SITUATIONAL ANALYSIS

OF

The Church Response to HIV/AIDS in Zambia

FINAL REPORT

Study Commissioned By

Expanded Church Response Trust (ECR)
&
Pan African Christian Aids Network (PACANet)

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ABBREVIATIONS AND ACRONYMS

AIDS	**Acquired Immune Deficiency Syndrome**
ACZ	**Apostolic Church in Zambia**
ADP	**Area Development Programme**
AME	**African Methodist Episcopal**
CCZ	**Christian Council of Zambia**
CHEP	**Copperbelt Health Education Project**
CLFGD	**Community Level Focus Group Discussion**
CSO	**Central Statistical Office**
DDCC	**District Development Co-ordinating Committee**
DHMT	**District Health Management Team**
EFZ	**Evangelical Fellowship of Zambia**
FGD	**Focus Group Discussion**
GDP	**Gross Domestic Product**
IEC	**Information, Education and Communication**
IGA	**Income Generating Activities**
LCMS	**Living Conditions Monitoring Survey**
MoH	**Ministry of Health**
NGO	**Non Governmental Organisation**
OVC	**Orphans and Vulnerable Children**
PLWHA	**People Living with HIV and AIDS**
RCZ	**Reformed Church in Zambia**
SCOPE-OVC	**Strengthening Community Participation for the Empowerment of Orphans and Vulnerable Children**
SDA	**Seventh Day Adventist**
STD	**Sexually Transmitted Disease**
STI	**Sexually Transmitted Infection**
TB	**Tuberculosis**
UCZ	**United Church of Zambia**
UNICEF	**United Nations International Children and Education Fund**
USAID	**United States Agency for International Development**
VCT	**Voluntary Counselling and Testing**
WHO	**World Health Organisation**
WVI	**World Vision International**
WVZ	**World Vision Zambia**
ZAMSIF	**Zambia Structural Investment Fund**
ZEC	**Zambia Episcopal Conference**
HBC	**Home Based Care**
HIV	**Human Immunodeficiency Syndrome**

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EXECUTIVE SUMMARY

The Churches in Zambia were among the first institutions to set up care programmes for people living with HIV/AIDS. The Salvation Army and Catholic Church stand out in this regard. The Church is now being challenged to move beyond debates surrounding condom use and make steps towards a collective and systematic fight against the Pandemic. Prevalence in Zambia is currently 20%, meaning one out of every five adults is infected. The country is among one of the most highly affected in the Sub-Saharan region.

Purpose of Study

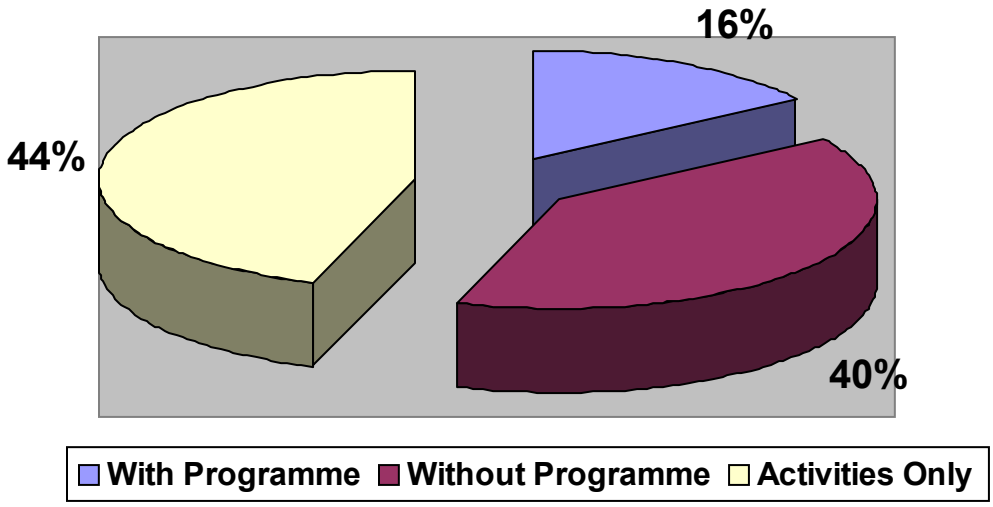
PACANet commissioned situation analyses to establish the church response to HIV/AIDS in four countries – Uganda, Zambia, Namibia and Swaziland. The objectives of the study were as follows:

1) To identify existing HIV/AIDS interventions by the church
2) To identify and document existing resources available and accessible to the church
3) To assess the capacity of the church based response
4) To recommend how the church can adequately scale up it's response

Key Findings

- A large proportion of churches do not have HIV/AIDS programmes. This means that they have no plans, no staff and no access to external funds. The following pie chart gives an indication of the existing situation as established by the research:

LEVEL OF RESPONSE



- Churches are more comfortable with care/support and mitigation intervention since they fit well into their routine activities. Prevention issues are considered rather sticky because they hinge on sexuality. Abstinence is the most widely supported prevention intervention in the church because it is in line with biblical principles.

- The biggest challenge that churches face is inadequate resources and the main strength is the spirit of voluntarism. This came out strongly in all churches surveyed.

- There are capacity gaps in the Zambian church response to HIV/AIDS. Major gaps are limited levels of knowledge in proposal development, limited access to external funding as well as poor monitoring and reporting systems.

Recommendations

1. SURVEY REFINEMENT
   - Carry out country level survey to obtain statistically representative data from larger sample size

2. FUNDING
   - The gap between donors/government and the church needs to be closed. There is need to recognise the church as a viable institution that can be funded

3. CAPACITY BUILDING
   - Conduct training in proposal development for church leadership
   - Support bible college HIV/AIDS training components to make leader training more in the face of this current pandemic
   - Establish local church councils and strengthen them through training of district core teams in line with country strategic plan

4. ADVOCACY AND LOBBYING

   - The church should recognise that it is a vehicle for lobbying. It should take advantage of the grassroots network, level of influence and constitutional backing to spearhead the fight against HIV/AIDS

5. BEST PRACTICE

   - Pilot areas should be selected for best practice development. Documentation of process issues and lessons learnt will provide a platform for replication of good models

1.0 INTRODUCTION

The church in Zambia, like in many sub-Saharan countries, has a pivotal role in the general development and welfare of society. It has been recognised that as a convergence point for people from different walks of life it certainly forms an integral part of many activities. These aspects were accentuated by the declaration of Zambia as a Christian nation towards the end of 1991.

Over the years the church has become increasingly and perhaps also more visibly involved in development issues. This has led to increased co-opting of clergy on various committees and boards in mostly service-oriented Government sectors such as health, community development and education. Clergy representation has also become more commonplace in a number of NGO and private sector activities.

There is however a thorny issue in which the church has sometimes been accused of being retrogressive and this is the HIV/AIDS pandemic. A most notable example is the use of condoms as a preventive measure between unmarried partners. This has been strongly condemned by the churches as an encouragement of promiscuous behaviour thus giving rise to a raging debate. Amidst this controversy the church still has to answer a question; how does it become more relevant in the face of this devastating pandemic?

In Zambia the church lends itself well as a platform for intervention because it has captured about 80%[1] of the population in terms of membership. This translates into over 12000 'points of presence' distributed across the nation in virtually every community. The Zambian church today represents the largest potential capacity in terms of human capital. It is therefore time to carefully think through how the church can systematically contribute to the collective fight against this crisis.

1.1 Rationale for study

Most churches in Zambia are affiliated to one of the three Christian mother bodies namely, Evangelical fellowship of Zambia (EFZ), Zambia Episcopal Conference (ZEC) and the Christian Council of Zambia (CCZ). Despite this affiliation individual churches have tended to act in isolation and there has been a long-standing need for concerted effort- particularly in terms of responding to the AIDS pandemic. Through facilitation by World Vision Zambia these three church mother bodies came together in August 2000 to form the Expanded Church Response Task Force. This became a legal body known as Expanded Church Response to HIV/AIDS Trust in April 2003. The ECR Trust's main goal is to provide a collective and massive church response to the HIV/AIDS pandemic.[2]

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[1] World Vision Zambia, HIV/AIDS Strategy 2002

[2] ECR brochure, 2003

The ECR has been identified by the Pan African Christian Aids Network (PACANet)[3] as an implementing agent for a "Church Response to HIV/AIDS Survey".
This survey was concurrently undertaken by various lead organisations in Namibia, Swaziland and Uganda as part of a proposed Southern Africa Initiative.

