PACANET

Pan African Christian AIDS Network

SITUATION ANALYSIS REPORT OF CHURCH RESPONSE TO HIV AND AIDS IN SIERRA LEONE

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Management PACAnet

ABBREVIATIONS

ACSA	-	Anglican Church of South Africa
BCC	-	Behavioural Change Communication
CARE	-	Care for American Relief Everywhere
CCSL	-	Council of Churches Sierra Leone
DFID	-	Department for International Development
EFSL	-	Evangelical Fellowship Sierra Leone
EHAIA	-	The Ecumenical Response to HIV/AIDS in Africa
FBO	-	Faith-Based Organizations
FHI	-	Family Health International
IEC	-	Information, Education and Communication
INGOS	-	International Non-Government Organizations
IRCSL	-	International Red Crescent Sierra Leone
MDGs	-	Millennium Development Goals
NAS	-	National HIV/AIDS Secretariat
NECHRAS	-	Network of Christian AIDS Response
NGOS	-	Non-Governmental Organizations
PACANET	-	Pan African Christian AIDS Network
PLWHAS	-	People Living With HIV and AIDS
PMTCT	-	Prevention of Mother to Child Transmission
PPASL	-	Planned Parenthood Association Sierra Leone
SDA	-	Seventh Day Adventist
SPSS	-	Statistical Package for Social Sciences
UNAIDS	-	United Nations AIDS Groups
UNICEF	-	United Nations Children’s Fund
USAID	-	United Nations Agency for International Development
VCCT	-	Voluntary Confidential Counseling and Testing
WCC	-	World Council of Churches
YMCA	-	Young Men’s Christian Association
YWCA	-	Young Women’s Christian Association

EXECUTIVE SUMMARY

This study was undertaken in order to assess the response of the church to the HIV and AIDS crisis in Sierra Leone, against a rising prevalence rate.

Data were collected from all four provinces in the country (See Maps) and a total of 383 church organizations were canvassed. Both quantitative and qualitative research techniques were used to obtain a clear picture of the church's HIV and AIDS activities.

The results indicate that just over one third of the churches implement HIV and AIDS activities. Indeed, all denominations of the church reportedly implement these activities although to varying degrees. Similar differentials in implementation by province are also reported. HIV and AIDS activities are most common in the Western Area and least common in the Eastern Province. Although various activities such as care and support, advocacy and networking are carried out, awareness raising and sensitization are the most popular. The churches also play various roles in coordination and networking.

Various challenges to implementation were identified. Paramount among these were inadequate financial and human resources.

It is not surprising that among the solutions to tackle these problems, increased access to funding and training in technical skills were recommended.

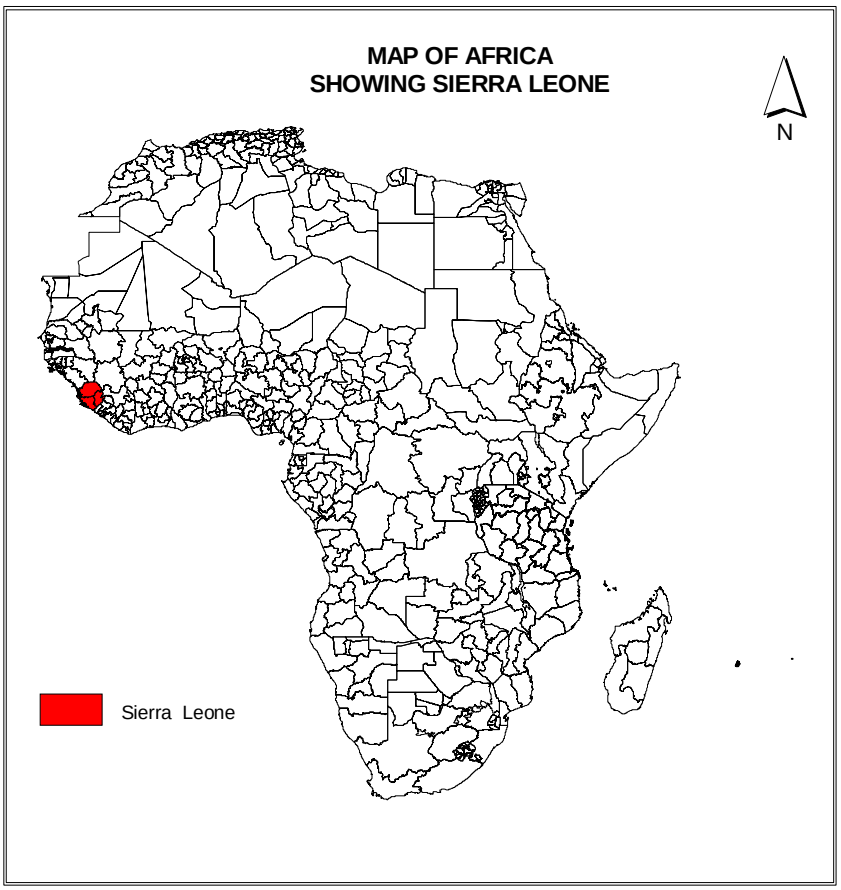
Although submitting proposals was identified as a major way of sourcing funds the research suggest that few church organizations have submitted such proposals and have not benefited much from this strategy. A major setback to funding is the lack of knowledge about funding resources.

Although 30. 0 percent of the churches use material resources, unavailability affects use. The materials are essential for IEC/BCC and are obtained from diverse sources.

Most HIV and AIDS use volunteers and employ staff although these are few, part-time in nature and of local background. Lack of funds is a key-inhibiting factor in this regard.

Generally, implementers have basic facilities such as office space, bank accounts, account personnel but lack monitoring systems and submit few proposals.

On the whole, most churches consider their HIV and AIDS activities as basic with little or no funding as a major characteristic.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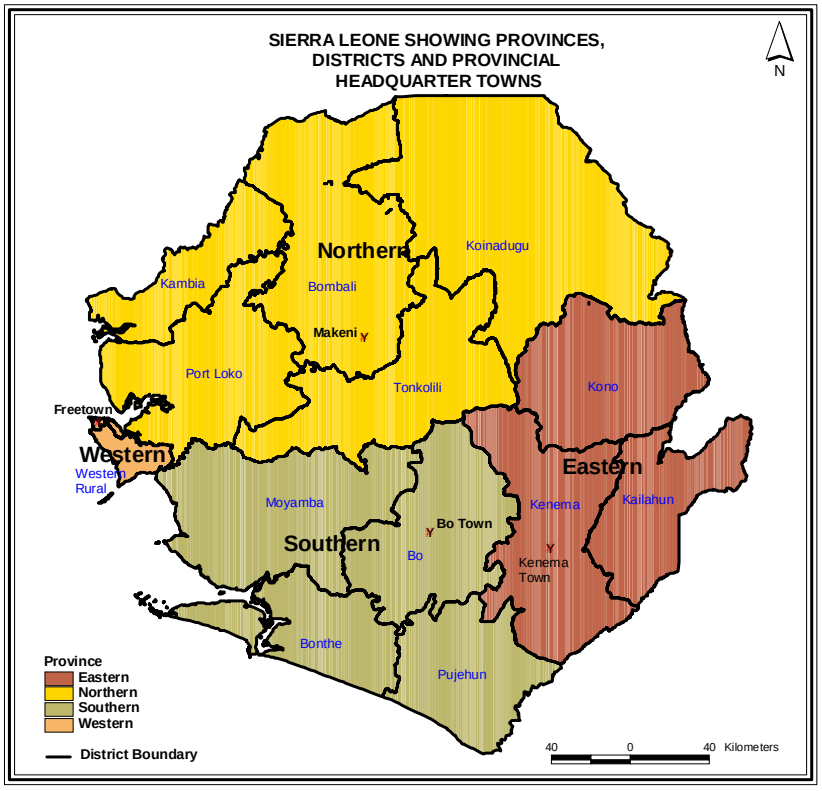
Sierra Leone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SECTION 1
INTRODUCTION

1.0 BACKGROUND

HIV and AIDS is undoubtedly one of the most serious clinical and socio-economic problems of our time. In Sierra Leone, the first case of HIV and AIDS was diagnosed in 1987. Since then, Government and its partners, including the UNAIDS have made considerable strides in controlling the spread of the virus

The National AIDS Secretariat (NAS), for example, was set up in 2002 expressly to address the ramnifications of the disease. A major component of the National AIDS project is the Community and Civil Society Initiatives, which encourages religious, and other community, civil society and private organizations to contribute to tackling the HIV and AIDS problem by implementing short-term projects on HIV and AIDS. These projects are funded by NAS through its Sierra Leone HIV and AIDS Response Programme (SHARP).

A review of the list of collaborative groups however suggests that the involvement of the Church, irrespective of denominations or other criteria, has been low.

In Sierra Leone, few studies if any, have been conducted on HIV and AIDS that deal directly with the church and similar religious organizations, as primary target groups.

Nationwide, estimates of the prevalence of HIV and AIDS in 2005[1] suggest that 1.5 percent of the population were already infected. Although this rate may be considered as low and below the threshold of 5.0 percent, it reveals a 66.7 percent increase in three years over the 0.9 percent estimates of 2002.[2] The fact that the incidence is rising suggests that more efforts are required to control the spread of the disease.

1

[1] National HIV AND AIDS Secretariat commissioned a national sero-prevalence study in 2005.
2. This study was conducted by Centres for Disease Control, Atlanta, USA.

About 30-40 percent of the national population are christians[3]. These are the two major religions in the country. Other religious such as Bahai Traditional, and others account for only 2.4 percent. Programme interventions on the Christian sector of the population could produce some positive impact on behaviour, attitude, knowledge and practice, this could have a spill over effect to the general population.

1.2 Rationale of the Study

1. This study will serve as a situation analysis of the church's involvement in HIV and AIDS activities whilst at the same time providing the necessary data for the design of specific interventions in the area.
2. The study contributes to the available database on the disease especially among faith-based organizations.
3. The Government of Sierra Leone puts as much premium on tackling the HIV and AIDS crises in its Poverty Reduction Strategy Paper as it does in the MDGs. The study will therefore contribute to understanding the views, practices, and attitude , the successes and shortcomings of the religious sector of the population, as a vital step in controlling the spread of the disease, nationwide.

1.3 Objectives

The study has five key objectives:

1. To identify existing HIV and AIDS interventions by the church and Christian organizations.
2. To identify and document existing resources available and accessible to the church and Christian organizations.
3. To assess the capacity of the church and Christian organizations based on their responses.
4. Identify and learn from best church practices in Sierra Leone.
5. To recommend mechanisms of how the church and Christian faith based community can scale up its HIV and AIDS response.

3. Based on the national Housing Census of 2004.

SECTION TWO LITERATURE REVIEW

2.1 Introduction

Following the discovery of HIV and AIDS, numerous programmatic and non-programmatic responses have been implemented to control its spread. Various governmental and non-governmental community and private organizations have been at the forefront of the campaign to tackle the disease. HIV and AIDS are considered as a challenge to which all religious organizations have been struggling to respond. In essence, the church has however lagged behind in this drive to contain the greatest scourge of our time.

2.2 Stereotype Arguments

Many arguments have been put forward in trying to highlight and explain the church's position. Although the views vary across geographic frontiers they are however coterminous in perspective. Adenuga et al (2002) submit that many church leaders continue to link HIV infection to sin despite the high level of awareness and amidst a growing demand for spiritual counseling. Similar views are expressed by MaCabe (2006) who in addition, points out that by attributing HIV to a punishment from God we can free ourselves from any concern for our neighbours. Phiri (2004) argues that the view that HIV and AIDS is a punishment from God was the predominant initial theological stand of the church. This was associated with the mode of transmission of the disease which in the main is heterosexual multiple relationships.

Part of the stereotyped justification for the church's inability to act is related to the aloof posture adopted by the church. Chaava (accessed 28/10/07) discussing the situation in rural Zambia makes the following points.

> "that many church leaders had been reserved and treated HIV as a health issue; they became only involve during funerals when HIV and AIDS was not even mentioned; nor did church meetings reflect the seriousness of the epidemic. Neither youth nor women meetings highlighted the magnitude of the problem. In more general terms congregations themselves have only rarely responded to the epidemic. Similarly, funeral rites and burials were conducted with little or no reference to HIV and AIDS."

Part of the church's inability to respond to the disease is that they have struggled to read the writings on the wall as far as HIV and AIDS is concerned (Phiri, 2004 ibid). Faith-based organizations have also been accused of being slow in acting on their responsibility to help

prevent the spread and also provide care for those infected (Steinitz, 2006). The underlying rationale has been the unwillingness to discuss issues of sexuality, which is considered a taboo in Namibia. Steinitz further notes that the churches slow or non-existing response is associated with constraining factors such as:

(i) Lack of programmatic experience, administrative capacity and accountability;
(ii) Church's disapproval of condom use.
(iii) Diversity of cultures and nations makes it difficult to transplant models or best practices.

Complacency among some Christian groups may have also contributed to inactivity by the church. Phiri (2004 ibid) draws attention to the nature of views expressed among a group known as "women of faith' from different parts of Africa but meeting in South Africa. One view expressed was:

> "We need not worry about being infected with the virus, because as long as we remained faithful to our husbands and prayed for protection, God was going to hear our prayers and protect us from the virus."

Paradoxically though, among the group was one woman living with HIV and had become infected while she was a committed christian and faithful wife.

Phiri (op.cit) has argued that the theological issues raised by the 'women of faith' group represent an on-going theological discussion on the mission of the church in Africa, in the context of HIV and AIDS

2.3 Changing Views

In a rather reconciliatory tone, the church has in more recent times acknowledged its short-comings in addressing HIV and AIDS.

Three partners have noted that as HIV and AIDS enfolds it has exposed serious deficiencies of the theology, ethics, liturgy and practice of their ministry. They argue further that in modern times, churches are obliged to acknowledge that they have, unwittingly contributed

both actively and passively to the spread of the virus; their difficulty in addressing issues of sex and sexuality has contributed immensely to their inability to handle issues of sex education and prevention with honesty and realism. They are guilty of marginalization and that the church's interpretation of the scriptures and the theology of sin have all combined to promote stigmatization, exclusion and suffering of people with HIV or AIDS. The wider effect is to undermine the effectiveness of care, education and prevention efforts and inflict additional suffering on those already affected by HIV. The partners acknowledge further that a rethinking of their mission and the transformation of their structures and ways of working are required.

Chaava (op. cit)makes the point, agreeably, that throughout African Christian churches, a response to HIV and AIDS is emerging (e.g. Kenya, Zambia, South Africa, Sudan) and that deep reflections on the meaning of HIV and AIDS for congregation is now taking place at all levels of church organizations.

In Oceania, the young church is desirous of responding to the growing AIDS pandemic, which they consider a challenge (MaCabe, 2006, ibid). Some church organizations have more or less personalized' their concern about HIV and AIDS. Handysides (Director of Health Ministries for the Seventh Day Adventist Church) for example, points out that AIDS is an Adventist problem. On a more dismal note, the ACSA HIV and AIDS office recognizes the central role the global church has played in the generation and perpetuation of HIV and AIDS related stigma. Phiri (2004, op.cit) submits that HIV and AIDS is an urgent issue for the theology of mission in Africa.

