ROLES OF CHURCHES IN A WORLD LIVING WITH HIV / AIDS

PRESENTATION BY

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1. BACK GROUND

The Lord Jesus Christ makes a powerful declaration of his mission on earth in John 10:10: “I have come that they may have life and have it abundantly.” This is what he came to do and called upon his disciples to continue doing even after his ascension. “As the Father sent me, so I send you.” We are called upon, by our master, to lead men and women, boys and girls, through out the world to “live abundant lives in Christ.”

Abundant, life here, does not mean a life without challenges, but rather a life of unspeakable “peace and joy” as in Isaiah 9:1-7. Integral Mission, is about bringing about the ‘shalom’ of God upon communities, often amidst hardships and intense suffering, including the challenges poised by the HIV/AIDS pandemic, especially in third world countries.

As has been stated before in many forums, there is no one definition for Integral Mission. However, the simple definition by Micah Network is the easiest. “Integral Mission or holistic transformation is the proclamation and declaration of the Gospel. It is not simply that evangelism and social involvement are being done along side each other. Rather, in integral mission, our proclamation has social consequences, as we call people to love and repentance in all areas of life. And our social involvement work will have the evangelistic consequences as we bear witness to the transformation grace of Jesus Christ.” This is the main calling of the Church.

2. THE CHURCH AND HIV/AIDS

The Church is a very influential institution in Africa. In the case of Malawi close to 63% of the educational institutions are provided by the Church operating under Association of Educators in Malawi, (ACEM). In the case of health, 43% of the health institutions are owned by Churches through Christian Health Association of Malawi (CHAM).

There is no any other institution so strategically positioned to tackle the HIV/AIDS pandemic the way the Church would. Come to think of these strengths:-

(i) Compassionate Ministry
Church involvement in mitigating HIV/AIDS impact is a mandate given to the Church from God. James 1:27 “True religion that pleases God is to take care on Orphans and widows in their hour of need.”

(ii) Grassroots Structure
In most of the countries, especially in Southern Africa, where the pandemic is highest, the Church has permanent structures present at grassroots level in most of the communities, unlike other NGO’s or even the Government.

(iii) Holistic approach
HIV/AIDS is not only a health issue; but also has an economic, social and spiritual dimension. Only the Church can holistically and effectively tackle the problem from all these fronts. No any other institution has such an advantageous position.
(iv) Behavior Change Message
It is generally agreed that behavior Change is probably the only sure solution to addressing the HIV/AIDS crisis. The Church, being a strong advocate for high moral principles, is the best vehicle to effectively address this.

The role of Churches in mitigating the spread and impact of the HIV/AIDS pandemic is therefore very crucial. It is encouraging to note that many circular bodies, including Governments, especially in Southern Africa, are beginning to understand and appreciate this unique role which only the Church can play in the fight against HIV/AIDS. The Church is now being consulted on social development and other policy formulation forums by both the public and private sector. The Church is becoming a key stakeholder in the battle front. The onus is now on us, as Churches to prove to the world that we are a trustworthy partner who can indeed change the course of the war from defeat to victory. Micah Network, I believe, can play a significant role to bring about this a change of attitude amongst the evangelicals to jointly chart greater and effective participation the Church in integral missions in the face of HIV/AIDS crisis.

3.0 HIV/AIDS SITUATION IN MALAWI

The Sub Saharan Region is reported to be the worst hit in the World. Southern Africa, in particular, is still worse off than other parts of Sub-Saharan with Zimbabwe, Zambia, Mozambique and Malawi having the highest prevalence rates.

According to the 1998 Population and Housing Census Malawi’s population is at 13.2 million. Approximately 86% live in rural areas with only 14% living in the urban areas. With regard to age, approximately 44% of the population was aged below 15 years. About 4% of the population is above 65 years of age and 52% between 15-64 years. When this is disaggregated further it is found that approximately 23% f the population is aged between 10-19 years old. This demonstrates that Malawi’s population is young hence the need to protect it from HIV infection.

With regard to the social economic indicators, Malawi is considered one of the poorest countries in the world ranking 165 out of 177 countries according to the UNDP Human Development Index. According to the National Statistical Office, 52.7% of the population is considered poor. About 22% of the population is ultra poor and can not meet the recommended daily food requirements. The country has a per capital gross national product of US$190. Such economic status serious impact on the ability of many infected and affected with HIV and AIDS to access basic material needs including drugs and nutritional requirements.