The Zambia survey aimed to establish existing HIV/AIDS related activities being undertaken by the church, assess resource capacities as well as identify gaps and strengths. The survey objectives were outlined as follows:

1.1.1 Objective 1

To identify existing HIV/AIDS interventions by the church

Specific objective

To classify interventions by theme, level and type

1.1.2 Objective 2

To identify and document existing resources available and accessible to the church

Specific objectives

a) *to establish funding opportunities available to the church and their limitations*
b) *to identify behaviour change and communication (BCC) materials available to the church and their limitations*
c) *to ascertain human resource currently involved in the response*

1.1.3 Objective 3

To assess the capacity of the church based response

Specific Objectives

To assess the following programme areas

a) *leadership and governance*
b) *skills and training*
c) *partnership and networking*
d) *Infrastructure and logistical support*

1.1.4 Objective 4

To recommend how the church can adequately scale up it's response

Specific objectives

a) *way forward*
b) *dissemination and utilisation of findings*

[3] PACANet is a young organisation originally established under the umbrella of the Botswana Christian Aids Intervention Project based in Gaberone. It liases with church networks throughout Africa.

2.0 HIV/AIDS IN ZAMBIA

2.1 Background

Zambia is a landlocked country with a population of approximately 10.3 million.[4] The country has a mixed economy - an urban sector that historically developed along the line of rail and a largely rural agricultural sector.

At the time of independence (October 1964) Zambia with it's then thriving copper industry had one of the strongest economies in Africa. The country became over dependant on the mining industry and was therefore adversely affected when copper prices plummeted during the mid seventies. Economic indicators such as the GDP have continued to nose dive since then. Zambia also carries a huge debt burden and by 1998 a total of 69% of the amount budgeted for all sectors went into debt servicing.

It is against this background that Zambia faces yet another challenge – the HIV/AIDS pandemic. It has been documented that HIV/AIDS is the most critical development and humanitarian crisis Zambia faces today.[5] Decades of hard earned economic gains have been reversed in all sectors of the economy.

2.2 Prevalence

The Zambian population is largely youthful and approximately 50% are below 20 years of age. The HIV prevalence peaks between the 30 to 39 years age group and kills large numbers of active breadwinners. Currently one out of every five adults is infected placing the country among those most highly affected in the region. Life expectancy without HIV/AIDS was projected to be 60 years at birth but it now stands at 37 years. Women are more likely to be infected than men (18% for women versus13% for men).[6] The peak infection age groups are 30 – 34 years for women and 35 – 39 years for men. The urban-rural gap in HIV infection rates is wider at all ages for women as compared to men. This indicates a critical level of infection among urban women. At the peak ages of infection two out of every five urban women are infected as compared to less than one out of five for rural women.

2.3 Orphans and Vulnerable Children

Orphans[7] were estimated at approximately one million by the 1998 Living Conditions Monitoring Survey. There has generally been an increase in the number of orphans. This has forced communities/families to take on the burden of extra children in the midst of widespread poverty and unemployment.

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[4] National Census,2000

[5] National HIV/AIDS Strategic Plan,2002

[6] Zambia Demographic and Health Survey, 2001 - 2002

[7] UNICEF defines orphans as children who before the age of 15 have lost both parents or their mother

Research[8] has shown that the number of paternal orphans is much higher than that of maternal orphans. This may be due to the steeper rise in mortality rates for men at older ages (30-44 years).[9]

2.4 Government Response

In 1984, when Zambia recorded the first AIDS case, Government realised there was need for intervention. The National AIDS Prevention and control Programme was formally established in 1986 with assistance from the WHO Global Programme on AIDS. In 1987 an emergency short-term plan was put in place to ensure safe blood supply. The first medium term plan (1988-1992) prioritised eight operational areas, namely Laboratory support; Counselling; Epidemiology and Research; STD and Clinical Care; Programme Management; TB and Leprosy; IEC and Home Based Care. In 1993 the second MTP was put in place with greater multi-sectoral participation in recognition of the fact that the AIDS problem was not just medical in nature. To ensure a coordinated approach the AIDS, STI and TB programmes were integrated. This integrated approach sought to foster political commitment and encompassed all government ministries, private sector and civil society. The MTP II also fully involved PLWHA, increased access to STD care, strengthened condom promotion/distribution and the control of TB.

Currently the Government response has brought together in partnership, the private sector, church organisations, NGOs and the government itself. The three main interventions are activities around the following:

- reduction of the socio economic impact of HIV/AIDS on individuals and families
- reduction of HIV/STD transmission
- mobilisation of local and external resources to support the response

Implementation of these activities is guided by the National HIV/AIDS strategic plan (2002-2005).

2.3 Church and FBO Response

Churches were among the earliest bodies to become concerned with HIV/AIDS. Catholic and Salvation Army home based care programmes are among the most longstanding and effective in Africa[10] – Zambia is no exception to this. This is consistent with the fact that mission hospitals have a long and distinguished history in health care provision. Until the 1960's most of the health care was provided by various Christian denominations. Currently mission hospitals provide slightly over 50% of formal health care in rural areas and about 30% of total health care at national level.

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[8] USAID/ Zambia; Displaced Children and Orphans Fund; SCOPE-OVC/Zambia and Family Health International Preliminary Results of OVC Household Baseline, 2001 and CSO, LCMS 1996

[9] Zambia Demographic and Health Survey, 2001-2002

[10] AIDS and African Churches, Extracts 2001

The Churches Health Association of Zambia (CHAZ) was created in 1970 as an umbrella organisation representing work carried out by church administered (or mission) health institutions. There are a total of 91 institutions affiliated to CHAZ and these are composed of 30 hospitals and 61 rural health institutions. The CHAZ AIDS Care and Prevention Programme started in 1987 and has since been responsible for various HIV/AIDS related activities. The CHAZ AIDS programme now wishes to focus attention on emerging local HIV/AIDS FBO responses that are non-health oriented. As a first step toward this, CHAZ has compiled an inventory of FBOs providing HIV/AIDS related services in all provincial headquarters in the country.

Currently the church is in an interesting position with regard to HIV/AIDS. The church is one of the most effectively organised community oriented institutions but the moralistic stand on sexuality makes it difficult for members to disclose HIV status. This has led to a culture of silence and hence also a level of stigma and discrimination. This is in line with the national picture as reflected by the demographic and health survey. Survey results show that social stigma is major problem and PLWHA experience discrimination. The stigma aspect and the church response in general is now a major subject of discussions and some Christian organisations are running related programmes.

World Vision Zambia (WVZ) has played a leading role in the church response by working in partnership with churches. World vision has encouraged churches to outline strategic policies on HIV/AIDS that are based on strong biblical and Christian principles. Steps have also been made to involve churches in community level interventions. Partnerships have been established in a pilot programme where church leaders identify “guardian angels” for OVC in three ADPs.

A programme has also been formulated to address risky behaviour patterns that contribute to the spread of HIV/AIDS. An example is the “Cross Border Initiative” which targets commercial sex workers and truckers in border and transit areas. The main objective of the initiative is to achieve behaviour change through peer educators. Another programme is the “Models of Learning” (MoL) which is developing integrated responses that optimise the WVI response to the HIV/AIDS prevention, care and advocacy. The MoL is centred in Zambia and Uganda with a focus on orphans and other highly vulnerable children.

Scripture Union (SU) mainly targets the youth in schools and it is another organisation with great potential of contributing to the church response. Currently SU is active in three provinces (Lusaka, Copperbelt and Western). In terms of HIV/AIDS the SU focuses on behaviour change through a life skills programme.

3.0 METHODOLOGY

3.1 Survey Sites and Sampling

The survey was carried out in four districts namely Kapiri-mposhi, Mkushi, Mpongwe and Kitwe. The criteria used in selection were mainly proximity to the survey team base (Kitwe) and the rural versus urban setting. This was decided upon as a smaller radius after downsizing of the country survey due to limited funding.

The church[11] was used as a unit of analysis. Data was collected from a random sample of churches under the three mother bodies, independent churches and a few para church organisations. The analysed data refers only to the churches.

