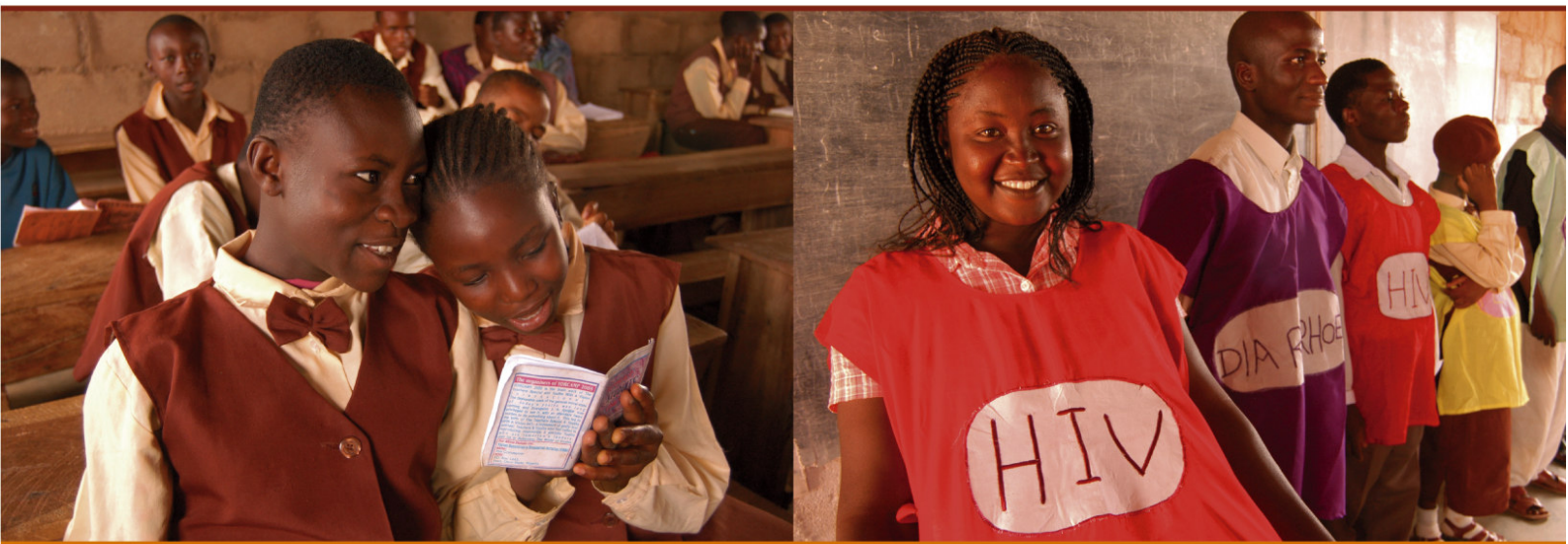


Faith untapped



Why churches can play a crucial role
in tackling HIV and AIDS in Africa

TEARFUND



Foreword

**By Lord Carey of Clifton
Tearfund Vice President & former Archbishop of Canterbury**

When I see the devastation that HIV and AIDS are wreaking across Africa, I can understand why people talk of losing hope. My wife and I have seen evidence of this terrible scourge in South Africa, Rwanda, Kenya, Uganda and elsewhere. Families, communities, whole nations are in the grip of an appalling pandemic which is gnawing away at the very fabric of society.

But there *is* hope, even in remote communities decimated by disease and largely overlooked by the rest of humanity. I have seen it first-hand. And much of this hope lies in the hands of African churches which, for years, have been on the front line of care for millions of people living with HIV and AIDS. For these people of faith, hope is not abstract: it's something practical and powerful. It is seen when someone holds a child's hand as his mother slowly slips away; and it is seen when a church leader risks his reputation by having an HIV test and sets the example for others to do the same.

The churches and their vast networks of volunteers are one of the few groups which are wrestling with the pandemic at close quarters every single day. And yet they receive little recognition and scant funding from outside sources; in some cases churches' capacity is being stretched to breaking point.

And yet churches are also part of the problem. Many people of faith need to think long and hard about the part they have played in feeding the stigma and discrimination surrounding HIV and AIDS. Churches represent vast untapped potential to change behaviour and attitudes. If we put our own house in order and if we are properly resourced and trained, churches and other faith groups could become one of single most effective strategies for tackling the pandemic.

We are at a critical juncture: we have international targets for halting the relentless march of HIV and AIDS, and a consensus among donors and governments that this is a real possibility. The funding and political will are falling into place. The challenge now is to ensure that international action translates into results in the worst-hit areas – and in this, I believe, churches have a crucial role to play.

Lord Carey of Clifton



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This report highlights 3 key points about the impact of HIV and AIDS on the worst-affected continent, Africa:

1. Churches in Africa are a hidden and powerful force in tackling the HIV and AIDS crisis. They need international recognition, support and funding.
2. Many churches contribute to the HIV and AIDS crisis through stigma and discrimination. Action is needed to overcome this.
3. One of the single most effective areas into which churches could expand their HIV and AIDS work is preventing the virus being passed from mothers to children.

Executive summary

HIV and AIDS crisis is no longer just a development issue: it is a global disaster.

- AIDS now claims 8,000 lives every day: that's about five every minute.
- Every day another 14,000 people are infected with HIV, most of them in countries already crippled by deep poverty.
- The number of children orphaned by HIV and AIDS is nudging 15 million.

Fresh thinking is needed - especially in Africa - as the HIV and AIDS crisis spreads, fueled by ignorance, stigma, poverty and complacency. While there is finally talk of scaled-up responses to the pandemic, with rich countries belatedly committing billions of pounds to the struggle against HIV and AIDS, money takes too long to get to the grassroots.

But there is an untold story about HIV and AIDS in Africa. Largely unrecognised, a huge and growing network of groups is toiling on the front line, tending the sick, caring for orphans, wrestling to halt the spread of infection. This network receives barely a mention in international and national strategies to tackle the pandemic, even though its volunteers' work is worth billions of pounds a year.

This network is Africa's churches. Almost uniquely, their members are reaching the communities and people whom governments and NGOs cannot easily reach. International funding agencies and governments do not understand the nature of faith in local communities, nor do they appreciate how churches are working at village level.

If these faith-based groups were properly funded, and if they committed themselves to mobilising and training more volunteers, they could play a crucial role in the struggle against HIV and AIDS in Africa today. They remain an untapped potential.

‘Millions of community volunteers are caring for the poorest people in the worst affected areas... They are shouldering a huge burden of care – yet they remain largely invisible, under the radar of governments, NGOs and international bodies.’

Dr Geoff Foster OBE, Consultant in Paediatrics and Child Health, Mutare, Zimbabwe.

Many churches’ responses to HIV and AIDS go undocumented – despite the fact they involve millions of volunteers helping millions of people. Some of these responses are professionally run, coordinated at denominational level, reaching thousands of orphans. Many more, however, are simply individual church members sharing food with someone dying in a dirt hut – literally the poor serving the destitute.

There is mounting evidence that churches of all denominations are having a real impact:

- Faith groups provide on average 40 per cent of the healthcare in many African countries.
- 97 per cent of congregations across six African countries are working with orphans and vulnerable children, according to a UNICEF survey.
- Church volunteers in one Kenyan project are supporting 29,000 people affected by HIV and AIDS.

In the African continent, 99.5 per cent of people claim a ‘religious connection’: there are 2 million congregations of different faiths and more than half of these are Christian. In some churches, every single member is involved in caring for orphans and vulnerable children.

With proper resourcing the potential of churches is huge:

- **Prevention:** churches have unparalleled influence and a long reach into remote areas. They have captive audiences and wide communication networks for spreading messages about AIDS.
- **Care:** church volunteers could move beyond offering counselling and moral support, to more proactive roles such as, for example, ensuring children in affected families can stay at school.
- **Treatment:** overstretched healthcare systems could delegate some testing and treatment services to community groups, if they were given

proper training. One key low-cost area of treatment in which churches could get involved is in stopping HIV being transmitted from mother to child in pregnancy or early infancy – a preventable tragedy in which up to 600,000 children are infected each year.

