

### AIDS And You Contents

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What should we do about AIDS? Personal and Project Responses

Living life to the full

You are important. I believe you were made for a purpose and that you will find your greatest happiness finding that purpose for yourself. Part of that involves starting to live for others. Jesus said that the only way you could find your true self, that is becoming truly human, is by losing yourself - not by becoming a passive doormat that everyone else can tread on, but by letting go of the right to run your life your own way, and instead inviting Jesus to show you how to live his life. I believe God has a plan for you and that because he loves you, his plan is the one that will make you truly happy.

The most important part of that plan is that wants you to know him personally, not as a 'human being', but as your friend, and that he wants to you have new power, strength and inner resources so that you can live life to the full. Often this brings healing and sometimes physical healing as well.

Getting involved

Secondly, there is some action you can take will be of practical help to those who have AIDS.

You might want to become a volunteer, to offer, to visit someone who is ill, or to help support their family. Or you might want to help save lives by telling people how to protect themselves against HIV. Why not talk to others in your church, or to other people involved already in a Christian response to AIDS, and offer time to them. You will find many resources to help you on the ACET International Alliance website. You can download them and print them out.

What can be done?

Start with what you have. I recently visited a school for AIDS orphans and an income generation project started by six grandmothers in a very poor area of Uganda. They started with what they had and got on with it themselves, gradually mobilising others in the village and little by little the work has been established. They saved up and bought some land. Then they saved to buy a cow. The milk from that cow pays to run the school. Gradually they made bricks and replaced straw roof on poles with a small building. And then they built another. They started to teach the children as best they could in their own spare time. Everyone was helping. Some brought food, others cooked, others carried water each day so the thirsty children could drink. The grandmothers realised they needed some training and went off to government programmes to get a basic qualification. A visitor came and gave them money to get electricity. Another provided a pipe for running water. Another gave them a sewing machine to train older girls. and gradually the work has grown.

Every church can encourage members to do something to help. As George Hoffman once said, the founder of Tear Fund: "You can't change the whole world but you can change someone's world somewhere.

Go and save someone's life today.

Go with food to a family stricken by AIDS today.

Go and comfort a widow or an orphan today.

Go and encourage someone who is giving their lives to AIDS ministry today.

Pray for God's protection on them and for God's provision.

And you may be part of the answer to those prayers !

### Good Practice in HIV/AIDS Projects

This section is written by Mark Forshaw - Africa Inland Mission International

What can we do? How can you and I make a difference? Firstly, always start with what you already have. It's a scriptural principle. God's work done in God's way never lacks God's supplies, as Hudson Taylor, the famous missionary to China once said. So what is God calling *you* to do? What has he laid on your heart?

You need neither funds nor a large team to start. It costs nothing to care for a friend or neighbour, nor to talk to your own children and colleagues about HIV and AIDS, nor to include HIV issues in your church teaching programme, or work training schemes, or school curriculum. Together we can make a real difference.

You may not be able to save the whole world but you can save someone getting HIV somewhere. You may not be able to help all those with HIV or orphaned by it, but you can give practical help and encouragement to a few, and you can get involved in other projects that are already running. But do it all in fellowship with others. Such work can be stressful, draining and lonely and you will need people supporting you too. , , What about larger projects? Thousands of programmes have been developed, countless papers published and millions of dollars expended in the struggle against HIV/AIDS. Yet spread of the pandemic rapidly continues. Many governments and NGO agencies now recognise that their strategies are

failing to stem the tide, yet continue to pump money into condom distribution alone and one-off awareness campaigns, neither of which address related problems such as poverty, education, the rights of women, and broader lifestyle questions.

Here are some stories to encourage you: remember these are lessons from different countries which need careful adaptation to your own situation. However the Case Studies illustrate many general points which are vitally important.

Every one of these stories has a small beginning. An individual touched by the love of God, and deeply affected by what AIDS is doing to the world He made. People who felt they *had* to do something, and who began, usually with almost nothing, step by step, following God's calling, in fellowship with others and learning from those around them as they went. In many cases the road was long because there were few role models for such programmes at the time. But now the programmes they began are an inspiration and practical encouragement to us, and accelerate us on our own journeys.

### Care Case Study - FACT Zimbabwe

In the face of a high level of need and limited formal health resources, those who began FACT (Family AIDS Caring Trust) in Mutare, Zimbabwe, saw the pressing need to mobilise the local community to provide care. Churches were approached who had individuals willing to be trained to provide care to families and neighbours in their communities. FACT home care programmes are co-ordinated by experienced health workers who are responsible for local teams. Each team is headed by a volunteer, managing other local church volunteers who provide the actual care to those in need in their areas.