Kapiri-mposhi *is a transit town on the main route for trucks and buses. It also is the starting point for Tanzania-Zambia (TAZARA) railway which makes it also a foreign trade and travel entry point.*
Mkushi *is located in a prime fertile agricultural belt. This is home to a number of Zambia's most prosperous and productive commercial farmers. The area produces large quantities of maize grain, tobacco and tomatoes making it an important destination for truckers and traders*
Mpongwe *is another agricultural belt located in the Copperbelt province. It forms a large portion of the province's 'rural' component and is home to medium and small-scale farmers. It is also home to the Mpongwe Development company which produces large quantities of wheat and coffee.*
Kitwe *occupies a central position in the Copperbelt province and is historically a mining town. It is now a marketing centre and a notable trade that flourishes in the city is the selling fish obtained from the neighbouring Luapula province. It is also a good market for horticultural products.*

[11] The church was defined as designated geographical site used by groups of people as a meeting place
for prayer at scheduled times

3.2 Questionnaire Development

PACANet facilitated development of the survey questionnaire through a tools development workshop held in Botswana at the end of May 2003. The questionnaire was developed with the input of country consultants and task force representatives.

A survey team composed of three research assistants and a lead researcher was put together soon after the tools development workshop. The questionnaire was refined by the survey team to include information on gender and ranking of interventions. Questionnaire refinement, translation and information sharing around the survey objectives were carried out during a day's meeting. Data collection and analysis was carried out over a period of 23 days.

3.3 Data Collection Methods

A test survey was conducted to assess the suitability of the questionnaire. The testing revealed that the questionnaire was considered lengthy by a larger proportion of the respondents and this made them give rather scanty information. In addition it was noted that respondents needed further explanation during the data collection process. It was therefore decided that the main survey should utilise interviewer-administered questionnaires and focus group discussions (FGD) in order to obtain more detailed data. Data obtained from church leaders was crosschecked and added upon through FGDs with church members. In Kapiri-Mposhi FGDs were also carried with the community in "Material" compound - the largest shanty compound in the district.

3.4 Data Entry and Analysis

During the survey, data entry and debriefing were carried out on a daily basis. Analysis at this stage was mainly around observations made as well as perceived levels of intervention by the various contacted churches and organisations.

3.5 Quality Control

The following quality control procedures were carried out:

a) Daily debriefing to establish constraints in the data collection process. As much as possible this was followed up by remedial action.
b) Daily discussions and documentation on next day appointments to ensure optimum use of time and coverage.
c) Supervision by the lead researcher to ensure all was being done appropriately.

3.6 Limitations

a) Time allocated to the field survey was inadequate and this contributed to the downsizing of the coverage area
b) Limited literature on church response to HIV/AIDS in Zambia
c) Difficulties in locating church leaders in some sites where residences are far from churches
d) Some church leaders were reluctant to participate in the survey (particularly in Kitwe) due to little or no feedback from previous HIV/AIDS surveys. Sometimes the reluctance was due to protocol requirements.
e) Delays in funding led to a late start of the field survey

4.0 RESEARCH FINDINGS

4.1 Overview

Data obtained from the survey is summarised in the following tables to give an overview of the churches contacted. The data obtained was analysed in line with the stated objectives and the tables show the mix of churches from which information was obtained.

Table 1: Churches contacted per District

DISTRICT MOTHER BODY	KITWE	MPONGWE	KAPIRI	MKUSHI	TOTAL CHURCHES PER MOTHER BODY
ZEC	1	1	2	1	**05**
CCZ	7	1	7	3	**18**
EFZ	4	4	5	4	**17**
INDEPENDENT	5	4	5	1	**15**
SPIRIT BASED	1	-	2	-	**03**
TOTAL CHURCHES PER DISTRICT	**18**	**10**	**21**	**09**	**58**

Table 2: Total Persons Contacted Through FGD per District

	KITWE		MPONGWE		KAPIRI		MKUSHI		TOTALS
	Male	Female	Male	Female	Male	Female	Male	Female	
ZEC	**4**	**2**	**4**	**26**	**4**	**28**	**-**	**-**	**068**
CCZ	**3**	**29**	**-**	**-**	**8**	**23**	**26**	**61**	**150**
EFZ	**4**	**1**	**4**	**12**	**2**	**12**	**3**	**8**	**046**
INDEPENDENT	**-**	**-**	**1**	**4**	**6**	**15**	**11**	**24**	**061**
SPIRIT BASED	**3**	**21**	**-**	**-**	**3**	**1**	**-**	**-**	**028**
TOTALS	**14**	**53**	**9**	**42**	**23**	**79**	**40**	**93**	**353**

Table 3: Total Church Leaders Interviewed

	KITWE		MPONGWE		KAPIRI		MKUSHI		TOTALS
	Male	Female	Male	Female	Male	Female	Male	Female	
ZEC	1	-			1	-	-	1	**03**
CCZ	5	1	1	-	4	-	3	-	**14**
EFZ	4	1	2	-	4	-	2	-	**13**
INDEPENDENT	5	-	3	-	3	-	2	-	**13**
SPIRIT BASED	1	-	-	-	-	-	-	-	**01**
TOTALS	**16**	**2**	**6**	**-**	**12**	**-**	**7**	**1**	**44**

Table 4: Total Contacts: Interviews and FGD combined

District/Mother Body	KITWE		MPONGWE		KAPIRI		MKUSHI		Total persons
	Male	Female	Male	Female	Male	Female	Male	Female	
ZEC	5	2	4	26	5	28	-	1	**71**
CCZ	9	30	1	-	12	23	29	61	**165**
EFZ	7	2	6	12	6	12	5	8	**58**
INDEPENDENT	5	-	4	4	9	15	13	24	**74**
SPIRIT BASED	4	21	-	-	3	1	-	-	**29**
	30	**55**	**15**	**42**	**35**	**79**	**47**	**94**	**397**

Table 5: Churches Contacted but Resisted

	KITWE	MPONGWE	KAPIRI	MKUSHI
ZEC	**Sacred Heart Parish St Peter's kapoto (Leader interview)**	**Mpongwe Catholic (leader interview)**	**-**	**-**
CCZ	**Salvation Army (town) RCZ Kapoto RCZ Wusakile**	**-**	**-**	**-**
EFZ	**Baptist Central (town)**	**-**	**-**	**Church of God**
INDEPENDENT	**New Apostolic**	**-**	**Jehovah's Witness**	**-**

4.1.1 Comments

- The ZEC churches exhibited a high level of resistance to the survey. Information was obtained with difficulty at all sites except Mkushi. An Interview was conducted with only one priest (Kapiri-mposhi) out of the four contacted. In terms of programmes the churches are at varying levels.
- The CCZ churches were largely receptive. Most of the urban churches (Kitwe) had programmes or activities. A number of the CCZ respondents in Mkushi and Kapiri-mposhi districts complained that information and training is mainly concentrated in urban areas.
- The EFZ and Independent churches are a diverse lot. A large proportion of these churches do not have programmes or activities.
- Spirit based 'Mizimu' churches present a challenge with their belief in polygamy. Some also prohibit the intake of medicines and the seeking of medical attention. This group cannot be ignored because there is a two-way flow of membership between it and the affiliated churches.
- In all districts women were in majority during the FGDs.

4.2 Research Findings Against Outlined Objectives

4.2.1 Church HIV/AIDS Interventions

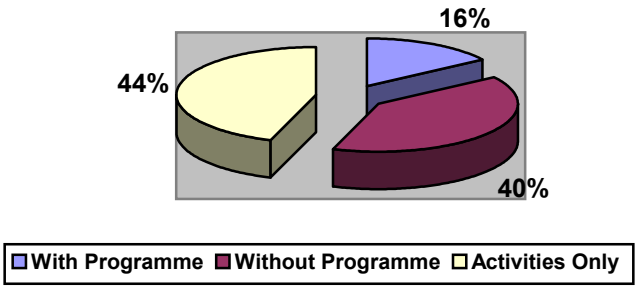
The following table gives figures on the number of churches with programmes and their distribution across mother bodies and districts.