Crucially, churches are in a unique position to dispel the prejudice and gender inequality on which HIV and AIDS feed – provided they recognise the part they often play in reinforcing stigma and discrimination.

- Many churches still associate HIV and AIDS with promiscuity, which fuels stigma and makes people reluctant to take the HIV test.
- Too often church leaders fail to talk openly about sex and so miss the opportunity to change attitudes and behaviour.
- Many churches ignore or even oppose the use of condoms in preventing HIV transmission, despite evidence that thousands of women who are faithful to their husbands are infected within marriage.

International agencies and governments are beginning to acknowledge the work of 'faith-based organisations' and want to engage them further in HIV prevention work.

Their potential is vast. For example, there are some 250,000 church congregations in the AIDS belt of East and Southern Africa alone – more than enough to support the region's 12 million orphans. Many churches are keen to do more and be more effective – but need help to upgrade their own responses.

It is now time for recognition and investment to help churches become one of the world's most effective responses to the global AIDS crisis.

Recommendations

Recommendations for international donors

- International donors should acknowledge the huge and unique contribution that churches are already making in responding to HIV and AIDS in Africa. They should also recognise churches' potential to be even more effective with proper resourcing.
- Donors should ensure that more funding reaches grassroots level and so has a real impact on those communities which need it most. They should therefore direct more funds towards Africa's churches which are strongly engaged with local communities.
- International donors should work hard to understand the nature of faith in traditional society and how churches are working at village level.
- Donors should help small-scale groups develop their capacity both to access and use funds effectively.

Recommendations for churches

- Churches should look again at their own attitudes to gender, sex and HIV and AIDS, and recognise the part they often play in fuelling stigma and discrimination.
- Faith groups should be open to new ways of developing their response to HIV and AIDS. They should have the courage to expand into new areas of prevention, care and treatment – and review some of their existing strategies.
- Churches should work hard to understand how international donors operate and actively seek partnerships with them.
- Churches should take advantage of their unique influence and reach within society to lobby governments on behalf of the worst-hit and poorest communities.

Section 1: the HIV and AIDS crisis

AIDS is set to become the worst pandemic in human history. Every day, it claims another 8,000 lives:¹ every day another 14,000 people are infected with HIV. In 25 years AIDS has killed more than 20 million people worldwide. It is gnawing away at the very fabric of society and turning back the clock on years of development. And it is spreading, fueled by poverty and stigma. AIDS is no longer just a development issue: it is a global disaster.

Vital statistics

On the planet today there are nearly 39 million people living with HIV. In some parts of Africa, more than one in three people live with the virus.² And these statistics grow more improbable every year: 4.1 million people were newly infected in 2005 alone.

Geographically, the pandemic is concentrating on the very communities least able to withstand its assault. Seventy per cent of all new infections occur in Africa.³ HIV prevalence is now growing at an alarming rate in India and China. But sub-Saharan Africa remains the epicentre of this disaster: 2 million people in the region died of HIV and AIDS in 2005, and 24 million more are living with HIV. The pandemic has a tight hold on every country in Southern Africa and prevalence levels may not yet have peaked everywhere; statistics in countries such as Mozambique and Swaziland continue to rise.⁴

- **In South Africa, about 5.5 million people are living with HIV.**⁵
- **One in three adults in Swaziland, Lesotho and Botswana lives with HIV.**⁶
- **Almost one in three pregnant women attending antenatal clinics in South Africa in 2004 had HIV.**⁷
- **Life expectancy in Namibia dropped from 60 to 42 in one decade.**⁸

The impact on poor communities is almost incalculable. AIDS is robbing children of their parents, decimating workforces, overwhelming health services, undermining economies, even shaking national security. It is reversing decades of development and undermining many countries' efforts to reach the UN's Millennium Development Goals to halve poverty by 2015.

¹ Stop AIDS Campaign. www.stopaidscampaign.org.uk

² Weaver, R (2004). *Reaching out? Donor approaches to faith-based organisations in the response to HIV and AIDS*. Tearfund.

³ World Council of Churches (2006). *Responses of the faith-based organisations to HIV and AIDS in sub-Saharan Africa*.

⁴ UNAIDS. http://www.unaids.org/en/Regions_Countries/Regions/SubSaharanAfrica.asp

⁵ UNAIDS (2006). *2006 Report on the global AIDS epidemic*.

⁶ World Council of Churches (2006). *Responses of the faith-based organisations to HIV and AIDS in sub-Saharan Africa*.

⁷ Ibid.

⁸ PACANet (2003). *Situational analysis of the church response to HIV and AIDS in Namibia*.

‘The countries most affected by HIV and AIDS will fail to achieve Millennium Development Goals to reduce poverty, hunger and childhood mortality, and countries whose development is already flagging because of HIV and AIDS will continue to weaken, potentially threatening social stability and national security, if the response does not increase significantly.’

UNAIDS, *2006 Report on the global Aids epidemic*.

The bitter twist to this tragedy is that the vast majority of people with HIV are oblivious to the fact they are infected. Only one in 10 people living with HIV worldwide has ever been tested for it and knows they are living with a time-bomb.⁹ Testing facilities are few and far between and, even where such clinics do exist, stigma and shame prevent people from attending them. And as ignorance festers, so the virus spreads...

‘AIDS has a woman’s face’¹⁰

Like most consequences of poverty, HIV and AIDS are having a disproportionate impact on women – particularly young women. About 60 per cent of the 12 million people aged 15 to 24 who are living with HIV and AIDS worldwide are women.¹¹ Of the 24 million people currently living with HIV in sub-Saharan Africa, more than half are female.¹² In certain age groups in some countries in the region, more than half of all women are infected.

In Kenya, infection rates are higher for women than for men in every age group surveyed, except in the 45- to 49-year-old group. In the 20- to 24-year age group, 8.7 per cent of women and 2.4 per cent of men were infected in 2003.

Source: Kenya Demographic and Health Survey 2003.

Blind assumption would perhaps have us believe the statistics prove women are more promiscuous than men. But the facts simply do not add up. Canon Gideon Byamugisha, the first Anglican priest in Africa to speak out about having HIV, reports that 61 per cent of HIV-positive women in Africa have never had sex with more than one man.¹³ As Section 7 explores in greater depth, women are not only living with HIV: they are dying of deeply entrenched gender inequalities.

⁹ Dr David Evans, HIV and AIDS consultant.

¹⁰ UN Secretary General Kofi Annan, December 2002.

¹¹ Weaver, Richard (2004). *Reaching out? Donor approaches to faith-based organisations in the response to HIV and AIDS*. Tearfund.

¹² Foster, G (2004). *Study of the response by faith-based organizations to orphans and vulnerable children*. World Conference of Religions for Peace/United Nations Children’s Fund.

¹³ Strategies for Hope Trust (2004). *What can I do?* video. Oxford.

Shocking research from 30 countries in Africa shows that even where women living with HIV can access services to prevent mother-to-child transmission, take-up is dire. One in five pregnant women in Africa is offered and accepts HIV testing.¹⁴ Stigma is largely to blame for this tragedy. (More information on parent-to-child transmission in Section 6.)

Broken homes

Yet, the devastation caused by the pandemic is best seen in the lives of the children floundering in its wake. There are 15 million children today who have lost one or both parents to HIV and AIDS. By 2010, that number will probably exceed 25 million. Eighty per cent of the world's children orphaned by HIV and AIDS live in sub-Saharan Africa.¹⁵ By 2021, 40 per cent of all children under 17 in Namibia will be orphans.¹⁶

And so families are gradually losing their bread-winners and adult carers. Young children are left to fend for themselves and fight off destitution. Vulnerable and desperate, they easily fall into child labour, sexual exploitation, illiteracy, poverty – and therefore HIV infection.

Indeed children are far from immune to infection. Some 600,000 children are newly infected with HIV each year, mostly via their parents.¹⁷ Mother-to-child transmission in pregnancy and early infancy is the main culprit – even though, with proper education and low-cost drugs, it is largely preventable (see Section 6).¹⁸

On average, infected children are between two and three years old when they die. They are killed by malnutrition, malaria, bacterial pneumonia, common diarrhoea. By contrast, a child born with HIV in a rich country had a 50 per cent chance of reaching the age of 12, even before anti-retrovirals became available in the mid-1990s.¹⁹

- **About 2.3 million children worldwide are living with HIV.**
- **One in five deaths due to AIDS-related illnesses is a child under 15.**
- **One in seven newly infected people is a child under 15.**

Sources: Desk review by Dr Rena Downing, Limuru, Kenya, for Tearfund; UNAIDS.

