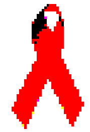
EHAIA NEWS



Newsletter of the Ecumenical HIV/AIDS Initiative in Africa

No. 2 **June 2003**

Dear Readers,
We are pleased to announce that Ayoko Bahun-Wilson has joined the EHAIA staff as regional coordinator for West Africa as from April 1 and that the EHAIA Programme is now fully operational in all four regions of Africa. Ayoko is from Togo, speaks both English and French and is stationed in Accra, Ghana. The host organisation providing office space for her is FECCIWA. You will find her address at the end of this newsletter. Please also note the changes in Ms Maingi's and Ms Dube's telephone and fax numbers as well as e-mail addresses.

Our lead article in this issue is from Dr. Manoj Kurian, WCC Programme Executive for Health and Healing.

Reclaiming the Vision: HIV/AIDS as a threat and an opportunity in achieving 'health for all'

25 years ago at Alma Ata, the World Health Organisation adopted **Primary health care** as the key method to achieve health for all. Primary health care is defined as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination". The most prominent feature of the movement was that it recognised that health was closely interlinked with improving social justice. The needs of those who were poor and powerless and least able to benefit from 'development' and the necessity of empowering people to seek and access health care were highlighted.

The Alma Ata declaration provided a great incentive for a radical rethinking about health policies, which influenced the planning, organisation and management of health sectors all over the world. There have been rapid changes in the global economic, political and social circumstances after 1978. Much has been achieved, but clearly there is a long way to go. There have been shifts in health budgets to promote more equitable distribution of health resources and expansion of services to previously under-served populations. There has been more emphasis on preventive health and great advances have been made in appropriate technology. The associated improvement in immunisation coverage has contributed to the overall decline in infant and child mortality, and marked reduction in the morbidity of many preventable illnesses the world over.

The church-related health networks sought to create primary health care systems by decentralising the training of health care workers and the delivery of health care itself. Christian communities began to train village health workers at the grassroots level. Equipped with essential drugs and simple methods, these workers were able to treat most common diseases and to promote the use of clean water and better hygienic conditions. They facilitated the introduction of small health centres that offered low-cost in-patient care, as well as prenatal and early childhood health services. In these new de-centralised health care systems, district hospitals and many Mission hospitals began to play an essential role by acting as intermediaries between local village health services and the centralised state-supported hospitals.

But much ground has been lost recently in the quest for health. This has to be seen against the background of the global geopolitical situation during the last 30 years. The economic recession that began in the 1970s accelerated in the 1980s. The benefit of recovery from the recession from the second half of the 1990s was limited to the developed economies and to some emerging ones. The new millennium is showing increased levels of poverty and greater inequalities between groups within regions and countries. The AIDS epidemic, the resurgence of communicable diseases such as tuberculosis and malaria, natural disasters, violence, civil strife and the displacement of populations have further compromised the already stretched economies and limping health services. Political changes in the 1980s and 1990s have pushed many already crippled economies of socialist countries into market capitalism.

These strengthened policies that favour market reforms have contributed to the collapse of many country health systems and hastened the impoverishment of societies. The growth in populations and rapid and unplanned urbanisation and the degradation of the environment have further worsened the health status of many. The AIDS epidemic multiplies the negative impact many times over.

How humanity faces HIV/AIDS will chart the future of many communities world-wide, for generations to come. As a result several issues become apparent: are the faith based communities, such as the congregations, the laity, the youth, the clergy, along with the health workers being mobilised sufficiently to counter the epidemic as these form the greatest resource within the community? Are the health institutions preparing the ground in anticipation of the need to "scale up" the work, as there is an increasing flow of external resources - and an even greater need? Is there synergism between HIV/AIDS programming and the existing health systems? Do the resources invested in the battle against AIDS compliment the communities' ability to access comprehensive health care?

The response to HIV/AIDS could be the pivotal issue that strengthens the primary health care response by the community.

In order for the community response to be successful, two key pillars are important: a caring and welcoming community and a community equipped to serve effectively.