The training of volunteers consists of basic counselling and care skills. Care skills required for people ill at home are: bathing and personal hygiene, washing clothes and bed linen, house cleaning, provision of appropriate food and the treatment and dressing of minor wounds. While the main aim of the volunteers is to attend to those infected with HIV, they are trained to care for all who are chronically ill or dying, e.g., people with TB, diabetes or simply from old age. It felt wrong to visit only those who were ill due to HIV while not caring for their neighbours who were equally ill but not necessarily HIV positive.

Above all it is necessary for volunteers to recognise that the needs of those they visit are not purely physical, but also emotional and spiritual. Volunteers are drawn from the local community and it is often their neighbours they are caring for. The formation of serving relationships are the basis for good practical care and supportive counselling.

The majority of those visited are living with members of their families and the role of the volunteers is also to support them. They offer advice on ways to deal with different infections common to HIV; other informal and formal services available and how to access them. Importantly the volunteers also offer emotional and spiritual support to the family carers.

Through this relatively low skill and low cost team a larger number of people are able to receive help, utilising the traditional family and community caring mechanisms. Through volunteers, each church is able to reach into its community to serve and support families, neighbours and other carers. Volunteers contribute to programme development with data collection and in decision making and planning meetings. This is a good practice: involve people who are closest to those who need help.

Home care helps those most in need of assistance in their own areas. However providing practical care alone only meets physical needs. There are also very real emotional needs as people face prejudice and rejection, and spiritual needs as they are facing death. Care must therefore encompass counselling of the individual by appropriately trained and supported workers.

For Christian organisations, home care and counselling can be opportunities for finding faith, as people with no human hope discover eternal hope through Christ. Care for a PWA is a powerful way of sharing the love of Christ practically within the community and sometimes this can lead to naturally sharing Jesus, our motivation for caring.

Basic physical care of sick people is an obvious need that must be met. Destigmatisation, normalisation and inclusion by family, friends and community are also all needs though less immediately obvious. They can all be achieved by low-cost, yet trained and caring volunteer home visitors, who are themselves, well supported and managed.

The relational-based care offered by the volunteers naturally opens up opportunities to raise awareness and understanding more widely about HIV/AIDS and especially how it is transmitted and prevented. HIV/AIDS prevention that develops out of the context of care often makes it easier to talk about sensitive social and moral issues. People whose friends or family are infected are facing the reality of the disease and therefore tend to listen and subsequently pass on information to others. For an AIDS organisation working in prevention, one of the best entry points is care, which most often also brings credibility to their work.

### Summary on Care

Community based care reaches more people

PWAs often prefer to be cared for in their own homes

Be prepared to care for those with many different illnesses, not only those living with HIV/AIDS

Families, friends, communities and volunteers are a resource for care

Communities must own the work and so must be consulted from the beginning and throughout the life

Care in the community, provides opportunities for prevention education

Community based care is most often cheaper than hospital based care.

Care should be holistic: physical, emotional, social and spiritual

Effective care in the community is best linked to other services and works in partnership with them e.g.

Communities have many resources within them that can be drawn upon

Summary on use of Volunteers

Ask the question: is the use of volunteers appropriate, how, where and to what extent?

Selection criteria must be established at the start. Motivation is key.

Relevant training at the start and throughout the programme

Monitoring and support of volunteers throughout the programmes life

Involvement in decision making and planning.

Clear parameters for volunteers on what is expected of them and when they should refer to paid staff.

Regular group and individual monitoring and support of volunteers by the organisation. People are our

### Issues in Counselling

A central part of care and prevention.

Training is critical.

So is supervision and clear boundaries i.e. Know when to stop and who to pass issues to.

### Prevention Case Study - ACET Uganda

The aspiration in all HIV/AIDS care and prevention work should be the reduction of the spread of HIV. Here is the greatest challenge to those in HIV-related work: are you spending as much effort and resource on saving lives, as in caring for those affected. You only have today to save someone's life and the next 10 years to plan their care. We must do all we can to fight this terrible problem. Care programmes, while vitally needed, are no answer on their own to the spread of AIDS.

But changing behaviour is a real challenge. HIV/AIDS awareness campaigns and education alone have limited impact in changing high risk activities of individuals. Information received by an individual does not necessarily mean that the individual understands, relates to or wishes to change their behaviour.

ACET Uganda has developed a three- pronged approach to communication to assist effective and sustainable behaviour change.