¹⁴ Professor Andrew Tomkins OBE, Institute of Child Health, London.

¹⁵ Weaver, R (2004). *Reaching out? Donor approaches to faith-based organisations in the response to HIV and AIDS*. Tearfund.

¹⁶ Ibid.

¹⁷ UNICEF.

¹⁸ Professor Andrew Tomkins OBE, Institute of Child Health, London.

¹⁹ Dr Geoff Foster OBE, international HIV and AIDS expert.

Plugging the gap

The world is only now waking up to the catastrophe which has been unfolding in village huts and city slums for more than two decades. Funding for HIV and AIDS is increasing sharply: programmes such as anti-retroviral distributions are mushrooming. And still the pandemic is outstripping efforts to contain it. The Millennium Development Goal of halting the spread of HIV and AIDS by 2015 seems still far off.

Remarkably, very few of Africa's orphans have been abandoned by society. Traditional extended family networks have absorbed most of the burden of care. More than 90 per cent of orphans and vulnerable children in sub-Saharan Africa are taken in by their own extended family or other families.²⁰

This is no cause for complacency. Too many orphans 'adopted' in this way are used as cheap labour in the home or local employment. Relatives and friends do what they can for these orphans but, on a limited budget, they are more likely to send their own children to school.

Furthermore, as the burden of care increases, community safety nets are being stretched to breaking point and children are in danger of slipping through them. Resourceful families are running out of ways to eke out a meagre existence. But, as the next section shows, this outcome is avoidable.

²⁰ Olson, Kerry et al (2006). *From faith to action: strengthening family and community care for orphans and vulnerable children in sub-Saharan Africa*. Firelight Foundation.

Section 2: the untold story of the churches

The UN General Assembly agreed at its Special Session on HIV and AIDS in 2001 that the world needed to ‘mobilise an army’ to reverse the spread of HIV and AIDS. That army has already been commissioned – but its work remains largely hidden. Across the globe, it is doing what it can to stave off the worst effects of the HIV and AIDS pandemic. It rarely features in international donors’ statistics and is barely mentioned in national HIV and AIDS action plans. This hidden force is Africa’s churches²¹ – and they are already the front line of care for millions of people. They receive little recognition, virtually no outside funding or partnerships, and so their potential remains largely untapped.

AIDS in the churches

Congregations of all denominations have found themselves inextricably entangled in the pandemic. Church leaders’ diaries are full of funeral bookings, often for members of their own congregations. Their pastoral workload – counselling and comforting the sick and bereaved – is becoming unbearable. In fact, the effect of the HIV and AIDS crisis has been to change their focus altogether, says Veena O’Sullivan, Tearfund’s HIV and AIDS Advisor:

‘The burden of care on churches is immense. I met recently with a pastor who was conducting three funerals the next day. Another said to me: “I trained in theological college to do evangelism but I spend most of my time conducting funerals and counselling bereaved families. Theological college did not prepare me for this.”’

Drawn almost despite themselves into the thick of the battle, congregations and community groups have responded with spontaneous, home-grown responses to pressing priorities on their own doorstep – and, for many, in their own homes. These initiatives vary wildly in scope and scale. Some are professionally run projects coordinated at denominational level; many are simply individuals sharing their food with someone dying of AIDS in a dirt hut.

‘This disease has affected us very much. Half my congregation are orphans or widows. I have 200 orphans and vulnerable children and 50 widows in my church.’ Church leader, Homa Bay, Kenya.

The vast majority of church responses are small projects benefiting no more than 100 people – and overwhelmingly run by volunteers from within the community, with little or no external funding.

²¹ As stated in the Executive Summary, the word ‘churches’ is used as shorthand for a wide variety of Christian groups of all denominations: individual Christians, congregations, bodies coordinating churches such as denominational institutions, faith-based NGOs (which have paid staff) and community-based organisations (which rely mainly on volunteers). The faith groups on which this report focuses are largely congregations and small community-based organisations.

What churches do already

Churches – in the broadest definition of faith-based organisations (FBOs) – play a key role in providing education and healthcare systems across the African continent. Faith groups provide an average of 40 per cent of the healthcare in African countries, particularly in rural areas where HIV infection rates are high.²² This contribution is widely acknowledged.

- In Kenya one third of the health and education infrastructure is run by FBOs: this puts them second only to government as national care providers.²³
- Up to 50 per cent of healthcare provision in Zambia is through church-owned hospitals.²⁴

But in the church's narrower definition, that of individual congregations and community groups, it is playing an equally important role. This work is largely 'beneath the radar' of governments, non-governmental organisations (NGOs) and international donors.²⁵

'Theirs is an untold story: millions of community volunteers are caring for the poorest people in the worst-affected areas, in a way that is uniquely in tune with people's needs. Government safety nets don't do anywhere near as well in catching these vulnerable groups. In fact they barely work at all in Africa, except to distribute food aid during famines. These community groups are shouldering a huge burden of care – yet they remain largely invisible, under the radar of governments, NGOs and international bodies.' Dr Geoff Foster OBE, Consultant in Paediatrics and Child Health, Mutare, Zimbabwe.

To date, the main foci of congregations and community groups have been spiritual and pastoral care, centred on home-based care, and orphans and vulnerable children. In some countries, many groups have also been working hard on prevention.

1. Prevention

In some countries, many church groups start by spreading prevention messages, before branching out into care. They provide life skills and sex education through youth groups, where the basic message is about delaying sexual debut and abstinence. For adults, the teaching has tended to focus on abstinence and sexual fidelity or 'zero-grazing'.²⁶

²² PACANet. *Keeping the promise? African churches speak!* PACANet response to the UN General Assembly Special Session on HIV/AIDS Review of the 2001 Declaration of Commitments.

²³ Ibid.

²⁴ Nussbaum, Stan (ed) (2005). *The contribution of Christian congregations to the battle with HIV and AIDS at the community level*. Global Mapping International, 2005, for Oxford Centre for Mission Studies.

²⁵ The term 'under the radar' is used by international AIDS expert Dr Geoff Foster OBE. Cf: Foster, G (2005). *Under the Radar: Community Safety Nets for Children Affected by HIV/AIDS in Extremely Poor Households in Sub-Saharan Africa*. United Nations Research Institute for Social Development, Geneva.

²⁶ PACANet (2003). *Situational analysis of the church response to HIV AND AIDS in Namibia*.

Churches' insistence that people should remain faithful to one person is not just a moral imperative: it is also a proven means of reducing the spread of HIV infection. The virus is most easily passed when someone is newly infected: if someone has several sexual partners at a time, the virus spreads quickly, particularly if partners are also carrying other sexually transmitted infections.

The churches' call for abstinence and faithfulness appears to be reaping dividends in some countries. US AIDS prevention expert Daniel Halperin insists that falling HIV infection rates in countries such as Kenya can be attributed to increased sexual fidelity.²⁷ Others claim the same has happened in countries such as Senegal.²⁸ In traditional African society, the church has an acknowledged role in challenging sexual behaviour which might spread infection. Not all of the churches' prevention messages have been helpful, however, as Section 7 explores further.

2. Home-based care

Today, most of the care which AIDS-affected homes receive comes not from governments or NGOs but from within the local community – and often from the churches.²⁹ Only 10 per cent of financial aid to families in Tanzania who have lost breadwinners to HIV and AIDS comes from official sources.³⁰ As national healthcare systems are stretched further beyond their limits, the need for home-based care will only increase.

Church volunteers, predominantly women aged 25-50,³¹ offer basic nursing care for the sick, practical and moral support for the family, and often counselling and prayer. Children are relieved of the burden of caring for sick parents; if the family budget allows, the children are freed up to continue their schooling, though this is rarely possible.

3. Support for orphans and vulnerable children

Church and community groups are also tackling, almost single-handedly, one of the most devastating social impacts of the epidemic – the issue of orphaned and vulnerable children (see also Section 1).