There is need for communities which no longer stigmatise or discriminate against sisters and brothers, living with AIDS, and which live in solidarity with all as part of one body - the 'Body of Christ', the 'Umma' (the Islamic concept of a community) or the 'Ubantu' (the Bantu word for humanity).

These communities become caring, welcoming and healing communities with integrity and inclusive cohesion of their community as the central theme, supporting the idea of the individual's importance, and care being drawn from the community. "I am-because we are"[1]

The second pillar that becomes apparent is in communities that are both able, and willing to better serve people living with HIV/AIDS, through practical and helpful steps that make a discernible impact on their lives. They are also equipped to be professionally competent, spiritually sound/supportive and socially relevant in countering this pandemic.

Benchmarks that measure the success of the community response include advances in *Policy, Practice* and *Partnership. Policy* must promote an openness of leaders and teachers within communities as opposed to the perpetuation of a culture of silence. There must be sound preaching and teaching, recognition of core issues and policies that encourage involvement of people living with HIV/AIDS. There must be a clear *practice* that ensures that the community responds to the needs of its members. Mechanisms must be in place to address the issue consistently, the community must be involved in the planning and implementation of interventions and practice must ensure the mainstreaming of the issue into the key facets of community life. There should be a *partnership* that promotes working relationships with civil society and governments, action in synergism with other stake holders, networking and collaboration among faith-based groups; and partnering with People living with AIDS as resource people and as stakeholders.

Only the primary health care approach which empowers individuals and communities, with the knowledge and skills necessary to achieve health

[1] John Mbiti, a leading African Theologian

for themselves, will ensure that the battle against AIDS is sustained and won.

After Christoph Mann, EHAIA Project Manager, returned from the May 7-9, 2003 Partnership Consultation on HIV/AIDS, he wrote the following article:

Funding HIV/AIDS Programmes of Faith-Based Organisations

These days a frequently heard message from UN organisations involved in HIV/AIDS work is “scale up” or “go big”. And indeed the fight against HIV/AIDS can only be won if programmes cover whole dioceses, churches, communities and countries. The often very good small projects reaching only a few dozens of people are not sufficient. Yet those churches which have accepted the task that HIV/AIDS has put before them and try to mobilise all their human (employees and volunteers) and physical resources and make proposals to traditional donors, find the funds are not enough.

On the other side international organisations have recognised that faith-based organisations (FBO) can give unique access to people through church services, group meetings, and their health facilities, which form a substantial part of the national health system in many countries. Their value based systems of interaction are reconfirmed weekly through regular events within congregations and communities. Sizeable amounts of money have been made available for FBOs, only often they are unaware of this fact or find the application and administrative requirements difficult and beyond the capacities of their staff.

To bridge this gap, the World Council of Churches, Caritas Internationalis and the World Conference on Religion and Peace organised a conference in Nairobi from May 7 to 9 to improve the general understanding between international and faith-based organisations and give concrete information about the procedures required. EHAIA committed funds and staff to this important exercise. During the conference there were major presentations by staff of the Global Fund to fight AIDS, Tuberculosis and Malaria, the MAP facility of the World Bank, and the CORE Initiative executed by CARE International. These three can be briefly characterised as follows:

1. The Global Fund is refilled by member countries every year. A board, which is composed of an equal number of members from North and South as well as NGO representatives, approves proposals that have before passed a "country co-ordinating mechanism". This is a process during which government and non-government institutions agree on the activities they want to submit for funding. The resulting proposal has to have the signature of NGOs and FBOs. They also have to determine who receives the funds and how they are distributed. Thus co-operation with the civil society is clearly built into the system, but its functioning depends much on the political will and integrity of a country’s government, because in most cases a government ministry is the lead institution. In its first two rounds of approvals, 1.5 billion USD were endorsed for 153 programmes in 92 countries. But only 4 % go to FBOs. 23 % go to NGOs and 54 % to government institutions. Compared to their involvement in the fight against HIV/AIDS, few church projects are submitted and in many countries FBOs should make serious efforts to become part of their country co-ordinating mechanism. Details can be found under www.globalfundatm.org During the conference it was gratifying to see that representatives of various faiths from the same country spontaneously called first meetings to exactly plan better access of FBOs to the Global Fund.
2. The Multi-Country HIV/AIDS Program for the Africa Region (MAP) of the World Bank has made available 550 million USD to countries in Africa so far. It operates through the National Aids Council existing in most countries. Within the guidelines of MAP these councils set up the local criteria of fundable projects and the approval mechanism. Thus FBOs can submit their own proposal without co-ordinating it first with government and other players in a lengthy process. In addition, the decision-making body is within their country and thus accessible to them. MAP is also making efforts to be accessible for small organisations through simplifying administrative procedures for small projects from civil society organisations. For FBOs much depends on the efficiency and commitment of

the national government to make use of their resources and abilities. Extensive documentation isavailable under www.worldbank.org/afr/aids/map.htm

3. The CORE Initiative is a USAID-funded global programme to strengthen the responses

   of community-based organisations and FBOs to HIV/AIDS. It was awarded to CARE International, which is using a consortium of five organisations for execution. WCC is one among the five and plays the role of advisor. One of CORE's major strategies is filling a gap found frequently by FBOs just starting their involvement: small grants of up to 5000 USD. The exact conditions of approval still need to be worked out until the official launch of this programme during the ICASA meeting in Nairobi in September. Interested FBOs should observe www.coreinitiative.org

These three sources of funding large or small projects represent by no means all opportunities that exist. There are other UN organisations such as WHO, UNDP or UNICEF who give funds directly for certain types of activities. In addition there are also private foundations. Presently the time to approach them is a good one, because they all seek contact with FBOs. But it does mean that churches have to leave their circle of traditional donors, go out to the market of possible offers in their country, seek professional help from outside if necessary to write proposals and/or manage the approved funds, and show the necessary integrity and transparency to make the money reach those for whom it is intended. It is part of EHAIA's mandate to assist in this process, if necessary links are outside reach or if bundling of efforts between ecumenical partners is necessary for better success. Churches should not hesitate to approach their regional co-ordinator for assistance (see addresses in this newsletter)

The WCC EHAIA co-ordinator from Central Africa, Hendrew Lusey-Gekawaku, has sent us two examples from his region which illustrate positive and negative attitudes by churches affecting people's lives.

People living with AIDS as resources and the involvement of the Cameroon Baptist Convention in the fight against HIV/AIDS

The HIV/AIDS epidemic is demanding all of us to encourage scientific progress, find more effective ways of moving the governments and faith-based institutions of this world to undertake positive actions for their own people and believers, support better ways of caring for each other, and ensure that others don't have to endure the nightmare. For two decades, religious communities in Africa felt that HIV/AIDS should be considered as "the valley of the shadow of death". Today, one hopes, most of them would agree that HIV/AIDS is ultimately a spiritual journey. The reality of HIV/AIDS in its various manifestations is still causing everyone concern since science, law, sociology, politics, psychology and even medicine do not in themselves provide answers to the spiritual dilemmas that are related to HIV/AIDS. That is why the Cameroon Convention Baptist (CBC) undertook actions on preventive treatment and curative health care as well as scientific research in the field of HIV/AIDS.

The following story focuses on the prevention of mother-to-child transmission programme of CBC. In 2002, the Prevention of Mother-to-Child Programme was operational in 66 sites where 11,881 women received Antenatal clinic services and were pre-counselled for HIV screening. Of this number, 805 (7%) women refused to go for HIV testing for many reasons, including the stigma of being found HIV positive and the subsequent denial of this diagnosis by their husbands. However, 11,088 women (93%) accepted. Still 91 of the 11,088 women were left destitute without receiving post-counselling for many reasons such as: long waiting time, long distance from home, impatience and fear of what others will say if they happened to be HIV positive. Of the 11,088 pregnant women tested 1,056 were tested positive.