Caritas International identified HIV and AIDS as a priority theme for reflection and action among organizations of the confederation. It also notes that the enormous challenges which AIDS poses for members of religious orders and clergy is only becoming evident.

2.4 How the Churches Can Respond to HIV and AIDS

The church, it is agreed has certain qualities, which make it capable of dealing with the AIDS situation rather successfully.

Hobbs (1999) noted that the church has the ability to influence the values and actions of not only the congregation, but also wide segments of the community.

Avornyo (2007) goes further and points out that the church has the following comparative advantage in dealing with HIV and AIDS. (i) The largest participation; (ii) the widest distribution; (iii) the simplest administration; (iv) the fastest expansion; (v) the longest continuation (vi) the strongest authorization and (vii) the highest motivation.

Against this background, the following are among the strategies that have been suggested to deal with the pandemic.

Macabe (2006 ibid) observes that there needs to be open and honest dialogue between local culture and the gospel. He further points out that one of the greatest challenges of the church is to reflect upon the ways in which it has understood sexuality and equality, the ways in which it dialogues with different cultural understanding of sexuality. Although the stance of the World Council of Churches (2006) parallels this view, it also emphasizes promotion of open and inclusive discussions on issues related to gender based violence and intravenous drug use to empower individuals and communities to be less vulnerable to HIV. It is also suggested that there should be universal treatment of HIV and that the churches must advocate for such access.

The ACSA approach involves:

(i) Christian-based ecumenical, multi-sectoral partnering with other denominations, faiths, NGOs, and engaging government departments at all levels;
(ii) Breaking the structural cycles of inequality, patriarchy discrimination, poverty and oppression, which have sustained and aggravated the effects of the HIV and AIDS pandemic (in South Africa).

It was pointed out by Donohue (1994) that there is need to reestablish the church's credibility and begin the task of rebuilding trust between priest (catholic) and non-ordained members of the church.

The same point was made that AIDS has highlighted some long-standing and complex issues that should be addressed. These include: church's teaching on topics such as chastity, celibacy, marriage, parental responsibility and family life. These should be addressed in the context of sexuality. It is posited that a renewed theological and spiritual reflection is needed in these areas.

Donohue (1994) observes that the initial response of many bishops and superiors in dealing with priests of the Catholic Church and the HIV issue was to institute HIV testing as a requirement for all candidates of seminaries and religious life. Apart from raising issues on human rights, justice and other pastoral concerns. These approaches have not been successful.

Indeed, Arvonyo (ibid) also makes the point that in the early 1990s the church responded to the HIV pandemic by developing theologies which were not necessarily correct or helpful. He also suggests that the most essential strategy to overcome HIV is behaviour change. He adopts Stephen Covey terms "character ethic" as opposed to "personality ethic" as the goal of his change.

2.5 Programme Response To HIV AND AIDS

The response of the church to HIV and AIDS has grown considerably over the years. In the 1980s the church was unaware and unprepared for the HIV and AIDS epidemic and responded with denial. By the 1990s the church's response was assessed as fragmented and uncoordinated and with limited resources Avornyo (2007 op.cit). Steinitz (2006) for example observes that the willingness of local churches in Namibia to get involved in the fight against HIV and AIDS has improved in recent years. Such an improvement has been global in extent and diversified in nature. Programmes have covered a broad spectrum ranging from awareness raising and sensitization to the formulation and implementation of Action Plans on HIV and AIDS.

In Oceania, awareness-raising seminars were organized for various levels of the religious hierarchy and the laity. Quite crucial is the fact that participants identified various social, cultural and economic factors affecting the church's response to HIV and AIDS. These factors include the community as against the individual, gender. It has stressed that culture has values, which are consistent with the gospel. These enable communities to both initiate and strengthen pastoral responses to HIV and AIDS. Some of these values include respect for elders, strong support for family life, hospitality, generosity and a communal life style (MaCabe 2006 op.cit).

The Confederation of Caritas International on behalf of the Catholic Church identified a working group on HIV and AIDS with representation from every region of the world. They have also floated information, education and communication programmes at regional, national and local levels for church leaders, health personnel and social service professionals. Resource mobilization has also been part of their programme in Africa, Latin America, East and Central Europes, Middle East, Asia and Oceania. Other responses have included institutional support and promoting networking on AIDS.

In South Africa, the Anglican Church (ACSA) in 2003 officially launched its first comprehensive and provincial wide response to HIV and AIDS known as "the Building of Foundation [Isiseko Sokomoleza]. It was intended to reduce stigma and the impact of HIV and AIDS. Its priority areas were prevention, treatment, care and support, research and human rights.

The programme aimed at mobilizing and building the capacity of the Anglican churches on regional, diocesan and parish level to plan, implement and run projects offering care to those living with or otherwise affected by HIV and AIDS, and to establish initiatives to prevent future spread and development of AIDS. The programme complements the South African Government's National HIV and AIDS Strategic Plan of 2000-2005. It is expected to cover 2.5m Anglicans in 815 parishes in 26 dioceses in the following countries Angola,

Mozambique, Namibia, South Africa, Losotho and Swaziland, St. Helena and Ascension. Funding was by DFID.

The Uniting Presbyterian Church also adopted a four-pillar HIV and AIDS strategic framework and a vision statement to guide future HIV and AIDS activities.

In Nigeria, the 20 million-member Anglican Church had not traditionally addressed the health related needs of its congregation. With technical assistance from USAID an Anglican Church Policy was adopted in March 2004 together with a five year plan that deals with prevention, care, and support and the protection of rights for infected and affected members. The catholic church of Nigeria, after adopting a HIV and AIDS policy in 2002, developed an Action Plan in 2003. The Plan had three objectives: reducing transmission of HIV in catholic health institutions and parishes in Nigeria, improving the quality of life of PLWHAs and mitigating the impact of HIV and AIDS on communities.

The United Methodist Church in Zambia response to HIV and AIDS was centred around four main areas.

(i) Home of Hope – infant AIDS orphans received care by surrogate mothers and fathers and extended family members were encouraged to adopt them.

(ii) Church leadership training on AIDS.

(iii) Youth AIDS training

(iv) Orphan trusts. (General Board of Global Ministries. The United Methodist Church).

The Salvation Army in Zambia is considered to be among the first religious bodies to respond to HIV and AIDS by setting up home-based care for PLWHAs and community counseling. (Chaava ibid) further makes the point that in Uganda, every Salvation Army congregation has an income generation activity to support widows and orphans and home visiting teams are becoming a part of their church life.

In Uganda also, the decline of HIV and AIDS prevalence from 28.9 to 6.9 percent was achieved through programmes involving both the church and state. The crux of the programmes was on counseling, reducing peer pressure, advising young people to abstain and

encouraging the older to be faithful in marriage. Problems of alcohol and drug abuse were also addressed.

The Pan African Lutheran Church aimed to work to improve the lot of PLWHAs, by breaking silence about HIV and speaking openly and truthfully about human sexuality and HIV and AIDS. Specific areas include IEC, advocacy and prevention, care and counseling. (WCC, 2002)

The development of comprehensive Plans of Action to deal with HIV and AIDS has also been part of the church's proposal to tackle the crisis.

In Africa, the ecumenical response is concretized in a Plan of Action, which is the result of collaboration among three partners. The Plan was designed to turn around the negative approach to HIV and AIDS that had characterized the partner churches. It was a new and realistic initiative that would enable the churches to speak honestly about HIV and AIDS while at the same time act practically in response to the disease.

Some of the major areas of the Plan are issues of commitment, PLWHAs, education, training, prevention, care and counseling, support, treatment, advocacy, gender, culture, liturgy and resources. Each of the partner churches is encouraged to own this plan and to ensure its implementation (EHAIA 2001).

The Adventist contribution involved the establishment of an office in Africa to provide "leadership and focus for the church's response to the HIV epidemic, as part of its initiative aimed at dramatically stepping up its ministry to people affected by HIV and AIDS. The ministry will encourage and coordinate broad church involvement from local churches, humanitarian organizations, health care and educational institutions.

Hobbs (2006) in discussing some problems encountered by the black church in Boston in the attempt to respond to HIV and AIDS notes: the following:

- The lack of faith-based leadership support for HIV prevention policies and programmes in the African American communities.
- Lack of spiritual based HIV prevention programme and HIV services targeting African American communities.

- Faith leaders are in need of a clearer ‘road map’ for developing effective HIV prevention ministries that are sensitive to the church’s ‘cultural’ values and norms.

Finally, in Nigeria, one lesson learnt regarding the response of the church to HIV and AIDS was noted by Adenuga as:

- Church based initiatives work best with a combination of approaches, which recognize the peculiar barrier of the church (Adenuga 2002 et al op. cit).

2.6 Summary

This review has revealed the following crucial points:

(i) The attitude of the church has been at best lukewarm to the issue of HIV and AIDS. At worst it was one of denial.

(ii) But the church is well placed to address HIV and AIDS in terms of numerous comparative advantages it has.

(iii) Most churches across denominations and geographic regions are now realizing that they need to play more active role in addressing the pandemic.

(iv) As a sequel to this diversified programmes such as IEC, counseling care and support for PLWHAs are being supported by donors both in church circles and outside it.

(v) Nevertheless, some obstacles exist as the church itself may not just now have the capacity to deal with the pace of the pandemic.

3.0 SECTION THREE - METHODOLOGY

3.1 Research Methods

The study made use of both qualitative and quantitative techniques.

As regards the first technique, Focus Group Discussions were held with three groups of Pastors from thirteen churches mostly from the Pentecostal denomination. Each group consisted on average of seven participants. They were interviewed in Freetown the capital and Waterloo a rural setting about 20 kilometers outside the capital. The discussions wer lead by the Consultant.

3.2 Determination of Sample Size

Previous studies have shown that the church is hardly involved in HIV and AIDS interventions In one assessment, Christian organizations constituted about 7.0 percent of fifty six partners of NAS. Using a projected estimate of 10.0 percent involvement by the church, a 95.0 percent confidence interval and a level of precision of 3.0 percent the total sample arrived at was 384 churches to be drawn from various denominations.

3.3 Sampling Frame and Sample Size Distribution

Regarding the quantitative technique, the sampling frame consisted of various church umbrella bodies such as the National Pentecostal Mission, Methodist Church Sierra Leone, Wesleyan Church Sierra Leone, Baptist Convention Sierra Leone, Anglican Diocese, the Catholic Church and others.

Attempts were made to distribute the sample size proportionally by denominations to achieve a fair representation of each denomination. The sample was further proportionally distributed by district to reflect a representative coverage of all twelve districts and the Western Area of the country.

3.4 Data Collection

The field work was preceded by a two-day training of field staff (8 Enumerators and two Supervisors). A pre-test of the questionnaire was carried out on the second day. Data were collected by teams comprising of both sexes.

Two research instruments were used for data collection.

1. A structured questionnaire that contained the following sections:
   (i) Information on the church and other details of the Leader/Respondent.
   (ii) Intervention in HIV and AIDS
      (a) Type and level
      (b) Funding sources and limitations
      (c) Human resource base – qualification training, and experience
      (d) Nature and gaps in BCC materials
   (iii) Capacity of church and Christian organizations
      (a) Governance and leadership
      (b) Infrastructure and logistical support
      (c) Skills and training
      (d) Partnership and networking

2. Semi-structured questionnaire for the qualitative study. Issues to be discussed will include:
   (i) Attitude to HIV and AIDS
   (ii) Policy on HIV and AIDS if any
   (iii) Networking on HIV and AIDS
   (iv) Capacity for project writing on HIV and AIDS
   (v) Current intervention on HIV and AIDS

3.5 Data Entry

Data will be entered in EXCEL by a trained data entry clerk and later imported into SPSS for analysis.

3.6 Data Analysis

SPSS Version 12.0 was used for data analyses. Qualitative data were analyzed thematically. Examples of themes looked at were: church's policy on HIV and AIDS; partnerships and networking.

Quantitative analyses involved both univariate and bivariate techniques.

The latter was used to understand relationships between variables in the study better).

To aid presentation, appropriate charts/graphs are used.

4.0 SECTION FOUR – FINDINGS OF QUANTITATIVE STUDY

4.1 Quantitative Results

4.1.1 Introduction

This section looks at the non-programmatic background issues.

4.1.2 Coverage

The results of the study show that data were collected from all administrative regions as seen in Table 1.

Table 1: Percentage Distribution of Churches Based on Province (N = 384)

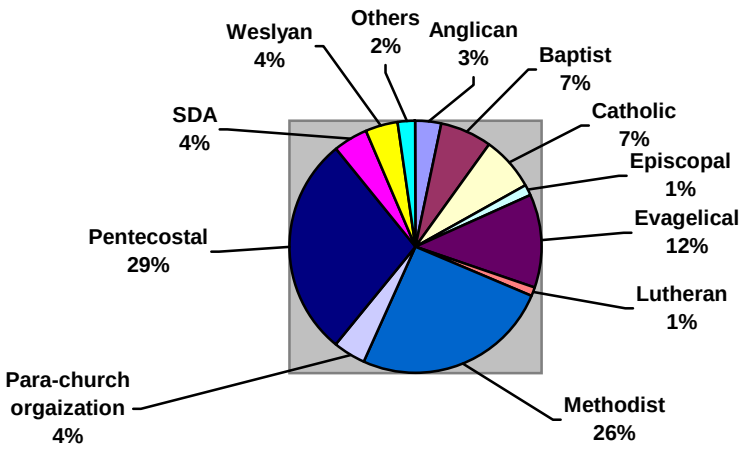
PROVINCE	PERCENTAGE
Northern	14.6
Southern	13.3
Eastern	12.1
Western Area	65.6
Total	100.0

Almost two thirds of the Christian organizations were covered in the Western Area although all districts except Pujehun were canvassed given the timing frame of the study because of transportation difficulties

4.1.3 Composition of Sample

The sample reveals a number of denominations as seen in Figure 1.

FIGURE 1 Composition Of The Sample



The results suggest that the Pentecostal Churches account for more than one fourth of the sample or 29.0 percent, followed by the Methodist Church, which comprise 25.6 percent of the sample. Smaller denominations such as Episcopal and Lutheran each representing 1.1 percent are also reflected in the sample. The category 'others' included churches which were reported as spiritual 'self', 'charismatic', for example.

4.1.4 Type of Christian Organizations

The results of the study indicate that 92.1 percent of the samples were individual churches as seen in Table 2.

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Table 2: Percentage Distribution of Christian Organizations

TYPE OF CHRISTIAN ORGANIZATIONS	PERCENTAGE
Church	92.1
Head Office/Diocese	2.0
Network Umbrella Body	1.1
Para Church Organization	3.1
Partners	1.7
Total	100.0
Sample Size	383

Network umbrella bodies make the least contribution to the overall sample.