People must know the facts. This must be designed to meet individual and local needs. It must be able to fill gaps in information and lay a foundation for understanding the medical, social, economic, cultural and spiritual issues related to HIV/AIDS. But facts alone will rarely change behaviour.

Identification:

Assisting individuals to understand high-risk behaviours that they are, or could be, involved in. Help people make important lifestyle choices to be made based on understanding the options and consequences of particular behavioural practices. This method is in contrast to the "Fear Method" of many HIV/AIDS campaigns.

Interaction:

Having been shown the choices, the individual is then encouraged to think through the options. These relate to life-skills that reduce vulnerability to infection, enabling long-term fulfilling relationships, taking personal responsibility for their behaviour, having confidence to make and live by their own decisions, and respecting the worth of others.

As ACET Uganda developed its HIV/AIDS prevention work it soon became apparent that HIV/AIDS could not be dealt with in isolation and it was necessary to deal with general sex education and, importantly, the development of an individual's relationships through developing personal self-worth and a high regard for others. These are skills that are critical not only to HIV/AIDS prevention but also to the general development of every individual.

ACET Uganda describes lifeskills as "formal and informal teaching of requisite skills for survival, living with others and succeeding in a complex society. It can no longer be assumed that these skills are automatically learned or that they are automatically passed on, as was in times past." (Lifeskills Education for Responsible Behaviour among Adolescents, ACET Uganda) Many existing cultural teachings may not prepare people for new pressures.

For example, with the increased urbanisation, people are facing new economic and social pressures, while traditional social structures are breaking down. Development of life-skills by people (in particular those most vulnerable, such as young people and women) can equip them to respond more positively to the challenges that they face in life.

How life-skills are learned

ACET Uganda uses interactive teaching methods to provoke people to think and discuss issues that affect them, assisting them to analyse situations they will face and their responses.

Peer pressure is very effective in developing individual thinking and social understanding. This can be both negative and positive. The role of the education team is to develop peer-group thinking that will help reinforce and sustain of positive and healthy behaviour.

Focus group discussions.

Debates and Panel Discussions.

Films, reels, slides and video. "Do not expect films to speak for themselves" but they can form the stim

Questionnaires.

Talks, not long lectures, but short and dealing with contemporary issues

There are common principles for educators/facilitators to employ during the learning process:

The issue is not primarily raising awareness, but assisting personal and community behaviour change

Attention to vulnerable groups, in particular women and young people. Research their needs.

Commitment to people.

Respect for the listener and their views.

Co-operative not competitive learning.

Importance of peer education.

Interactive methods of learning.

Time for reflection.

Clarity of the message.

Relationship building.

Training of others to assist in the process e.g. peer educator

The Gospel - a framework for life.

For Christians involved in lifeskills education the gospel can be brought in naturally when appropriate, for many it offers them a framework for life. It is the news of Jesus Christ who can help people face the challenges of life. It may not always be appropriate to be evangelistic, but often educators are asked where they receive the strength and purpose to face life's challenges and can legitimately testify to their faith.

The integration of HIV/AIDS Prevention with other issues.

Addressing HIV/AIDS prevention education should form part of a more comprehensive teaching on lifeskills. The educators of ACET Uganda have gained credibility, in part because they are dealing with many of the other pressures people are facing. For other organisations such as FACT, involvement in the care of people living with HIV/AIDS has given them the basis and opportunity from which to undertake prevention education.

Church Mobilisation Case Study - Chinkinkata Hospital

A church which serves the community It is of course important that the church serves the local community. But part of serving means handing power and decision making to the community, and even to people living with HIV/AIDS. The central verse in Mark's gospel, Mark 10 verse 45 describes Christ as a servant "For even the Son of Man, did not come to serve, but to serve and to give his life as a ransom for many" Not only a servant, but a servant who gave his life.

The Salvation Army hospital at Chikankata, describe their education work 'community counselling' as "an activity expressed through dialogue, directed towards genuine transfer of responsibility for prevention - from health personnel and other concerned 'helpers' to individuals, families and perhaps most importantly, communities" (AIDS Management An Integrated Approach Campbell I.D, Williams G). Such a community wide interactive approach is essential in the context of AIDS in communities with high rates of HIV infection. The task of prevention is very great and communities must own the desire to change. Instruction alone is not enough. They need education, information and training from people they respect. The church must serve in order to mobilise the community.

