Case Study - HIV/AIDS Christian Response in Zambia

Mrs Leah Mutala
EFZ/PACWA, Zambia

1 BACKGROUND

1.1 Zambia is situated in central Southern Africa and is in a region known as “the Sub-Saharan Africa” where the HIV/AIDS epidemic has been particularly severe. The latest UNAIDS report estimates that in this region there are 24.5 million people living with HIV.

1.2 Zambia has been and continues to experience a lot of changes from the last decade and now into the 21st century. Critical political, social and economic changes have had adverse effects on the lives of many citizens. Most companies and firms have been privatized (Structural Adjustment Program or Economic Structuring) leading to job losses for many breadwinners. Unemployment is high and poverty has rocketed to 80%.

1.3 The HIV first case was isolated in Zambia in 1984. It was unknown then that this infection would grow into an epidemic becoming part of the global HIV/AIDS pandemic. The suffering caused by the HIV/AIDS epidemic and its impacts demand that the church and individual Christians respond with urgency and empathy. This epidemic was declared a National Disaster requiring an emergency response at the ICASA - International Conference on AIDS and STDs in Africa (September 1999 in Lusaka, Zambia). The infection rate remains at 20% or one in five of the reproductive age group of 15 - 49 years.

1.4 Among the poor the pandemic has had a very serious effect because of an already vulnerable economic situation in which they are found. This increases their vulnerability to prostitution and malnutrition. The impact of the HIV/AIDS epidemic is devastating and multi-sectored, affecting education, health, agriculture, labor force and transport. Communities have been robbed of fathers, mothers including children, and the country of highly qualified personnel and potential development.

1.5 The number of orphans left behind by deaths of a parent or both will continue to increase from the current figure of 1.2 million (National AIDS Council – government). The social safety net of the extended family for orphaned children and others in extreme need is already over-stretched and inadequate to cope with the additional burden. Children in nearly every household not only have to suffer physical deprivation but also the stress and psycho social trauma of witnessing chronic illness (associated with weight loss, rejection, stigma, isolation, job losses, poverty and fear) and painful deaths of their loved ones including siblings. This leaves very deep wounds in the lives of orphaned children resulting in depression, insecurity and anger.
2 **GOVERNMENT RESPONSE**

2.1 In the early years of the epidemic the interventions were by the government through Ministry of Health and later with the partnership of NGOs. Prevention and control campaigns consisted of the ABC – Abstinence, Be faithful to one sexual partner and Condoms. The care of the chronically sick and increasing number of TB patients brought a heavy demand on the limited bed capacity of hospitals and depleted medical personnel. Government hospitals with the weakened economy are incapable of providing drugs. As a result of this situation relatives move into hospitals to nurse their sick.

2.2 This scenario shows the problem to be out of control hence the government"s invitation to the church and community at large to join in the fight against and mitigation of HIV. The recognition of the immensity and negative impact was a challenge not only to the government but the whole nation. Home based care/community care was being recognized and encouraged to ease the burden of family and the sick in hospital were encouraged to go home.

3 **THE CHURCH RESPONSE**

3.1 The Evangelical Fellowship of Zambia Response to the HIV epidemic through it’s wing of the women department/PACWA (Pan African Christian Women Alliance) arose out of the challenge church women were experiencing in their ministry within the church and community. The challenge was the escalating number of orphans in the community most of whom were without care or support of any kind. It was discovered that there were more paternal orphans and usually nursing a chronically sick parent in the home and often a mother. It was very obvious that we (group of member churches - PACWA groups) were faced with two crises at hand, the HIV epidemic and it’s impact of orphanhood. The challenge was the escalating number of widows and orphans needing food for survival, education, above all love, protection, understanding and emotional support.

3.2 The church is the only institution endowed with spiritual resources to address the needs of the human heart facing terminal illness or an orphaned child trying to understand whether there is a God out there!

4 **STRATEGY FOR CARE AND SUPPORT**

4.1 **Awareness and Envisioning** - A seminar was organized to share with women from various member churches the situation analysis concerning the HIV/AIDS crisis and large numbers of sick people in the community and the orphans who needed care and support. The statistics and projections were staggering and threatening (20% of the population infected, 300 people getting infected daily and an orphan situation of one million in 2000.

4.2 **Envisioning the women** - The biblical mandate for care of orphans and widows was shared from James 1v27. The mission of the church – extending the Kingdom of God and making Jesus Christ Lord by His presence being felt in the community through the believers.
The Lord Jesus said, “The Spirit of the LORD is upon me because He has anointed me to bring good news to the afflicted, He has sent me to bind up the broken hearted, To proclaim liberty to captives, To comfort all who mourn.” Isaiah 61 v 1,2

4.3 Volunteer Identification (through the church) - These are usually women who volunteer to do the work freely without pay. The qualification is that: each must be a Christian and have a sense of call for this work. Must not be in full time employment, must be honest, trustworthy, keep confidences (secrets) and mature. Must be credible and have a good testimony in the community.

4.4 Training - The volunteers are trained in basic counseling, psycho socio support, how to care for the sick in the home, identifying children in crisis, recognizing malnutrition. They should report any crisis situation to the clinic or spiritual leadership for crisis counseling especially at time of death.

Material support is sourced from among the women groups and usually sacrificially for families in crisis.

5 ORPHAN CARE AND SUPPORT

5.1 The church has a biblical mandate to care for orphans and widows (James 1 v 27). Orphans have many needs regardless of the socio – economic status of their deceased parent(s). The support for orphans is not just in giving material support only but also the giving of ourselves to them in an expression of love.

5.2 The orphans and vulnerable should be seen as God sees them in His divine purpose. Orphans from poor families have a lot of challenges i.e.:  
   - Financial needs for education, skills training
   - Social needs – Need to relate to a family for love, guidance, discipline, and character formation.
   - Physical – Shelter, good nutrition, health care.
   - Psychological – Emotional restoration and counseling.

Orphans from wealthy families have needs for protection, love, emotional support, guidance, character formation and discipline.

5.3 The Bible is against oppression of the orphan: Ex 22 v 22-24; Isaiah 1 v 17; Deut 14 v 29; Deut 16 v 11,14; Malachi 3 v 5:  
   - The Orphan Care ministry calls the church to long term commitment and sacrifice.
   - The church leaders are envisioned on the needs of OVC.
   - Church leaders mobilize the whole church and sensitize them to love and embrace the orphans in the church or community.
   - Identify volunteers with a heart who will visit and take Jesus’ love and strength.
   - Identify real needs through Needs Assessment or Questionnaire.
   - Volunteers report to church leadership on a monthly basis.
5.4 In the years 2001 and 2002 about 280 women volunteers from various EFZ member churches in four (4) provinces were capacity built in psychosocial support for orphans and affected families. Spiritual empowerment is part of the continuing process for care teams, so they can be able ‘to bind up the broken hearted and comfort all who mourn’ (Isaiah 61). Unity has been exhibited in the community through volunteers and many families’ commitment to church has deepened. The spiritual lives of volunteers have been transformed positively as they stand in intercession for affected families and orphans.

6 CONCLUSIONS

6.1 The church is an agent of change to transform communities. Its mission includes bringing the heart of God into any crisis facing mankind. The church commands grassroots respect and should voice the HIV/AIDS crisis, remove the stigma and reduce poverty.

6.2 Church leadership should mobilize the whole church membership to be relevant and to share the love of Christ in the communities in addition to seeking the Lord according to 2Chronicles 7 v 14.

6.3 The government efforts, NGOs and other partners providing interventions in the epidemic should be encouraged to continue partnering with the church, strengthening networks and together we can make a difference in our world.