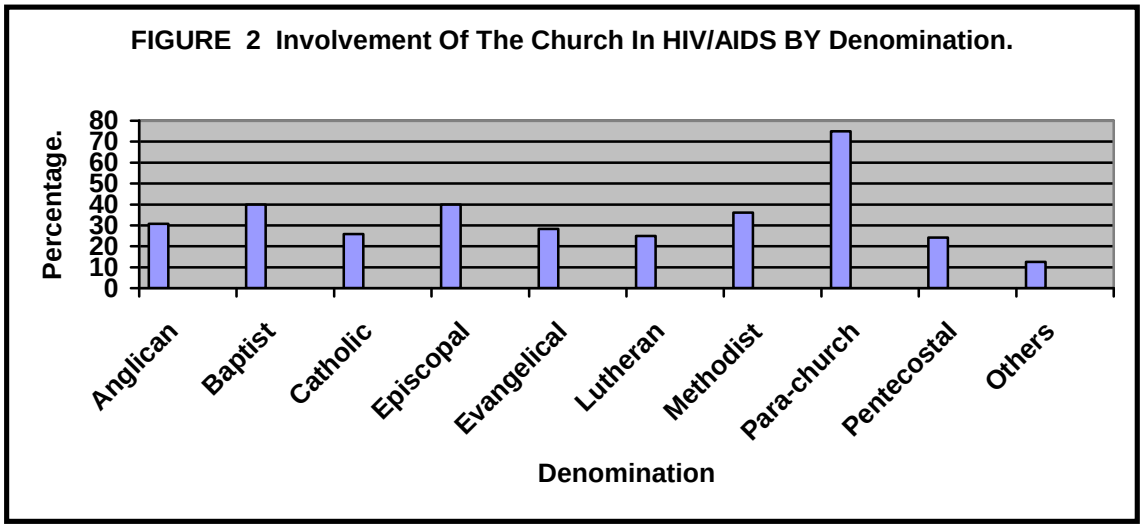
4.1.5 Involvement in HIV and AIDS Activities

The results indicate that 34.0 percent of the FBO indicate that they are involved in the implementation of HIV and AIDS activities.

The distribution by region as suggests that the Western Area has the largest involvement 44.8 percent whereas the Eastern Province has the lowest involvement of 9.3 percent

4.1.5.1 Involvement By Denomination

The various faith-based organizations are involved in HIV and AIDS activities to varying extent. As seen in Figure 2 Para Church Organizations reported the highest percentage of involvement reaching 75.0 percent. The results reveal that apart from the category 'Others' the Pentecostal Church, which constitute the largest proportion of the sample, has the lowest level of involvement – less than three in ten churches.



4.1.5.2 Nature of Involvement In HIV and AIDS Activities

For those organizations, which are already involved in HIV and AIDS activities, the questionnaire sought information on the type of activities they are engaged in. The results are outlined by type of activity below.

4.1.5.3 Prevention Activities

In this section, a number of issues are identified as noted in Table 3.

Table 3: Percentage of Churches Based on Prevention Activities Implemented by Province

Prevention Activities	Province				
	Northern	Southern	Eastern	Western Area	Average
General Awareness and Sensitization	100.0	100.0	75.0	99.0	98.4
Life skills	55.6	75.0	50.0	51.4	67.0
Voluntary Counselling and Testing	44.4	41.7	0.0	34.9	35.2
PMTCT	22.2	50.0	0.0	29.0	20.0
Promoting Abstinence	77.8	91.7	25.0	75.7	75.8
Sample Size	9	14	5	103	131

The overall results suggest that the most common activity is general awareness and sensitization. Two other preventive activities are also popular in the regions namely, promoting abstinence and life skills in descending order of popularity. The least common activity is the prevention of mother to child transmission of HIV and AIDS. In this connection, only about two out of every ten churches in the sample reported implementing this activity.

There are variations by region. It is noted for example that in the churches in the Eastern Province, no church carries out either VCCT or PMTCT. Similarly, in each of the provinces, PMTCT is the least common activity. On the contrary, sensitization and awareness raising activities are easily the most popular activities in each of the provinces.

4..1.5.4 Care and Support Activities

Information on a total of twelve care and support activities was sought in questionnaire. The results as outlined in Table 4 indicate that care activities seem to be more popular than support activities even though, on the whole, both activities are low keyed.

Table 4: Percentage of Church Organizations Implementing HIV and AIDS Programmes by Care and Support Activities Reportedly Being Implemented in Various Provinces

Care and Support Activities	Provinces				
	Northern	Southern	Eastern	Western Area	All
Provision of home care	33.3	25.0	25.0	18.4	21.1
Counselling support	66.7	83.3	25.0	62.1	63.3
Treatment of opportunistic infections	11.	16.7	0.0	12.6	12.5
Income generating activities	22.2	16.7	0.0	19.4	18.7
Shelter construction	11.1	0.0	0.0	8.7	7.8
Vocational skills	11.1	41.7	25.0	20.4	21.9
Linkages with health units and other service providers	33.3	83.3	25.0	37.9	41.4
Social support	22.2	75.0	0.0	35.0	36.7
Material support to those affected and infected	11.1	50.0	25.0	14.6	18.0
Orphan and vulnerable children support	33.3	50.0	25.0	28.2	30.5
Medical/health care services	22.2	50.0	0.0	24.3	25.8
Total	9	14	5	103	131

The results in Table 4 suggest the following:

(a) That the church's greatest strength regarding care and support is the provision of counseling. Almost two thirds of the church is involved in this activity.

(b) Shelter construction is the least common method of support provided by the church. Even in the Western Area where the largest percentage of churches implement HIV and AIDS activities only 8.7 percent erect shelters.

(c) Provision of care and support activities are lowest in the Eastern province where no involvement takes place in five out of twelve activities.

(d) In the Southern province, counseling support, linkages with health units and social support group are quite popular.

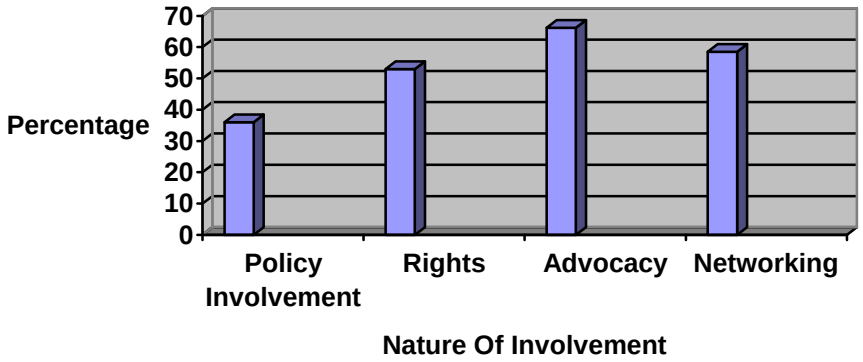
(e) Apart from counseling activities, all other activities are hardly implemented in the

Northern province. This can also be said of the overall situation (in all provinces).

4.1.6 Advocacy and Networking

Figure 3 provides a summary of the nature of involvement of the church in advocacy and networking in relation to HIV and AIDS.

FIGURE 3 Percentage Distribution Of Churches Based On the Nature Of Their Involvement In HIV/AIDS Activities.



These results suggest that the church is involved in various activities related to advocacy and networking. About two thirds are engaged in advocacy. Involvement in development of the HIV and AIDS policy is the least common activity in this category.

The role of the church in advocacy for PLWHAs and OVCs is to a large extent reported as sensitization and awareness raising accounting for 63.3 percent of all functions as seen in Figure 4.

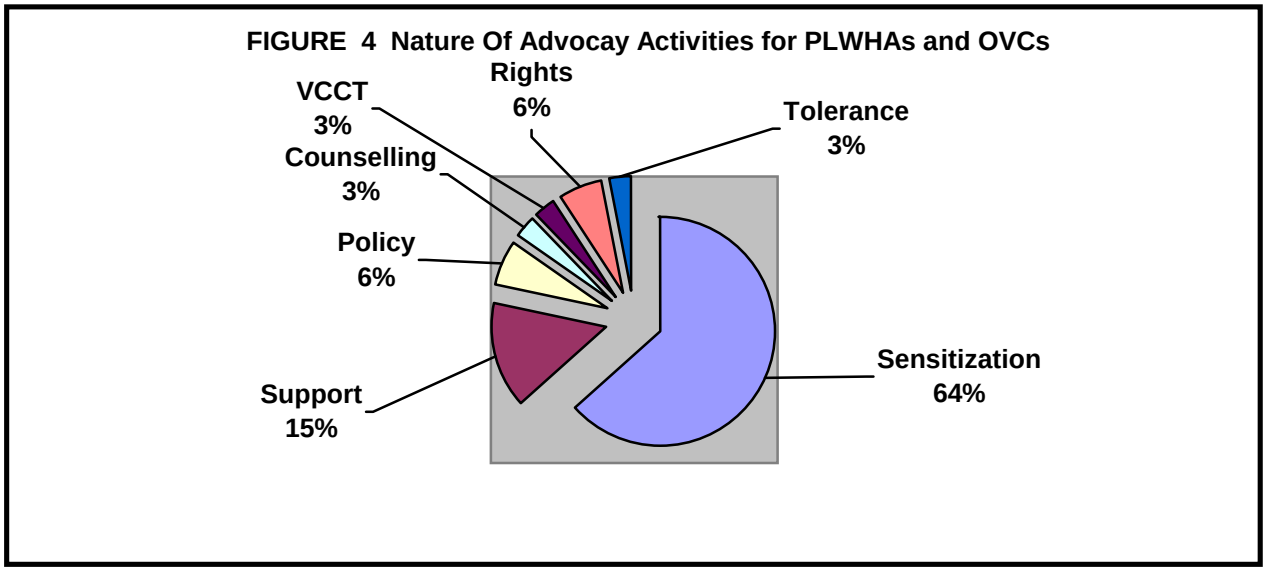


Figure 4 indicates that the least forms of advocacy for PLWHAs and OVCs counseling and VCCT activities. Only a total of 21.3 percent of the churches reported that they have participated in any HIV and AIDS network and coordination structure. For churches, which have not participated in the network structure, the main explanation is that they have not been invited to take part. The issues of advocacy and networking are looked at in greater depth in Table 5.

Table 5: Percentage of Church Organizations Based on the Nature of Their Involvement in Advocacy and Networking Activities Across Provinces

Advocacy and Networking Activities	Province			
	Northern	Southern	Eastern	Western Area
Development of HIV Policy	66.7	41.7	75.0	32.0
Securing rights of PLWHAs and OVCs	66.7	83.3	100.0	47.6
Member trained in advocacy skills	66.7	91.7	100.0	63.1
Participation in HIV AND AIDS Networking/Coordination Structure	55.6	100.0	100.0	53.4
Sample Size	9	14	5	103

The results point to the following:

(i) That the church in the Eastern Province appears to be very active in advocacy and networking activities more than the church elsewhere.

(ii) A similar pattern is noted for the Southern and Northern Provinces although to varying degrees.

(iii) Apart from having members trained in advocacy skill, the church in the Western Area does not stand out in other areas of advocacy and networking activities.

4.1.7 Role of Church in Coordination and Networking Structure

Various roles are performed by the church in the above structure. These include head of organization such as NECHRAS; facilitating work among women and youth; liaising with member organizations for the promotion of HIV and AIDS, providing material support; provision

of IEC strategies; contribution to policy formulation.

4.1.8 Non-involvement in HIV and AIDS Activities

The results on this issue are presented in Table 6.

Table 6: Percentage of Respondents Based on Reasons for Not Involving in HIV and AIDS Activities by Province.

Reasons for Non-Involvement	Province									
	Western Area		Eastern		Southern		Northern		All	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Lack of human resources	57.1	42.3	23.8	76.2	22.0	78.0	13.3	86.7	37.9	62.1
Lack of financial resources	75.4	24.6	69.2	30.8	100.0	-	93.3	6.7	81.8	18.2
Lack of material resources	77.5	22.5	59.0	41.0	87.8	12.2	88.9	11.1	78.4	21.6
No interest at all	20.2	79.8	-	100.0	-	100.0	-	100.0	10.4	89.6
HIV AND AIDS is not a problem in our church	19.3	87.7	2.6	97.4	2.4	97.6	8.9	91.1	12.3	87.7
Others are doing it	27.3	72.7	2.6	97.4	-	100.0	13.3	86.7	29.8	70.2
Do not know what to do	22.5	77.5	56.4	43.6	-	100.0	4.4	95.6	20.9	79.1

Based on Table 6 the following points are observed:

(1) Apart from the Western Area, the absence of human resources is not a serious hindrance to the involvement of the church in HIV and AIDS activities. In all provinces, though close to forty percent see this as a setback to their involvement.

(2) Lack of financial and material resources however seem to be major impediments to the church's involvement in HIV and AIDS activities.

(3) The results also point to the view that the church's justification is not 'disinterestedness', except in the Western Area where about one fifth of the church hold this view.

(4) The church adequately registers its view that their non-involvement is not that HIV and AIDS is not a church concern. However, the proportion of the church in the Western Area who holds this view is even higher than the three other regions, put together.

(5) In the Eastern Province, the church has not participated in HIV and AIDS because to a large extent (56.4 percent) they do not know what to do.

Apart from these main reasons, other reasons provided were:

(1) Lack of contact to initiate the activities.

(2) Centralization – church reported that they have not been asked to take off or they are waiting for approval or not mandated from their central office.

(3) Messages on HIV and AIDS can be effectively passed on through preaching and teaching the congregation.

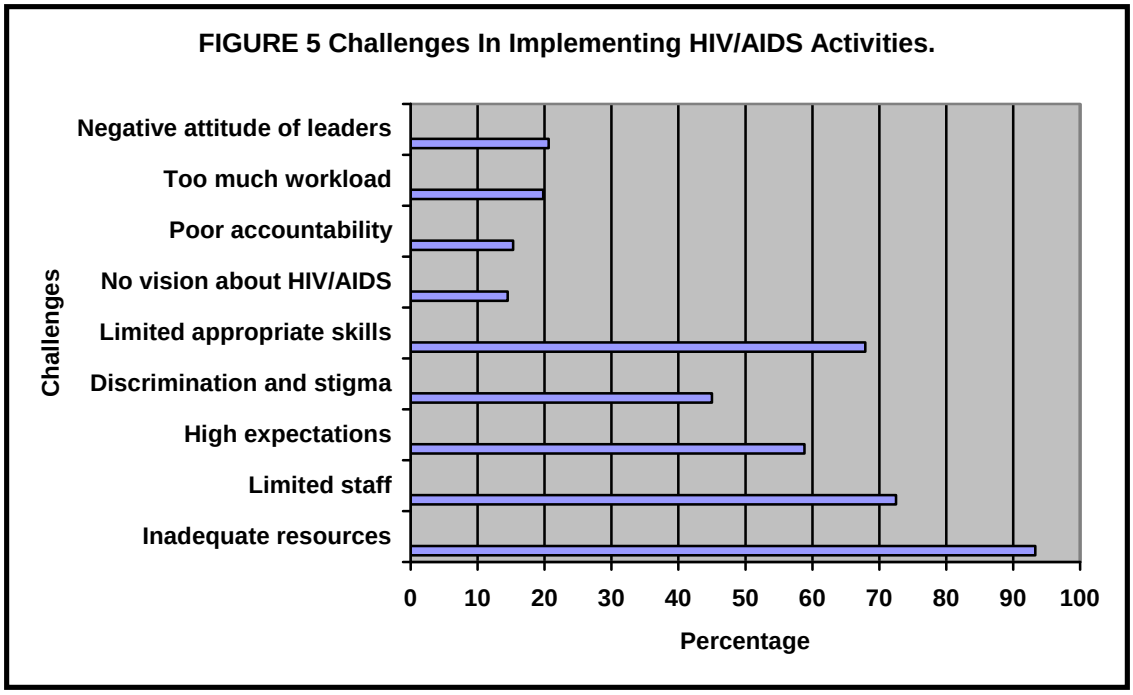
(4) The age composition of the church was cited as a reason for non-involvement. This particular church is reported to be comprised of old people.