The first HIV/AIDS case was diagnosed in Malawi in 1985. HIV is most prevalent among urban residents than rural. The national prevalence rate among those aged 15-49 years old is now at 12% down from 14.4% in 2003.

There are nearly 100,000 new HIV infections in Malawi annually with at least half of these accruing among young people aged 15-24 and nearly the same number of deaths. As of 2005, there were an estimated 930,000 people including children under the age of 15 who were living with HIV and AIDS. The number of orphans has increased significantly with current estimates being at over 1 million orphans half of whom are due to HIV and AIDS and related factors. The advent of HIV and AIDS has also impacted negatively on Malawi’s fight against tuberculosis. In 1985, a little over 5,000 cases of tuberculosis were reported. In 2004 the number rose to 27,000. The Ministry of Health estimates that the HIV and AIDS epidemic is a major public health problem in Malawi hence the need to urgently contain it.

3.1 Proportion of Children who are orphaned.

HIV/AIDS mostly affects those who are young and economically productive. When they die they leave behind orphans. While the extended family system has been used as a coping strategy for orphans and
grand parents, this system is, however overwhelmed due to the large number of orphans that have arisen since the advent of the HIV and AIDS epidemic. With high prevalence of poverty, it is increasingly difficult for the system to cope. This is an area where the Church can come in fulfillment of James 1:27.

Over the 20 years of the HIV and AIDS epidemic, Malawi has seen the evolution of strategies for taking care of orphans, for example, the use of community-based child care centers (CBCC’s), adoption and orphanages. During this period, there has also been an increase in the number of community based organizations (CBO’s), which are playing an important role looking after orphans addressing the physical/material needs as well as their psychosocial needs.

There are more orphans in urban areas than rural areas, possibly because of the prevalence rates in urban areas is higher than in rural areas. However, with the introduction of free ART and possibly urban residents having more access to this service than rural residents, the proportion of orphans in the rural areas might surpass those from urban areas.

4.0 CHURCH’S RESPONSE TO THE EPIDEMIC

The Church in Malawi, as is the case for with countries, welcomed the HIV/AIDS epidemic with a mixed reaction. HIV/AIDS was immediately labeled a disease for the immoral. The push for condoms, then, by some other activist, as the most effective tool to avoid contracting the disease only compounded the Church’s resentment. HIV and AIDS was seen at a distance.

However, twenty years down the line, HIV and AIDS has come into our homes even our own bedrooms. Indeed the Church has AIDS. Almost each and every household has been affected either directly or indirectly.

In 2003, the first ecumenical Conference on HIV/AIDS was organised by the three Christian mother bodies, namely the Evangelical Association of Malawi, Malawi Council of Churches and the Episcopal Conference of Malawi. The theme of the Conference was breaking the silence on HIV/AIDS. There was a sense of denial that the Church has HIV/AIDS and need to get involved in the fight.

During the Conference, a survey was conducted to determine the levels of stigma and discrimination against PLWHIV and AIDS. A question was put over to them: “Would they allow an HIV/AIDS Christian to take leadership role in the Church.” Over 60% of the respondents categorically said no!! About 30% said they would decide then. The rest did not know what they would do. The Programme, at this Conference, included testimonies from some PLWA’s. The Church was moved. For many it was their first time to hear first hand experiences of those who are positive.

This Conference achieved to break the silence on HIV/AIDS by the Church. Church leaders were challenged to face reality and accept that HIV and AIDS is with us and we needed to learn to live with it. During the Conference several gaps were identified in the whole Church response. Firstly, it was noted that, though Churches were responding, the initiatives were uncoordinated and lacked resources. This later led to the establishment of the Malawi Interfaith Aids Association (MIAA) by the three Christian bodies to spearhead the coordination of the faith response. The Muslims were later included, to give the institution its interfaith nature. This followed a recommendation from the Government and the main supporting donor. The Evangelical Association of Malawi (EAM) has been on MIAA Board ever since.

The second gap that was identified was the lack of qualified counselors in the Churches. The HIV and AIDS pandemic has brought about great demand for psycho social counseling services. Consequently, a year later Ecumenical Counselling Center was established, by the same Christian mother bodies, with the aim of developing the capacity of Churches in Counselling. The Evangelical Association of Malawi has been chairing this institution since its inception in 2004.
5.0 EVANGELICAL ASSOCIATION OF MALAWI RESPONSE

In the last four years that the Evangelical Association of Malawi has been implementing the HIV/AIDS Programme a new concept to working through the local Churches in a community has been piloted. This is called HIV/AIDS local Churches Consortium approach.