The Word of God The size and moral nature of the epidemic has left many programme implementers uncomfortable with the slow pace at which the church, missions and Christian NGOs have responded. Church leadership is key in the mobilising of HIV/AIDS programmes. If church leadership remains unmotivated or, worse, prejudicial about church involvement, time needs to be invested to help influence a change in this attitude before sustainable action is expected from a church or group.

When you have support and encouragement of the church leadership the resources within the church can easily be mobilised. The key appears is the power of the Word of God with the Holy Spirit to motivate, to care, and to give people a framework for life. Christian care must model that of Christ, which was not restricted to the physical needs of people, but went way beyond this to their emotional, relational and ultimately spiritual needs. Christians have an opportunity through HIV/AIDS care and prevention education to practically express the love of Christ for the marginalised, but also for all in the community living under the threat of AIDS.

### Mobilising a Church Case Study - TAIP, Jinja,Uganda

Under the leadership of Pastor Sam Mugote a number of the members of Deliverance Church, Jinja, formed a group to offer physical and spiritual care to people in their community living with HIV/AIDS. They were motivated by the many needs of their neighbours but also by the call of God's Word to care sacrificially for those in need, without prejudice or judgement. The programme grew through other churches seeing the positive impact upon the lives of individuals, the community and the church itself, and requesting to become part of the programme or to be allowed to replicate the work. The Deliverance Church formed TAIP, The AIDS Intervention Programme, to enable and assist churches to respond to the HIV/AIDS epidemic in their communities.

The aim of TAIP is to assist churches to develop sustainable support to people living with HIV/AIDS. Churches are facilitated to plan and manage both care and prevention programmes through volunteer-based work to their immediate communities. The foundation for these programmes is a spiritual premise that Christians should take initiatives in the HIV/AIDS epidemic.

The implementers of the care and prevention work are individual volunteers from churches. The majority of them are untrained in formal health care, but have been equipped to provide the basic physical care that people living with HIV/AIDS need in their homes. Furthermore the volunteers are trained to provide counselling intended to meet the emotional needs of both the PWA and their families. They also offer advice on nutritional matters and other services available to individuals and families. At the heart of the provision of this practical care the love of Christ is shared.

Generally, the TAIP team works with churches that approach TAIP for guidance. In the words of Pastor Sam Mugote, he sees the role of TAIP as assisting Churches "to develop work that churches are already doing", that they care about people and the Biblical model for life.

The churches that seek assistance and are selected to receive training share two key qualities.

Firstly, they see the need of people in their community infected by HIV and the effect this has on their families and community. Secondly, the church is active in the verbal and practical proclamation of the gospel i.e. has recognised and is already practising a response to the call of Gods Word to tell people of the good news of Jesus Christ in word and deed.

These are fundamental building blocks, without which it is difficult to then start an HIV/AIDS programme. The role of TAIP is to offer guidance on how a congregation may direct their vision and skills to offer effective care and prevention.

As stated above the experience of TAIP is that a local church must already show evidence of commitment to and practical outworking of, the biblical teaching cited above. From this starting point it will be more of a natural development for churches to then make a local response to the HIV epidemic. ,

The TAIP team begin by making an initial visit to a church to meet with the minister, church leadership, and interested individual members in the congregation. It is important that the leadership not only agrees to the development of a programme but is also actively involved in the work. The church may meet a number of challenges through which the active support of leadership is needed. Volunteers may face prejudice and will certainly need regular support and understanding when involved with chronically ill people and their deaths. The TAIP team train motivated *and* selected members of the church to become a Support Action Group (SAG) to visit people with HIV/AIDS. This group of volunteers is also equipped to be able to review its activities and support one another by meeting together regularly.

The emphasis of the TAIP training and of the SAG volunteers is to develop relationships with individuals. This meets one of the central needs of people, to realise that they are loved and have worth and it is from this base of emotional support that the other elements of care can be supplied.

It is important to note that the experience of TAIP has been that the mobilisation of a church can take between six and eighteen months as volunteers are selected, trained and learning practically applied between training sessions. Training is then followed up by supervision, support and update training visits by TAIP. Another important factor in the development of the church's programme is clear liaison and communication with the local community. The community should agree to and own the initiative and this will often require time and resources dedicated to developing relationships, even training in the development of surveys and planning with communities.

It is the experience of TAIP and other organisations that volunteer-based projects can be developed with less difficulty in rural areas compared to urban areas. The main reason for this is the availability of volunteers with time to care for people outside of their own families. In urban areas there are often reduced family structures and the need to earn a wage can severely restrict the time volunteers have to offer. A solution has been to mobilise those who do have some available time. Furthermore training has often concentrated on the training of families to provide more of the care needs of people living with HIV/AIDS.