Their responses vary hugely, from ad hoc programmes (such as Christmas parcels for children running their own households) to well-established regular care such as daily soup kitchens.³² Crucially, for children at risk of dropping out of school, many groups provide school

²⁷ Chicago Tribune (23 April, 2006). *Circumcision, fidelity touted in AIDS fight*. www.chicagotribune.com

²⁸ Green, E (2002). *The impact of religious organisations in promoting HIV prevention*. SAFAIDS News, 10:1, 9-12.

Available at www.safaid.org.zw

²⁹ Dr Geoff Foster OBE, international HIV and AIDS expert.

³⁰ UNAIDS/WHO (2005). *AIDS epidemic update: December 2005*.

³¹ PACANet (2003). *Situational analysis of the church response to HIV and AIDS in Namibia*.

³² Ibid.

uniforms, shoes, books and fees. Congregations and community-based groups' involvement in home-based care means they are already monitoring children in precarious situations, even before they are orphaned.

This contribution is slowly being acknowledged by agencies such as the UK's Department for International Development (DFID):

*'Most households caring for orphans and vulnerable children, including child-headed households, do not get any support. Community- and faith-based organisations are in the front line of caring for these vulnerable households.'*³³

Branching out

Churches' responses so far have focused largely on the pastoral and spiritual: care and support of poor and sick people has been a natural first step. Some churches are also starting to branch out into more complex areas of treatment and prevention. Many churches, for example, have an AIDS desk at the denominational level, which provides trainers and counsellors to support local churches in developing their own HIV and AIDS response.³⁴

Other activities include:

- setting up income-generating schemes for affected families
- raising awareness of HIV and AIDS issues
- distributing condoms when appropriate
- training volunteers
- lobbying and advocacy³⁵

However, most small religious groups are not yet fully engaged in prevention and treatment. They remain an untapped potential.

A rising tide

The churches' potential becomes clearer when the scale of its response is understood. It is not limited to a few congregations in remote locations. A UNICEF survey of congregations across six African countries found that 97 per cent of them were working with orphans and vulnerable children.³⁶ The vast majority of churches in Namibia – more than 80 per cent, according to one survey – have some kind of HIV and AIDS response.³⁷

³³ DFID (2004). *Taking action: the UK's strategy for tackling HIV and AIDS in the developing world.*

³⁴ Nussbaum, Stan (ed) (2005). *The contribution of Christian congregations to the battle with HIV and AIDS at the community level.* Global Mapping International, 2005, for Oxford Centre for Mission Studies.

³⁵ PACANet (2003). *Situational analysis of the church response to HIV and AIDS in Namibia.*

³⁶ Foster, G (2004). *Study of the response by faith-based organizations to orphans and vulnerable children.* World Conference of Religions for Peace/United Nations Children's Fund.

³⁷ PACANet (2003). *Situational analysis of the church response to HIV and AIDS in Namibia.*

And churches' engagement with the crisis is rising exponentially. A small flurry of responses in the 1980s and 1990s is now turning into a flood. Nearly two-thirds of congregations surveyed by UNICEF in 2004 had set up their HIV and AIDS projects between 1999 and 2002.³⁸ The Pan African Christian AIDS Network (PACANet) reports that home-based care programmes have 'scaled up tremendously' since 2001. Nor are these responses a fringe activity in churches' weekly schedules: in some congregations, every single member is involved in caring for orphans and vulnerable children.³⁹

Faith at society's core

The impact churches are having – and their unmined potential – are also better appreciated in the context of their social status and their reach. In contrast to the secularised society of Western countries, faith continues to play a huge part in the daily lives of most Africans. Some 99.5 per cent of Africa's 750 million people have some 'religious connection'.⁴⁰ There are an estimated 2 million faith congregations in Africa – more than half of which are Christian.⁴¹

Churches' long reach, deep into people's psyche and far down potholed tracks into even the most remote villages, means that they are uniquely placed to respond to people's needs. Their reach often extends far beyond that of governments and NGOs.

And in terms of connecting communities, churches' established structures such as denominations offer unique channels of communication and resources. Many dioceses cover 100-plus churches: some of the largest embrace thousands.⁴² The potential for networking and disseminating information about HIV and AIDS is huge.

'Today, faith-based organisations play a leading role in the fight against HIV. You have an extensive network of people and institutions, especially in rural areas, where few other institutions exist. Many Africans are far more committed to their churches than to other social or political organisations. That is why so many churches and faith-based organisations have an incredible history of helping people with AIDS.'

UK International Development Secretary Hilary Benn, addressing the Church of England General Synod on HIV and AIDS, February 2004.

³⁸ Foster, G (2004). *Study of the response by faith-based organizations to orphans and vulnerable children*. World Conference of Religions for Peace/United Nations Children's Fund.

³⁹ Ibid.

⁴⁰ Foster, G (2005). *Religion and responses to orphans in Africa*. Chapter in: Foster G, Levine C, Williamson J (2005). *A generation at risk: the global impact of HIV/AIDS on orphans and vulnerable children*. Cambridge University Press, New York.

⁴¹ Ibid.

⁴² Ibid.

Christian mandate

Crucially, the church workforce brings a unique contribution which is intricately entwined with its biblical mandate for action. Churches see their role as serving the local community, out of a sense of duty and compassion. And the Bible instructs them to pay particular attention to the sick and needy, the underprivileged, the widow and orphan – the very people who are most at risk in this pandemic.⁴³ Christian volunteers can provide spiritual support and prayer, a valued offering in an African society steeped in religion. Most importantly, they offer hope (see Foreword by Lord Carey of Clifton).

‘If we ask, “What would Jesus do and where would he go in the 21st century?” he would be doing home-care visits in the slums to people dying of AIDS, and he would be showing people how a godly way of life protects life.’

Dr Jo Lusi of DOCS Heal Africa, a Tearfund partner organisation.

For churches, this is a lifetime’s calling, not a short-term project: churches are committed for the long term. While other civil society groups and external donors come and go, churches remain at the heart of a village. As a Zambian bishop puts it, ‘NGOs pack up their work after programmes finish: churches will never leave the community.’⁴⁴

Strength in numbers

In strategic terms, the church in Africa is a huge resource base of volunteers willing to give their time – as millions already do. It also has an unparalleled ability to motivate and mobilise them through its biblical mandate.

It is almost impossible to estimate the numbers of church volunteers currently involved – or the number of potential volunteers yet to be envisioned and engaged. If every church in Africa fielded one volunteer, that would be a million workers. In many churches committed to HIV and AIDS work, a high proportion of members are already involved.

There are more than a quarter of a million congregations in the AIDS belt of East and Southern Africa alone – more than enough to support the region’s 12 million orphans. Kenya alone has 80,000 congregations: if each cared for 20 orphans, all the country’s 1.6 million orphans would be supported.⁴⁵

⁴³ Key motivating Bible references include: James chapter 1, verses 27; and James chapter 2, verses 15-17.

⁴⁴ Tearfund.

⁴⁵ Foster, G (2005). *Religion and responses to orphans in Africa*. Chapter in: Foster G, Levine C, Williamson J (2005). *A generation at risk: the global impact of HIV/AIDS on orphans and vulnerable children*. Cambridge University Press, New York.

Churches' volunteer numbers immediately give them an advantage over many other groups who cannot generally count on such a ready-made workforce. Furthermore, these armies of local people grappling with local priorities are also reinforcing a sense of community ownership, just as HIV and AIDS threaten to isolate individuals and break down communities.

A UNICEF study across six African countries in 2004 showed 322 faith-based organisations were supporting 139,000 orphans and vulnerable children. Between them, these organisations fielded more than 7,800 volunteers. In other words, organisations had an average of 24 volunteers, each supporting 17 children.

Mining churches' potential

Many churches want to develop their work with HIV and AIDS but lack the resources to do so. Most church responses to the crisis are sustained purely by financial and material gifts (such as food) from the congregation, individuals and local fundraising activities.⁴⁶ In poor communities, it is very much a case of 'the poor serving the destitute'. Churches are already doing a great deal – but have the potential to do more.