5.1 Goal and Programme Location
The goal of the Programme is to contribute to reduce new HIV and sexually transmitted infections, alleviate the suffering of the HIV and AIDS infected and affected people and mitigate the impact of the epidemic. The Programme is now being implemented in sixteen out of the twenty eight districts in the country. A total of 630 Churches are involved in the program, representing a population approximately 112,000 people. It is the intention of Evangelical Association of Malawi to saturate the whole country with local Churches Consortiums as part of its program of implementation of Integral Missions through the local Church. The program targets rural or semi-rural areas not serviced by any service provider. To date The map below, points at some of the districts targeted by the Programme.

5.2 How the local HIV/AIDS Consortiums work
The HIV/AIDS Churches Consortiums comprise of different denominations in a particular geographical location of not more than 15 Kilometer radius. The Churches are assisted to design, manage and implement together one huge HIV/AIDS Programme with several interventions. This is One Enemy, One Body, One Programme concept. The area is divided into smaller manageable areas commonly known as Consortium Zones as programme activity implementation areas.

In this approach all the Church leaders of the congregations participating in the Consortium form the policy body of the Programme, commonly known as the General Assembly. The General Assembly then establishes two bodies which are Zone Committees made up of leaders within the zone, and an Executive Board comprising of selected 10 leaders amongst themselves with additional technical people from various fields like health, agriculture, social welfare, chiefs and businessmen.

The Executive Committee, in turn, establishes a Consortium Programme Office and recruits a Consortium Programme Coordinator and an assistant. These become responsible for the coordination role within the Consortium and with other agencies outside the Consortium, including EAM Secretariat. The General
Assembly then identifies men, women, boys and girls from various congregations to be trained as service providers working as volunteers. Currently the five programs are Adult and Youth Peer Education, Home Based Care, Community Based Child Care for orphans and vulnerable children; and People Living with HIV and AIDS Support, (PLWA) and Pastors and Church leaders. Lately, some Consortiums have started to target traditional chiefs and community leaders as well. These are important stakeholders in developmental decision making processes in the villages, besides being the custodians on culture.

At each level i.e. the General Assembly, the Executive Committee, the coordinating office and service providers, the EAM Secretariat has through training, technical support, mentoring and networking provided knowledge, skills and resources. Each programme area has a male and a female trained as trainers and supervisors who have in turn trained and continue to supervise service providers in the particular programme area. A Consortium structure would normally take the following from:-

- **Consortiums with HIV/AIDS Prevention, Care, Support & mitigation Programmes managed by a committee with representatives from various congregations of different denominations**

- **The Consortium divided into smaller manageable zones as implementation areas with church and community leaders, men, women, boys, girls and children trained in programme thematic area service delivery including peer, PLWHA education, HBC, OVC, care and IGA**

- **Impact – Making a difference in project design, management, implementation and service delivery in consortiums and zone committees resulting into a reality of HIV/STI prevention and quality of life with HOPE for the infected, affected and suffering people**
5.3 Role of EAM in the Program

The Evangelical Association of Malawi HIV/AIDS Secretariat has a responsibility to build the capacity of the Churches and church organisations to ensure effective and efficient, professional and coherent programming, management, implementation and service delivery of the programme activities. The program seeks to mobilise and equip systematically and effectively all key groups in the targeted communities to mitigate the impact of the HIV and AIDS crisis. Basic training is provided to volunteers from local Churches in Home Based Care (HBC), Community Based Child Care Center volunteers, Peer educators for youth and life skills training. As regards the general management of the Consortium, the Coordinator and the main committee are trained in project management and implementation, financial management, reporting, proposal writing and general fund raising. Recently, other specialized trainings addressing specific concerns have also been incorporated. These include gender, economic justice issues, paralegal services to victims of injustices and stigmatization.

In most of the cases, the training is provided by experts from either Government or private sector to ensure quality in compliance with Malawi Government requirement.

The Programme isolates the following groups as the priority rights holders of the programme:

5.1 People living with HIV infection and AIDS

In addition to suffering from HIV/AIDS related infections and diseases, people living with HIV infection and AIDS face a tremendous obstacle of survival in life as a result of stigma and discrimination that creates loneliness and depression. This group which accommodates those with chronic illnesses is a priority group of rights holders in the Programme.