4,760 deliveries took place in 66 sites. 365 HIV positive women and 348 babies were treated with Nevirapine that was given to the church leaders after many advocacy efforts. About 191 babies are listed for follow-up. Since some husbands accompany their wives during the antenatal clinics, CBC personnel encourage them to undertake HIV testing. In 2002, 121 husbands were screened and most of them were found HIV negative.

The Prevention of Mother-to-Child Transmission of CBC is being expanded to villages by including trained traditional birth attendants to handle the programme at the grassroots level. Because of its expertise and credibility, CBC has been chosen by the Cameroon government to lead and expand the Prevention of Mother-to-Child Transmission within five other institutions -the Government, Catholic, Presbyterian, PAMOL and CDC health facilities.

Lessons learnt

1. The Cameroon Baptist Convention deserves encouragement and attention since the CBC has been recognised by the government and the population at large as one of the main key players in the field of HIV/AIDS.
2. For such a programme to be successful, among other contributing factors, training at all level is a prerequisite.
3. Such training must be followed by incentives and commitment from the church's side that the right number of right personnel with appropriate skills are available at the right place and time.
4. The director of health has considerable experience that helps both the church and the government programme. However, he is overloaded with work and responsibilities.
5. Time has come now for government and faith-based institutions to network for fruitful collaboration and partnership rather than to regard each other with suspicion.

When the Church is ill-equipped to address the HIV/AIDS crisis

In Africa, churches are among the few institutions that have large numbers of people gathering on a regular basis, within a common set of altruistic values and valid system of communication in the congregation. And yet, some churches fail to use this opportunity to accurately inform and sensitise their audience about the HIV/AIDS crisis. With a spiritual support system from their congregations, churchgoers are expected to enlighten and help people living with HIV/AIDS in a creative, efficient and loving way to ease the burden caused by HIV/AIDS. However, the following story demonstrates how much harm is being done to persons with HIV/AIDS by segments of African religious leaders and laity.

Dr Peter NGE (not a true name) has been trained as medical doctor in his home country for six years. After completing his training, he worked as a general practitioner at the Central Hospital of the capital city for a short time before testing HIV positive. When his condition became known he was rejected, discriminated and stigmatised by his own relatives and friends, and he finally decided to go back to his home village where he would die peacefully and with dignity.

However, the news about his status reached his village beforehand. On his arrival, the local religious leader, laity and the local administrative authorities launched a campaign of hate, bigotry and discrimination against him. Dr Peter was denied the ability to live in the same village with the entire community. This decision was taken in order to avoid the spread of HIV/AIDS to other people.

On the church side, Dr Peter NGE was considered "intrinsically evil and sexual promiscuous" because he was living with HIV/AIDS. Therefore, church leaders and laity felt that he deserved AIDS. Consequently, nobody was allowed to visit and give him relief. Dr Peter NGE died within a short span of time. Church leaders and the local administration authorities decided to bury him in the forest away from the ordinary cemetery. This, they felt, would prevent the spread of HIV to other people living in the area and those already dead. Dr Peter NGE is buried alone in the forest because of ignorance and stigma attached to HIV/AIDS in that congregation.

It is completely understandable that some individuals want to distance themselves from the "church" because of the acute pain inflected on them by church leaders who condemn them to hell.

With the advent of HIV/AIDS, time has now come for us to re-examine what faith means for us, how we find it, how we could nurture and share it with people living with HIV/AIDS. Indeed, homophobic campaigns of hate, racism, bigotry and discrimination have caused serious damage to the hearts and souls of people already stigmatised by a fatal disease. In the end, it is the way the churches are handling the HIV/AIDS crisis which determines whether they are churches of Jesus Christ or not. A quote from the *Colour of Light*, a helpful AIDS meditation from Hazelden Press, says: "the real test is not whether faith makes more sense than fear. The real test is how our lives change. Is life better when we trust in a

force for good?" In Africa, a substantial commitment from churches to the spiritual journey for those infected or affected is needed right now. Tomorrow will be too late.

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