Their current work with orphans and vulnerable children, for example, does not usually extend to ensuring children get into school. In Africa, the average cost of sending a child to school is £30 a year, even where the government is paying school fees; parents still have to pay for uniforms, books, stationery and admin fees.⁴⁷

Church groups need funding, training and, in some cases, a radical rethink about their own attitude to HIV and AIDS (see Section 7). There is also an urgent need to refocus some of the churches' existing efforts so they become more effective – and so volunteers are freshly motivated.

Change must come quickly: the current army of volunteers is unlikely to be able to keep pace with the pandemic. Even the current effort may prove unsustainable: many volunteers are stretched to breaking point.

⁴⁶ PACANet (2003). *Situational analysis of the church response to HIV and AIDS in Namibia*.

⁴⁷ Professor Andrew Tomkins OBE, Institute of Child Health, London.

Section 3: case studies of the church in action

Zimbabwe: caring for a child-headed household

Mrs Tomm died in 2004, six years after her husband. They left a 16-year-old son, a 12-year-old daughter and a granddaughter of primary school age. No relatives came to check on the children after their parents died so it fell to Mrs Tomm's close friend to get help.

This young family is now under the supervision of a local church. Church members have given the children counselling: others help with housework. The congregation also provides some financial help, food packs, clothing and school fees.

The children's house was being built when their mother died. Two years on, they still live in two rooms under a makeshift roof. The church is raising money to install proper flooring for them.⁴⁸

Catherine was thrown out of her family by her husband when she admitted to her neighbours that she was HIV-positive. Fortunately, caring members of a local church and community-support group in Lusaka, Zambia, gave her enormous support, compassion and care. The outcome might easily have been very different. It is quite common across Africa for women to be thrown out for admitting they have HIV, even if they were infected by their partner. In Durban, at least two women have been killed for admitting they were HIV-positive.

Source: Professor Andrew Tomkins OBE, Centre for International Child Health, Institute of Child Health, London.

Zambia: caring for AIDS-affected families in their home

In the town of Livingstone in southern Zambia, nearly a third of adults have HIV. The symptoms of the pandemic are everywhere: street children run wild, school attendance statistics plummet.

Desperate to do something, a group of 15 women volunteers from the same church network got together and hatched a plan. Their church network, the Evangelical Fellowship of Zambia, which receives funding from Tearfund, embraces churches from many different denominations.

Each volunteer visits five families affected by AIDS each week. Typically these are households where grandparents are caring for orphans or a single-parent family; most don't have any regular income. Volunteers help with anything from housework to schoolwork. The women often provide food from their own resources, though struggle to help with things like school fees.

Where necessary they will try to put people in touch with trained counsellors and HIV testing facilities. Many of these volunteers are motivated by having seen the effects of AIDS in their own families. They are proud to be able to help.

⁴⁸ This casestudy is taken from the following report: Nussbaum, Stan (ed) (2005). *The contribution of Christian congregations to the battle with HIV AND AIDS at the community level*. Global Mapping International, 2005, for the Oxford Centre for Mission Studies.

Esther is a chemistry teacher and a student on the part-time Master's programme in Community Care and HIV/AIDS at St Paul's United Theological College, Limuru, Kenya (see below). Esther tells the story of Mary, a member of the community group that she set up in the slums as a result of her studies:

'I first met Mary in 2003. Her age is not known but she's got a daughter aged 11. The Masaai give birth at an early age so she may be in her early 20s. She found out she was HIV-positive four years ago when she was very ill with her third pregnancy. She told her husband and he ran away. The group has been providing money for her rent, her fare to visit an AIDS clinic and money for food. She, in turn, helps to make beaded jewellery which we sell. Then, in May, Mary withdrew from most of her friends. Every day someone from the group visited her. When I visited, she wept and hugged me. She eventually told me she had been raped and now was sure she was pregnant. She bitterly explained how the hooded man put a piece of cloth in her mouth and dragged her into the bush. She shared her story with the group. We read together the story of the rape of Tamar [in the Bible]. They were amazed to find such a story in the Bible. We prayed together and have promised to support Mary.'

Kenya: equipping the church to be focused and effective

Four years ago, Dr Rena Downing was in general practice and her husband John was a lawyer, both in Hull, England. Today, they've given all that up and are in Kenya, in the thick of the struggle against HIV and AIDS.

The pandemic claims up to 600 Kenyan lives a day. Some 2.2 million people out of a total population of 31 million are living with HIV. One in 10 children is an orphan.

Although Dr Downing and her husband had already started to make plans to serve in Africa, shocking statistics about HIV in Kenya confirmed the calling, she says. 'Research done in 1999 in Kisumu, a lakeside town, showed 33 per cent of the 19-year-old girls were found to be HIV positive. For many months I found myself weeping over those girls whenever I talked of them.'

Together with Kenyan colleagues, they have now set up a part-time Master's programme in Community Care and HIV/AIDS at St Paul's United Theological College, Limuru, in partnership with the Oxford Centre for Mission Studies and MAP International (Medical Assistance Programme). It is therefore very much a faith-based initiative.

The programme is aimed at people who are already involved in some kind of response to HIV and AIDS; pastors make up a third of its intake. All students are motivated by their faith. Students are trained to set up community groups of 20-25 volunteers in their own area and establish a response appropriate to local needs, helping local people prevent infection, care for each other and ward off the worst effects of the pandemic.

An Anglican bishop, who is sponsored by Tearfund, sited his community group in the cathedral and now heads up a network of about 200 groups, one for each congregation in his diocese.

By August 2005, the programme had trained 74 students whose groups have more than 1,500 volunteers, serving more than 29,000 people.

Mozambique : tackling stigma together

Years of civil war have left Mozambique broken and bruised. Its health and education services are crippled. It has 1.5 million orphans, many of whom, particularly in urban areas, are fending for themselves.

Kubatsirana (which means 'to help one another' in Chitewe/Shona) is a home-grown Christian organisation with 58 member churches. In the past nine years, it has grown to become a lead player in Mozambique's HIV and AIDS response.

One of its main aims is to mobilise and support volunteers within the local church to help families affected by HIV and AIDS. In Chimoio city, there are 24 small groups of volunteers caring for 500 people who are too sick to work and more than 750 children orphaned by HIV/AIDS.

Kubatsirana is also setting up mutual support groups for people living with HIV and AIDS: these groups educate, lobby for people's rights and run micro-enterprise projects, from growing vegetables to making beads. Four local churches are running day-care centres for orphans and helping them get into school or vocational training.

The organisation is working hard to address stigma associated with HIV and AIDS. Its community teams offering counselling and education at grassroots level include many people who are HIV-positive. It also builds links with community and religious leaders to educate them about the pandemic. Slowly, church leaders are becoming advocates for accepting people with HIV and AIDS rather than rejecting them.

The government of Mozambique has now invited Kubatsirana to expand its work into every province in the country.

A pastor in Mutare, Zimbabwe, set up a project supporting orphans after visiting a church and seeing orphaned children with no shoes. His church is now supporting 45 orphans.

Section 4: why funding is missing its target

At the UN High-Level Meeting on HIV and AIDS in New York in June 2006, the UN produced a declaration on HIV and AIDS, committing countries to work towards universal access to HIV treatments by 2010. It recognised that the fight against the disease will cost \$23 billion (£12 billion) annually between now and then. So far funding levels have failed to reflect the urgency of the situation – but are now slowly increasing.

Even now, however, very little of that funding is reaching those who need it most. That is partly because the grassroots, often faith-based, organisations which are best placed to reach these people appear to receive only a tiny helping from the funding pot – despite widespread top-level rhetoric about the importance of their work. The struggle against HIV and AIDS will only be won if churches are properly supported and resourced.

Missing the target

Billions of pounds are now being ploughed into the struggle against HIV and AIDS. Three major sources of funding are now priming the pump:

- The Global Fund to Fight AIDS, Tuberculosis and Malaria (aka: the Global Fund)
- The World Bank's Multi-Country HIV and AIDS Program (MAP) for Africa
- The US President's Emergency Plan for AIDS Relief (PEPFAR)

And yet millions of people are *still* not accessing the care they need. Section 2 reveals just how little of this funding goes to orphans and vulnerable children – a top-line priority in churches' response. Still only one in five pregnant women in Africa is offered and accepts HIV testing, due to lack of available facilities (and stigma).⁴⁹ And HIV treatment statistics are still dire. Mother-to-child transmission is the main cause of HIV infection in children under 15: up to 600,000 children are infected in this way every year, according to UNICEF. And yet, mother-to-child transmission can largely be prevented with proper education and treatment which costs about £7 per mother and child.