(5) Lack of knowledge about HIV and AIDS by church leaders themselves.

On the whole, lack of contacts and the issues of centralization of the churches through their parent body seem to be key setbacks.

4.1.9 Challenges/Problems/Gaps in Implementation

The church faces a number of problems in implementing HIV and AIDS activities. These range from inadequate resources to discrimination and stigma. Although the seriousness of the problems vary the results reveal that inadequate resources is the most serious gap in implementation. The frequency distributions are outlined in Figure 5.



Essentially, the most serious problems reported by over two thirds of the church are poor financial and human resources including poor expertise in implementing HIV and AIDS activities. The negative attitude of church leaders is reported by just over a fifth of the church. Further analyses of these challenges are looked at across the provinces as seen in Table 7.

Table 7 : Percentage of Churches Based on Challenges Faced in Implementing HIV and AIDS Activities by Province

Challenges	Province			
	Western Area	North	South	East
Inadequate resources/funds	95.1	100.0	92.9	100.0
Personnel capacity	72.8	66.7	86.7	40.0
High expectations from congregation/community	59.2	44.0	78.6	40.0
Discrimination and stigma	44.6	66.7	35.7	60.0
Limited appropriated skills	72.0	66.7	64.3	40.0
No vision about HIV and AIDS	13.9	44.4	7.1	0.0
Poor accountability of resources	18.2	22.2	0.0	0.0
Too much work load	19.0	22.2	21.4	40.0
Negative attitudes and teaching of church leaders	21.6	22.2	21.4	0.0
N	103	9	14	5

The results by province are in line with the previous distribution. Inadequate funding for example runs across all four provinces with the East and the North being the worst hit. Other findings include:

(a) Limited staff as a gap is least experienced in the Eastern Province.
(b) High expectations from the congregation are most prominent in the South.
(c) Stigma and discrimination are most common among the church in the North and East.
(d) The North has the least vision about HIV and AIDS.
(e) The negative attitude of church leaders is about the same magnitude in all provinces except the East where the church leaders are perhaps more positive.

The church also identifies cultural taboos, traditional belief, disbelief about the existence of HIV and AIDS and identifying of PLWHAs as other challenges posed in the implementation process. These are however in rather small percentages.

4.1.10 Solutions to Challenges

Although many proposals are made regarding solving the problems highlighted above, there are differences in emphasis based on the regions, as seen in Table 8.

Table 8: Percentage of Churches Based on Their Perceived Solutions to Problems Encountered in Implementing HIV and AIDS Activities by Provinces

Perceived Solutions	Province				
	Northern	Southern	Eastern	Western Area	Average
Access to funding/resources	100.0	92.9	80.0	92.3	92.5
Training in technical skills	81.8	92.9	60.0	83.5	83.5
Sensitization to deal with stigma and discrimination	81.8	78.6	60.0	82.5	81.2
Facilitating staff	81.8	92.9	40.0	77.7	78.2
Training in financial management skills	54.5	50.0	40.0	64.1	60.9
Training in Organizational Management skills	63.6	78.6	48.0	69.9	69.2
Mainstreaming and integrating of HIV and AIDS in on-going church	81.8	78.6	60.0	80.6	79.7

From the point of view of all the provinces, the church places premium on each of the solutions although issues of access to funding and manpower development stand out. This pattern also runs through the provinces. The results also indicate that considerable emphasis is also put on dealing with stigma and discrimination as well as mainstreaming HIV and AIDS within church circles. In each of these cases, eight out of every ten church, on the whole, consider these as a way of improving HIV and AIDS activities.

4.1.11 Strengths in Responding to HIV and AIDS

These responses are presented below in Table 9.

Table 9: Percentage of Churches by Provinces Based on Their Percepted Strengths in Implementing HIV and AIDS Activities by Province

Strengths	Province				
	Northern	Southern	Eastern	Western Area	Average
Volunteerism	63.6	100.0	60.0	92.5	89.7
Access to resources/services with the Agency and outside Environment	81.8	57.1	40.0	33.7	40.3
Committed people	81.8	100.0	80.0	88.6	88.9
Good leadership	72.7	100.0	80.0	95.2	93.2
Established networks and referrals	63.6	64.3	40.0	51.9	53.7
Support by the congregation	70.0	92.9	80.0	61.4	66.2
Sample Size	9	14	5	103	131

The results above suggest the following:

(i) Only 40.3 percent of the church in all the provinces consider access to funding as their strength.

(ii) The existence of established networks and referrals is relatively low as strength of the church.

(iii) The most outstanding strength are those which deal with leadership and the congregation, such as volunteerism

4.1.12 Identification of Resources

This section deals with various resources available to the church to implement HIV and AIDS activities. These results are presented in sections below.

4.1.12.1 Financial Resources

The percentage of churches receiving financial support is 23.0. This suggests that the majority of churches do not have financial assistance. They constitute 76.3 percent. The remaining 0.7 percent of the target respondents did not know whether they were receiving any such support.

The sources of support vary as seen in Table 10.

Table 10 : Percentage of Churches Receiving Financial Support Based on Sources of Support by Provinces

Sources of Support	Provinces				
	Northern	Southern	Eastern	Western Area	Average
International Donor	100.0	100.0	100.0	93.8	96.3
Sister churches overseas	0.0	0.0	66.7	0.0	14.3
Congregational Contributions	0.0	0.0	66.7	0.0	13.9
Government	0.0	0.0	50.0	12.5	16.7
Private sector	0.0	0.0	66.7	33.3	37.5
NGOs	0.0	0.0	50.0	12.5	20.0
N	9	14	5	103	131

The results above indicate the precarious nature of funding for the church in implementing HIV and AIDS activities. It is noted that international donors are the paramount sponsors across all the provinces. A number of churches receive no other funding, especially in the Northern and Southern Provinces.

Figure 6 indicates that the biggest source of funding is from international donor whilst the least is from private organizations.

4.1.12.2 Strategies to Obtain Funds

The successful strategies used to obtain funds vary by Province as seen in Table 11.

Table 11: Percentage of Churches Based on Strategies for Resource Mobilization by Province

Strategies	Province				
	Northern	Southern	Eastern	Western Area	Average
Submitting proposals	22.2	42.9	20.0	42.4	40.2
Local fund raising	77.8	64.3	0.0	32.7	38.7
Contacting private companies	11.1	0.0	0.0	4.1	4.0
Using individual contacts	44.0	59.1	0.0	16.3	22.2
Going through a network	0.0	14.3	33.3	17.3	16.1
Going through denomination contacts	22.2	7.1	33.3	25.5	23.4
Congregational support	66.7	78.6	33.3	24.7	34.1

The results suggest that on the whole, the strategies listed above are being under-utilized. For example, only 40.2 percent of the churches submit proposals as a strategy to attract funding for HIV and AIDS programme implementation. It is also revealed that little or no use is made of private companies. Fund raising in churches in the Eastern Province appears to be weak since only four sources are used and these are poorly tapped. Local funding and congregational support appear to be high in the church in the Northern and Southern Provinces.

4.1.12.3 Nature of Problems in Obtaining Funds

The various churches across the provinces implementing HIV and AIDS activities accept that they have had problems obtaining fund, as revealed in Table 12.

Table 12: Percentage of Churches Based on the Nature of Their Problems in Obtaining Funding by Province

Nature of Problems	Province				
	Northern	Southern	Eastern	Western Area	Average
Had problems	55.7	100.0	100.0	84.2	86.9
Proposals not accepted	57.1	18.8	80.0	37.7	38.2
Delays in receiving funds	33.3	56.3	0.0	38.7	39.3
Lack of information on where to go for funds	87.5	62.5	40.0	74.0	71.6
Mis-match between donor priorities and church priorities	16.7	18.8	20.0	23.2	21.7
Too many donor requirements	0.0	18.8	40.0	14.3	15.7
Sample Size	9	14	5	103	131

These results indicate that although the reasons for the problems vary, lack of information as to the source of funding is a prominent problem. The least problem, on the whole, is that there are too many donor requirements. In the Eastern (more so) and the Northern provinces the fact that proposals have not been accepted poses the biggest problems in sourcing funds.

4.1.12.4 Funding Pattern

The following table examines the funding pattern for some HIV and AIDS activities across the church. The findings are presented at aggregate level, in Table 13.

Table 13: Percentage of Churches Based on Funding Pattern for Various Activities

Activities	Funding Pattern				
	Receiving Fund	Need more Funding	Would undertake as a priority if funding provided	Total	Sample Size
Prevention	3.8	16.2	80.0	100.0	105
Home based care	2.1	11.7	86.2	100.0	94
OVC support	3.3	10.0	96.7	100.0	90
Life skills training	2.0	13.9	84.1	100.0	101
Counselling	2.8	15.9	82.1	100.0	106
BCC/IEC	2.9	15.5	81.6	100.0	103
Volunteer incentives	0.9	15.l	84.0	100.0	106
Organizational Development	3.2	7.4	89.4	100.0	94
Core support (operational)	2.2	7.5	90.3	100.0	93
Infrastructure	1.1	5.6	93.3	100.0	90
VCCT	0.0	9.6	90.4	100.0	94
Training	2.8	17.6	79.6	100.0	108

The Table reveals the following points:

(i) Very low percentages of churches are receiving funding for various HIV and activities. In this regard, VCCT and volunteer activities are the most affected.

(ii) In all cases, the churches would need more funding for each of the activities outlined.

(iii) All activities would benefit from improved funding. This suggests that large percentages of churches would want to scale-up their respective HV and AIDS activities.

4.1.12.5 Recommendations on How to Source Funding for HIV and AIDS Activities

The following were some of the recommendations made on the issue above:

(i) The congregation should be challenged to support HIV and AIDS activities.

(ii) Churches should ensure they belong to networks.

(iii) Community fund raising should be carried out.

(iv) Church should benefit from a separate fund set up by government for them to carry out HIV and AIDS activities.

(v) NGOs should work in partnership with the church.

(vi) National HIV and AIDS Secretariat should target the church by providing funding.

4.1.13 Use of Material Resources

On the whole, 30.0 percent of the churches reported that they use material resources for their HIV and AIDS activities. This means that over two times more of these churches do not use material resources in implementing their HIV and AIDS programmes.

The reasons for not using these materials are depicted in Figure 6.

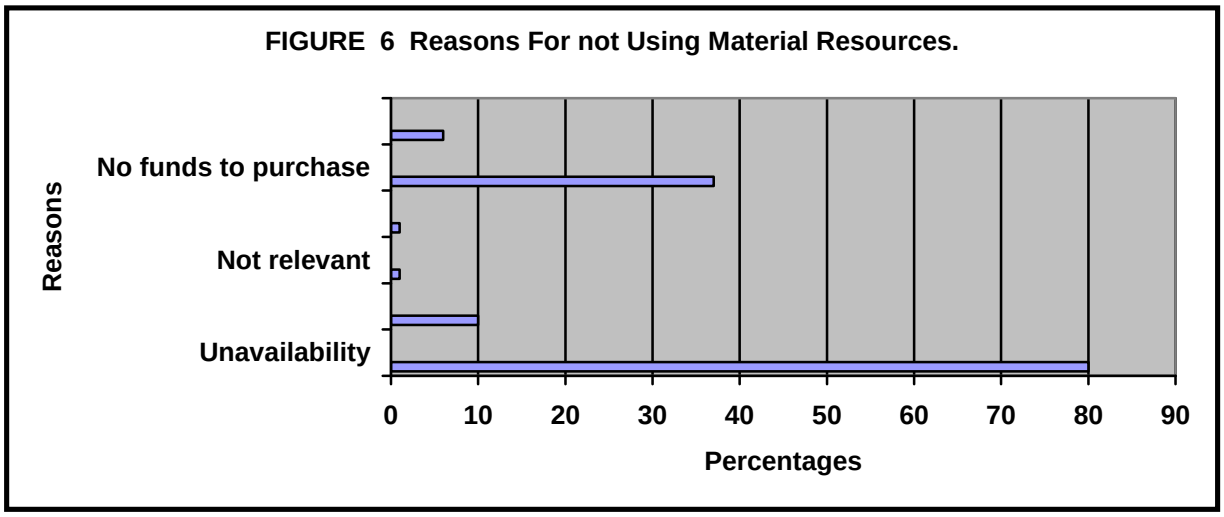


Figure 6 suggests that unavailability of these materials is the paramount issue. It also points to the view that it is hardly a question of relevance or that they are not required or that they present the wrong messages.

4.1.13.1 Nature and Source of Materials

Various materials are identified by those who use them. These are to a very large extent IEC/BCC materials. Typical examples are charts, books, brochures, films, flyers/posters, handbills, leaflets, pamphlets, manuals, video clips and journals.

Promotional materials such as T-shirts, badges, are also indicated. Condom as a preventive is also identified as part of the material resources

4.1.13.2 Sources of Materials

There are various sources from which the materials are obtained. Materials are received from government – Ministry of Education, Science and Technology (then), Ministry of Health and Sanitation;. Church organizations such as CCSL, NECHRAS, EFSL, Bible Society, Methodist Church, SDA, World Council of Churches, Sister Churches; INGOs such as UNICEF, IRCSL, CARE; Local NGOs including YMCA, YWCA, NAS, PPASL, Red Cross Sierra Leone. Apart from these examples, some materials are locally made or produced.

4.1.13.3 Rating of Materials

Churches, which make use of various material resources, were asked to assess the materials they use. The indications are presented in Table 14.

Table 14 : Percentage of Respondents Based on Their Assessment of the Materials They Use in Implementing HIV and AIDS Activities

Assessment Factor	Rating				
	Good	Fair	Poor	Total	Sample Size
Language easy to understood	90.1	8.9	1.0	100.0	101
Relevant to target group	94.1	4.0	2.0	100.0	101
Culturally sensitive	64.4	27.7	7.9	100.0	101
Easy to use	95.0	2.0	3.0	100.0	101
Covers the necessary information	89.9	8.1	2.0	100.0	101

The results suggest that apart from the cultural factor most churches consider their material resource adequate to a large extent. In all cases, less than 10.0 percent rate the materials as poor.