Table 6: Church HIV/AIDS Programmes per District

	CHURCHES WITH PROG						CHURCHES WITHOUT PROG						CHURCHES WITH ACTIVITIES ONLY – NO PROG					
	ZEC	CCZ	EFZ	IND	SP	Total	ZEC	CCZ	EFZ	IND	SP	Total	ZEC	CCZ	EFZ	IND	SP	Total
KT	-	3	-	-	-	**3**	1	1	3	2	1	**8**	-	3	1	3	-	**7**
MP	-	-	1	1	-	**2**	1	-	2	1	-	**4**	-	1	2	1	-	**4**
MK	-	-	1	1	-	**2**	-	-	-	-	-	**-**	1	3	2	1	-	**7**
KP	2	-	-	-	-	**2**	-	2	4	3	2	**11**	-	5	1	2	-	**8**
	2	**3**	**2**	**2**	**-**	**9**	**2**	**3**	**9**	**6**	**3**	**23**	**1**	**12**	**6**	**7**	**-**	**26**

From the total number of churches surveyed, only **16%** had HIV/AIDS programmes.[12] Churches with no programme[13] constituted **40%** and the largest category of the sample was the number of churches with ad hoc activities[14] and no programme which accounted for **44%.**

Figure 1: Level of Response



[12] programme entails some members fully involved with designated leadership, planned activities with records and a monitoring system, outside funding and/or outlined fund raising/allocation, access and use of resource materials , established HBC and volunteers

[13] No programme-no members involved in HIV/AIDS activities, no plan, no records, no external funds, no sensitisation or awareness carried out, no expression of future plans and intentions

[14] Ad hoc HIV/AIDS activities -some sensitisation and awareness and other occasional HIV/AIDS related activity, expression of future plans and intentions, no records, no external funds,

A. Classification of Interventions

In terms of theme, church interventions were classified into prevention, care/ support and mitigation. Data was obtained on the types of HIV/AIDS related activities carried out and these were ranked under each theme. The ranking was done to determine which activities (under each intervention) are more commonly undertaken. The following summary gives the interventions:

Table 7: Summary of Interventions

PREVENTION	SCORING	CARE AND SUPPORT	SCORING	MITIGATION (for OVC)	SCORING
Promoting abstinence	33	Spiritual support	31	Food	21
General awareness and sensitisation	29	Counselling and support	26	Clothes	18
Voluntary Counselling (and no testing)	19	Social support group	17	Fees	12
Life skills	6	Resource mobilisation	12	School requirements	9
Condom use	4	Material support	9	Cash	6
		IGA	8	Toiletries	3
		Shelter construction	7	Shelter	2
		Provision of home care	3	Toys	1
		Treatment of opportunistic infections		MATERIAL SUPPORT (for affected and infected)	
				Food	19
				Clothes	11
				Medicine	7
				Cash	7
				Toiletries	3
				Firewood/charcoal	1

1) Prevention Interventions

Some leaders pointed out that it was sometimes very difficult to speak explicitly about prevention because it hinges on sexuality. Some church leaders associate prevention intervention and HIV/AIDS teachings in general with the youth. It was possibly the reason why they bemoaned the absence of youths during the interviews saying they needed to be present as a main target group. Could this be because Zambian media advertisements have generally used youths as models/actors?

Among the prevention activities, promotion of abstinence was highly favoured and most church leaders spoke very emphatically about it.

> ***"The church believes in abstinence and that is what we teach - the only resource material we use and need is the bible".***
> Mpongwe church leader

Specific comments on the prevention interventions are as follows:

a) Life skills and condom use ranked very low with most of the scores clustered around the first three interventions.
b) Leaders indicated voluntary counselling as an intervention mostly in connection with pre marital arrangements.
c) Information from the FGDs indicated a great need for detailed teachings associated with awareness and sensitisation.
d) Condom use was widely condemned by church leaders during interviews and the women during the FGDs. Women in Kapiri-mposhi indicated that condoms were encouraging their husbands to have multiple partners and thus posing a great risk.

2) *Care and Support*

Under this theme spiritual support and counselling ranked highly. Part of the reason for this is possibly the fact that these aspects are in line with church routine activities. It was mentioned that care and support was being provided even before the advent of HIV/AIDS.

Some leaders associated the social support group and the provision of home care as being part of the ladies church hospitality ministry. This was also noted from the FGDs.

> ***" We have always been visiting and looking after the sick at our church. Now that there are aids patients we look after them also. What else can we do?***
> Kapiri-mposhi female FGD participant

Resource mobilisation is mostly in form of member contributions. The Kapiri-mposhi and Mkushi churches stated that fund raising events do not yield much because a large proportion of church members are poor. They however mentioned farming as a source of food and money for the affected and infected. This linkage to agricultural production was also noted in Mpongwe.

Shelter construction was noted as an important intervention in Kapiri-mposhi where resource poor family houses tend to collapse during the rainy season. The collapsing of houses in this area is caused by the sandy soil profile that requires deep and very strong building foundations.

On treatment of opportunistic infections only one church out of the sample procures drugs which are administered by a nurse on the church HBC team.

Churches do not venture into treatment of opportunistic infections because they lack funds and appropriate skills.

Respondents were asked to list the institutions they collaborate with in carrying out HIV/AIDS interventions. A list of institutions/organisations is given in the appendices. Churches link with these institutions in various ways:

a) Training for pastors and other church leaders
b) Training for HBC group and general church membership
c) Provision of resource materials
d) Nomination to institutional governing/implementation boards

3) Mitigation

Data obtained under this theme indicated activities associated with OVC support. Leaders and members alike underscore the importance of OVC support. The major complaint was the inability to adequately and consistently provide this support. Like the care and support, mitigation is associated with the church ladies ministry.

> ***"Our women are doing a lot for the orphans in church through giving basic requirements but it is not enough to go round- it is only done once in a while"***
> Kitwe church leader

It was noted that there was a thin line between OVC support and material support for affected/infected in terms of church interventions. Most churches took these two aspects as a package most probably because they involve similar kinds of support.

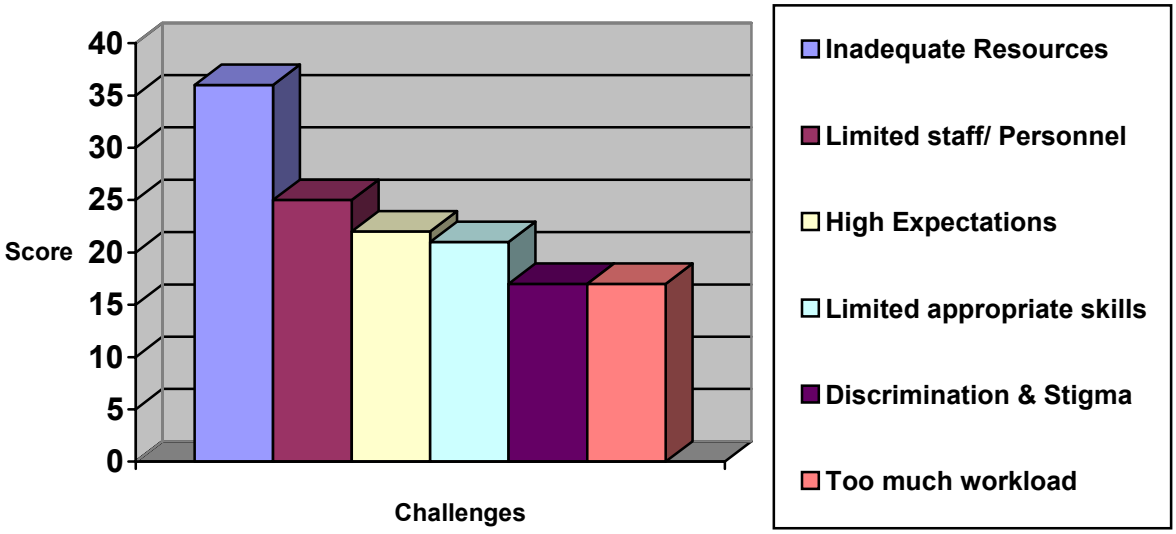
B. Challenges and Gaps in Implementation

Churches face challenges in implementing HIV/AIDS initiatives and they were listed and ranked as follows:

Table 8: Challenges in Implementation

CHALLENGES	SCORING
Inadequate resources	36
Limited staff/personnel	25
High expectation from community and church	22
Limited appropriate skills	21
Discrimination and stigma	17
Too much workload	17

Figure 2: Challenges in Implementation



a) As can be determined from the scoring and graph all the listed problems affect implementation with inadequate resources as the main challenge. Church leaders perceive implementation of programmes as extremely expensive. Leaders were also asked what they felt could be done without funding and most mentioned prevention/counselling.

b) The issue of limited staff and personnel came out strongly. Church leaders with active medical staff as part of their membership seem to be at an advantage because in many cases they are used as resource

personnel for sensitisation sessions. For churches with programmes such members are incorporated into HBC groups largely for prescription and administration of medication.

c) Given the inadequacy of resources the aspect of high expectations is a major challenge for churches. Focussing on the most vulnerable is usually questioned and viewed as favouritism.
d) Limited appropriate skills were widely cited by both leaders and members. Leaders felt they do not have the skills to spearhead implementation while members felt they lack skills and training in care giving for example.
e) Discrimination and stigma is a problem. The church is seen as a symbol of righteous living and infected persons are reluctant to disclose their status to church leaders for fear of being stigmatised.
f) Too much workload is associated with frequent burials arising from HIV/AIDS related deaths. Churches with programmes are sometimes left to cover all care and medication requirements for ostracised patients and this becomes a big burden. Two church HBCs cited cases when they were left to shoulder care and burial expenses.