Tearfund and its partners internationally are deeply concerned that international action on HIV and AIDS is not translating into effective responses for those worst affected, particularly women and children.

The churches and their legions of volunteers offer an eminently cost-effective way to get the money to where it is most needed (see page 24) . At the moment they are running on empty. It costs very little to protect an unborn child from being infected (see Section 6) – but churches serving poor communities often can't afford even this small amount.

⁴⁹ Professor Andrew Tomkins OBE, Institute of Child Health, London.

All talk, little action

The Global Fund, MAP and PEPFAR have all acknowledged the importance of community responses to the crisis, making special mention of the crucial role of faith-based organisations. DFID and UNAIDS have frequently talked of the need to mobilise and support 'community-based responses'. As recently as May 2006, UNAIDS stated: 'Civil society must be fully engaged in the development and implementation of national plans.'⁵⁰

'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.'

Source: World Bank (2004). Concept note for HIV and AIDS workshop for faith-based organisations and national AIDS councils. Accra, Ghana, January 2004.

Church volunteers' work is worth billions of pounds a year (see page 24) and touches millions of lives – yet, the rhetoric about funding community groups has not translated into hard cash. In a survey by PACANet, 79 per cent of churches and Christian NGOs responding to HIV and AIDS in Namibia said they received no outside funding.⁵¹

A breakdown of Global Fund allocations to different sectors after five funding rounds appears to confirm this: only 2 per cent of funding went to faith-based organisations (FBOs), compared with 64 per cent to governments.⁵²

Even where allocations to 'community-based responses' are made on paper, it is rarely possible to track how much of these funds actually reach faith groups. The World Bank predicts that 50 per cent of MAP funds will be channelled to 'civil society groups' – but so far the trickle-down effect from the national to the local level has been slow. It is not possible to estimate what proportion of current MAP funding goes to FBOs.⁵³

The US has a long history of supporting faith-based organisations in the response to HIV and AIDS. For example, USAID is ahead of other donors in its commitments to community-based responses to children affected by HIV and AIDS. The UK lags some way behind. However, DFID has recently funded UNICEF's own programme for orphans and vulnerable children, which in turn has supported Christian associations in some African countries – a positive example of how UK donors could make a difference.

⁵⁰ UNAIDS (2006). *2006 Report on the global AIDS epidemic*. Executive summary.

⁵¹ PACANet (2003). *Situational analysis of the church response to HIV AND AIDS in Namibia*.

⁵² The Global Fund. http://www.theglobalfund.org/en/funds_raised/distribution/#sector_recipients

⁵³ Weaver, R (2004). *Reaching out? Donor approaches to faith-based organisations in the response to HIV/AIDS*. Tearfund.

Running on empty

If it is difficult to establish just how much funding is provided for faith-based initiatives generally, it is virtually impossible to track how much reaches small grassroots organisations. This is because reporting back on where funding has been used tends not to go beyond national bodies (such as National AIDS Councils which distribute Global Fund allocations).

A grassroots sounding by a Tearfund partner, the Evangelical Association of Malawi, however, paints a telling picture. A study of 15 churches in Malawi in 2004 found that nine had begun to make applications to the National AIDS Council, for funding from the Global Fund and MAP. Only one of the nine had had its proposal approved — and even then this one was still waiting to receive funding. Applications from the other eight had failed. Many of the churches had submitted proposals, had feedback, sent in more information — and then heard nothing further.⁵⁴

Extra reinforcements

If churches are to have better access to funding, bridges — or funding mechanisms — need to be built between donors and smaller-scale projects. Some larger churches simply need training in how to negotiate with donors. Other, perhaps smaller, groups will need 'middlemen' such as denominational bodies to relieve them of this administrative burden. This should not be one-sided: national coordinating authorities such as National AIDS Councils also need to help build groups' skills base.

To scale up their response and to attract more funding, the churches and their members will also need more training. Faith-based groups need to address concerns about their professionalism. Churches have tended to employ 'trusted religious persons' to head up their HIV and AIDS response, rather than people with specific relevant expertise. Any effective church response will need to be underpinned by strong counselling skills and sound medical knowledge. Churches will, of course, need funding to put this in place.

On the eve of the UN's High-Level Meeting in June 2006, several hundred people of different faiths representing more than 70 organisations involved in HIV and AIDS action held a prayer meeting in St Bartholomew's in New York. They united in a common mission — to create a world free of AIDS. But they recognised this would not be possible without greater effort, a stronger focus, better networking — and more resources.

⁵⁴ Taylor, N (2004). Many clouds, little rain? The Global Fund and local faith-based responses to HIV and AIDS. Tearfund.

What is the churches' contribution worth?

The claim:

'Millions of Christians are involved as volunteers in churches throughout Africa working on behalf of those who are sick or orphans. Their labour is worth billions of pounds a year in UK terms.' Dr Geoff Foster, international HIV and AIDS expert based in Zimbabwe.

The matchbox maths:

- If there are 1 million Christian congregations in Africa and each has just one volunteer working on HIV and AIDS, that makes 1 million volunteers. This is a very low estimate: most have many more.
- With a guesstimate of 5 million volunteers, it can be assumed that they work at least two hours a week – again a low estimate. That's 10 million person-hours each week.
- Set that against a low UK salary (£10,000 pa) and assume a 40-hour week. So each person's work is worth $(2 \div 40) \times 10,000 = \text{£}500$ pa.
- The cumulative total value of 5 million volunteers' work is therefore $500 \times 5,000,000 = \text{£}2.5$ billion pa.

This is the equivalent of the UN's estimated costing for a 'comprehensive HIV prevention package' which could avert 29 million (or 63 per cent) of the 45 million new infections expected between 2002 and 2010 (UNFPA). The total initial cost of this prevention package has been estimated at £2.3 billion annually.

The implications :

Volunteers are overburdened and threatening burn-out. If their goodwill were to be exhausted and their contribution withdrawn, the global fight against HIV and AIDS would be significantly weakened.

Conversely, if this army of volunteers expands because it is being better resourced, focused and motivated, new injections of global HIV and AIDS funding could yield disproportionately better results.

Section 5: why donors ignore churches

The reasons for this mismatch between public rhetoric and hard cash filtering through to the grassroots are not easy to pin down. However, Tearfund and its partners believe the following issues play some part:

I. Secular agencies and donors have not understood the unique role churches play.

Secular agencies and donors have failed to grasp both the scale of churches' response – and the unique contribution they are already making to action on HIV and AIDS. Because their work is largely hidden from the view of international and national decision-makers, the churches are quite simply an 'unknown quantity'.

II. Funders shy away from small-scale projects.

Funders tend to avoid small-scale projects, putting a high premium on large numbers of beneficiaries. The majority of church responses are small: a survey for UNICEF found most congregations and community-based organisations are supporting fewer than 100 orphans and vulnerable children.⁵⁵ Small-scale projects have been seen as 'idiosyncratic' in the past.⁵⁶ Their cumulative impact is also much harder to measure in concrete terms.

III. Large international donors do not have mechanisms to allow small local groups to apply for funding.

Major donors tend to operate mainly at the international and national level. There are no effective mechanisms in place to allow smaller church initiatives to access funding directly.

IV. Small players sometimes lack the capacity to apply for funding.

Most Christians involved in HIV work lack the time, inclination and skills needed to do the administration required for funding applications. Also, many churches simply do not know who to approach for funding or how to write an application.

V. Funders lack confidence in the churches' professionalism and financial accountability.

There is keen debate over the quality of services which churches are providing – and particularly their attitudes surrounding prevention messages. (For more details, see Section 7.)

It is true that church groups are often reluctant to take on the kind of roles that donors would like them to adopt. Many prefer to focus on

⁵⁵ Foster, G (2004). *Study of the response by faith-based organizations to orphans and vulnerable children*. World Conference of Religions for Peace/United Nations Children's Fund.