EAM’s role to this group has been:

5.1.1 Training of Home Based Care givers -20 per zone (10 men and ten women).
5.1.2 Provision of bicycles to HBC volunteers since most of them travel long distances.
5.1.3 Provision of bicycle ambulances. One ambulance per a zone.
5.1.4 Ensure that the PLWA’s are food secure. Where necessary connect them with agencies which can help them with start up loans for small business.
5.1.5 Provide paralegal training to Consortium inorder that they may fight for the rights of the PLWA and the disadvantaged groups in the community.
5.1.6 Provision of fertilizers and agricultural inputs to the chronically ill.

5.2 The Youth (boys and Girls)

The silent voices of boys and girls in decision making, and the recipient role they are positioned in by the community has made them, especially girls, to be more vulnerable than adults.

Capacity building of this group mainly focuses on the following:

5.2.1 Peer educators training of trainers (20 Youths trained per zone)
5.2.2 Life Skills for the youths.
5.2.3 Drama and sports outreach programs
5.2.4 Facilitate girls and the most vulnerable youth remain in School by provision of basic needs such as fees and note books. Their local churches are now taking over the responsibility.
5.3 vulnerable children and orphans

Children from poor families, single or child headed families, parent(s) with disabilities and child abuse families are equally vulnerable. These too are a priority a priority group of rights holders for the programme.

Activities for the group include the following:-

5.3.1 Two weeks training of CBCC care givers. The training is provided by experts from the Ministry of Children and Social welfare. Four per a zone (Two men and two women).
5.3.2 Establishment of the CBCC centers in each zone.
5.3.3 Feeding program for the vulnerable children in the CBCC in each zone. The Churches through the Consortium contribute the food and take turns to cook for the children.

5.4 Chiefs and Traditional leaders
• HIV/AIDS Awareness workshops.
• Gender and human rights issues,
• Cultural issues which promote the spread of HIV/AIDS.
• Good governance sensitization
• Economic justice issues.

5.5 Pastors and key church leaders
• Evangelism & discipleship training
• Advocacy & good governance
• HIV/AIDS awareness, prevention, care and support.

6.0 LESSONS LEARNT FROM THE LOCAL CONSORTIUM APPROACH PROGRAM.

6.1 Ownership of the program
There is joint ownership of the program by the Churches and community as a whole, instead of a single Church or Organization.

6.2 Duplication of services significantly reduced
This has also reduced the likelihood of duplication of services and unnecessary competition amongst the Churches in the targeted community as the church consortium management and service delivery teams look at community needs collectively. Further, since the Consortium approach generally focuses on the needs of people in an area other than church affiliation, resources are thus maximized.

6.3 Unity amongst participating churches strengthened
The Program has promoted unity amongst the Churches in the community. The Church and not denomination is seen working in the communities attracting more and more demands for services. Bringing different denominations managing and implementing one programme is, from a spiritual perspective, a miracle on its own. This emphasises the focal point being the suffering community and not church membership.

6.4 United Church Voice
It has enabled the Churches and community leaders speak with one voice on specific issues of concern to their respective areas. This includes lobbying for greater share of resources and technical support from the District Assemblies. Some Local Church Consortium groups have already managed to link up with their respective District Assemblies for support. Doctrinal differences are proving not to be a barrier. The approach has demonstrated the highest possibility of leaders of different denominations joining hands when it comes to wanting to address a crisis and in this case an epidemic.
6.4 Wider coverage of information and messages
More people can be reached with HIV, AIDS, Sexual and Reproductive Health, Gender and Human Rights in a short period of time than would have been the case using a single church structure. In this approach, within a short time, information can easily be passed to a huge population in the targeted zones.

6.5 Stigma and discrimination
Stigma is collectively being dealt with. The consortiums have registered a growing number of PLWHAs seeking services from the church consortiums.

6.6 Transparency and Accountability
Unfaithfulness and dishonest in programme management, implementation and service delivery is minimized as there are numerous eyes and ears watching and listening.

6.7 Capacity building
Training is made easy and cheaper since it is the Church in the Community which is targeted instead of individual congregations.