Additional Comments on Challenges/Weaknesses are as follows:

- There is generally little communication between members and church leaders as regards HIV/AIDS related information. All but one of the church leaders interviewed has received training. There were a total of eighteen churches where both leader interview and FGD were carried out but none of the FGDs brought out data on information passed down from the pastors. Another aspect that was observed was variance in terms of information. In four of the eighteen churches there was a sharp contrast in information given - the pastors said that the churches had programmes while the members stated their churches had no programmes. Could this have been a true reflection of the prevailing situation or was the survey team perceived as a donor? This perception can sometimes make communities reflect a negative picture in order to improve chances for donor support.
- The FGDs in Mkushi brought out the fact that a number of infected persons from urban areas are taken to rural areas when critically ill yet rural church members receive very little sensitisation and information. Traditional beliefs and practices in these areas create even bigger barriers between male church leaders and female members for example. This poses a serious challenge for churches in outlying areas
- The Mkushi FGDs also highlighted the fact the few sensitisation meetings were usually attended by a majority of women. The women stated that they feared that their husbands had very little information. The reason given for non-attendance was that men were usually busy.
- One pastor felt that people from outside his church gave better sensitisation information because they could easily go into detail. He stated that he felt embarrassed to speak on details concerning

HIV/AIDS when addressing his congregation. This sentiment is worth noting for church leader sensitisation.

- Two Pentecostal church leaders stated that they were putting up church buildings as a current priority. They said the building process had placed high demands on the church in terms of resources thus making it difficult to undertake HIV/AIDS activities. This is an issue that raises a number of questions – is this a problem affecting a particular category of churches? How will such leaders deal with the possibility of reduced number of members (due to increased deaths/illnesses) after a five-year building project for example?

Suggestions to overcome the challenges were listed and ranked as follows:

Table 9: Suggestions to Overcome Challenges

Suggestion	Scoring
Access to funding/resources	32
Training in technical skills	25
Facilitating staff/personnel	20
Sensitisation to church to deal with stigma and discrimination	16
Training in financial management skills	13
Training in organisational management skills	11
Income generating activities	1

Comment

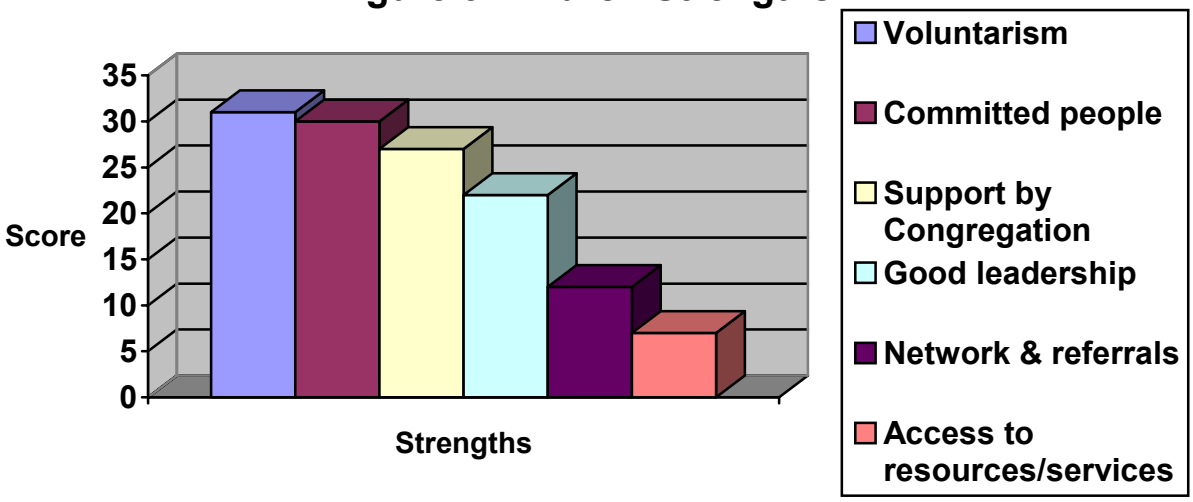
From the suggestions listed it is clear that access to funds is a major constraint for most churches. Given the general complexity of most donor proposal formats church leaders are likely to encounter difficulties in developing proposals even when funds access information is available. The need for training also came out strongly and respondents voiced a particular need for technical skills training.

Church strengths are listed and ranked as follows:

Table 10: Strengths

STRENGTHS	SCORING
Voluntarism	31
Committed people	30
Support by congregation	27
Good leadership	22
Network and referrals	12
Access to resources/services	7

Figure 3: Church Strengths



The large volunteer base and the high level of commitment from members is a definite strength for the church. Churches collectively have thousands of potential volunteers who can be very useful in terms of implementation.

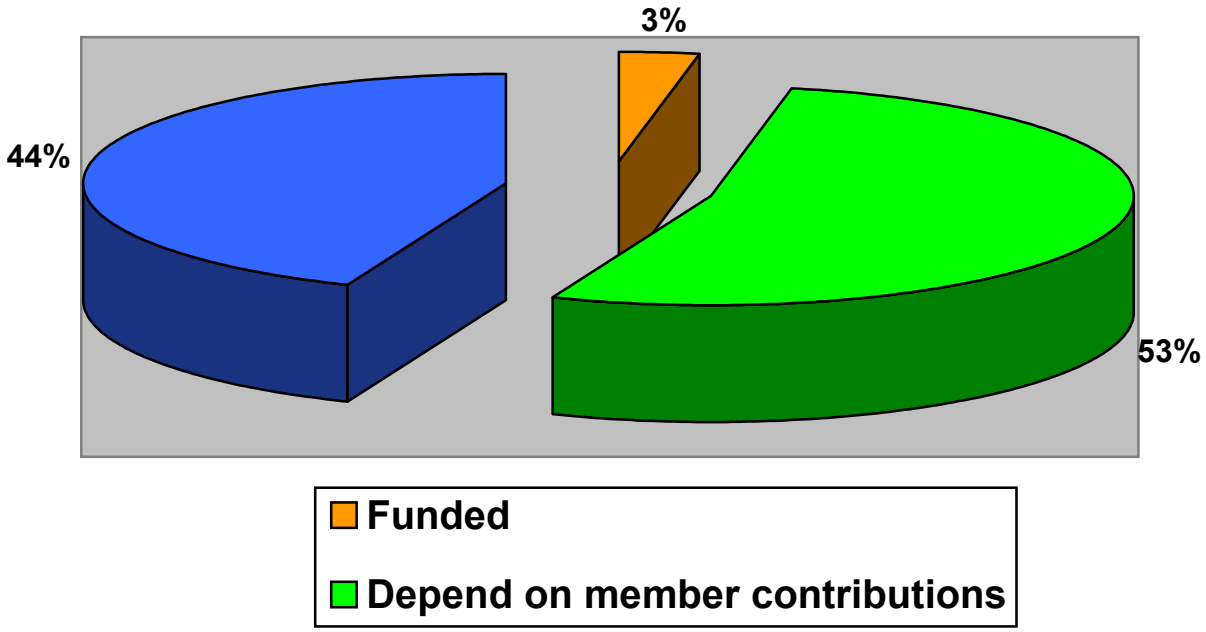
4.2.2 Available Resources

A. <u>Financial Resources</u>

Only two out of the churches surveyed have had access to funding. This represents 3% of the total sample. These churches are Catholic in Kapiri-mposhi, which receives funds from the archdiocese of Lusaka and New Apostolic church in Mpongwe that has been funded by ZAMSIF.