⁵⁶ Ibid.

providing spiritual and pastoral support, home care and basic health services. Some do not feel they are up to the tasks which donors have identified as priorities such as addressing stigma and discrimination, educating people to help them change their behaviour, or providing services such as anti-retroviral distribution.⁵⁷ Many, however, are keen to progress and are constrained only by lack of funds, according to a UNICEF report of 2004.⁵⁸

This same report found that governance and financial systems of faith-based organisations, including small newly established initiatives, were 'as well organised as those of larger NGOs and religious coordinating bodies'.⁵⁹

VI. There is a misconception that churches are partisan about who they will help.

Donors sometimes withhold funds from church projects because of the perception that they are funding 'a denomination'. As the World Council of Churches points out, donors need to be made aware that 'the vast majority of FBOs are non-partisan service providers'.⁶⁰

⁵⁷ Taylor, N (2004). *Many clouds, little rain? The Global Fund and local faith-based responses to HIV and AIDS* Tearfund.

⁵⁸ Foster, G (2004). *Study of the response by faith-based organizations to orphans and vulnerable children*. World Conference of Religions for Peace/United Nations Children's Fund.

⁵⁹ Ibid.

⁶⁰ World Council of Churches (2003). *Responses of the faith-based organisations to HIV and AIDS in sub-Saharan Africa*.

Section 6: churches' untapped potential

The churches have played an important role in the battle against HIV and AIDS – but they could do so much more. Churches' unique reach and influence make them ideal candidates for spearheading a new scaled-up response to HIV and AIDS, focusing on HIV prevention, care and treatment. Indeed, churches *must* step up their response if the Millennium Development Goal on HIV and AIDS is to be reached by 2015. Professor Andrew Tomkins OBE of the Institute of Child Health in London proposes some areas in which the churches could potentially have a huge impact – given the right resources.

PREVENTION

Prevention work is much more cost-effective than treatment and must be the mainstay of any HIV and AIDS response. The churches' communication networks and social standing make them an obvious channel for spreading prevention messages. Some sectors of the church have already grasped this nettle but the church as a whole could do so much more. Churches could:

- **Help dispel the stigma which fuels the spread of HIV.**
Stigma and silence have played a huge part in spreading HIV. They are quite literally lethal: even where testing and treatment facilities are available, people often do not attend for fear of being judged. This will mean churches confronting the part they play in reinforcing this stigma (see next section). Pastors and women's group leaders could take a lead in having an HIV test, to encourage others to do likewise.
- **Promote a radical change in sexual behaviour, emphasising faithfulness to one partner.**
There is no doubt that the best public health approaches to the crisis have Christian values such as abstinence and sexual fidelity at their core. Infection rates are falling in regions where societies are apparently starting to embrace these values (see Section 2). Churches could spread these prevention messages through, for example, networks of full-time youth workers operating in schools and community groups.

HIV prevalence in Kenya has fallen in recent years – and is mirrored by a significant drop in the number of men reporting multiple sexual partners in the previous 12 months (24% in 1998, compared with 11.9% in 2003). The number of men engaged in high-risk sex who were using condoms hardly changed at all (42.5% compared with 46.5%) in the same five-year period.

Source: Ministry of Health, Kenya (2005). AIDS in Kenya: trends, interventions and impact.

- **Promote the use of condoms and distribute them.**
The three key principles in HIV prevention are commonly summed up as ABC: A (Abstain), B (Be faithful) and C (Condoms). While abstinence and faithfulness will remain the first line of defence in church-run HIV prevention programmes, the churches could adopt a more comprehensive

HIV prevention package, one which accepts the value of the appropriate use of condoms. Condom distributions without education are generally considered not just a waste of resources but even a catalyst for casual sex and prostitution. But churches are increasingly recognising that there is a place for condom distribution backed up with counsel and advice to those who are not willing or able to change their lifestyle.

Women, however, have little control over whether or not a condom is used to protect them. A key challenge for churches is to address gender inequalities endemic in African society and to lead by example in giving women greater respect and value (see Section 7).

- **Get involved in preventing parent-to-child transmission (PPTCT).** Although the term 'mother-to-child transmission' is commonly used, it is more helpful to talk of parent-to-child transmission. Even when pregnant women agree to HIV testing, their partners often do not.⁶¹ So even women who test negative are still vulnerable to being newly infected by their partners and passing the virus to their babies during pregnancy or infant feeding.

Churches could set up community support groups for people living with HIV and ensure they had access to PPTCT services. Some churches would be capable of providing these services themselves: HIV testing, administering Nevirapine and giving advice on infant feeding (for more details, see page 30). Churches could also specifically encourage men to have an HIV test and recognise their role in protecting children.

TREATMENT

Churches already have an extensive network of health facilities reaching into remote communities. It could easily extend treatment services to those in greatest need, by working through smaller groups. Churches could:

- **Set up community support groups.** The strain on national healthcare systems means that patients are being discharged from hospital when they are still weak: others are seen briefly in clinics then dispatched with a supply of medicines. Neighbourhood support groups could offer follow-up care by, for example, ensuring people take their medication.
- **Employ community treatment workers.** The role of these workers, who could be paid a small stipend, would be to encourage people to take an HIV test or continue taking their anti-retroviral drugs. They would not need to be professional medics, just volunteers who had attended a short training course in treatment issues. A similar strategy – directly observed treatment programmes or DOTS – is used to monitor people with TB within the community.

⁶¹ Dr Rena Downing, Limuru, Kenya.

CARE AND SUPPORT

The church could step up its care of vulnerable groups such as orphans, if it could better equip its existing volunteers. It could probably also attract more volunteers if the incentives were greater: if volunteers could help people with HIV access treatment, they would get a 'better return' on the time they invest, in terms of people's lives being improved – or even saved. Churches could:

- **Develop the role of volunteers into 'community carers'.** Volunteers offering support to sick people and their families could move beyond simply offering counselling and basics such as food. With external funding, 'community carers' could, for example, ensure that children in families affected by HIV and AIDS continue their schooling.

Parent-to-child transmission – an avoidable scandal

Every year, 600,000 children are newly infected with HIV (UNICEF). Most infection occurs through parent-to-child transmission (PTCT) in pregnancy or early infancy. Transmission can occur in the womb, during labour or through breast-milk. And yet, PTCT can be largely prevented with proper education and treatment. What's more, it costs very little.

Professor Andrew Tomkins OBE of the Institute of Child Health, London, is closely involved with a medical practice in Chilenje, Lusaka. Its key aim is to reduce PTCT. Churches, he believes, could – and should – have a huge impact by following suit. He outlines six key preventative steps:

- The pregnant mother *and her partner* must have an HIV test. Many people refuse to do so, because of the stigma attached to a positive test result. The test, which involves putting a pinprick of blood onto paper infused with chemicals, costs **£2**.
- The mother needs good delivery care. Prolonged or difficult labour without professional medical care can increase the risk of infection.
- A dose of Nevirapine must be given to both mother and child after the birth. This medicine, which has a significant impact on reducing transmission, costs just **£2.20** for both doses.
- Nursing mothers should be persuaded not to mix breastfeeding with bottle feeds: if dirty water is used with formula milk, the baby's stomach lining may be damaged, increasing the risk of possible infection.
- Infected mothers must take a daily dose of the antibiotic Septrin which builds up her resistance to other illnesses. Diseases such as malaria increase the likelihood of transmission through breastmilk. A year's supply of Septrin costs just **£2.75**.
- A mother's cell count can be tested to see if it is sufficiently low for her to take anti-retrovirals.

Total cost: HIV test + Nevirapine + antibiotics = £6.95.

A small price to pay for a child's life.

If all these steps are worked through, the odds are high that the child will escape infection and the mother's life will be prolonged, if not spared.

Churches are ideally placed to make this framework of care a reality for millions. They need to support pregnant women and their partners, educating them about the risks to their unborn child and helping them access testing and treatment facilities. Churches could provide treatments, through their established health networks. And their biblical understanding of the special value of children, born and unborn, makes them highly motivated to defend children's rights. Most importantly, churches must address stigma, for which they must take some responsibility, says Professor Tomkins:

'Children have largely been neglected because people have been focusing on [HIV- and AIDS-affected] adults, who are seen as more important politically. But it is a baby's birth right to be born uninfected, so it is a baby's right for his mother to have HIV testing. The church needs to be envisioned, inspired and resourced. The church has been too quiet for too long about ways of preventing innocent children from becoming infected with the deadly HIV virus.'