4.1.13.4 Other Useful Materials Recommended

Essentially, IEC, BCC and promotional materials are suggested as useful. Exercise books and pens with HIV and AIDS inscriptions, billboards, sign boards, projectors, computers,

vehicles, test kits, anti retroviral drugs, syringes and needles, traditional/local materials are considered as useful. The female condom is also indicated as a needed and useful material.

4.1.14 Human Resources and Programme Capacity

This section of the report deals with staffing and voluntarism. The results are outlined below:

A total of 78.0 percent of all churches involved in HIV and AIDS activities reported that they make use of volunteers in implementing their activities. The Western Area has the largest percentage of volunteers 74.8 (76) and is 5.5 times greater than the Southern Province, which has 13.6 percent (14) of volunteers. The Northern Province has 6.8 percent (7) whilst the least is in the Eastern Province – 4.8 percent (5). For those who do not use these personnel the following reasons were pointed out:

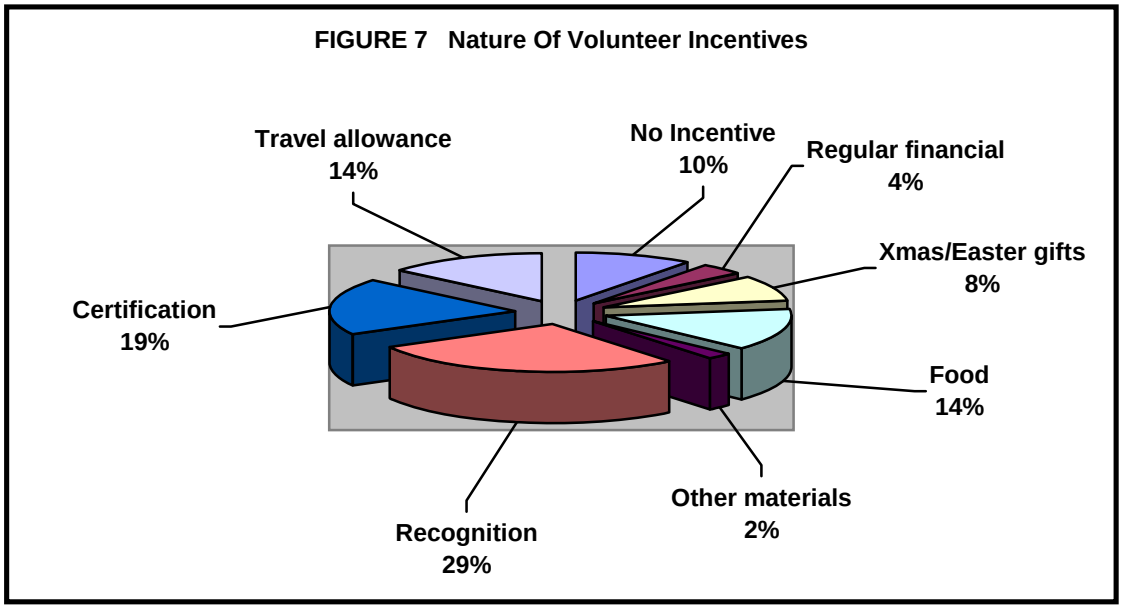
(i) No funding for incentives
(ii) No training has been provided for them.
(iii) Volunteerism is not part of their programme.
(iv) Programme is limited to awareness raising only.
(v) Few cases of HIV and AIDS in the church.
(vi) Lack of logistics.
(vii) People are not properly informed about volunteerism.

The pervading factors in this analysis are: lack of funding and training and low level of awareness about the use of volunteers in implementing these programmes.

The overall mean number of volunteers for those programmes, which use them, is 4.0 and the range is from 1 to 30 volunteers. The mean number of volunteers varies by provinces. In the Western Area and the Southern Province, it is 5.3 and 5 respectively compared to the Northern and Eastern Provinces, which reported 3.1 and 2.2 volunteers respectively.

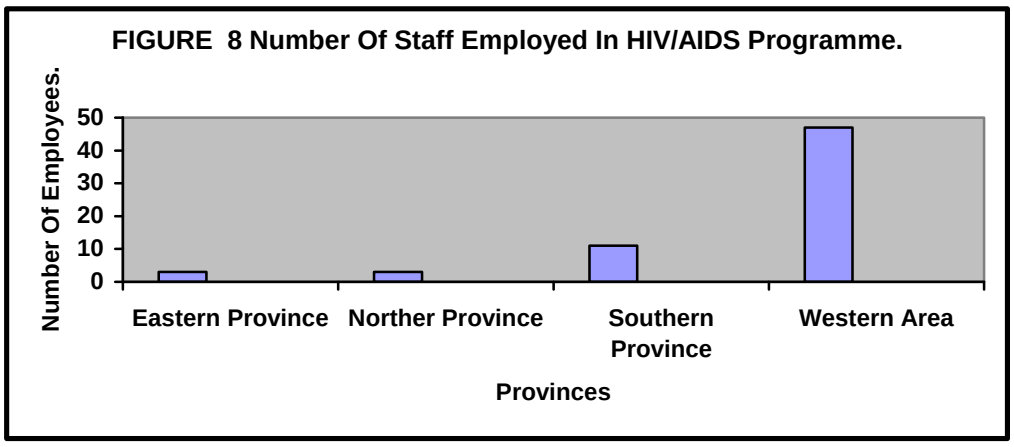
4.1.14.1 Volunteer Incentives

As seen in Figure 7 the emphasis with respect to volunteer incentives is on recognition including certification. Both constitute 47.0 percent of the total sub sample. In all, 10.4 percent do not receive any form of incentives whilst 13.8 receive travel allowances.



4.1.14.2 Staffing

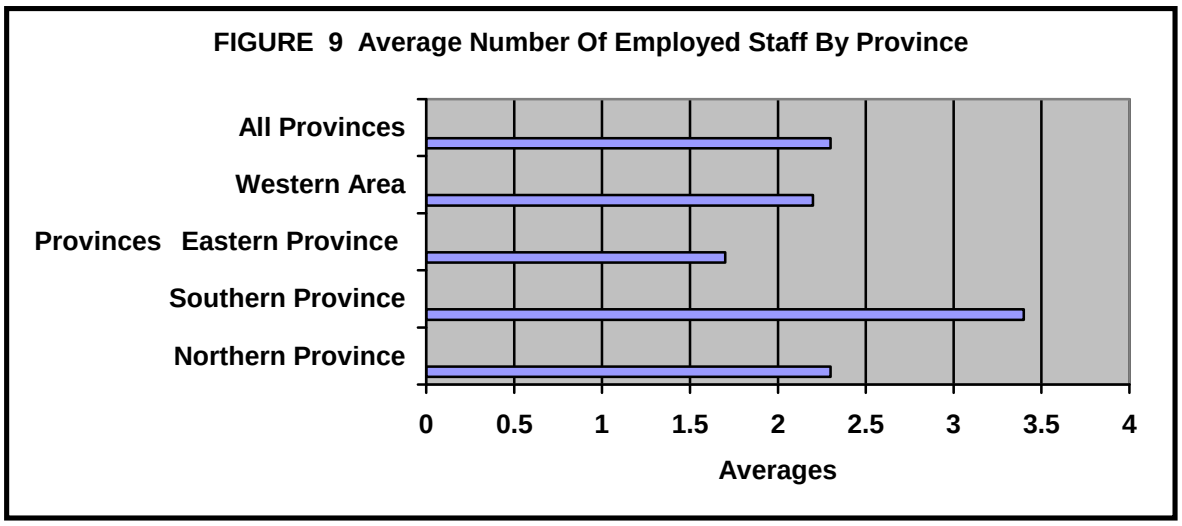
The results on this issue indicate that on the whole, 48.8 percent of the programmes employ staff in implementing the HIV and AIDS activities. The bulk of the staff are however in the Western Area, as noted in Figure 8.



They constitute 73.4 percent of the total number. The least percentage of staff are reported in the Northern and the Eastern Provinces.

4.1.14.3 Number of Staff Employed

The average number of staff working in HIV and AIDS activities is 2.3. But as seen in Figure 9 the highest mean is in the Southern Province with 3.4 whilst the least is recorded in the Eastern Province 1.7.



4.1.14.4 Nature of Staff Engagement

This issue is looked at from two points of view (a) the permanence of the staff, (b) origin. With respect to the first issue, the results reveal that 56.9 percent are part time compared to 43.1 percent is full time. On the second issue, 81.2 percent of staff are local compared to 6.2 percent expatriates and 12.5 percent consultants. In summary, the staff are essentially local and part time.

4.1.14.5 Reasons for Not Employing Staff

The following are some of the justifications for not employing staff.

(i) The HIV and AIDS initiative is new.

(ii) No trained personnel.

(iii) Lack of funds.

(iv) Unapproved by head office – programme is centralized at head office.

(v) No special department created for HIV and AIDS.

(vi) The church is young.

4.1.15 Assessment of Institutional Capacity

This section deals with a number of issues covering policy, decision-making, office space and documentation. Although not all churches are involved in implementing HIV and AIDS activities, the analyses for this section consider those involved as well as those not presently engaged in the activities. For those not presently engaged in the activities, the results would provide baseline data to help the establishment of such programmes. The results are presented in sub-sections below.

4.1.15.1 Policy and Decision-Making

These results are presented in Table 15.

Table 15 : Percentage of Churches Based on Availability of Some Crucial Facilities by Involvement in HIV and AIDS Activities

Involvement in HIV and AIDS Activities	Facilities							
	Existence of a Policy or Constitution				Existence of a Board or Committee			
	Yes	No	Total	Sample Size	Yes	No	Total	Sample Size
Yes	93.9	6.1	100.0	131	94.7	5.3	100.0	131
No	98.0	2.0	100.0	252	98.0	2.0	100.0	252

The results suggest that whether churches participate in HIV and AIDS activities or not, over 90.0 percent of the churches have a working constitution and existing Boards or Committees, which take decisions. The results even suggest that more churches not implementing HIV and AIDS activities do have these as part of their current administration.

Further analyses of the nature of the committees suggest that regular meetings and decisions are taken in 79.4 percent of churches involved in HIV and AIDS activities and 80.7 percent among those not involved. As reported, less than 1.0 percent of these two categories of churches do not hold meetings.

4.1.15.2 Finances of the Church

This section looks at various financial aspects of the church. The results are presented in Table 16.

Table 16: Percentage of Churches Based on Financial Facilities Available by Level of Involvement

Issues	Involvement in HIV and AIDS Activities	
	Yes	**No**
Availability of Treasurer	4.6	5.2
No treasurer/accounts personnel		
Treasurer appointed but does not do the work	0.0	1.6
Treasurer/accounts personnel supervises the finances	95.4	93.2
Total	100.0	100.0
Sample Size	131	252
Keeping Accounts and Making Reports	3.8	5.7
No accounts kept		
Accounts monitored and presented annually	3.8	9.2
Accounts kept on regular presentations made	92.4	85.1
Total	100.0	100.0
Sample Size	131	252
Ownership of a Bank Account	6.0	18.6
Has no account		
Has funds but no account	9.2	10.4
Uses some ones' personal account	21.4	35.3
Has its own bank account	63.4	35.7
Total	100.0	100.0
Sample Size	131	252
Auditing of Accounts	9.2	11.1
No auditing		
Not audited every year	16.0	23.4
Audited annually	74.8	65.5
Total	100.0	100.0
Sample Size	131	252

The above Table reveals various issues related to some financial sector aspects of the church.

(i) Irrespective of the level of involvement in HIV and AIDS activities the church does have a treasurer or accounts personnel. There is only a slight difference in extent of the practice between those churches implementing HIV and AIDS activities and those not involved in the implementation process.

(ii) Far less than 10.0 percent of the church organizations do not keep accounts and make reports. Again the good practice is slightly more common among HIV and AIDS implementers.

(iii) Ownership of a bank account is not as satisfactory as the two previous issues. It is realized that 6.0 percent of church organizations implementing HIV and AIDS do not have a bank account. This percentage is three times higher among non-implementers. Also, less than two thirds of implementers reported owing a bank account. The situation is even worse among non-implementers.

(iv) Annual auditing appears to be fairly common, more so among implementers. But about 10.0 percent of the church organizations do not audit their accounts.

4.1.15.3 Accommodation

Two issues are considered in this section as seen in Table 17.

Table 17: Percentage of Church Organizations Based on The Availability of Office Facilities By Level of Involvement

Office Facilities	Level of Involvement	
	Yes	**No**
Own Office Base	23.7	34.5
No office		
Access to share office	9.9	11.1
Own office	66.4	54.4
Total	100.0	100.0
Sample Size	131	252
Facilities Available	67.9	40.6
Telephone		
Fax	9.2	3.2
Computer	43.5	15.7
E-male and Internet	42.0	17.3
Total	100.0	100.0
Sample Size	131	252

The above results suggest that even having an office base presents a problem for some churches. Over one-fifth of such churches are reported among implementers and more than one-third among non-implementers. The results further reveal that the situation regarding communication facilities appears to be better among implementers than non-implementers. Only 15.7 percent of the latter group of churches has access to computer. Their counterparts are almost three times better off.

4.1.15.4 Documentation

This section examines the level of documentation carried out by the churches. These results are outlined in Table 18.

Table 18: Percentage of Churches Based on Their Level of Documentation by Level of Involvement in HIV and AIDS

Documentation	Level of Involvement	
	Yes	**No**
Production of Report		
No information produced	26.0	30.6
Some information given out	37.4	34.1
Regular reports distributed	36.6	35.3
Total	100.0	100.0
Sample Size	131	252
Record Keeping and Documentation		
No records or documentation kept	10.7	13.9
Records kept but incomplete	19.8	9.9
Records complete and accessible	69.5	76.2
Total	100.0	100.0
Sample Size	131	252

The results suggest that record keeping and documentation are better off in non-implementing churches than churches implementing HIV and AIDS activities although the former reported a high level of no record keeping.

The production of reports is low and of almost equal level in both categories of churches.

4.1.16 Strategies to Improve HIV and AIDS Activities

Table 19 contains some efforts that have been made by implementing churches to improve their HIV and AIDS activities, as seen in Table 19.

Table 19: Percentage of Churches Based on Efforts Made to Improve The Implementation of HIV and AIDS Activities

Issues	Percentage
Planning Development of HIV and AIDS Activities	
No planning	22.2
Occasional planning	26.7
Regular planning	51.1
Total	100.0
Sample Size	131
Existence of Monitoring System for HIV and AIDS	
None	43.5
Occasional	32.8
Monitoring at least monthly	23.7
Total	100.0
Sample Size	131
Submission of Proposal and Receipt of Funds	
Never submitted a proposal	60.3
Submitted proposal but received no funds	22.1
Successfully submitted a proposal	17.6
Total	100.0
Sample Size	131
Receipt of Technical Support From External Source	
None	63.3
Participated in external workshops	19.2
Received training from external source	12.2
Receive regular support from outside	5.3
Total	100.0
Sample Size	131

Key highlights of Table 19 are:

(i) Just about one-half of all implementers reported that they are engaged in regular planning of HIV and AIDS activities. However, over one-fifth also pointed out that no planning is effected.