About 53% of the churches cited member contribution as a major source of funds. The other churches said they had no source of funds and only depended on very little contribution from members.

Figure 4: Sources of Funds



Successful methods for obtaining funds were listed as follows:

Table 11: Successful Fund Raising Methods

METHODS	SCORING
Local fund raising events	18
Lima programme	4
Denomination contacts	4
Submitting proposals through networks	4
Special appeal	2
Awareness on giving	1
Contacting private companies	1

Local fund raising events is a commonly used fund raising strategy and it cuts across rural and urban churches. A Kitwe church cited contacting private companies while the lima programmes are used in farming areas.

The following table lists and ranks the problems encountered by churches during the process of accessing funds:

Table 12: Problems in Funds Access

PROBLEM	SCORING
Lack of information	30
Proposal not accepted	9
Mismatch between donor and church priorities	7
Delays in receiving funds	3
Too many donor requirements	2
Small congregations sidelined	1
Inadequate transparency	1
Prejudice	1

Many churches cited lack of information on donor sources and submission of proposals. Some church leaders said they did not know how to write a proposal and had no knowledge of possible donors.

Sources of Funds

Information on sources of funds was difficult to find during the survey. A short list of donors was however compiled and the aspects funded are stated according to the information given by respondents.

Table 13: Sources of Funds

DONOR	ASPECTS FUNDED
Hands at Work – South Africa	HIV/AIDS training and monitoring of implementation
Partner Support Group (PSG)	Training
Glaxo Smith Kline (GSK)	Drugs at reduced cost and training
Tearfund Australia	OVC Community schools
Medical Association Programme International (MAP)	Training
Serving in Missions (SIM)	Not given
Dan Church Aid	Not given
Zambia VCT	Testing kits
Missions for Tools	Vocational skills

Prioritisation of Activities (if funding was available)

Respondents were asked how they would prioritise activities in case of funding. Activities were prioritised as follows across the survey sites:

Table 14: Priority Activities

KITWE	MPONGWE	KAPIRI	MKUSHI
1. Prevention	1. OVC	1. VCT	1.Training
2. HBC	2. Training	2. Prevention	2. Prevention
3. Counselling	3. Prevention	3. Counselling	3. Life skills

Respondents in all districts cited prevention activities as part of the first three priorities.

Recommendations on Increased Funds Access

Respondents gave the following recommendations on how churches could get more funds for HIV/AIDS activities:

a) Government should allocate funds to churches for HIV/AIDS activities since it is a national concern. This recommendation came out very strongly in all districts.
b) The National Aids council should employ a focal point person at district level
c) Funds sources should be decentralised to district level and separate church accounts for HIV/AIDS should be opened to improve donor confidence
d) Farming and various IGAs should be encouraged in the church as a source of funds
e) Establish vocational skills training centres
f) Volunteers should be provided with incentives
g) There should be a district HIV/AIDS programme spearheaded by DDCC

B. Resource Materials

Resource materials refer to mostly posters, pamphlets and books giving information on HIV/AIDS**.** A large proportion of churches do not have access to them and major reasons cited were non-availability and lack of funds. About 17% of the churches said they had access to resource materials. One respondent said the materials had wrong messages and two said they did not need them because they have no programme. The types of materials used are listed below.

Table 15: Materials and Sources

TYPE OF MATERIAL	SOURCE
Let us talk 1&2	Christian education department
How to be safe from HIV/AIDS	CHEP
What is VCT?	CHEP
HIV/AIDS information	CHEP
Stepping stones	CHEP
Parenting skills	CHEP
HIV/AIDS	Pastoral centre
SDA stand on HIV/AIDS poster	Adventist H/Q Zambia Union
Manual for hospice care	Catholic church
HBC manuals	PSG
Responding to stigma and discrimination	Kitwe DHMT
Awake	Watchtower society
Why me	unknown
Keeping hope alive	PAOG HQ

Two respondents said that the materials are not culturally sensitive, one cited problems with the language, and two said necessary information is not adequately covered. All respondents with access said the materials were relevant and easy to use.

C. Human Resource

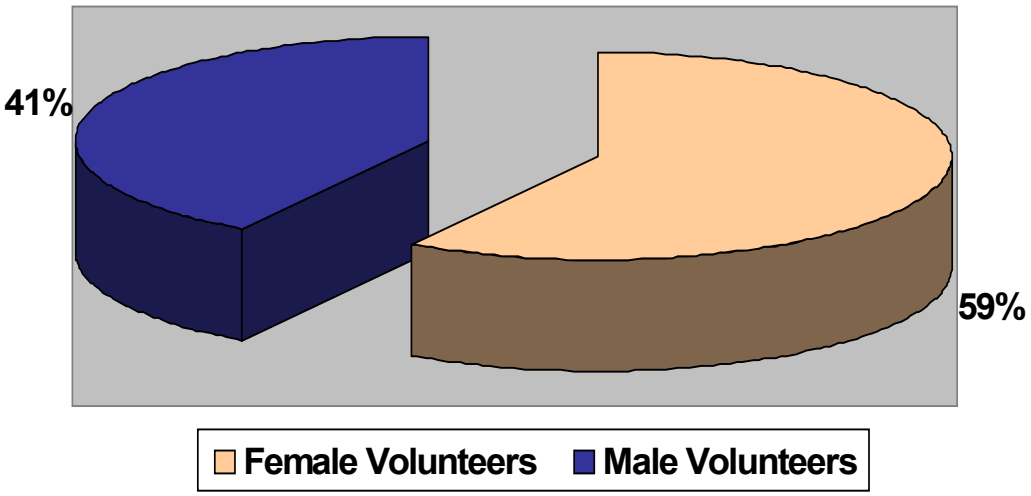
The table below gives information on number of volunteers per district.

Table 16: Church Volunteers

	KITWE *NCV=10*	MPONGWE *NCV=4*	KAPIRI *NCV=10*	MKUSHI *NCV=5*	Total *NCV=29*
Male	057	53	34	43	187
Female	110	39	44	75	268
Total	**167**	**92**	**78**	**118**	**455**

NCV = Number of churches with volunteers

Figure 5: Church Volunteers



In all districts the number of female volunteers was more than the males except in Mpongwe where the New Apostolic church had a much higher number of males because their doctrine does not allow females to be leaders.

Only one church (Kapiri-mposhi Catholic) consistently gives incentives to volunteers. The incentives mentioned were money, food, umbrellas, shoes, travel allowance and certification. None of the churches has full time staff working on HIV/AIDS programmes

The following table gives information on the training volunteers have received and further training needs.

Table 17: Volunteer Training

Area	Volunteers trained in this	Volunteers need training
Basic HIV information and awareness	17	25
Home based care	13	23
Prevention intervention	12	24
Counselling	11	23
Mobilisation	3	17
Psycho social support	2	22
Developing IECD/BCC materials	1	18
Financial management	-	23
Other? specify	-	