TAIP have seen that a programme developed naturally by one local church provoked other neighbouring churches to catch the vision.

Summary on Church mobilisation

Biblical lifestyle of the church members must be in evidence

Leader must be supportive and involved

Quality and relevant training

Regular support for volunteers

Emphasis on relationships with PWAs and the community

Include support for families

It can take up to eighteen months for an effective programme to develop

Clear liaison and communication with the local community

More difficult to develop in urban area

The following biblical texts are drawn upon by TAIP. We can see their relevance for today, especially for those infected and affected by HIV/AIDS.

Called to care 2 Corinthians 1, verses 3 and 4. "Praise be to the God and Father of our Lord Jesus Christ, the Father of compassion and the God of all comfort, who comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves have received from God." We have been given much by God and we have the responsibility to reach out to others in practical, caring compassion. The example of Jesus Mark 1, verses 40 to 45. "A man with leprosy came to him (Jesus) and begged him on his knees, 'If you are willing you can make me clean.' Filled with compassion, Jesus reached out his hand and touched the man. 'I am willing he said. Be clean!' Immediately the leprosy left him and he was cured." We may not be able to touch and cure, but here we see that Jesus was filled with compassion for a person who in the times of the New Testament was not only afflicted by a disease, but suffered the prejudice and rejection of the community. Lepers were even seen as cursed, yet Jesus talked with this man and touched him. The call to be non-judgmental John 8 verses 2 to 11. The woman caught in adultery, and the judgmental attitude of the religious leaders of the day. verse 7 - "If anyone of you is without sin, let him be the first to throw a stone at her." No one did, including Jesus who was without sin. Should we not follow this example and show compassion and not judgement or prejudice against people with HIV, whether they have innocently contracted the virus, or not? The call to serve practically and sacrificially Luke 10 verses 25 to 37. The parable of the Good Samaritan. , , Mercy was shown to a man, who was most probably a Jew, by a Samaritan, the Jew's enemy. Yet the Samaritan gave time, his donkey, his medicines and money to care for the injured man - he showed mercy; Jesus says to us "Go and do like wise" verse 37.

The call to advocacy and care for the marginalised Isaiah 1 verse 17 "Seek justice, rescue the oppressed, defend the orphan, plead for the widow" The language is strong, proactive and action based.

The church has a message that offers the framework for life HIV/AIDS prevention education should be part of a wider teaching on lifeskills that equips individuals to develop themselves and to counter pressures, including those that lead to increased vulnerability to HIV infection. The Word of God offers the framework for life and for hope; the church is obligated to tell others. This includes assisting members of communities in developing safe behaviour that can prevent the spread of HIV. The AIC (Africa Inland Church) Kenya AIDS Team has developed, to great benefit, materials that utilise the Bible for guidance in HIV/AIDS prevention, sex education and relationship development. Utilising materials from other parts of Africa and so "not reinventing the wheel" they have worked not only with local churches, but in their

associated schools and importantly in Theological colleges, where the church leaders of tomorrow are equipped with Bible based skills and resources. , , A people of prayer Ephesians 3 verses 14 - 21 includes verse where Paul prays "that out of his [God's] glorious riches he may strengthen you with power through his Spirit in your inner being". Prayer for people infected and affected is essential. And prayer support for those involved in the work is also essential. This work is draining, physically, emotionally and spiritually, God's help is needed at every step of the way.] -