(ii) Over four in every ten implementers have no monitoring systems in place for their HIV and AIDS activities.

(iii) A total of 82.4 percent have never benefited from funding as a result of submitting a proposal. Quite important though is that of over 60.0 percent of these have never submitted a proposal.

(iv) External technical support has benefited only 63.3 percent of the implementers. Regular external support is considered as low.

4.1.17 Networking

This section examines how widespread and participatory the church activities on HIV and AIDS are. It looks at the involvement of government, the community and networks. These findings are presented in Table 20 .

Table 20: Percentage of Churches Based on How Involved They are With Other Organizations

Participation	Yes
Community Participation	
None	16.0
Some participation	33.6
Active involvement and participation	50,4
Total	100.0
Sample Size	131
Whether Relevant Departments of Government are Aware of Programme and Provide Support	61.1
Unaware of activities	
Aware but no support	20.6
Occasional support	13.0
Regular government support	5.3
Total	100.0
Sample Size	131
Affiliation and Support From Network	
No affiliation or support	54.2
Affiliated but no support	23.7
Affiliated with minimal support	19.1
Affiliated and receive regular strong support	3.0
Total	100.0
Sample Size	131

The findings suggest that the HIV and AIDS activities of the churches are not well known in government and network circles. It is therefore not surprising that little support originates from these sources. Only 3.0 percent of the churches benefit substantially from their affiliations with networks. A similarly low percentage 5.3 noted that they derive strong benefits from government. Communities however seem to participate fairly in church HIV and AIDS activities.

4.1.18 Assessment of Church Programme

The overall picture as seen in Figure 10 indicate that more than one-half of the churches 53.4 percent consider their HIV and AIDS activities as basic (with little or no funding, no work plan no proper committees and so on).

The results by provinces are presented in Table 21.

Table 21 : Percentage of Church of Churches Based on The Rating of Their Current HIV and AIDS Activities

Rating	Provinces				
	Northern	**Southern**	**Eastern**	**Western Area**	**Total**
Basic	60.0	37.5	40.0	56.0	53.4
Developing	40.0	62.5	60.0	31.0	36.7
Full Scale	-	-	-	13.0	9.9
Sample Size	9	14	5	103	100.0

Only 9.9 percent of all churches implementing HIV and AIDS programme consider their programmes as full scale. These churches are all in the Western Area. This implies that they have funding, good work plan, staff in place and scaling up at the same time. No programme in the provinces is in this position.

4.1.19 Stigma and Discrimination

This section deals with a number of factors related to the above issues. Although they are related to HIV and AIDS the views of other churches not implementing these activities are crucial in understanding the perceptions of the church as a whole. The analyses therefore deal with both implementers and non-implementers.

4.1.19.1 Treatment of Sick Parents and Orphans

The findings are presented in Table 22.

Table 22: Percentage of Respondents Based on Their Views About the Treatment of Sick Parents and Orphans

Practice	Level of Involvement											
	Implementers				Non-Implementers				Average			
	Yes	NO	DK	NS	Yes	No	DK	NS	Yes	No	DK	NS
Church treats differently children whose parents are sick	16.8	74.0	6.9	2.3	25.0	57.5	2.0	15.5	22.2	63.2	3.6	11.0
Church treats orphans differently	16.8	71.0	7.6	4.6	24.2	56.3	2.4	17.1	21.7	61.3	4.2	12.8

DK = Don't Know; NS = Not Stated

Based on the result above, the views for both issues are similar for each group of respondents. A higher percentage of non-implementers hold the view that both groups of people are discriminated against. Their percentage is even higher than the overall.

In conclusion, across churches, the general perception is that neither sick parent nor orphans are treated differently. However, a sizeable percentage, reaching 17.0 percent for all churches could not tell whether orphans are treated differently.

Among those respondent churches who noted that sick parents are treated differently the following explanations were pro-offered – Table 23.

Table 23: Percentage of Churches Who Reported That Children Whose Parents Are Sick Are Treated Differently and Their Rationale for Such Views

Rationale	Status of Church		
	Implementers	Non-Implementers	Average
Support provided unequal	4.5	4.8	4.7
Favour children whose parents are sick	18.2	50.8	42.3
Treat them kindly	72.7	44.4	51.8
Love given is conditional	4.5	0.0	1.2
Total	100.0	100.0	100.0
Sample Size	22	63	85

Based on the Table the emphasis is different for both groups. Whereas the implementers feel children of sick parents are treated kindly the non-implementers feel that the children are favoured. By and large, the fact remains that both groups hold the same view.

4.1.19.2 How Orphans are Treated Differently

The explanations provided on this issue are outlined in Table 24.

Table 24: Percentage of Respondent Churches Based on the Perceptions on How the Church Treats Orphans Differently

Explanations	Status of Church		
	Implementer	Non-Implementer	Average
Favouring those with parents	-	1.6	1.2
Support provided is unequal	-	4.9	3.6
Treat them kindly	68.2	24.6	35.2
Favour orphans	22.7	68.9	56.6
Love given is conditional	9.1	-	2.4
Total	100.0	100.0	100.0
Sample Size	22	61	83

The overall picture reveals that orphans are favoured. This view is also held by the non-implementers whilst the implementers feel that orphans are treated more kindly.

4.1.20 Views About HIV and AIDS

This section looks at two traditional views of the church regarding HIV and AIDS. These are outlined in Table 25.

Table 25: Percentage e of Respondent Churches Based on Their Perceptions of Selected Issues on HIV and AIDS by Status of Church

Issues	Status of Church								
	Implementer			Non-Implementer			Average		
	Agree	Disagree	NS	Agree	Disagree	NS	Agree	Disagree	NS
HIV and AIDS is a punishment from God	10.7	82.4	6.9	20.6	70.6	8.8	17.2	74.7	8.1
People with HIV and AIDS do not deserve compassion or support	9.9	89.3	0.8	19.4	79.0	1.6	16.2	82.5	1.3

NS = Not Stated

Generally, more respondents reported that they disagree with both issues vis-à-vis those who support the views. For both issues, fewer implementers support the views compared to the non-implementers.

Irrespective of their status for more respondents are undecided as to whether HIV and AIDS is a punishment from God compared to whether compassion should be extended to people with HIV and AIDS.

4.1.20.1 Assessing the Attitude of the Church to PLWHAs

This section contains a number of conventional questions used to assess attitude to PLWHAs. The results of these analyses are presented in Table 26.

Table 26 : Percentage of Respondents Based on Their Attitude to Various Categories of Persons Living With HIV and AIDS by Implementing Status of Church

Status of Church	Attitudinal Items				
	Shake hands with PLWHAs	If family member infected should remain secret	Whether religious leader should continue preaching if infected	Church members buy goods from known PLWHA	Would church members help a known PLWHA.
Implementer					
Yes	91.6	53.4	84.7	85.5	85.5
No	1.5	42.0	12.2	3.8	6.1
Don't Know	6.1	0.8	3.1	10.7	8.4
Not Stated	0.8	3.8	-	-	-
Total	100.0	100.0	100.0	100.0	100.0
Sample Size	131	131	131	131	131
Non-Implementers					
Yes	63.1	52.4	73.0	63.6	66.7
No	8.3	24.6	6.7	4.4	4.8
Don't Know	9.2	4.0	2.8	10.3	11.0
Not Stated	19.4	19.0	17.5	16.7	17.5
Total	100.0	100.0	100.0	100.0	100.0
Sample Size	252	252	252	252	252
Average					
Yes	72.8	52.8	77/0	74.4	73.1
No	6.0	30.5	8.6	4.2	5.2
Don't Know	8.1	2.9	2.9	10.4	10.2
Not Stated	13.1	13.8	11.5	11.0	11.5
Total	100.0	100.0	100.0	100.0	100.0
Sample Size	383	383	383	383	383

Irrespective of the status of the church, there is generally positive attitude in all the attitudinal items used. However, the percentage of implementers who hold positive views is in all cases higher than those of the non-implementers.

One varying point though is that up to 53.4 percent of the implementers want any infection of their family members to remain a secret. A similar percentage is reported for non-implementers. This suggests that the 'culture of silence' about HIV and AIDS is fairly prevalent in church circles especially when a family member is involved.

Finally, the levels of 'not stated' cases are high irrespective of the status of the church-respondent.

4.1.20.2 Existence of a Church Policy on HIV and AIDS

Among current implementers, 43.5 percent reported that they have a HIV and AIDS policy. A slightly higher percentage 45.8 indicated that they do not have such a policy. A total of 10.7 percent either did not know at the time or did not respond.

Among those who noted that they have a church policy on HIV and AIDS 91.2 percent indicated that all the church members are aware of this common position.

Among those who do not have a common policy some of the reasons advanced were:

(a) They are implementing the National HIV and AIDS Policy since they do not have one.
(b) Some programmes are just starting and not well established.
(c) Lack of trained manpower- some have only volunteers.
(d) Funding is also a constraint.
(e) Some doubt the existence of HIV and AIDS.
(f) Some strictly advise the congregation to abstain from sex.
(g) One response pointed out that the position of the church about HIV and AIDS is still lukewarm.

4.1.21 Gender and Culture

A number of issues are raised in this section about the involvement of the sexes in matters relating to HIV and AIDS. The aim is to determine the gender differential. The results are presented below for the entire sample, in Table 27.

Table 27: Percentage of Respondents and Their Views on Selected Gender Issues

Issues	Level of Participation				
	Never	Sometimes	Often	Total	Sample Size
How often do women care for orphaned children?	16.4	42.3	41.3	100.0	383
How often do men care for orphaned children?	19.8	48.8	31.4	100.0	383
How often do women care for neighbour' children in need?	9.7	49.1	41.2	100.0	383
How often do men care for neighbour' children in need?	15.9	49.6	34.5	100.0	383
How often do women visit and care for people in the neighbourhood/community who are seriously ill?	5.2	37.4	57.4	100.0	383
How often do men visit and care for people in the neighbourhood/community who are seriously ill?	7.6	38.6	53.8	100.0	383
How often do women volunteer with community or religious group to provide care and support for PLWHAS?	67.9	19.3	12.8	100.0	383
How often do men volunteer with community or religious group to provide care and support for PLWHAs?	66.3	20.9	12.8	100.0	383
How often do women participate in a HIV infected and/or affect support group?	67.1	23.0	9.9	100.0	383
How often do men participate in a HIV infected and/or affect support group?	67.1	23.2	9.7	100.0	383

Noticeable gender differences do occur in first three issues. The results indicate that more women than men often care for orphans, needy children in the neighbourhood and pay visit to seriously ill people.

However, the gender differentials are reduced considerably for the two last issues. In fact, there is no difference between the percentage of males and females who volunteer to provide care and support to PLWHAs. Finally, only a small difference is observed between the sexes in respect of the last gender item.

4.1.22 Seizure of Property

The results on this issue do indicate that no property has been seized from any female at the death of the husband. This response is overwhelming and accounts for 97.7 percent of the

responses. This implies that only 2.3 percent of all respondents acknowledged this occurrence.

4.1.23 Focused Programmes

Among churches involved in HIV and AIDS activities 18.3 percent indicated that there are specific programmes for women and girls infected or affected by HIV and AIDS. Some of the activities in the programme include income generation through training on gara tie dying, provision of food and other materials, adult literacy classes, reproductive health sensitization including HIV and AIDS, counseling to help them feel part of the church family and visitation.

For the vast majority of churches without such focused programmes, the reasons include: HIV and AIDS is not a paramount issue to avoid stigma and discrimination of PLWHA is identified, lack of funds, the church is against HIV and AIDS issues, lack of human and material support. No member of the congregation has been detected with HIV and AIDS, focus is on spiritual issues, programme has just commenced, authority has to be sought from the parent church and lack of vision by members of the congregation.

4.1.24 Future Plans

The general results suggest that among current implementers 72.3 percent have plans to start more focused programmes to capture girls and women. One good thing is that the programmes would have a wide coverage if the plans as indicated in Table28 come to fruition.

Table 28: Percentage of Churches With Plans to Implement More Focused HIV and AIDS Activities for Women and Girls by Provinces

Provinces	Percentage
North	88.0
South	90.6
East	100.0
Western Area	73.9
Average	91.7

The results indicate that in all, the churches in the provinces which currently do not have programmes for girls and women, intend to start such programmes.

4.2 Results of the Qualitative Survey

4.2.1 Belief About the Existence of HIV and AIDS

The results unanimously point to the fact that the church accepts that HIV and AIDS is real. In other words, they do exist. One pastor recalled seeing a family member with symptoms of the disease before dying. Another pastor noted that he has paid visits to Connaught Hospital in Freetown, where he saw some PLWHAs. Some pastors argued that the occurrence of such conditional diseases such as HIV and AIDS and Ebola fever were predicted in the Bible – (Deueteronomy Chapter 8).

The cause of HIV and AIDS was associated with disobedience of God's word and this has lead to an increase or spread of the disease. Some Pentecostal Pastors felt it was the result of immoral practices resulting from failure to abide by God's dictates.

Despite these view, they rejected the view that PLWHAs should therefore be neglected. Instead they should be shown compassion and efforts should be made to save the souls of such people. The church it was pointed out is full of compassion and empathy should be demonstrated regarding PLWHAs. To further buttress their point, they noted that not every body who has contracted HIV has actually sinned because there are other causes of HIV infection apart from sexual contact. They further argued that adopting a negative attitude to PLWHAs can even shorten their life span.

4.2.2 What is the Most Effective Intervention

As indicated in the quantitative survey, involvement of the church is to a large extent awareness raising and sensitization of their congregation. Among some Pentecostal churches, awareness raising involves emphasizing the A and B of sex (Abstinence and faithfulness). Some churches handle abstinence and faithfulness under their physical health education programme within their churches.

For most pastors, the most effective HIV and AIDS intervention is education because this is apparently a 'holy' approach and a safe mode of addressing the issue through preaching and

teaching. Specific methods of education on HIV and AIDS identified included film shows, seminars, training of trainers and drama.

This argument is also supported by churches which are not currently implementing HIV and AIDS programmes. But in addition, they mentioned that youth programmes can also be effectively implemented because young persons from the bulk of most of their congregations. They also indicated that youth are sexually adventurous but lack indepth knowledge about HIV and AIDS.

Interventions to prevent stigma and discrimination against PLWHAs could also be effective as part of the HIV and AIDS programme of the church. Some pastors argued that this will be important to protect unfortunate members of congregations, who may contract the disease.