Figure 6: Volunteer Training Recieved

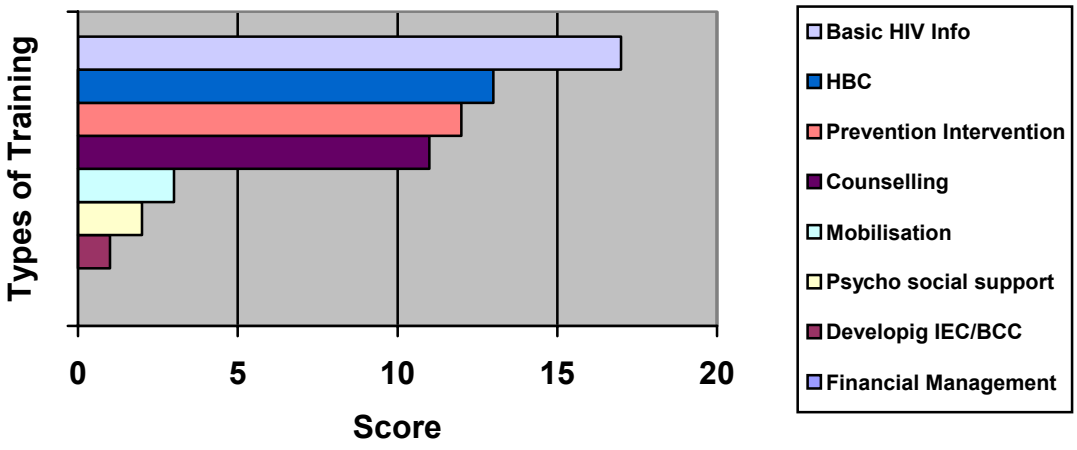
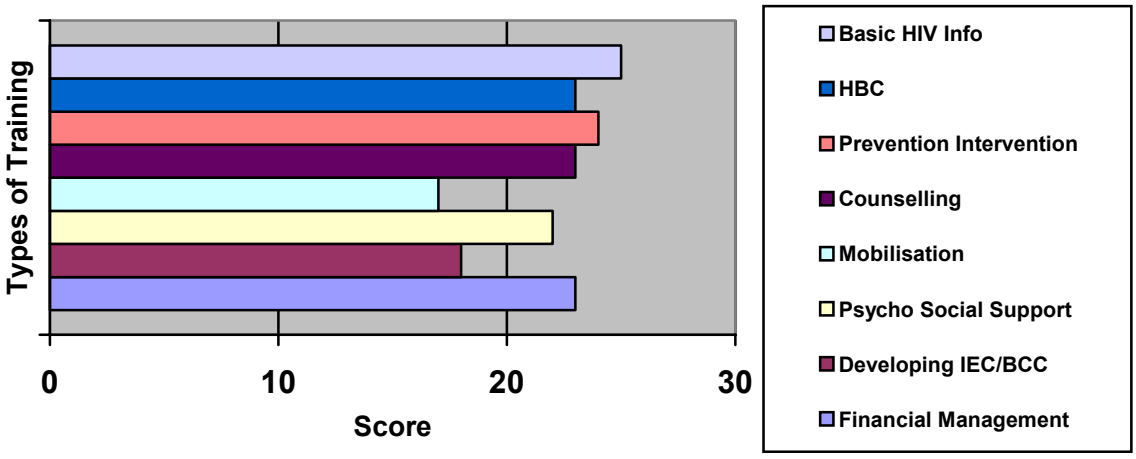


Figure 7: Training Needed by Volunteers



From the clustering of the scores in the training needs table17 and figure 7 it can be seen that gaps exist in the training of volunteers. Even those that are trained still need further training.

4.2.3 Governance/Capacity of The Church Based Response

Assessment of church capacity was carried out and is reflected below. The total number of questionnaires analysed was forty-one.

Table 18: Church Capacity

CONSTITUTION	**KT**	**MP**	**KP**	**MK**
No constitution	-	-	-	-
Principles written down	-	-	-	-
Written constitution not approved or non-functional	01	-	-	-
Approved constitution which guides organisation	14	06	12	08
COMMITTEE THAT MEETS AND MAKE DECISIONS				
No meetings	01	01	-	-
Rare meetings, few decisions	-	-	-	-
Regular meetings and frequent decisions	14	05	12	08
TREASURER TO SUPERVISE FINANCES				
No treasurer	-	-	-	-
Treasurer appointed but not functional	-	-	-	-
Treasurer supervises finances	15	06	12	08
CHURCH ACCOUNTS AND PRESENTATION				
No accounts kept	01	-	-	01
Accounts monitored and presented annually	01	-	03	-
Accounts kept monthly/quarterly and presented regularly	13	06	09	07
BANK ACCOUNT				
No funds	01	01	01	-
Funds with no account	02	02	-	-
Use someone's personal account	-	-	01	-
Own bank account	09	03	10	08
AUDITING				
Not audited	04	03	04	01
Not audited every year	02	-	-	-
Audited annually	09	03	08	07
OFFICE SPACE				
No office	04	03	02	04
Shared office	-	-	-	-
Own office	11	03	10	04
REPORTS				
No information produced	04	01	02	01
Some information given out	04	01	05	02
Regular reports distributed	07	04	05	05
COMMUNICATION FACILTIES				
Land line	2	-	2	-
Cell phone	3	-	1	-
Fax	-	-	-	-
Computer	-	-	-	-
Email	-	-	-	-
None of the above	8	6	8	8
All of the above	2	-	-	-
Land line and cell	-	-	1	-
PLANNING DEVELOPMENT OF HIV/AIDS ACTIVITIES				
No planning	07	03	03	03
Occasional planning	05	01	04	03
Regular planning	03	02	05	02
MONITORING				
No monitoring	08	03	09	05
Occasional monitoring	05	02	02	01
Monthly monitoring	02	01	01	02

Table 18: Church Capacity (Cont.)

RECORDS AND DOCUMENTATION	KT	MP	KP	MK
No records/documentation kept	04	03	02	03
Records kept but incomplete	04	-	03	01
Records complete and accessible	07	03	07	04
WIDER COMMUNITY PARTICIPATION				
No participation	09	04	08	05
Some participation	06	02	02	01
Active involvement and participation	-	-	02	02
MEMBER FINANCIAL/MATERIAL SUPPORT				
No support	01	01	01	-
A little support	12	04	09	06
Strong support	02	01	02	02
OUTSIDE FINANCIAL MATERIAL SUPPORT				
No support	13	4	12	07
Infrequent support	02	2	-	-
Strong and frequent support	-	-	-	-
PROPOSAL SUBMITTED AND FUNDED				
Never submitted a proposal	12	05	04	06
Submitted a proposal but no funds	03	-	07	02
Successfully submitted a proposal	-	01	01	-
EXTERNAL TECHNICAL SUPPORT				
No external support	10	04	07	04
Participated in external workshops and training	05	02	05	04
Regular outside support	-	-	-	-
GOVERNMENT AWARENESS AND SUPPORT				
Unaware	10	03	06	03
Aware but no support	05	02	04	04
Occasional support	-	01	02	01
Regular government support	-	-	-	-
AFFILIATION AND SUPPORT BY NETWORK				
No affiliation or support	11	04	08	08
Affiliated but no support	01	-	01	-
Affiliated receive minimal support	02	02	01	-
Affiliated receive regular and strong support	-	-	02	-

The governance/ capacity information obtained translates as follows:

a) All churches surveyed have some form of constitution (except one spirit based “Mizimu” church)
b) Financial structure in terms of treasurers and accounts presentation are largely in place.
c) About **21%** of the churches have no bank accounts.
d) Close to **20%** have no reporting system.
e) Approximately **31%** have no offices
f) About **73%** have no communication facilities
g) Two fifths **(39%)** do not plan HIV/AIDS activities and 61% do not monitor
h) Approximately **29%** do not keep records or documentation
i) Around **63%** have no wider community participation
j) About **90%** have no outside support. No church recorded frequent and strong outside support.
k) Two thirds (**66%)** have never submitted a proposal
l) About **78%** said they are not affiliated to any network.

Analysis of all the data obtained shows that there are major gaps in the churches’ capacity. The church capacity must be improved in order to scale up the response.

4.3 Findings From Bible Colleges

A total of four bible colleges were visited in order to establish the extent to which HIV/AIDS is being addressed as part of church leader training. The findings were that three out of the four have incorporated HIV/AIDS training as part of the curriculum at varying levels. This incorporation for all the colleges was done during the last three years, indicating that only recent graduates have received HIV/AIDS training at Bible College.

5.0 RECOMMENDATIONS

i. SURVEY REFINEMENT

1. This study must be refined to make it more statistically representative. There will therefore be need to cover a wider geographical area and increase the sample size. To ease this work a comprehensive directory of all churches should be compiled. The study should also include a gender analysis to bring out the implications of a largely male dominated leadership structure for a largely female church 'workforce'.
2. The follow up survey should be carried out within the near future in order to build on feedback and awareness created by this first snapshot survey
3. The follow up survey should be carried out within the near future in order to build on feedback and awareness created by this first snapshot survey

ii. FUNDING

1. There is need to close the gap between government and the church. The church must be viewed as a viable institution that can be funded. The collaboration between the church and various para church organisations as is the case on the ECR board for example is a major advantage and should be built upon.

