaders were invited to the initial workshop in Jimma in 1999, but only 40 came. Attitudes changed as the realities of HIV became more apparent within churches and communities. Increasingly, church leaders began to request help from Medan ACTS to address issues around HIV. However, there remains a reluctance to talk about comprehensive prevention methods including condom use, and unhelpful attitudes around gender still need to be addressed. Tearfund is working in partnership with KHC to help develop capacity and understanding of these issues.

Sustainability

Medan ACT’s service provision is excellent. People prefer the Medan ACTS’ VCT centre in Jimma to the government clinic, because it offers reliable service and personal treatment. However, this is not ideal in the long term, as it is not the church’s mandate to replace government services, and such professional service provision is beyond the reach of most local churches. The church is instead well-placed to focus on advocacy to hold the government accountable to ensure service delivery, and to increase local uptake of existing services by continuing to tackle obstacles to access such as lack of awareness, stigma and discrimination.

Medan ACTS involves local KHC churches in its work, but there is a need to ensure long-term sustainability by motivating and empowering these churches to become more central to the response to HIV, rather than participants in an NGO-led response. The importance of developing local capacity and ensuring local ownership of the work was illustrated when there was a temporary gap of funding and some projects, such as the youth clubs for out-of-school youth, were discontinued. The church-based and school programmes continued, because they were integrated into church and school structures and pastors and teachers had taken ownership of the programme. It is important that exit plans are integrated into all programmes from the beginning.

CHALLENGES

'It is a difficult task to spend so much time doing this, yet we do it joyfully because we want to serve God. I enjoy visiting and serving people.’

Adanech Mariam (church volunteer providing home-based care)
Integration

Networking is key to KHC’s approach, both to develop capacity and to ensure sustainability. As a large and well-established denomination, with a history of delivering services, KHC has credibility with the government and can work in partnership, to compliment and where necessary, to fill gaps in government service provision.

Jimma is a predominantly Muslim area, and there has been a history of sectarian conflict. Although Jimma Medan ACTS is part of a Christian denomination and works with local churches, the beneficiaries they serve come from across the whole community and the programme is endorsed by, and works closely with, local government authorities.

Scaling-up responses

The communication networks of large church denominations such as KHC provide a unique opportunity to scale up responses to HIV through their direct links to thousands of local churches. Since it represents over five million members, KHC has a voice and influence that could be used for advocacy at national level. Coordination between KHC and other church denominations ensured that on Good Friday 2006 there were services in churches across the country that discussed PMTCT, reaching over 80,000 people with this message. Over three million people in Ethiopia belong to a church so the potential of such inter-denominational cooperation is extensive.

Capacity

Many local congregations in poor communities have doubts about their capacity to respond to HIV-related needs in their communities. These concerns are valid but another KHC development programme has demonstrated the huge potential of poor communities to mobilise resources, through its self-help group model. Women in Nazareth were organised into savings groups, and by saving only tiny amounts each week have now saved a total of around US $20,000. Good cooperation and sharing of learning between departments within KHC could see this approach integrated into the Medan ACTS programme, to provide resources for people living with or affected by HIV.

KHC’s well-established structure means that sustainable, capacity-building approaches can be replicated across programmes.

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The scale of the AIDS pandemic means that individual NGO projects cannot provide an adequate or sustainable long-term response. There is a recognised need to engage both with governments and civil society. Faith groups form a distinctive part of civil society, and in many of the areas most affected by the pandemic they play an influential role at a local and national level. Churches are an established part of the local community and have the ability to mobilise large groups of local volunteers who are motivated by shared values. International agencies can help realise the potential of the local church and strengthen existing church-based care and support for people living with or affected by HIV.

Working together

There remain many challenges to be addressed, such as the capacity of the local church in poor areas, and the sustainability of its response in the face of chronic and overwhelming need. At the local level, the church’s strength – that it is an integral part of the community – is also a potential weakness as it is affected by the same poverty and problems faced by the community. ZOE’s work illustrates this, as the church volunteers are themselves increasingly stretched beyond capacity by the overwhelming crisis in Zimbabwe.

It is also vital that the church acknowledges and tackles harmful attitudes related to gender and sexual practice that have contributed to stigma and discrimination. There remains a role for international agencies and local NGOs to mobilise, encourage and support the local church, to challenge attitudes, coordinate responses and to strengthen capacities. Tearfund has been working in partnership with churches and faith-based organisations to respond to HIV for over twenty years. Tearfund’s shared values base and established relationships mean that it is able to engage and challenge the church on sensitive issues such as comprehensive harm prevention methods, including condom use.

Tearfund has developed resources to help local church groups and partner organisations to provide good practice responses to HIV.

Addressing challenges

The Christian church is an existing and sustainable grassroots network with unparalleled reach and authority in many local communities. Working with the local church provides a unique opportunity to mobilise thousands of volunteers and scale up responses to HIV.

The local church has the potential to effectively disseminate information, influence attitudes and values, advocate with and on behalf of the vulnerable and reach marginalised populations. There remain many challenges, but in communities across the world local churches are already providing services and sustainable care to those living with or affected by HIV.

'‘The role of African faith-based organisations in combating HIV and AIDS is widely recognised as having growing significance, but, at the same time, one which is not fully exploited given the influence and reach of FBOs in African societies. Their impact at the community and household levels and their well developed on-the-ground networks make them uniquely positioned to influence values and behaviours and to mobilise communities.’

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Engaging in advocacy

KHC’s Medan ACTS programmes in Ethiopia demonstrate that people may prefer the quality of care and the holistic treatment they receive at
a Christian VCT centre, but it is not the church's responsibility to replace government services. Local churches have access to marginalised populations in remote rural areas and urban slum communities. Christian denominations have unique reach, linking thousands of local churches to national and international networks, so the church has great potential in advocacy against injustice and in holding governments accountable to provide services and access to treatment.

Transforming lives

The local church has unique potential to be an agent of transformation in communities in response to HIV through promoting awareness, changing attitudes and providing sustainable hope and practical support for those living with or affected by HIV. The hope, sense of belonging and of individual worth that faith and the faith community can provide to people living with or affected by HIV may be intangible, but the resulting improvements to mental, physical and emotional health are both visible and vital.

These case studies show how international funding agencies, governments, local faith-based organisations and local churches are already working together to reach local communities and respond effectively to HIV.

The church is a trusted institution that people often turn to in times of hardship. In Zimbabwe, local churches are responding to the hunger crisis by distributing food to vulnerable families.

All available from www.tearfund.org/tlz