In order to cater for the entire well-being of the congregation especially PLWHAs, counseling, provision of shelter, soccer and sports and job creation were also identified as interventions that will be effectively implemented in future HIV and AIDS programmes.

4.2.3 Least Effective Intervention

Those churches which were implementing HIV and AIDS programme were unable to identify least effective interventions. One explanation was that their programmes were rudimentary and based on sensitization to a large extent.

Nevertheless, the churches provided indications of what may not be successful in the church's HIV and AIDS programme. These were:

(i) Over centralization of programmes – limiting programmes to headquarters only to the neglect of the branches. This could also take the form of little or no consultations or involvement of junior pastors in the programmes.

(ii) Disunity among churches in implementing HIV and AIDS programmes. It was necessary for the church to speak with one voice to its congregation universal.

(iii) Promotion, distribution and use of condom in the church. This sparked off a heated debate. For over ninety percent of the pastors in one discussion group, use of condom either for prevention of STIs or pregnancy was unacceptable in the church. For those who supported this view the reasons were:

(a) It would lead to promiscuity. (b) Fervent prayers can prevent both problems. (c) The HIV and AIDS prevalence in Uganda declined markedly through the promotion of moral teachings, abstinence and divine healing rather than the use of condom. One

pastor noted that any church which promotes condom use was not a real church. Another pastor recalled a church group he saw promoting condom during a mass campaign and he condemned this practice.

Finance Scheme

(iv) Some pastors felt that introducing some financial interventions such as micro-credit schemes into HIV and AIDS would kill the prgorammes because of possible high levels of corrupt practices in handling the funds.

4.2.4 Challenges to Implementations

Among some churches currently implementing HIV and AIDS programmes the following were identified as challenges:

(i) Denial among some church members. It was noted that some young pastors do not believe that HIV and AIDS is real. One pastor also cited a congregation dominated by mostly soldiers as one group that expresses doubt about the existence of HIV and AIDS. One participant recalls the following views of an individual who was also asked to deliver a talk on HIV and AIDS to some church members.

(a) HIV is manufactured in order to reduce the birth rate.

(b) It is put into tablets.

(c) HIV and AIDS is actually chronic gonorrhoea.

The participant pointed out that views of this nature contribute to disbelief about the existence of HIV and AIDS, among church members and the community

(ii) Inadequate or lack of materials. These, participants felt are currently too inadequate in type and content to convince people that the disease exists.

(iv) Not all churches talk about HIV and AIDS. They only mention it in passing when they do. The church needs to be outspoken about it.

(v) Finance is inadequate or non-existent.

(vi) Making a break-through to sponsors, even though project proposals were written, was another challenge. The discussions pointed to a problem of not knowing exactly what the requirements of the sponsors are.

(vii) The lower cadre of pastors who are more enthusiastic in implementing HIV and AIDS programmes are often sidelined by their superiors. They, (junior pastors) hardly participate in seminars and workshops, for example.

4.2.5 Needs of the Church

During the discussions, Pastors identified a number of needs if they are to effectively contribute to implementing HIV and AIDS programmes in the church. These needs were:

(i) **Training** - It was argued that the pastors need to be educated on the ramifications of the problem of HIV and AIDS because it is not within their normal purview. Secondly, it is necessary for them, the preachers, to be able to handle the issues successfully. One pastor even noted that training should extend to issues involving project implementation.

(ii) **Finances**. Among discussants, the National HIV and AIDS Secretariat is the most popular source of funding. Little appears to be known about other sources from which funding can be accessed.

(iii) **Logistics or infra- structure**. Some discussants indicated that successful implementation of HIV and AIDS programmes would require basic facilities such as office space, vehicles and communication facilities. For some churches, these would beef up their existing infra-structural base. For most churches however, these would be new facilities.

(iv) **Strong decision making bodies** - These would help the church leader to take necessary decisions. One pastor mentioned that such bodies would strengthen the hand of the pastor and prevent him from engaging in financial malpractices.

4.2.6 Stigma and Discrimination

Few indications of stigma and discrimination in the church are noted by the discussants. One explanation is the fact that few churches are actually engaged in implementing HIV and AIDS programmes. Secondly, even if there are PLWHAs the prevailing culture of silence in the society in general would make it difficult for people to know the HIV status of any member of the congregation.

These arguments notwithstanding, one pastor cited the example of one lady in a church who was responsible for leading Praise and Worship. After she tested positive for HIV, she was shunned by the congregation. The church showed no concern which caused the lady to leave the church in search of a church which shows care.

Another example of discrimination was cited. A pastor who had confided in his friend was 'betrayed' and the general congregation did not show much concern for his plight. Another example of a pastor who was outspoken about HIV and AIDS in his church was nick-named 'Pastor HIV'.

Some participants felt that stigma and discrimination was more common in the community than in the church. Two forms of these were: keeping a distance between PLWHAs, and members of the community; refusal to share materials and meals.

In explaining why stigma and discrimination are less prominent in the church, some pastors (of both sexes) pointed out that the church has and shows true love and compassion than families in the community. They (participants) used this to justify the need to engage the church fully in implementing HIV and AIDS activities.

4.2.7 Gender Concerns

This concept appears to be little known among implementers and non-implementers alike. It was therefore difficult to relate it to HIV and AIDS programmes even though two of the discussions consisted of participants of both sexes.

SECTION FIVE – SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary of Findings

Involvement in HIV and AIDS

1. A total of 34.2 percent of the churches are involved in HIV and AIDS activities. This means that 65.8 percent are not involved in these activities.
1. The Western Area has the highest percentage of churches involved in HIV and AIDS compared to Eastern Province which has the lowest involvement.
2. Para church organizations have the highest percentage of involvement whilst the Pentecostal Church has the lowest level of involvement.

Nature of Activities

1. The most common HIV and AIDS activity in all provinces is awareness and sensitization. The implementation of more specialized activities such as PMTCT is low.
2. The percentage of churches involved in care and support activities are relatively low although care activities seem to be more popular than support activities. The most common care activity of the church is reported as counseling. In advocacy and networking, the least popular activity is involvement in the development of the HIV and AIDS policy. The most common activity is advocacy for PLWHAs and OVC. The church in the Eastern Province appears to be the most active in advocacy and networking activities compared to the Western Area where such activities seem poor.

Coordination and Networking Structure

The church plays various roles in the coordination and networking structure. These include headship, liaison, provision of material support and contribution to policy formulation.

Non-Involvement in HIV and AIDS

For those churches not involved in HIV and AIDS, the reasons include lack of financial, human and material resources.

Challenges affecting Implementation

Various challenges were identified that affect the implementation of HIV AND AIDS

activities. These include inadequate financial resources, limited appropriate skills and limited staff. These challenges vary by Province.

Solutions to Problems

Various solutions were pro-offered to these problems. Key among these are increased access to funding, training in technical skills and sensitization to deal with stigma/discrimination.

Strengths in Implementing HIV and AIDS Activities

Three key strengths identified in implementing HIV and AIDS activities are good leadership, volunteerism and committed congregation.

Financial Support

1. Less than one fourth of the church receives financial support for HIV AND AIDS activities. Churches reported that international donors make 96.3 percent of their financial support.
2. Although various strategies for sourcing funds are identified, the most common is submitting proposals whilst the least popular is use of private companies.
3. Problems in obtaining funding were identified by 86.9 percent of all churches involved in HIV and AIDS activities. The most common problem noted was lack of information on funding source.
3. Few churches are currently receiving only small funds for a number of HIV and AIDS activities. Over eight out of every ten church organizations would implement various HIV and AIDS activities if funding was provided.
4. Some recommendations suggested for sourcing funds include: challenging the congregation to support HIV and AIDS, community fund raising should be carried out; churches should ensure that they belong to networks.

Use of Material Resources

1. Thirty percent of the churches report that they use material resources. However, seventy percent do not use such materials because about 80.0 percent of them noted that such materials are unavailable.
2. Different types of materials are identified although they are essentially IEC materials. These are obtained from various government and non-government sources.

3. Most implementers rate their materials as good, although about a third does not consider these materials as culturally sensitive.

Use of Volunteers

1. Over three fourths of the implementing churches use volunteers in their programmes. The largest user is the Western Area whilst the least user is the Eastern Province. For those who do not use volunteers, the reasons include: no funding, no training provided, lack of knowledge about volunteerism.
2. Volunteers' main incentives are recognition and certification. About 48.0 percent of them benefit from these as opposed to financial resources.

Staff Employment

1. In all, 48.8 percent of the programmes employ staff. These are mostly in the Western Area as opposed to the Northern and Eastern Provinces. The overall mean number of employed staff is 2.3. These are essentially part-time and local.
2. Organisations do not employ staff because they are not trained, lack of funds, no special department for HIV and AIDS etc.

Governance

Over 90.0 percent of the churches indicated that they have a Constitution and an existing Board or Committee, which takes decisions.

Financial Probity

A total of 95.4 percent have treasurers and a similar percentage keep regular accounts. They also have a bank account and the accounts are audited.

Logistics

Accommodation and other facilities such as telephone and computer facilities are fairly common in the programmes.

Scaling Up HIV and AIDS Activities

Although various strategies to scale up HIV and AIDS activities are suggested, these do not seem to be effectively utilized. For example, few programmes have a monitoring system, few proposals are submitted and large numbers do not receive technical support from external sources.

Evaluation of Activities

Most churches assess their HIV and AIDS programme activities as basic.

Reaction to Conventional Beliefs

Some conventional beliefs, such as HIV and AIDS is a punishment from God are rejected by both implementers and non-implementers, alike.

Attitude to PLWHAs

To a large extent, the church holds positive views about PLWHAs.

Owning a HIV and AIDS Policy

About 40.0 percent of the implementers reported that they have a HIV and AIDS policy and over 90.0 percent indicated that their congregations are aware of this.

Future Directions

Few churches have a focused programme for women and girls infected and affected by HIV and AIDS. Over 70 .0 percent of those who do not have such plans intend to in the future.

5.2 Constraints

1. The absence of comprehensive lists of church organizations for some denominations from which selections could be made with greater ease made the sampling process difficult.
2. Identifying heads of church organizations and fixing firm appointments with them proved time consuming in a number of cases with negative effects on the overall duration of the field work.

5.3 Lessons Learnt

1. More time will be required for such an exercise in future.

5.4 Best Practice

An attempt was made to identify an example of a church with best practice. The results suggest that such a church is from a long standing denomination. It has an existing governance structure, an annual auditing system in place, a work plan for its HIV and AIDS activities as well as existing full time staff to implement its HIV and AIDS activities.

A possible explanation is that some of these structures have been built up over time and HIV and AIDS activities are super-imposed on these existing structures.

The point needs to be made that such a church may not necessarily be among the denominations with the highest rate of involvement in implementing HIV and AIDS programmes.

5.5 Conclusion

The church's response to HIV and AIDS in Sierra Leone is rudimentary. Nonetheless, there is willingness among church leaders to implement HIV and AIDS programmes, if the necessary conditions are made. Few church organizations are currently involved in implementing activities of different nature throughout the country. The emphasis is on sensitization and awareness raising. There are financial, material and human resource constraints, which contribute to the current low status of the programmes. Many church organizations would benefit from diversified assistance packages by international and local donors.

5.6 Recommendations

It is crucial that the existing response of the church to HIV and AIDS be scaled up in a number of ways:

Coverage

Efforts should be made by heads of church and Christian networks and other relevant bodies to get more church organizations across denominations involved in HIV and AIDS activities, since it has been pointed out that they have the important comparative advantage that could help them to be successful.

Activities.

Current activities should be more diversified by the implementers to enable the church to deal more satisfactorily with all aspects of HIV and AIDS.

Funding

(a) This is a key problem and efforts should be made by the various denominations to access funding using more aggressive resource mobilization strategies that would involve both local and international sources. Training on proposal writing would be very helpful.

(b) The funding strategy should incorporate viable sustainable plans developed by the

programmes.

Training

This is required in a number of areas for all categories of personnel in the existing HIV and AIDS programmes. Volunteers and staff must benefit from such training packages. Specific training should be provided for developing project proposals as a first step to improving the financial base of the programmes.

Networking

Existing and subsequent church responses should incorporate effective networking strategies. Effective collaboration strategies should be fostered with both Governmental and other organizations especially those involved in HIV and AIDS. Current networks such as NECHRAS should assist individual church organizations to become members.

Institutional Capacity

Institutional capacity should be built within the various programmes by beefing up communication and other facilities.

Governance

Improved governance structures should be put in place to ensure sepecially greater accountability of funds, especially.

Misconceptions

Existing misconceptions about the existence of HIV and AIDS, its origin as well as gender issues should be clarified using effective IEC strategies.

Monitoring

More organized systems should be developed by the programmes to assess the progress being made. This would require the recruitment of a monitoring personnel or use of a trained volunteer.

SECTION SIX - REFERENCES

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APPENDIX – 1 The Questionnaire

RESPONDENT: CHURCH LEADER/PROGRAMME LEADER

RESPONDENT NUMBER CHRUCH NAME AND/OR AIDS PROGRAMME NAME	
TYPE	Church ☐ Head office or diocese ☐ Network ☐ Umbrella body ☐ Partners ☐ Para church organization ☐
DENOMINATION/ADFFILIATION	Anglican ☐ Pentecostal ☐ Evangelicals ☐ Catholic ☐ SDA ☐ None/not appropriate Para church organization ☐ Lutheran ☐ Methodist ☐ Other……
DISTRICT	
LOCALITY	
RESPONDENT NAME	
CONTACT ADDRESS	
POSITION	

SECTION 1: IDENTIFICATION OF INTERVENTIONS

TYPES OF INTERVENTIONS (|Circle appropriate responses)

1. Is your church/programme involved in any HIV/AIDS activities?

   Yes 1
   No 2
   Don't Know 3
   If yes, proceed to question 2 and 3.
   (If no, proceed to question 4,5, and 6)

2. If yes, what HIV/AIDS activities is your church/programme doing? Please x the appropriate numbers.

(i) PREVENTION

	Yes	**No**
(a) General awareness and sensitisation	1	2
Life skills (youth)	1	2
Voluntary confidential counselling and testing (VCCT)	1	2
PPMTCT (Prevention of Mother to Child Transmission of HIV/AIDS	1	2
Promoting Abstinence	1	2

(g) Other (specify)……..

(ii) Care and support

Is your church providing any of the following care and support services to the community?

	Yes	**No**
(a) Provision of Home care	1	2
(b) Counselling support	1	2
(c) Treatment of opportunistic infections	1	2
(d) Income generating activities	1	2
(e) Shelter construction	1	2
(f) Vocational skills	1	2
(g) Linkages with health units and other service providers	1	2
(h) Spiritual support for those affected and infected by HIV/AIDS	1	2
(i) Social support groups	1	2
(j) Material support to those infected and affected	1	2
(k) OVC(Orphan and Vulnerable Children) support (educational, material	1	2
(l) Medical/health care services	1	2

Other (specify)……

(iii) Advocacy and Networking

	Yea	**No**
Was your church engaged in the development process of the OVC or HIV/AIDS policy/strategy framework etc.?	1	2
Has your church undertaken any actions to secure the rights and well being of people living with HIV/AIDS and OVCs?	1	2
What is the role of the church in HIV/AIDS advocacy for PLWHAs and OVCs? (Probe and write)		
Is any member of your church trained in any advocacy skills?	1	2
Does your church participate in any HIV/AIDS Networking/coordination structure? If No why/ (Probe and write)	1	2
If Yes, what is the role of your church in these Coordination and networking structure? (probe and write)		

3. What aspects of HIV/AIDS are you not addressing and would like to address?

…….