2. ECR should be funded to spearhead the church response

3. ECR should facilitate church proposal appraisals and recommendations for funding. Before funding there should be a period given for churches to go through their own dynamics so as not to destroy existing mechanisms

iii. CAPACITY BUILDING

1. Churches should be trained in proposal development in order to improve capacity for sourcing funds to be used for HIV/AIDS programmes

2. Bible colleges should be supported to set up well established HIV/AIDS units to make the church leader training more relevant in the face of the current pandemic

3 Church members/leaders should receive training in prevention as this is a gap in the current church response

4. Local church councils should be formed and strengthened through the training of district core teams. The training must be carried out in line with the country's strategic plans.

iv. ADVOCACY AND LOBBYING

The church in Zambia must view itself as a vehicle for advocacy. It has a good grassroots network, great influence and is operating in an environment with a constitutional backing for the church to voice out concerns. These aspects should be used positively in spearheading the fight against HIV/AIDS.

v. BEST PRACTICE

Pilot areas should be selected for best practice development. This will enable a continuous process of learning, feedback and analysis of what works (or does not work). It will also be a basis for documentation and exchange of lessons learnt. Models that work can then be replicated in other areas with a good backing in terms of process information.

APPENDIX 1

CHURCHES CONTACTED AND INDICATION OF LEADER INTERVIEWS/FOCUS GROUP DISCUSSIONS

KAPIRI-MPOSHI			MKUSHI			MPONGWE			KITWE		
Church/Org name	LI	FGD	Church/Org name	LI	FGD	Church Org name	LI	FGD	Church Org name	LI	FGD
UCZ	√	√	New Apostolic	√	√	UCZ	√		RCZ Kapoto		√
Baptist	√	√	UCZ	√	√	J witness	√	√	ACTS Comm ch PAOG	√	√
RCZ	√		Pent. Holiness	√	√	*Kabya and Chinwa Baptist	√	√	Catholic Kapoto		√
Anglican	√	√	SDA	√	√	*Mpongwe and Chipese Baptist		√	Pentecost church	√	
Catholic	√	√	RCZ	√	√	SDA	√		ACZ city cell	√	
AME	√		Catholic	√		Faith Assemblies	√	√	Christian Faith Church	√	
Grace min	√		Apostolic Faith Mission	√		Catholic		√	Pentecostal Holy Ghost	√	√
New Apostolic	√	√	Anglican	√	√	Mpongwe AIDS Project	√		UCZ town	√	
Church of Christ	√		*Baptist,Pent. Holiness		√	New apostolic church	√		UCZ Wusakile	√	√
ACZ (Calvary cross)	√		Baptist union		√				AME Wus	√	
Mizimu (John Marange)	√								AME Buchi	√	
PAOG Faith Assembly	√								RCZ Ndeke	√	
SDA	√								ECZ Parklands	√	
Cross Border Initiative WVZ	√								St. Michael's Anglican	√	

APPENDIX 1: (*Contd*)

KAPIRI-MPOSHI			MKUSHI			MPONGWE			KITWE		
Church/Org name	LI	FGD	Church/Org name	LI	FGD	Church Org name	LI	FGD	Church Org name	LI	FGD
		CLFG									
**Baptist,Anglican and Mutumwa*		√							Messiah Kingdom of Zambia	√	√
**SDA and ,New Apos*		√							SDA Wus	√	
Catholic Material compd		√							SDA Ndeke village	√	
**UCZ and RCZ*		√							Pentecostal Holiness	√	
									Pastoral centre	√	
									Ucz theological college	√	
									Anglican Seminary	√	
									Pentecostal Holiness	√	
									Kaniki bible College	√	
									Trans Africa Theological College	√	
									Scripture union	√	

* Combined groups
LI = Leader Interview
FGD = Focus Group Discussion
CLFG = Community Level Focus Group Discusion

APPENDIX 2

LIST OF ORGANISATIONS WITH LINKS TO SURVEYED CHURCHES

- Copperbelt Health Education Project
- Health Neighbourhood
- Drug Enforcement Commission
- Kitwe City Council
- World Vision International
- Ministry of Health
- Ministry of Education
- Church alliance
- Society for Family Health
- International Red Cross
- World Food Programme
- Tasinta
- Street Children Orphans and Widows Association (SCOWA)
- Zambia Structural Investment Fund (ZAMSIF)

APPENDIX 3

BEST PRACTICE EXAMPLE

CONTACT PERSON
NAME: PASTOR ANDREW KAYEKESI

ADDRESS: MPATAMATU HOME BASED CARE
P.O. BOX 36
MPATAMATU
LUANSHYA

LOCATION: FORMER 21 CLINIC
MPATAMATU
TEL: 096 99144
E-MAIL: mpatahbc@zamtel.zm

PRACTICE: HOME BASED CARE AND EVANGELISM AS A RESPONSE TO HIV/AIDS

1.0 BACKGROUND

Mpatamatu home based (MHBC) care is an interdenominational non-profit organisation which targets chronic and terminally ill patients regardless of age, sex, race or religious conviction. The programme started on small scale in 1997 and has expanded to include two other areas within Luanshya, Roan and Mikomfwa. It has also further expanded to Kabwe in Central Province. MHBC is steered by a 10-member management board. The program currently has 180 volunteers and approximately 1000 patients.

2.0 OBJECTIVES

a) To provide home care to patients who cannot receive hospital treatment due to various reasons such as inadequate bed space and lack of resources.
b) To additionally provide emotional spiritual and social help for patients.
c) To support and build on the strength of families and communities as a networking and care provision structure.
d) To provide holistic support to orphans.
e) To increase HIV/AIDS awareness in communities as a prevention measure and also provide training on caring for the sick and orphaned

3.0 ACHIEVEMENTS

a) Increase in number of beneficiaries from 8 at inception to current 1000
b) Capacity building programme for staff and volunteers with the potential of contributing to development programmes outside the existing project areas
c) Care beyond the medical realm in terms of spiritual support with testimonies of healing and salvation
d) Geographical expansion to other affected areas and thus potentially increasing impact
e) Effective networks established with Government ministries, NGOs and international organisations

4.0 LESSONS LEARNT

i) Church leaders with a heart for HIV/AIDS interventions are instrumental during the start up phase in new project areas.
ii) It is important to have an exit strategy from the beginning to enable component project areas to become gradually autonomous as initial model may not contain expansion beyond particular limits
iii) Volunteers are better trained through inclusion of 'hands on' practical work spearheaded by existing peers.
iv) Early introduction of incentives for volunteers interferes with the selection process because it becomes more difficult to judge levels of commitment and inherent initiative.
v) There is need to take care of sustainability aspects so as to reduce dependency on donor support.

5.0 IMPLEMENTATION

New project areas are selected based on a number of factors including prevalence levels. Identification of key leaders who are given initial training in administration accounting and management starts implementation.
Volunteers are identified across denominational lines and given a one-week theory training which is followed up with a 3 months practical training. During this period there are no incentives given and training is partly through observing existing volunteers carry out their community care duties. Each training session carried out within the programme incorporates teachings on discipleship and evangelism so that volunteers are able to share the gospel to all patients and care givers. At the end of training less committed volunteer trainees usually fall out and a further selection is carried out before graduation. The training aims at a maximum of 30 volunteers per session.
After graduation follow up training topics covered depend on problems encountered in the field
For the purpose of fieldwork volunteers are divided into teams of 8-10 and each team includes a nurse who prescribes medication. Each team covers a designated project area and systems have been put in place to monitor home care schedule and drug dispensing.

Volunteers each have a maximum of 10 patients and training is carried out for recruitment within existing project areas after assessment of the volunteer to patient ratios. Record s on each patient are kept and given to local MoH centres for the purpose of follow up treatment and statistical records.

Training is also carried out for project co-ordinators and facilitators. The nurses also have specialised training to improve knowledge on catering for the specific needs of hiv/aids patients.

6.0 CHALLENGES

i) Funding is inadequate and erratic and this affects field activities especially the consistent administration of drugs.
ii) High expectation from the community
iii) Dependence on the Ministry of Health for drugs sometimes jeopardises care support due to shortages
iv) The rising number of orphans
v) The project areas are situated in towns where most people are out of formal employment and the levels of vulnerability are high
vi) There is a dependency syndrome and some members of the community expect continuous handouts.

APPENDIX 4

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