*edit if desired*

Community based response to HIV/AIDS Case Study - Chinkinkata Hospital Zambia With the advent of the HIV/AIDS epidemic in southern Zambia, the response of Chikankata Hospital (Salvation Army) was to develop designated AIDS wards and comprehensive community and prevention services. However, it soon became apparent that there were too many people for the in-patient services to handle, and that many of the needs should and could be met by care services based in the community. Therefore, in 1987 a Home Based Care (HBC) programme linked to hospital diagnosis, counselling, education and treatment was established. This programme allowed people to be cared for in their own homes, and created opportunities to train families in the care of people living with HIV/AIDS (PWA) and discuss HIV/AIDS education and prevention with families and the wider community. The HBC teams are multi-disciplinary and include community nurses, nutritionists, and counsellors. The HBC programme at Chikankata soon developed into a comprehensive HIV/AIDS programme including: in-hospital counselling AIDS education schools, child support programmes and technical assistance programmes for other organisations. Chikankata has developed a diverse but integrated approach to supporting the local community in combating HIV/AIDS. The programmes that are developed are tailored to meet the needs of different sections of the community. Local communities in co-operation with Chikankata hospital have developed successful programmes providing care for persons with HIV infection. These community-based programmes belong to the community that benefits from the services, not to the aspirations of an NGO or health care institution. The community is not necessarily restricted to a geographical area, but rather the term 'community-based' denotes that the local community owns it. The result of the link between home care, prevention and general community development has been an investment in a community not so readily achieved through hospital in-patient care. Furthermore, home care proved to be 50% cheaper than inpatient care. But to obtain such savings requires good planning and management. Community based care, still has many costs attached, including the training and support of volunteers. Holistic care, whereby the physical, social, spiritual, economic and psychological needs of both the individual and the community are met, is of paramount importance to the team at Chikankata. Such diverse needs can only be met by working with all those that contribute to a community, that is, individuals, families, communities, government institutions and the NGOs working together. However, the expectations of many in the communities in the Chikankata area were increasingly that the Hospital, and not themselves, would meet many of their needs. And not only those related to HIV/AIDS, but often those related to other aspects of their lives, such as income generation, food production and schools. The management of the hospital recognised that the use of paid hospital-based community care teams was expensive and that they were increasingly unable to meet the growing workload as HIV prevalence increased. One manager said the community health care structure was being used as a 'Neighbourhood Watch Scheme' that the community used to ask for help on a wide range of community issues. The response of the hospital management

was to meet with the local leaders and communities and share their concerns that they could not continue to meet all the demands being made upon them. The result was the development of Care and Prevention Teams (CPTs) which are run by the community and not the hospital. Care and Prevention teams have the following components:

Community elects the CPT committee members

The CPT address not only health issues but general development matters

Local key stakeholders are invited to join the committee e.g. Volunteer Health Workers, business men

The local church is not forced to join, and is encouraged to take on a servant role, rather than leadership

Hospital-based staff work as team members

The CPT works with their communities to highlight and rank them according to their perceived importance. This is followed by an identification of available resources: environmental (water, roads, trees, fertile land), services (hospitals, clinics, donors, banks, schools, NGOs) and human resources (teachers, farmers, politicians, committed individuals). A shortage of money does not mean a shortage of other resources. , ,

The CPT and community agree on a management structure and plan of action to provide most of the

An influential individual from the local community, or someone particularly committed, is selected by the

The CPT then negotiates with the hospital staff to agree the assistance that can be offered by the hospital.

Above all, the CPT strategy encourages the community to take on responsibility for the provision of care.

The CPT is not only concerned with the provision of HIV/AIDS care, but also the prevention of HIV/AIDS. And their focus is on behaviour change. As care of individuals is provided, opportunities for raising awareness and then addressing the underlying issue of behaviour change in the lives of individuals and communities (see below).

To quote Dapheton Siame a member of the Chikankata management team "This is not a new way of working, but finding again our old ways of [community] working". Why HIV/AIDS is a major development issue HIV/AIDS contributes to poverty and is a product of poverty. It strikes predominantly the sexually active, who are most often the economically active, the subsistence farmers, factory workers, urban professionals or mothers and carers of the elderly. HIV/AIDS therefore impacts all aspects of development from education and women's rights to economic development programmes. So there is a need for HIV/AIDS programmes to research and act on the context within which they work. Likewise other development programmes must not ignore HIV/AIDS and the devastating undermining impact it can have on their projects. What is called for is an integrated approach.

### Integrated Approach to HIV/AIDS

For example those training traditional birth attendants or irrigation workers can highlight the need for them to address the issue of HIV/AIDS. There is also the need for HIV/AIDS programmes to be internally integrated, to approach the issue holistically in the case of each person helped. Providing practical care alone only meets physical needs of people. There are also very real emotional needs as people face prejudice and rejection, and spiritual needs as they are facing death. Care must therefore encompass counselling by appropriately trained and supported workers. Consult with, listen and act on the needs of people living with AIDS. It is they who are most in need and who can give critical insights to a programmes work. They need to be fully integrated into the programme development. Holistic care, whereby the physical, social, spiritual, economic and psychological needs of both the individual and the community are met is of paramount importance to the most effective of AIDS programmes. Such diverse needs can only be met by all those effected individuals, families, communities, government

institutions and other NGOs working together in an integrated way. Advocacy is often a new activity for Churches and Christian AIDS NGOs (non-government organisations), many of which have previously felt it best to avoid the political arena and to concentrate on care and prevention. However many Churches and NGOs are increasingly finding that they must act as advocates for PWAs and communities affected by AIDS. There are issues of justice with an absence of others to speak on their behalf. Many churches and Christian NGOs are acting as advocates for PWAs when they seek improved health care from clinics. But this has not necessarily led to planned strategies of how to respond to other advocacy needs. Issues for advocates