…….

4. If no why are you not doing so?	**Yes**	**No**
(a) Lack of human resources	1	2
(b) Lack of financial resources	1	2
(c) Lack of material resources	1	2
(d) No interest at all	1	2
(e) HIV/AIDS is not a problem in our church	1	2
(f) Others are doing it	1	2
(g) Do not know what to do?	1	2

(g) Others (specify)…….

5. Do you have any plan to start addressing HIV/AIDS aspects in your church? (Please explain)

……

……

6. What aspects of HIV/AIDS would you like to address or to do?

……..

……

…….

GENERAL CHALLENGES/PROBLEMS/GAPS IN IMPLEMENTATION

	Yes	No
7. What challenges does your church/agency/progamme face in implementing its HIV/AIDS initiatives?		
Inadequate resources/funds	1	2
Limited staff/personnel capacity	1	2
High expectations from the congregation/community.	1	2
Discrimination and stigma	1	2
Limited appropriate skills	1	2
No vision about HIV/AIDS	1	2
Poor accountability of resources	1	2
Too much workload	1	2
Negative attitudes and teaching of church leaders	1	2

(i) Others (specify)…….

8. What does your church/agency suggest/adopt to overcome these challenges?	**Yes**	**No**
Access to funding/resources	1	2
Training in technical skills	1	2
Sensitization to the church to deal with stigma and discrimination	1	2
Facilitating staff/personnel	1	2
Training in financial management skills	1	2
Training in organizational management sills	1	2
Mainstreaming and integrating of HIV/AIDS in on going church programmes/activities/responses	1	2

(g) Other (specify)……

9. What does your church/agency consider as its strength in responding to HIV/AIDS?	**Yes**	**No**
Voluntarism	1	2
Access to resources/services with th3 agency and outside environment	1	2
Committed people	1	2
Good leadership	1	2
Established networks and referrals	1	2
Support by the congregation	1	2

(f) Others (specify)……

……

(g)

SECTION 2: IDENTIFICATION OF RESOUECES

Financial Resources

10. Do you receive any HIV/AIDS funding resources?

Yes	1
No	2
Don't Know	3

11. How do you fund your HIV activities?	
International donor	1
Sister churches overseas	2
Congregational' contributions	3
Government	4
Private sector contributions	5

(f) Others (specify)……..

12. What successful methods/strategies have you used to get funds for your work?	**Yes**	**No**
(a) Submitting proposals to donor partners	1	2
(b) Local fund raising events	1	2
(c) Contacting private companies	1	2
(d) Using individual contacts	1	2
(e) Going through a network	1	2
(f) Going through denomination contacts	1	2
(g) Congregational support	1	2

(g) Others (specify)……

13. Have your had any problems in getting funds? What were the problems	**Yes**	**No**
(a) No problems	1	2
(b) Proposal not accepted	1	2
(c) Delays in receiving funds	1	2
(d) Lack of information on where to go for funds	1	2
(e) Miss-match between donor priorities and church priorities	1	2
(f) Too many donor requirements	1	2

(g) Others (please specify)…….

14. Which of your activities are funded and which still require funding? (Please X)

Activities	**Receiving funds**	**Need more funding**	**Would undertake as a priority if funding were available**
Prevention activities			
Home-base care			
OVC support			
Life skills training			
Counseling			
IGAS (WHAT IS THIS?)			
Resources materials (Behaviour change communication and information education communication materials or (IEC)			
Volunteer incentives			

Organizational Development			
Core support (operational)			
Infra-structure			
VCT			
Training			

Others (specify)……..

15. Do you have any recommendations on how churches could get more funds for HIV/AIDS activities?

……

……

……

Material Resources

16. Do you use any HIV/AIDS resource materials?

Yes	1
No	2 (GO TO Q.21)
Don't Know	3

17. If no, why not?	
(a) Not available	1
(b) Not required	2
(c) Not relevant	3
(d) Wrong messages	4
(e) No funds to purchase	5

(f) Others (specify)……

18. If yes, which materials and where do you get these materials? (E.g. source)

Name/Type of material	**Source**

19. Please rate the materials you use

Factor	**Good**	**Fair**	**Poor**
(a) The language is easy to understand	1	2	3
(b) It is relevant to target group	1	2	3
(c) it is culturally sensitive	1	2	3
(d) It is easy to use	1	2	3
(e) It covers the necessary information	1	2	3

(f) Others (specify)……

20. What other material would be useful or do you need?

……
…….

……
…….

……
……

……
……

Human Resources and programme capacity

21. Does your church/programme use volunteer? Yes 1
No 2 (GO TO Q.25)
Don't Know 3

22. If Yes, how many?……

23. If no, why?
……
……
……

24. Do the volunteers receive any incentives?

	Yes	No
(a) None	1	2
(b) Regular financial incentive	1	2
(c) Christmas/Easter gifts	1	2
(d) Food	1	2
(e) Other material (bicycle, umbrella, shoes)	1	2
(f) Recognition	1	2
(g) Certification	1	2
(h) Travel allowance	1	2

(f) Others (specify)……

25. Do you have any staff working on HIV/AIDS? Yes 1
No 2 (GO TO Q.27)

26(a) If yes, how many?……..

(b) What nature of staff working on HIV/AIDS does your Church have?

	Yes	No
(a) Full time	1	2
(b) Part time	1	2
(c) Local	1	2
(d) Expatriate	1	2
(e) Consultants	1	2

27. If no, why?……
……
……

(f)Others(specify)………………………………………………………………………………
……………

28. What training has been received by staff and volunteers and what is still needed? Please tick

Area	**Volunteers trained in this**	**Volunteers need training**	**Duration**	**Staff trained in this**	**Staff need training**	**Duration of training**
Basic HIV information and awareness						
Prevention Interventions						
Home-base Care						
Psycho-social Support						
Counselling and Testing						
Developing IECD/BCC Materials						
Financial Management						
Orgganizational Development (management)						
Prevention of Mother to child Transmission (PMTCT)						
Vaccine trial						
Networking and Advocacy						
Anti retroviral Treatment (ART)						

Others

(specify)…….

SECTION 3: ASSESSMENT OF INSTITUTIONAL CAPACITY

29. Does your church programme/agency have a constitution/policy?

	Yes	**No**
(a) No Constitution	1	2
(b) Some principles written down	1	2
(c) Written constitution, not approved or non-functional	1	2
(d) Approved Constitution which guides organization	1	2

30. Do you have a Committee or Board that meets and makes decisions?

Yes 1

No 2 (GO TO Q.)

Don't Know 3

31. If yes do they meet and make decisions	
No meetings	1
Rare meetings: few decisions	2
Regular meetings and frequent decisions	3

32. Does your church programme have treasurer/accountants personnel who supervise the finances?

(a) No Treasurer/Accounts personnel	1
(b) Treasurer accounts personnel appointed but does not do the work	2
(c) Treasurer Accounts personnel supervises the finances	3

33. Does your church keep accounts and make reports?

No accounts kept	1
Accounts monitored and presented annually	2
Accounts are kept monthly or quarterly and presented regularly	3

34. Does your church/programme have a bank accouant?

(a) Has no account	1
(b) Has funds but no account	2
(c) Uses someone's personal account	3
(d) Has its own bank account	3

35. Are your accounts audited?	
No audited	1
Not audited every year	2
Audited annually	3

36. Does your church/programme have its own office base?	
No office	1
Access to share office	2
Own office	3

37. Circle if your church/programme has	**Yes**	**No**

the following:		
(a) Telephone	1	2
(b) Fax	1	2
(c) Computer	1	2
(d) Email and internet	1	2
(e) Photocopying Facilities	1	2

Others (specify)……..

38. Does your church plan the development of its HIV/AIDS activities?	
(a) No planning	1
(b) Occasional planning	2
(c) Organization regularly plans its HIV/AIDS activities	3

39. Does your church/programme produce any reports (newsletters/annual reports)?	
No information produced	1
Some information given out	2
Regular reports distributed	3

40. Does the church./programme have monitoring systems for its HIV/AIDS activities?	
(a) No monitoring	1
(b) Occasional monitoring activities and/reports	2
(c) Monitoring undertaken at least monthly	3

41. Does the church./programme keep records and documentation of its activities?	
(a) No records or documentation kept	1
(b) Records kept but incomplete	2
(c) Records are complete and accessible	2

42. Are members of the wider community participating in your HIV/AIDS activities? (e.g. members of church, Pastors, and other leaders, administrators, spiritual overseers, deacons and other stakeholders, external to the institution/agency e.g. community leaders, government officials, etc.	
(a) No participation by the wider community	1
(b) Some participation	2
(c) Active involvement and participation	3

44. Has the church/programme ever submitted and received funds from a proposal? (Refer to 13)	
Never submitted a proposal	1
(a) Submitted a proposal but received no funds2	2
(B) Successfully submitted a proposal	3

45. Has your church/programme ever received technical support from an external source?	
(a) No external support	1
(b) Have participated in external workshops	2
(C) Have received training from, an external source	3
(d) Receive regular support from outside	4

46. Do the relevant government departments know about and support your HIV/AIDS activities?	

(a) Unaware of activities	1
(b) Aware but no support`	2
(c) Occasional support	3
(D) Regular government support	4

47. Are you affiliated to and supported by any network?	
(a) No affiliation or support	1
(b) Affiliated to a network/forum but no support received	2
(c) Affiliated to a network and some minimal support received	3
(d) Affiliated to a network and receive regular, strong support	4

48. How do you rank this church/programme intervention in HIV/AIDS activities?	
9a) Basic (with no funding no work plan, no committee etc.)	1
(b) Developing (with some funding, organized committee, etc.)	2
(C) Full scale (with funding, scaling up, good work plan, staff in place	3

SECTION 4; HIV/AIDS STIGMA AND DISCRIMINATION

No	Question and filters	Coding categories	Code
Q.49	Do you think that the Church treats differently children whose parents are sick?	YES NO DON'T KNOW NO RESPONSE	1 2 3 4
Q.50	If yes to Q.49, how does the church treat children whose parents are sick differently?	Favouring those whose parents are not sick Support provided not equal Mistreat them Favour children whose parents are sick Treat kindly Love given is conditional Children with sick parents have work for any form of payment Other (specify)…….. DON'T KNOW NO RESPONSE	01 02 03 04 05 06 07 08 98 99
Q.51	Do you think that the church treats differently children whose parents have died than other children?	YES NO DON'T KNOW NO RESPONSE	1 2 8 9
Q.52	If yes toQ.51, how does the church treat children whose parents have died (i.e. orphans differently) (Probe for more responses)	Favouring those with parents Support provided not equal Mistreat them Treat them kindly Favour orphans Love given is conditional Orphans have to work for any form of payment Other (specify)……	01 02 03 04 05 06 07 08 98 99

		DON'T KNOW NO RESPONSE	
Q.53	Do you agree or disagree with the statement that HIV/AIDS is a punishment from God	Agree Disagree Undecided/not sure	1 2 3
Q.54	Do you agree, or disagree, that people who have HIV/AIDS do not deserve compassion or support?	Agree Disagree Undecided/not sure	1 2 3
Q.55	Would your church members shake hands with a person they know living with HIV/AIDS?	YES NO DON'T KNOW NO RESPONSE	1 2 8 9
Q.56	If a member of your family got infected it to remain a secret?	YES NO DON'T KJNOW NO RESPONSE	1 2 8 9
Q.57	If a religious leader/preacher has HIV/AIDS should he/she be allowed to continue preaching?	YES NO DON'T KNOW NO RESPONSE	1 2 8 9
Q.58	Would your church members buy goods from a person they knew was living with HIV?	YES NO DON'T KNOW NO RESPONSE	1 2 8 9
Q.59	Would your church members help someone you knew was living with HIV to bathe?	YES NO DON'T KNOW NO RESPONSE	1 2 8 9

SECTION 5: POLICYAND STRATEGY

Q..60	Does your church have an HIV/AIDS policy or strategy or a common position on HIV/AIDS in place?	YES NO DON'T KNOW NO RESPONSE	1 2 8 9
Q.61a	If yes, are all the church members aware about this common position or policy?	YES NO DON'T KNOW NO RESPONSE	1 2 8 9
Q.61b	If no, why is there no common position or policy? (probe and record)		

SECTION 6: GENDER AND CULTURE

Q.62	**How often do women participate in the following activities? Would you say their participation is often, sometimes or never?**			
	Caring for orphaned children?	Never 1	Sometimes 2	Often 3
	Caring for families that are affected by HIV/AIDS	1	2	3
	Caring for neigbour's children who are needy	1	2	3
	Visiting and caring for people in the neighbourhood or community who are seriously ill?	1	2	3
	Volunteering with a community/religious group that provides care and support to people living with HIV/AIDS?	1	2	3
	Participating in a HIV infected and/or affected support group	1	2	3

Q.63	**How often do men participate in the following activities? Would you say their participation is often, sometimes or never?**			
	Caring for orphaned children?	Never 1	Sometimes 2	Often 3
	Caring for neigbour's children who are needy	1	2	3
	Visiting and caring for people in the neighbourhood or community who are seriously ill?	1	2	3
	Volunteering with a community/religious group that provides care and support to people living with HIV/AIDS?	1	2	3
	Participating in a HIV infected and/or affected support group	1	2	3

Q.64. Has property of any female member of your church been grabbed by relatives because of the death of

the Husband caused by HIV/AIDS? Yes No

Q..65. Are there any deliberate programs that are specific for women/Girls affected or infected by HIV/AIDS

in your church? Yes No

Q.66. If yes, what are some of the activities?

……

……

……

Q.67. If No, why?

……

……

……

Q.68. Are there any efforts/plans to start such programs by your church?

Yes

No

THANK YOU

B FOCUS GROUP DISCUSSION GUIDE

A number of Churches are engaged in HIV and AIDS Interventions, what are some of these interventions

What have been the most effective HIV/AIDS interventions implemented by the Church and why ?

What have been the least effective HIV/AIDS interventions implemented by the Church and why ?

What are some of the challenges/Problems/Gaps the Church is experiencing in implementing these HIV/AIDS interventions ?

How has the Church funded the HIV/AIDS interventions and what are some of the challenges ?

What type of training does the Church require in order to effectively implement the HIV/AIDS activities

Are there any forms of stigma and discrimination which exist in the Chruch and what has the Church done to address them ?

What gender concerns are being addressed by your church in handling the HIV/AIDS issues ?