6.8 Establishment networks and linkages with other service providers
Consortiums are encouraged to link with other existing services providers within the community such as NGO’s or relevant Government agencies. So far strategic alliances have been established with other service providers, for instance; VCT providers, hospitals or clinics for treatment and ARV’s, agencies supporting PLWA’s, Counselling agencies for psycho-social support, Social Welfare offices at district level responsible for child development; etc. The actual cost of running a Consortium is therefore spread over a number of stakeholders.

6.9 Integrated approach to HIV and AIDS
HIV and AIDS is multi-faceted. The program has to be open and flexible to other interventions as need arises. For instances lately, nutrition, IGA’s and small business enterprises for PLWA’s and orphans have been incorporated. In other Consortiums, a strong component of advocacy has been brought in; working closely with traditional leaders to revisit some harmful cultural practices. We are now considering including a component of water and sanitation in all the Child development interventions in most of the Consortiums.

6.10 Cross learning and Sharing of experiences
Regular forums for learning and refresher sessions have been organised for service providers or management teams drawn from various Consortiums. Orientation visits between Consortiums are also being done. In the case of youths, drama competition and soccer tournaments are taking place between the various Consortiums. Cross learning and sharing of experiences is greatly enhanced through the Consortium approach.

8.0 EMERGING ISSUES AND RECOMMENDATIONS

8.1 GLOBAL ECONOMIC TRENDS
The General global economic disturbances will have an impact on the Church’s response to the crisis in the short and long term. In particular, food prices have risen up by over 45% over the past two years, in Malawi. This will greatly affect the ability of PLWA’s on ART to access appropriate food. Transport prices have also gone up by almost a similar margin due to fuel increases. Most of the ART patients in rural areas are experiencing problems to travel to district centers every month as is required to access drugs. The Church may have to come and advocate for a decentralization of such services by the service providers. Otherwise we risk losing a lot of lives.

Another major concern at the moment, linked to global price trends, is the ability of PLWA’s accessing agricultural inputs such as fertilizers and seeds for their nutritional requirements. Prices have gone up by 400% over a period of one year due to global disturbances in oil markets.
8.2 A UNITED AND COORDINATED EVANGELICAL RESPONSE REQUIRED.

The voice of the Evangelicals on HIV and AIDS is conspicuously missing on most of the international HIV/AIDS forums. There is quite some good work taking place within our constituency but often uncoordinated and working in isolation.

There is need to establish networking and coordination structures at all levels of WEA; namely international, regional and national levels. Such structures will assist facilitate the sharing of best practices, research, policy development, advocacy and resource mobilization and dissemination of information.

8.3 HOW INTEGRAL IS OUR INTEGRAL MISSION?

The ministry of our Lord Jesus Christ, was holistic addressing the whole needs of human being, spiritual, socially and physical. Micah Network definition of Integral Mission is possibly the best definition, at the moment, to describe what must take place in our integral mission activities. However, experience has proved that much effort has to be made to make interventions really integral. The need to establish clear holistic indicators in the programs is critical to ensure that important pillars to our IM interventions are not overlooked, as has often been the case.

8.4 RESEARCH AND DOCUMENTATION

There is inadequate research and documentation taking place of the work of Churches in area of HIV/AIDS. The only available work is by circular Organizations and institutions often not taking into account the fundamental values which Churches hold on to very highly.

8.5 INVESTMENT IN CAPACITY BUILDING

For Churches to be empowered to take up the challenge of integral mission in their communities, through the local Churches Consortium Program, there is need for a substantial investment in capacity building/ community training and empowerment in program management and service delivery as regards HIV and AIDS interventions. Sustainability of the program is closely linked to the levels of investment, whether in terms of resources or time, in empowering the community groups, such as Church leaders, community leaders, youths, children, PLWA’s with appropriate skills for the effective delivery of interventions.

9.0 CONCLUSION

Integral Mission is a must for the Churches, more so now in the face of this crisis before us. If all other stakeholders fail to tackle the HIV and AIDS pandemic, it will be unfortunate. However, if the Church of Jesus Christ in the world today fails, it will be a tragedy. The Church, through its engagement in integral mission, addressing the pandemic, holding out the Gospel of Jesus Christ, though word and deeds, is capable of ensuring that God’s people are living dignified lives on earth, even in the face of trials and sufferings. This is the abundant life Jesus Christ promised in John 10:10. It is therefore imperative for evangelicals, world wide, to come out from our comfort zones and begin to make a difference in our communities for Jesus Christ, as we serve his people.