Develop relationships with key people and organisations

Try not to speak on behalf of PWAs and communities unless they agree

Facilitate meetings between marginalised groups and people of power

Be aware that prejudices and fears are often strong and will take time to change

Advocacy happens at many levels, local and national. From advocacy in a local clinic to national church

Orphans Case Study - Bethany Trust, Zimbabwe One of the most heartbreaking and also striking social consequences of the AIDS epidemic is the number of orphans and in many cases the increase of child-headed households. The responsibility for income and care, sometimes not only for siblings but also for their ailing parents and elderly grandparents, is falling increasingly on the shoulders of children. When assisting orphans, it is not practical and

rarely is it appropriate to restrict help to those who have lost parents due to AIDS. Be as inclusive as you are able to those orphaned from other causes, indeed to any children in need, irrespective of whether they are orphans or not. Very often children will be supporting parents who are ill and acting as their carers. To offer school fees only to those children affected by HIV/AIDS risks creating an imbalance in the community and increasing stigmatisation and prejudice. It is also important that programmes to support orphans always look to the longer term future: are they going to be able to support themselves as they grow up? Are communities going to be able to develop their own capacity to help in a sustainable way, without external funding? The principle of empowering the local community to care for their orphans has been central to the work of The Bethany Trust in Zimbabwe. Local churches and Christians are encouraged and trained to equip communities to care for the increasing numbers of children in need. Bethany will begin by discussing with communities and their orphans their needs, concerns and what possible solutions the community can identify for the challenges ahead of them. Volunteers are then trained to provide emotional and practical support for orphans. This could include guidance on planting crops to guidance on growing up. They speak to children, listen to them and then speak up for them when required. But this work is not restricted to child-headed households, but also to assisting any family that has suffered the loss of a parent. This is particularly critical for supporting the increasing number of grandparents who now act as sole carers for their grandchildren. By enabling families and communities to care for orphans and not sending them off to orphanages where they may become stigmatised (especially if it has 'AIDS Orphanage' written over the door) the children gain so much. They maintain their sense of belonging to a family and a community. This has often proven to benefit children emotionally, but also practically as they are supported in the present and learn relevant skills to survive long term in their home areas. [A similar methodology has also been repeated in Chikankata. The hospital is now moving away from providing school fees for individual orphans towards supporting the economic development of local communities and when grants are made they are for schools, not just individuals. These new initiatives are entitled not AIDS specific, but CHIN, Children in Need. This is a response headed by the local communities, that seeks to assist all children in need, not only orphans. It is an integrated approach that mobilises communities and strengthens bonds between children and their community. This reduces the stigmatisation of orphans and in particular, orphans who have lost their parents due to HIV/AIDS.] In the past people have often built orphanages as a response to the needs of orphans. But the Bethany Project has encouraged and trained communities to such an effective extent that in five years it has mobilised the care of over 6,000 orphans in the district of Zvishavane alone. Orphanages can be seen as the last safety net, but before that point is reached there is the existing family and community structures to be drawn upon. However every situation is different and in some communities other ways to support orphans have been successfully developed in locally sensitive and appropriate ways.

Summary on responding to Orphans

Involve orphans, listen to them

Empower families and communities

Support to all families in need, not only those affected by HIV/AIDS

Aim to keep children in their communities

Provide skills that will sustain families e.g. farming and income generation activities.