Section 7: challenges for churches

Churches have done much to contain the spread of HIV and AIDS – but often they have also been part of the problem. They need to tackle some deeply entrenched taboos – and recognise the part they have played in feeding them and so helped infection spread. In particular, churches need to change their own attitudes towards women, the worst-affected group in the African pandemic. Churches must confront gender inequality – one of the top risk factors for women vulnerable to HIV infection.

Stigma and silence

Although some parts of the church have broken the silence and stigma surrounding HIV and AIDS, many sectors remain tight-lipped. Meaningful preaching on issues surrounding sex, gender and disease is still not widespread. In fact it was found to be a ‘weak area’ in churches in seven countries surveyed for the Oxford Centre for Mission Studies in 2005.⁶²

‘Most people do not tell their church pastors when they find they are positive for HIV. There is a pastor who will not baptise a person who is HIV positive, while in another church there is a young lady who has been completely ignored after she disclosed her status. There is another pastor who is positive but unable to talk about it because of fear that he would be thrown out of the church.’

Ethiopian Christian interviewed for Tearfund, 2006.

In breaking that silence, churches have to think carefully about the prevention messages being delivered from the pulpit. Too often churches have helped feed stigma and rumour by moralising about HIV and AIDS instead of offering acceptance to vulnerable people. In some congregations, HIV is still seen as a curse for sinners. There is even evidence of people being thrown out of churches when they admit to having HIV.

In Kenya, it is common practice across denominations that when a young woman becomes pregnant out of wedlock, she is effectively ‘excommunicated’. She will not be supported by the church until the child is born. She then has to repent publicly, often at the child’s baptism. Unmarried women in Africa are particularly vulnerable to HIV as often sex is non-consensual.

Source: Desk review for Tearfund by Dr Rena Downing, Limuru, Kenya.

Archbishop Benjamin Nzimbi of the Anglican Church of Kenya made international headlines in March 2006 by apologising publicly that the church

⁶² Nussbaum, Stan (ed) (2005). *The contribution of Christian congregations to the battle with HIV AND AIDS at the community level*. Global Mapping International, 2005, for Oxford Centre for Mission Studies.

had previously shunned those with HIV and AIDS. 'Our earlier approach in fighting AIDS was misplaced, since we likened it to a disease for sinners and a curse from God. We apologise for earlier abandoning our flock, which was as a result of our ignorance of the disease. Today we are more informed.'⁶³

High-profile figures such as Canon Gideon Byamugisha, the first Anglican priest in Africa to speak out about having HIV, have done much to encourage open debate. Byamugisha, who has dedicated his life to HIV and AIDS advocacy, addressed the UN General Assembly in June 2006 at its High-Level Meeting on HIV and AIDS in New York.⁶⁴

The lesser of two equals: liberating women

Any new approach to HIV prevention is doomed to failure in the long term if it does not address the pressing problem of gender inequality. Statistics prove time and again that women are much more vulnerable to HIV: young women in sub-Saharan Africa are six times more likely to become infected than men. (See Section 1 for more statistics.) Biologically they are more susceptible, but far more critical is the role into which society casts them.

'Prevention methods such as the promotion of condoms are too simplistic. First of all there needs to be a huge paradigm shift in attitudes to women in Africa. Then we can prevent the spread of HIV.'
Dr Rena Downing, St Paul's Institute of Life Long Learning, Limuru, Kenya.

In Africa particularly, many women are coerced into having sex when they are still young. Sexual violence against women, within and outside marriage, is almost a cultural norm in some countries. Many women discover they have HIV when they are pregnant: many men abandon their wives at this point (see Mary's story in Section 3, page 19). Anecdotal evidence from Nigeria suggests women rarely have access to anti-retroviral drugs because their supply is controlled by men.⁶⁵

The traditional ABC prevention approach (Abstain – Be faithful – Condom) will remain ineffective until gender inequalities are tackled. It is men who are most likely to decide to flout the ABC code – yet it is women who bear the consequences of men's decisions:

Abstain. Women are more likely to abstain than men. A survey of African women with HIV found that 61 per cent of them had never had sex with more than one man.⁶⁶ The implication is that many a young bride is infected on her wedding night.

Be faithful. Men, married or otherwise, are much more likely to have several sexual partners than women. Marital fidelity is therefore no

⁶³ CAPA online news www.anglicancommunion.org/provincialnews/capa

⁶⁴ Christian Post (5 June, 2006). *HIV-positive priest calls for total commitment to AIDS fight.*
www.christianpost.com

⁶⁵ Dr David Evans, HIV and AIDS consultant.

⁶⁶ Strategies for Hope Trust (2004). *'What can I do?'* video by Gideon Byamugisha. Oxford.

guarantee of 'safe sex' for women. Men and women are much less likely to use a condom in a committed relationship than in a 'casual encounter'.⁶⁷

Condoms. Condom distribution without education offers no real protection for women. Even if women want their partner to use condoms, men reserve the right to refuse – and frequently do. Thirty per cent of Nigerian men feel women have no right to tell a man to use a condom.⁶⁸

'We know that in many societies now the biggest risk factor is to be married at an early age, always with an older man. The irony is that marriage is becoming a risk factor for HIV, and the majority of women, in Thailand, in East Africa, are now only infected by their only sex partner, their husbands.' Dr Peter Piot, Executive Director of UNAIDS.

From Reuters article: AIDS increases among women; sexual control absent, 30 May 2006.

Churches have reflected, perhaps even reinforced, this inequality. At a basic level, this is seen in the gender ratio of many churches' leaders. At worst, preaching distorts Bible references to female submission and becomes a means of justifying sexual violence against women. There is much anecdotal evidence of single women being 'excommunicated' during their pregnancy.

Again, churches are in a unique position to tackle deep-rooted stigma and inequality, given their social standing, influence and long reach. Tearfund has recently run HIV prevention workshops in Nigeria for some of its church partners, discussing the need for more comprehensive HIV prevention work. Confronting taboos and tackling gender inequality were identified as essential elements in any prevention portfolio.

Change to high-risk behaviour will only come if attitudes change. Funding will only be effective if it gets to the heart of communities and helps effect this change. Churches have a key role to play in helping transform communities – and the time to act is now. As Professor Andrew Tomkins puts it, 'The HIV and AIDS crisis is no longer a development issue: it's a disaster. The church does not sit by when there's a disaster: they get involved.'

⁶⁷ Kenyan Central Bureau of Statistics (2003). *Kenya Demographic and Health Survey 2003*. Nairobi.

⁶⁸ National Population Commission of Nigeria (2004). *Demographic and Health Survey of the National Population Commission of Nigeria 2004*.

Postscript

By the Most Reverend Njongonkulu Ndungane Anglican Archbishop of Cape Town

'[Churches] must bear a heavy responsibility in relation to the crippling issue of stigma, and its attendant problems of fear, denial and silence, which too often prevent treatment just as for any other disease.

We have too often espoused destructive theologies that inexorably link sex and sin and guilt and punishment. We must take the lead in overturning these distortions. Of course we must uphold sexual morality, but we must do so in a way that gives people, especially the young, a holy, healthy and holistic view of life, not merely a list of 'don'ts'. We must also do so in a way that does not allow people to be marked out, labelled, judged and ostracised.

Too often it is the faithful wives of unfaithful husbands who are most at risk – and their children, whether infected or affected, also suffer through no fault of their own from belonging to stigmatised families. Yet our Christian tradition teaches us to give special care to abandoned women, widows and orphans.

Stigma has become the silent killer: it decimates families, who cannot speak to each other about the illness in their midst. Stigma brings fear of alienation and rejection. People shun testing and even exclude themselves from treatment, since this would give the game away. So, often unwittingly, they continue to spread infection.

If we are to defeat this 'sleeping giant' we must break the silence and end the stigma. We must ensure we are no longer part of the problem and instead help lead the solution.'