Refugees HIV/AIDS has been seen to spread more easily in times of instability when social practices that often protect individuals are disrupted or even broken down completely. This includes protective sexual practices. In early 2002 there were an estimated 15 million refugees in the world. Three-quarters of them in Africa and 80% were women and children. In addition there are an unknown number of displaced people who have been forced from their homes but have not crossed country borders. HIV can spread at times of social crisis and its impact is greatest in developing countries, the very countries least equipped to combat the crises. In emergency situations of mass movement, HIV often seems less important than food, shelter, water, emergency health care and security. But what are the long-term effects of not prioritising the risks of HIV transmission? Relief workers must ask the question, are displaced people at greater risk of HIV infection and should this need not also be met at the same time as the short-term issues of security, shelter and nourishment? Poverty alleviation and Income generation activities Where there is poverty AIDS seems to follow close behind. And the evidence is that AIDS thrives in areas of poverty. The red light district of Mumbai, India is full of HIV + girls whose poverty stricken families have sold them to the owners of brothels. Income Generation Activities (IGAs) can be an effective intervention for the support of individuals, families, programmes and institutions, but they must be done with care and skill, particularly in the context of HIV/AIDS. It is important to consider the abilities of PWAs in relation to their health status. It must be remembered that an individual may not always be able to work on IGAs due to poor health, and that it may be necessary to supplement IGAs with welfare grants. Furthermore, IGAs that involve the families and supporting communities of PWAs will assist in the sustainability of IGAs during periods when people are too ill to play a full part in an activity. The integration of people who are not HIV positive, or whose HIV status is not known into an economic activity may also be an opportunity to increase the acceptance and integration within the local community of PWAs. Issues for Income Generation Activities

Previous experience of IGA management is essential.

The skills required are very specific and critical to avoid wasting money and causing disappointment

The activity must be viable, there must be a market and skills available. Seek proven expert help to test

Activities have often centred on women, which can lead to increased burden rather than self-reliance. A

The need for Good Management For work of any kind to be effective, there is a fundamental need for good management. Without good management a community's needs will not be heard and motivated volunteers or the skills of professionals will be wasted. Management includes many elements but two possible sub divisions are; leadership and organising. , , Organisation, , Information is important at each stage of the programme. To begin with research and evaluation of the needs of the community in which you wish to operate will give the basic information to form a plan and develop an organisational structure. The continued gathering of information will allow monitoring and the development of the work

Research issues

What does the community say is needed?

What do those with AIDS want?

What evidence is there for this?

What resources are available in the community? Are other resources required, how are they to be obtained?

Does the church/organisation want to meet the needs identified, do they sit well within the ethos of the church/organisation?

Does the organisation have the capacity in terms of personnel, structure and resources to work with the identified needs?

Are there other organisations that are already doing all or part of the work. If so, why set up another organisation?

Visit other projects, utilise proven methods and materials. Why reinvent the wheel?

### Planning

Having identified answers to the above it is important to set objectives with key indicators i.e. measurable outcomes.

Again those affected, community, staff and volunteers should be involved.

### Monitoring

Information should be gathered and reviewed on a regular basis to monitor success or failure to meet the objectives.

Failure to meet certain goals does not mean that the programme is not succeeding but could mean so

Review meetings should also be held with those who receive the service, the community and also with

### Organisational structure

An organisational structure should be prepared and made known to all in the organisation. People ben

If volunteers are to be used ensure they are motivated

Employed staff should have relevant experience and skills

Relevant initial training is critical and should be followed by regular updates.

All staff, paid and volunteers should have a support structure and receive regular appraisals, with oppo

Clear and open financial management

### Leadership

Qualities in leadership As stated above the most effective NGO responses to HIV/AIDS have been by those organisations that have not only sought to co-operate with the community, but have sought to serve. This serving of others should be central to leadership. A leader who is humble and models service will more likely produce a team and organisation that serves others.

When leaders and managers are being selected it is good to look for proven leadership and management

A leader should be developing quality relationships within and outside of the organisation. With commu-

Good relationships will allow a leader to influence for the good and reduce the need for over directing

Instead a leader will be facilitating the skills and motivation of people to be utilised effectively.

There is a need for vision from a leader, vision that is clear and understandable by others.

The leader should have empathy with people. The ability to put themselves "in the shoes" of the people

An ability to understand (listen and reflect) and be understood (communicate well)

A manager leader will require accountability from their staff and they too must be accountable to a gov

Ultimately in all Christian leadership there should be the visible qualities of being Christ centred, biblical thinking, humility, integrity and servanthood. These qualities are more important than any technical skill or specific experience in HIV/AIDS work. Such people can help facilitate communities and individuals respond to HIV/AIDS.

Time for Action

Lists like the ones above can make people feel that they are not qualified or they have nothing they can do themselves. The MOST important thing of all is to DO SOMETHING. As said before, it costs nothing to care, and you need no organising to go and visit a neighbour in need, or to talk to your own relatives about the risks of HIV, or indeed to lend someone this book, or to get involved in an existing programme. The battle against AIDS will not be won by great programmes. It will be won as millions of ordinary men and women in every nation rise up as a people movement, determined to take AIDS seriously and to make a real difference. And as those who belong to Christ, we have a message of strength and hope as well as of health and wholeness.

You can't change the whole world but today you can change someone's world somewhere.

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